Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

**Board of Directors**
**To be held on Tuesday 24 September 2019 at 9:15am**
**in the Boardroom, Fred and Ann Green Board Room, Montagu Hospital**

# AGENDA

| | | LEAD | ACTION | TIME / ENC |
|---|---|---|---|---|
| **A** | **MEETING BUSINESS** | | | **9:15** |
| A1 | Apologies for absence | SBE | Note | Verbal |
| A2 | Declarations of Interest<br><br>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. | SBE | Note | Verbal |
| A3 | Actions from previous meeting | SBE | Review | A3 |
| **B** | **PRESENTATION (15 minutes for presentation, 10 minutes for questions)** | | | **9:25** |
| B1 | DBTH Teaching Hospital phase II – Research<br>Julie Bury – Research Fellow<br>Suzanne Bolam – Head of Clinical Therapies<br>Sam Debbage – Deputy Director of Education | DP / KB | Note/ Discuss | Verbal |
| **C** | **STRATEGY** | | | **9:50** |
| C1 | Mental Health Strategy | DP | Approve | C1 |
| C2 | Hospital Services Programme – Final Report | RP | Note | C2 |
| C3 | Bassetlaw Place Plan - Update<br>Nicole Chavaudra - Programme Director, Bassetlaw CCG<br>http://www.betterinbassetlaw.co.uk/about-better-in-bassetlaw/better-in-bassetlaw-place-plan-2019-2021 | NC | Note | C3 |
| C4 | Council Motion on Climate & Biodiversity Emergency | RP | Approve | C4 |

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| **BREAK** | | | | **11:00** |
| **D** | **QUALITY, PERFORMANCE AND SAFETY** | | | **11:15** |
| D1 | Quality and Performance Report | RJ | Note | D1 |
| **E** | **CAPACITY AND CAPABILITY** | | | **11:35** |
| E1 | People and Organisational Development Update - Leadership Development, Staff Experience, Freedom to Speak Up | KB | Note | E1 |
| E2 | Business Case for Emergency Department Staffing<br>Dr Nick Mallaband - Divisional Director<br>Kate Carville - Associate Director of Nursing | NM<br>KC | Approve | E2 |
| E3 | Pensions – NHS Employers Guidance and Update on Consultation Proposals | KB | Decision | E3 |
| **F** | **FINANCE AND CONTRACT MATTERS** | | | **12:10** |
| F1 | Finance Report - 31 August 2019 | JS | Note | F1 |
| F2 | Use of Trust Seal | RP/JR | Note | F2 |
| F3 | Chairs Assurance Logs for Board Committees<br>Quality Effectiveness Committee 21 Aug 2019<br>Finance and Performance Committee 20 Sept 2019 | PD/NR | Note | F3/<br>To<br>Follow |
| F4 | Pharmacy Subsidiary – Governance | JS | Note | F4 |
| **G** | **GOVERNANCE AND RISK** | | | **12:35** |
| G1 | Board Assurance Framework and Corporate Risk Register – Refresh | JR | Note | Verbal |
| **H** | **INFORMATION ITEMS (To be taken as read)** | | | **12:45** |
| H1 | Chair and NEDs' Report | SBE | Note | H1 |
| H2 | Chief Executive's Report | RP | Note | H2 |
| H3 | Minutes of the Management Board, 15 July 2019, 12 August 2019 | RP | Note | H3 |
| H4 | Minutes of the Quality Effectiveness Committee, 17 June 2019 | PD | Note | H4 |
| H5 | Minutes of the Finance and Performance Committee, 21 June 2019, 23 July 2019 | NR | Note | H5 |

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| H6 | Board Work Plan | JR | Note | H6 |
| **I** | **OTHER ITEMS** | | | **12:45** |
| I1 | Minutes of the meeting held on 30 July 2019 | JR | Approve | I1 |
| I2 | Any other business (to be agreed with the Chair prior to the meeting) | SBE | Note | Verbal |
| I3 | **Governor questions regarding the business of the meeting** | SBE | Note | Verbal |
| I4 | Date and time of next meeting:<br>**Date: 29 October 2019**<br>**Time: 9.15am**<br>**Venue: Board Room, Doncaster Royal Infirmary** | NR | Note | Verbal |
| I5 | **Withdrawal of Press and Public**<br>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** | | | | **13:00** |



**Suzy Brain England**
**Chair of the Board**

Action notes prepared by: Jeannette Reay
Updated: 19/09/2019

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

# Action Log

A3

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| **Meeting:** | Public Board of Directors |
| **Date of latest meeting:** | 30 July 2019 |

| KEY | |
|---|---|
| **Completed** | **On Track** |
| **In progress, some issues** | **Issues causing progress to stall/stop** |

| No. | Minute No. | Action | Lead | Target Date | Update |
|---|---|---|---|---|---|
| **1.** | **19/3/21** | **Living Wage** - Set Aspiration to sign up to the living wage and discuss this at ISC/PLACE level. | **KB** | **October 2019** | Progress - Initial discussions held at ICS HR Directors – only Sheffield Health and Social Care Trust had signed up to Living Wage Foundation. This matter to be explored further when all HRD's present. |
| **2.** | **P19/7/5** | **Complaints and Concerns** - Information, including themes, on complaints and concerns for children and young people would be included in future Quality and Performance reports. | **DP** | **September 2019** | Close – included in the Quality and Performance report. |
| **3.** | **P19/7/5** | **Complaints and Concerns** - A review of complaints and concerns – including a response to Internal Audit recommendations – would be provided to a future meeting of the Quality and Effectiveness Committee. | **DP** | **October 2019** | Close – Included on the QEC work plan for October 2019. |
| **4.** | **P19/7/8** | **Board Assurance Framework and Corporate Risk Register** - An update on progress to refresh the Trust's Risk Management processes, including the Corporate Risk Register and Board Assurance Framework, and would be provided to the Public Board meeting in September 2019. | **JR** | **September 2019** | An update to would be provided to the September 2019 meeting. |

Action notes prepared by: Jeannette Reay
Updated: 19/09/2019

| No. | Minute No. | Action | Lead | Target Date | Update |
|---|---|---|---|---|---|
| **5.** | **P19/7/10** | **WRES and WDES** - A workshop to develop the Trust's approach to meeting and improving WRES and WDES would be undertaken. | **KB** | **December 2019** | Progress - Internal WRES and WDES action plans being developed. |
| **6.** | **P19/7/11** | **Learning Lessons to Improve our People Practices** - A progress update would be provided to a future meeting of the Quality Effectiveness Committee. | **KB** | **October 2019** | Close – Included on the QEC work plan for December 2019. |
| **7.** | **P19/17/12** | **Estates and Facilities Report** - Information on the response times for requests for wheelchairs would be provided to a future meeting of the Quality Effectiveness Committee. | **KEJ** | **October 2019** | Close – Included on the QEC work plan for October 2019. |
| **8.** | **P19/7/19** | **Virtual Meetings** - The potential to improve the Trust's systems for streaming and conference calling meetings between the Trust's three sites would be examined. | **KA** | **October 2019** | |

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Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

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|---|---|---|---|
| **Title** | **DBTH Mental Health Strategy** | | |
| **Report to** | **Board of Directors** | **Date** | **24th September 2019** |
| **Author** | **David Purdue, Director of Nursing, Midwifery and AHPs** | | |
| **Purpose** | | | Tick one as appropriate |
| | Decision | | X |
| | Assurance | | |
| | Information | | |

**Executive summary containing key messages and issues**

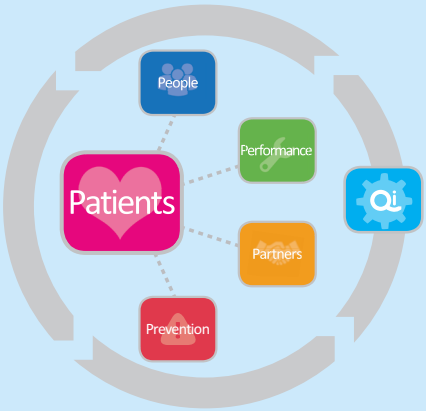
Mental health service improvement is a national priority, particularly focusing on crisis care, perinatal mental health, children and young people, better access to psychological therapies and parity of esteem (giving equal value to mental and physical health). Building on the NHS Mandate, NHS England has published the Five Year Forward View and the NHS Long Term Plan. The long term plan builds on the mental health five year forward view.
Many patients in DBTH have mental health needs which need addressing if we are to achieve high quality care and good clinical outcomes.
DBTH provides services for people who are particularly vulnerable or present a high risk.
People with a mental health problem or a learning disability tend to experience poorer physical health and die younger than other people.
DBTH has organisational development needs to support the improvement of mental health care which include training, practice development, communication and partnership working.

**Key questions posed by the report**

The Mental Health Strategy has been developed:
To achieve high quality patient care and good healthcare outcomes DBTH must be capable of understanding and responding to the mental health needs of the people who use its services.
At its most fundamental level this is achieved through the humanity of care exercised in the multitude of interactions that take place between service users and staff.
Moving beyond the generic are the particular needs of people with a mental health problem or a learning disability who require the support of staff with specialist skills and the development of services that have the capacity to provide effective physical and mental health care.
It is important to acknowledge that people with a mental health problem or a learning disability are

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|---|
| subject to widespread prejudice and disadvantage that contribute to their unequal access to services, treatment and health outcomes |
| **How this report contributes to the delivery of the strategic objectives** |
| The mental health strategy forms part of the clinical strategy and is essential to achieving of True North Objectives, specifically, CQC Outstanding. |
| **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 |
| **Recommendation(s) and next steps** |
| The Board is asked to support the implementation of the mental health strategy |

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# Doncaster and Bassetlaw Teaching Hospitals

## Mental Health Strategy







# A word from

## **David Purdue**, Director of Nursing, Midwifery and Allied Health Professionals




**Mental health service improvement is a national priority, particularly focusing on crisis care, perinatal mental health, children and young people, avoiding inappropriate out of area admissions, ending inappropriate use of police intervention, better access to psychological therapies and parity of esteem (giving equal value to mental and physical health).**

Building on the NHS Mandate, NHS England has published the Five Year Forward View and the NHS Long Term Plan. The long term plan builds on the mental health five year forward view.

Over the next 10 years, NHS 111 will be established as the single point of contact for those experiencing a mental health crisis. There will also be a new Mental Health Safety Improvement Programme, with a focus on suicide prevention. Milestones for mental health services for adults:

- New and integrated models of primary and community mental health care will give 370,000 adults and older adults with severe mental illnesses greater choice and control over their care and support them to live well in their communities by 2023/24.
- By 2023/24, NHS 111 will be the single, universal point of access for people experiencing mental health crisis. There will also be an increase in alternative forms of provision for those in crisis, including non-medical alternatives to A&E and alternatives to inpatient admission in acute mental health pathways. Families and staff who are bereaved by suicide will also have access to post crisis support.
- By 2023/24, the wider health service will introduce mental health transport vehicles, introduce mental health nurses in ambulance control rooms and build mental health competency of ambulance staff to ensure that ambulance staff are trained and equipped to respond effectively to people experiencing a crisis.

Many patients at Doncaster and Bassetlaw Teaching Hospitals (DBTH) have mental health needs which need addressing if we are to achieve high quality care and good clinical outcomes. DBTH provides services for people who are particularly vulnerable or present a high risk.

People with a mental health problem or a learning disability tend to experience poorer physical health and die younger than other people. They also experience ignorance, prejudice and discrimination which may result in their health needs being misdiagnosed or missed altogether.
There are examples of good practice in the promotion, prevention and intervention of mental health needs across DBTH, but as a Trust we have organisational development needs to support the improvement of mental health care which include training, practice development, communication and commissioning.

This Mental Health Strategy is aligned to our over arching strategic direction and fits with our vision and our True North objectives which can be viewed on the next page.

**David Purdue**

Director of Nursing, Midwifery and Allied Health Professionals



# Our vision and 'True North'

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## Our vision
And **how we make it reality**

**To be the safest trust in England,** outstanding in all that we do.

## Our mission

As an acute teaching hospital trust, a **leading partner** in health and social care across South Yorkshire and Bassetlaw, we will work with our **patients**, **partners** and the **public** to maintain and improve the delivery of high quality intergrated care.

## Strategic objectives

Patients | People | Performance | Partners | Prevention | Qi

## True north objectives

- **Objective one:** Achieved and maintained CQC oustanding.
- **Objective two:** 100% of staff know how to contribute to vision.
- **Objective three:** In top 10% for staff and patient feedback.
- **Objective four:** The Trust is in recurrent surplus.

## Breakthrough objectives

- **Objective one:** Achieve CQC good rating.
- **Objective two:** Level one of Qi roll-out (train 40 practice and 30 kata coaches).
- **Objective three:** Higher than average for staff and patient feedback.
- **Objective four:** Achieve control total in financial year.

We care

## Key Trust publications

Access the latest Trust publications using the links below:

**Strategic Direction and enabling strategies** for 2017-2022

**Annual report** 2018/19






# Introduction and Context

**The development of our Mental Health Strategy for 2019 - 2021 has been informed by a number of strategies and directives.**

These pieces of guidance include:

- A literature review including national guidance – in particular the Five Year Forward View for Mental Health- NICE and good practice evidence and the Long Term Plan.
- A review of what service users and carers have said about what is important to them following our System Perfect week in April 2019
- Key public health messages about mental health problems and our local population
- The views and needs of our local commissioners
- The expertise and knowledge of our local Mental Health providers and;
- Our vision and values as an organisation.

## Engagement

To develop our approach and identification of key priorities, discussions have been held with commissioners, clinical leaders and managers, Trust Governors, service users and representatives within our Children and Young People's Services, Adults and Older Adults Services.

**Why mental health matters?**

DBTH is the major provider of hospital-based healthcare for the adults of Doncaster, Bassetlaw and the surrounding areas. Most of the services we provide focus upon an illness group, or type of injury and consequently the emphasis of DBTH is that of physical health. However, physical health is not independent from other aspects of wellbeing and it is now widely recognised that physical and mental health are fundamentally linked: Perceptions of the relationship between physical and mental disorders have changed. This has been a key development.

It is now widely acknowledged that this relationship is complex, reciprocal and acts through multiple pathways. Untreated health disorders result in poor outcomes for co-morbid physical illnesses. Individuals with health disorders have an increased risk of suffering from physical illness because of diminished immune function, poor health behaviour, noncompliance with prescribed medical regimens and barriers to obtaining treatment for physical disorders.

Individuals with chronic physical illness are significantly more likely than other people to suffer from health disorders.

1). The occurrence of physical and health conditions at the same time is common.

2). It is evident therefore that in order to achieve high quality patient care and good healthcare outcomes DBTH must be capable of understanding and responding to the mental health needs of the people who use its services. At its most fundamental level this is achieved through the humanity of care exercised in the multitude of interactions that take place between service users and staff.

Building on this foundation and moving beyond the generic are the particular needs of people with a mental health problem or a learning disability who require the support of staff with specialist skills and the development of services that have the capacity to provide effective physical and mental health care.

However compelling the experience of the people who use DBTH services, and the research, national guidelines and legislation that underpin this strategy, it is important to acknowledge that people with a mental health problem or a learning disability are subject to widespread prejudice and disadvantage that contribute to their unequal access to services, treatment and health outcomes.



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# Development of Strategic Intentions

**The Mental Health Strategy intentions were developed following the week long system perfect completed on the 2nd of April 2019. The week was run supported by numerous social media and communication campaigns to address the needs of patients with mental health, learning difficulties and those with a dependency issue, who present to DBTH.**

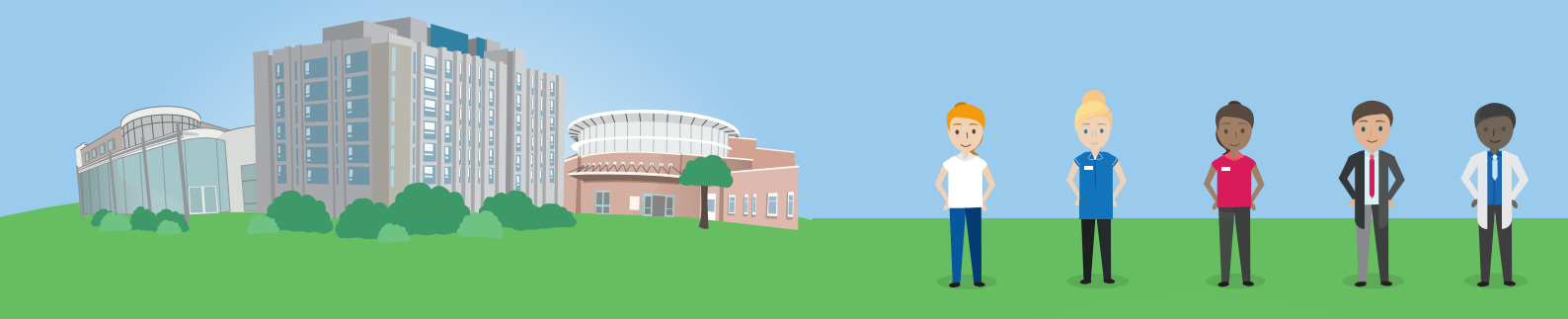
Throughout the project, there was a commitment between partners to continue to work closely together to identify areas for improvement and to further engage with staff and the public to provide even greater insight to inform this strategy development. The organisations involved in development of this strategy are:

- Doncaster and Bassetlaw Teaching Hospitals (DBTH)
- Nottinghamshire Healthcare Foundation Trust
- NHS Doncaster Clinical Commissioning Group
- NHS Bassetlaw Clinical Commissioning Group
- Rotherham, Doncaster and South Humber Foundation Trust (RDaSH)
- ASPIRE, Project 3
- Fylde Coast Medical Services (FCMS)
- Primary Care Direct (PCD)
- Healthwatch Doncaster
- Doncaster Metropolitan Borough Council (DMBC)
- Peoples Focussed Group (PFG)- Doncaster
- Change, Grow, Live (CGL)
- BCVS
- East Midlands Ambulance Service
- MIND
- Yorkshire Ambulance Service (YAS)

The key findings from the media campaigns, service user feedback and surveys were:

- The majority of patients did not know what mental health (MH) services where available in the area. This was a consistent message throughout the feedback
- The majority of patients stated that their first port of call if they needed MH support would be to visit their GP
- The majority of patients stated that they would access their GP for information on MH services
- Some people said that they would talk to their family and friends about how to get help in a crisis.
- A large % of patients stated that they would look for information on the internet for information on MH issues
- 40% of all patients who attended ED with a mental health need where known to community mental health services
- Individuals use ED due to not being able to get a GP appointment
- Individuals attend due to not getting the outcome expected from the community services
- Police bring individuals to ED and do not follow protocol
- Services do not understand the pathway for individuals with a diagnosed or suspected mental health issue.

In order to address the issues raised from the local surveys and National publications the following strategic intentions have been developed.



# Our Strategic Intentions: What we intend to do

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## **Effective** and **compassionate help**

- Evidence-based and responsive care delivered through clearly described pathways
- Focussed on providing safe, effective services that consistently achieve outcomes which are meaningful to service users
- All services represent a "centre of excellence"
- in line with best practice
- Move towards all core 24 standards

## **Supporting** our **staff**

- Recruiting and retaining skilled and compassionate staff
- Developing new roles and innovative approaches to Joint mental/physical health workforce planning
- Valuing, training and engaging staff to enable creativity, innovation and effective service delivery
- Building strong clinical and managerial leadership, a quality improvement and research culture.

## **Working with service-users** and **carers**

- Engagement with service users and carers guiding the development of our services.
- Developing supported self management models of care and support for carers.



## **Good experience** of **treatment** and **care**

- Personalised care supporting individual choice, independence, recovery and quality of life.
- Both physical and mental health needs of service users are assessed and responded to in an integrated way.



## **Straightforward access** to **services**

- People can access our services without discrimination or stigma where they live, learn and work
- Effective and integrated urgent care coordinated around service users and their families
- Using technology to provide more online and telehealth services where this makes sense.



## **Working with partners** and **communities**

- Effective partnerships with our Mental Health-care Providers, primary care, social care and voluntary sector organisations
- Ensuring mental health is a core part of integrated locality services and local system initiatives and wider sustainability and transformation plans
- Supporting development of prevention, early intervention, and peer support services .



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# Implementation planning

This summary strategy document will be supported by implementation plans within our major services.

- Adult Mental Health
- Child and Adolescent Mental Health Services (CAMHS)
- Learning Disabilities
- Dementia
- Autism

These plans, including existing and new initiatives, will be completed by November 2019. They will reflect the importance of partnership planning with commissioners and other providers to achieve a joined up experience for people who use services, along with effective use of resources within our two place plans.

We will work with partners to ensure effective engagement of service users and carers in our implementation, which will be supported by a communication and engagement plan to facilitate engagement of our staff, commissioners and partner providers. DBTH is part of the South Yorkshire and Bassetlaw Integrated Care System (ICS).

We will continue to actively contribute to these plans, seeking to ensure that mental health is embedded throughout, that specific targets are included and achieved, and the needs of people with serious mental illness are addressed.

## Strengths to build on

- Our organisational reputation, and good relationships with both commissioners, councils and Mental Health Providers
- Our existing strategies and governance for Learning Disabilities and Autism
- Our innovative approach to Dementia and jointly managed Older Peoples Mental Health Team
- Our engagement with people who use our services and carers in the Trust

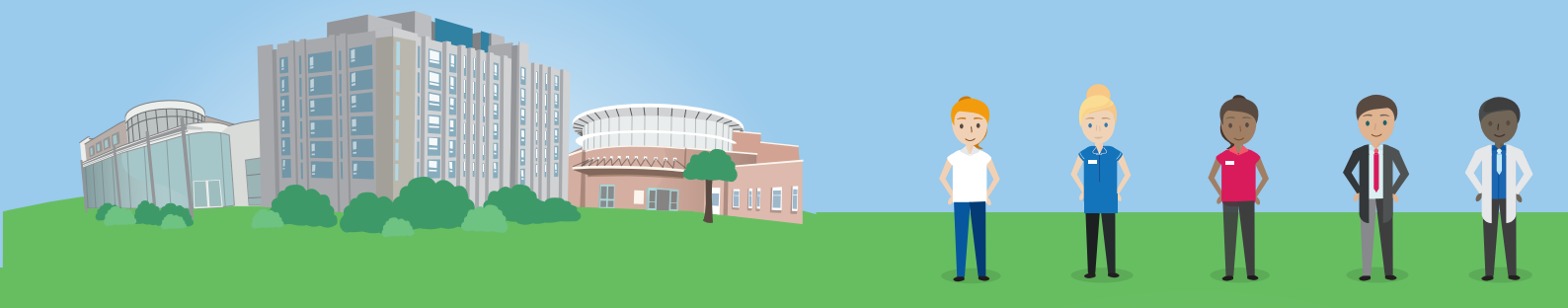
## Risks

Key risks and issues affecting implementation will be included in our plans. A number have been identified due to the complexity of commissioning across 2 CCGs and Mental Health Care Providers.

## Governance

The strategy implementation is the responsibility of the Director of Nursing. The progress against the strategy will be monitored through the Quality and Effectiveness Committee, as a standard item on the agenda.

This strategy will form part of the supporting clinical strategy.



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# Doncaster and Bassetlaw Teaching Hospitals

## NHS Foundation Trust

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**C2**

| | | | |
|---|---|---|---|
| **Title** | **Hospital Services Programme – Final Report** | | |
| **Report to** | **Board of Directors** | **Date** | **24th September 2019** |
| **Author** | **Richard Parker, Chief Executive** | | |
| **Purpose** | | | Tick one as appropriate |
| | Decision | | |
| | Assurance | | |
| | Information | | X |

**Executive summary containing key messages and issues**

**This report has been provided to the Governing Bodies of CCGs in South Yorkshire, Bassetlaw and Derby for consideration and agreement,**

**And**

**To the Boards of Foundation Trusts in South Yorkshire and Bassetlaw and Chesterfield for discussion.**

The recommendations in the report relate to acute providers in SYB and Chesterfield, and their commissioners, but exclude Mid Yorkshire which is part of the West Yorkshire STP.

This paper is therefore for discussion by the Governing Bodies of Barnsley, Bassetlaw, Derby and Derbyshire, Doncaster, Rotherham and Sheffield CCGs.

**Process of discussion by Foundation Trust Boards**
The paper is being shared with the acute providers, for discussion at Board of Directors' meetings.

**Summary of key issues**

Over the last two years, the South Yorkshire and Bassetlaw (SYB) health and care system has been considering how best to support the long term sustainability of acute hospital services in South Yorkshire and Bassetlaw (SYB), Mid Yorkshire and North Derbyshire (SYB(MYND)). Analysis of the options has now been completed, and have been discussed by Accountable Officers and the CEOs and Medical Directors of the acute providers.

In summary, system leaders concluded that:

- The system was strongly supportive of the approach to shared working between the Trusts.
- Work should go forward as quickly as possible on developing the Hosted Networks, as an important vehicle for transformation going forward.
- The transformation agenda should continue to go forward, in particular with a focus on strong workforce planning across the system, and development of new models of care and patient pathways, through shared working. This approach of collaboration was strongly supported by public engagement. Since it cannot be guaranteed that transformation will address all of the challenges, and unplanned workforce issues may arise, a monitoring system with early warning signals should be put in place at a system level.
- Reconfiguration was a more complex decision, but in summary the group agreed that reconfiguration itself carried a risk of unsettling the workforce and thereby destabilising the system. The group felt that reconfiguration should only be taken forward if there was an immediate risk of safety issues or immediate sustainability issues that would justify it, as had been the case at Bassetlaw in 2016. The group discussed paediatrics services at Bassetlaw. Clinicians consider that the Bassetlaw paediatrics service has been sustainable since the changes made in January 2017, with no detriment to clinical outcomes and no complaints related to the new model of care. However the underlying challenges with staffing that led to the original concerns at Bassetlaw have not been resolved, as shown in the modelling around the shortfall of workforce across the system, and ongoing recruitment challenges since 2017. These are exacerbated by Bassetlaw's geographical position which makes it more difficult to rotate staff across sites or build a locally-recruited workforce. It was felt to be unlikely that transformation alone would be able to improve the sustainability of Bassetlaw enough for it to return to running an overnight inpatient unit. The CEOs and AOs supported Bassetlaw CCG and Doncaster and Bassetlaw Teaching Hospital in continuing to test potential partnership working with Sheffield Children's Hospital as a way to strengthen services, but that it was not likely that this would be sufficient to support a reopening of overnight inpatient paediatric services. The report also invites the Bassetlaw commissioners, working with the Trust, to consider transformation and reconfiguration options for maternity services.
- Public engagement: Any proposed permanent change to services will need to go through public engagement, and (following discussion with the relevant Overview and Scrutiny Committee) the CCG may consider formal consultation with patients and the public. The timing of such a consultation and other issues that may also be included in a consultation process are matters for the CCG to consider.

| Key questions posed by the report |
| --- |
| The Board of Directors is asked to note the report. |
| How this report contributes to the delivery of the strategic objectives |
| Partners: We will increase partnership working to benefit people and communities. |
| How this report impacts on current risks or highlights new risks |
| All. |
| Recommendation(s) and next steps |
| The Board of Directors is asked to discuss and note the report. |

Health and care working together in South Yorkshire and Bassetlaw



Hospital Services Review

# South Yorkshire, Bassetlaw and North Derbyshire: Considering the case for change

## Report for Governing Bodies

June 2019

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# 1 Executive Summary

## 1.1 Introduction

Over the last two years, the South Yorkshire and Bassetlaw (SYB) health and care system has been considering how best to support the long term sustainability of acute hospital services in South Yorkshire and Bassetlaw, Mid Yorkshire and North Derbyshire (SYB(MYND)). This work has considered how far the system can address the challenges that it is facing through transfiguration, based on developing shared working between the Trusts within the current configuration of services, or whether the challenges of maintaining the current configuration of services is too great and change is needed to the configuration of services. The work has focused on five services which are amongst the most challenged in SYB.

Analysis of the options has now been completed, and Governing Bodies of Clinical Commissioning Groups are asked to take a decision on whether they believe that the system should continue with a focus on transformation; or whether, in addition, we should invite any of the Governing Bodies to take forward public consultation on reconfiguration.

Under the current legal accountabilities in the system, Governing Bodies are legally responsible for considering the impact on their own CCG's population. As members of the South Yorkshire and Bassetlaw Integrated Care System, the Governing Bodies are also asked to consider the issues as they impact on the sustainability of SYB(ND) as a whole, and the JCCCG will consider this under its delegated powers to discuss the Hospital Services Programme.

## 1.2 Background

In 2017 the SYB system, together with Mid Yorkshire and North Derbyshire, agreed to undertake a Hospital Services Review (HSR) to look at options for improving long term sustainability.

The HSR published its final report in May 2018, and the recommendations were considered by the system. The provider and commissioner organisations in SYB and North Derbyshire (Mid Yorkshire is focusing on working within its own STP area) considered these and published a Strategic Outline Case (SOC) in October 2018. The SOC laid out three areas of work for the system to take forward, the outcome of which is laid out in this report:

- **Hosted Networks:** Developing the infrastructure to support shared working between organisations, supported by a centralised workforce function and Innovation Hub;
- **Transformation:** Developing potential workforce and service models to look at making better use of the existing SYB workforce, and developing new roles;
- **Changing the clinical model:** Modelling and exploring more sustainable options for the delivery of paediatrics, maternity and out-of-hours gastrointestinal bleeds across SYB(ND).

## 1.3 Summary of the Case for Change

### 1.3.1 Paediatrics:

- **Quality:** All Trusts meet at least 7 Facing the Future (FT) Standards, with one Trust (Barnsley) meeting all 10 standards. The most common Facing the Future standards that Trusts are struggling to meet are those around workforce. In the most recent CQC assessments, all SYB(ND) Trusts achieved 'Good' Care Quality Commission (CQC) scores for Children and Young People[1], with the exception of Barnsley, which received a 'Requires improvement' score. Barnsley Hospital believe their 'Requires improvement' score may have been in large part due to a one-off event which has since been resolved.
- **Workforce**: There are significant staff shortages for middle-grade and junior doctors. Clinical Working Group (CWG) participants commented that consultants and nurses often work extra shifts in order to fill these gaps. One symptom of the extent of the pressure was that staff reported examples of study leave being declined across Trusts due to workload pressures, sometimes as a systematic approach for a period of weeks or months.
- **Interdependencies**: Rotherham, Doncaster, Bassetlaw and Barnsley have all experienced challenges in meeting the CQC standard of having two paediatric nurses present in their Emergency Department (ED) 24/7. Rotherham received an 'Inadequate' score in the last CQC inspection of its ED and Doncaster and Bassetlaw a 'Requires Improvement'.

### 1.3.2 Maternity

- **Quality**: In the most recent CQC Maternity assessment, Doncaster & Bassetlaw and Rotherham both scored Requires Improvement. All the Trusts meet Better Births standards.
- **Workforce**: All of the Trusts are currently meeting Royal College guidelines on consultant numbers and ratios of midwives to patients. The main concern is the medium term as a significant proportion of midwives are approaching the pensionable age of 55, so significant numbers are likely to retire.
- **Interdependencies**: The main interdependencies for maternity are neonatology and anaesthetics. Bassetlaw is struggling to maintain mid-grade rotas for both of these specialties.

### 1.3.3 Gastroenterology and endoscopy

- **Quality**: Considering the CQC Medical Care (incl. Gastroenterology) score, only Rotherham has a score that 'Requires Improvement.'
- **Workforce**: Rotherham has had a period of having no gastroenterologists although it is in the process of recruiting some posts jointly with Barnsley, with one substantive appointment made so far. Clinicians report that workloads have increased significantly owing to increased referrals for cancer screening.
- **Interdependencies**: The pressure on endoscopy services is contributing to poor performance on cancer waiting times in some Trusts.

[1] CQC, Inspection reports, 2016 - 2019

## 1.4 Proposed models

The options to address the challenges have been developed through studying existing case studies across the UK and working with SYB clinicians through the Clinical Working Groups.

The proposals relate to the 5 acute Trusts in SYB, and Chesterfield: Mid Yorkshire is developing its services as part of the West Yorkshire Sustainability and Transformation Partnership.

### 1.4.1 Paediatrics and maternity

For each service we considered maintaining the status quo; if the status quo was not sustainable, then looking at service transformation; and if this was not sufficient to meet the challenge, reconfiguration.

- For paediatrics, we considered changing one or two inpatient paediatric units (IPs) into Short Stay Paediatric Assessment Units (SSPAUs).

- On these sites, we then considered whether obstetrics was sustainable. If it was, we proposed to support obstetrics by moving to support the neonatology service with Advanced Neonatal Nurse Practitioners (ANNP). If it was not, we looked at moving to a Standalone Midwifery Led Unit (SMLU).

### 1.4.2 Gastroenterology and Endoscopy

Similarly, we have tested which issues around gastroenterology and endoscopy can be addressed through transformation such as the use of Hosted Networks and greater collaboration across sites; and those where we needed to look at changing the clinical model. This can be done through a formalisation of existing transfer protocols.

## 1.5 Analysis and conclusions

On the 18th March, and the 1st April, the Accountable Officers (AOs), Chief Executives (CEOs) and Medical Directors of SYBND commissioners and acute providers met to discuss the results of the modelling and feedback from the public, and to identify an approach to recommend to the Governing Bodies.

In summary, the discussion concluded that:

- The system was strongly supportive of the approach to **shared working** between the Trusts. Work should go forward as quickly as possible on developing the Hosted Networks, as an important vehicle for transformation going forward.
- The **transformation** agenda should continue to go forward, in particular with a focus on strong workforce planning across the system, and development of new models of care and patient pathways, through shared working. This approach of collaboration was strongly supported by public engagement. Since it cannot be guaranteed that transformation will address all of the challenges, and unplanned workforce issues may arise, a monitoring system with early warning signals should be put in place at a system level.
- **Reconfiguration** was a more complex decision as laid out below, but in summary the group agreed that reconfiguration itself carried a risk of unsettling the workforce and thereby destabilising the system. The group felt that reconfiguration should only be taken forward if there was an immediate risk of safety issues or immediate sustainability issues that would justify it, as had been the case at Bassetlaw in 2016.

### 1.5.1 Reconfiguration of inpatient paediatrics

The group discussed the current case for change, including the workforce issues, and also discussed how far a reconfiguration solution would address these:

- The group were not aware of immediate, known safety issues at any sites. A risk of safety issues on the Bassetlaw site has have previously been avoided by removing overnight stays and moving temporarily to a Paediatric Assessment Unit model. The work of the Review suggested that staffing issues remain acute, and that the same risk would arise again at Bassetlaw if Bassetlaw were to return to an overnight inpatient paediatric unit.
- The group concluded that workforce difficulties were significant and would continue to be so. Paediatrics and maternity are not the most challenged specialties, but the challenges particularly of recruiting paediatric nurses and A&E paediatric staff are well known.
- The modelling tested how far the total requirement for staff would be reduced by reconfiguration (over and above changes to skills mix within the existing configuration). Changing one or two IP paediatric units to a SSPAU results in a small workforce change for the region, although has a big impact for an individual site.
    - On an individual site, the amount of change depends on the current size and the number of patients, but could help workforce challenges by reducing staffing requirements at that site by between 20 and 46 posts.
    - However, the total saving for the system is less than that since most of the patients will still need to be cared for, even if this is on another site, so the total saving to the system is c.7 WTE middle grade and junior doctors overall. These savings come from having a rota of mid grades and junior doctors on a site able to provide care to larger numbers of patients.
    - Reconfiguration is therefore most appropriate if there is a specific challenge at a particular site which is particularly hard to staff, and if other staffing options and models have been explored but cannot address the issue.
- However, AOs and CEOs were concerned, learning from the experience of the Hyper Acute Stroke reconfiguration, that embarking on a reconfiguration programme might in the short to medium term exacerbate an already difficult workforce position.
- Public engagement had also raised concerns about reconfiguration, particularly around increased travel times, although some respondents were happy to travel further for higher quality or more specialised services.
- The group therefore felt that reconfiguration up front, unless there was a demonstrable safety argument for it, would carry a high risk of destabilising the service. They also recognised that patients frequently have concerns around reconfiguration. They therefore suggested that instead the system should focus on transformation and shared working, with ongoing change to services, unless there is a demonstrable safety need on a site.
- However, the AOs and CEOs recognised that there was a risk that transformation takes time and there is a risk that new issues may emerge while it is being implemented. They therefore recommended that we should develop a system-wide approach to monitoring performance and workforce issues, that will enable us to:
    - Identify in advance any safety or sustainability issues that may be emerging, and respond appropriately; and
    - Monitor whether transformation is having the intended effect of improving sustainability.
- The paper proposes that the Hosted Networks should be asked to identify and initially monitor up to five core metrics which will capture these points; they might ultimately be monitored by the system-wide Quality Group.

- Alongside this, individual Trusts are expected to have an ongoing programme of service improvement which may achieve the benefits of reconfiguration, for example through building community pathways to reduce reliance on inpatient services, though on a slower timeframe.
- The only Trust where the AOs and CEOs felt that there was a level of risk that could give rise to safety concerns, which was unlikely to be addressed by transformation, was if paediatrics services at Bassetlaw were to return to an overnight inpatient paediatric unit.
- Clinicians consider that the Bassetlaw service has been sustainable since the changes made in January 2017, with no detriment to clinical outcomes and no complaints related to the new model of care.
- However the underlying challenges with staffing that led to the original concerns at Bassetlaw have not been resolved, as shown in the modelling around the shortfall of workforce across the system, and ongoing recruitment challenges since 2017. These are exacerbated by Bassetlaw's geographical position which makes it more difficult to rotate staff across sites or build a locally-recruited workforce. It was felt to be unlikely that transformation alone would be able to improve the sustainability of Bassetlaw enough for it to return to running an overnight inpatient unit.
- The CEOs and AOs supported Bassetlaw CCG and Doncaster and Bassetlaw Teaching Hospital in continuing to test potential partnership working with Sheffield Children's Hospital as a way to strengthen services, but that it was not likely that this would be sufficient to support a reopening of overnight inpatient paediatric services.
- Any proposed permanent change to services will need to go through public engagement, and (following discussion with the relevant Overview and Scrutiny Committee) the CCG may consider formal consultation with patients and the public. The timing of such a consultation and other issues that may also be included in a consultation process are matters for the CCG to consider.

### 1.5.2 Reconfiguration of maternity

The AOs and CEOs agreed that the principle of reconfiguring only if there is a risk that cannot be addressed by transformation, applies to maternity as well:

- The modelling suggests that the workforce challenges in maternity are less pressing than those in paediatrics, except in recruitment of midwives.
- Changing one or two obstetrician led units to a SMLU results in a small workforce change for the region, although has a big impact for an individual site reducing the need for clinicians.
    - The size of the workforce saving depends on the individual sites chosen but the model could help the workforce challenges through reducing staffing requirements by no longer needing to provide any obstetricians, junior doctors or mid grades (an average of around 23 posts) and a reduced need for midwives.
    - At a cross system level, the workforce challenge would be alleviated by around 5-6 junior doctors and 5-6 mid-grade posts. Depending on the sites chosen, the number of midwives needed in SYB would also go down if patients flow out of area, but commissioner spend will remain the same under these circumstances.
- Changes to obstetric services will impact on the provision of interdependent services, as explored in section 10.2 below. This paper proposes ways to mitigate these impacts, particularly by introducing a model of supporting neonatology with Advanced Neonatal Nurse Practitioners.
- The most significant challenge identified in obstetric services was at Bassetlaw, where challenges in the workforce for interdependent services (only 3 of 8 anaesthetist posts are

filled) make an obstetric service difficult to maintain. At present the Trust is managing this by routing more complex patients from Bassetlaw to Doncaster.

- This report invites the Bassetlaw commissioners, working with the Trust, to consider transformation and reconfiguration options.

#### 1.5.3 Reconfiguration of gastroenterology and endoscopy

Across gastroenterology and endoscopy, the Hosted Networks will focus on transformation, through developing workforce solutions and shared working.

For Out of Hours gastrointestinal bleeds, it is proposed that the Hosted Network will take forward work on the development of shared, consistent out of hours protocols, to ensure that all patients have rapid and equitable access to urgent treatment if it is needed.

This would affect a small number of patients, we believe 2-3 patients per week. Proposed changes are likely to streamline and standardise transfers which already happen ad hoc, without greatly changing numbers of patients affected. Nevertheless strong engagement with patient and staff groups will be required, and a final decision on whether public consultation is required would need to be taken by the relevant Health Overview and Scrutiny Committees (HOSCs), in discussion with the Joint Health Overview and Scrutiny Committee (JHOSC).

## 1.6 Decision for Governing Bodies

Governing Bodies are asked to consider whether they agree with the conclusions reached by the AOs and CEOs above. In particular, they are asked whether they agree that an approach of focusing on transformation, and considering reconfiguration only if there is an immediate risk of safety issues, is appropriate in addressing the long term sustainability of acute services in SYB. If transformation fails to address the workforce issues in the medium to long term reconfiguration may have to be reconsidered.

They are also asked to agree the approach to monitoring the progress of transformation, and any emerging risk, that is laid out below.

Governing Bodies have agreed during their July 2019 meetings to delegate responsibility for agreeing the direction of travel laid out in this report to the Joint Committee of Clinical Commissioning Groups (JCCCG).

## 1.7 Next steps

There are the following key areas of next steps:

***Agreement of this paper***

- **Discussion within public meetings of the Governing Bodies**
- **Public engagement**: public engagement on the direction of travel laid out in this paper will take place in parallel with the GB discussions, so that the public discussion at JCCCG can be informed by this
- **Discussion and agreement of the proposed way forward by the JCCCG**

***Taking forward transformation***

- **Taking forward development of the level 1 Hosted Networks**. Recruitment to the Hosted Networks has already begun and the intention is to define their work programme over the summer. Where there is a need for public or patient engagement in any element of the work programme, this will be overseen by the Integrated Care System (ICS) communications team. Trusts will also lead engagement with staff as required.

- **Taking forward development of the level 3 Hosted Network for paediatrics**. A paper is going to the Board of SCH and DBTH in June and a work programme, and engagement with staff, will follow from that.
- **Developing monitoring**. As part of development of the Hosted Networks, clinicians and managers will be asked to help develop an approach to monitoring progress against transformation, and identify concerns with safety and sustainability. This will form part of wider work on monitoring within the ICS.
- **Taking forward other elements of transformation**. Each Trust is taking forward its own internal transformation programme.

### *Taking forward reconfiguration*

If any CCG decides to take forward reconfiguration, this will require:

- **Full equalities impact assessment (EIA)** led by the CCG. The ICS has considered equalities issues at each stage but CCGs have a statutory responsibility to undertake a full EIA for any consultation that they will be leading;
- **Engagement with the relevant Health Overview and Scrutiny Committee,** and engagement for information with the Joint Health Overview and Scrutiny Committee;
- **Engagement with the North of England Clinical Senate** (and/or the Yorkshire and the Humber Clinical Senate) around any suggested reconfiguration changes.
- **Public consultation** in line with legal requirements.

Hospital Service Review: Report for Governing Bodies

# The process to date and the scale of the challenge:

In this section we will consider the following:

- The background of the Hospital Services Review, including the original case for change identified and the outcomes of the Strategic Outline Case
- The national picture of workforce, funding and demand challenges
- The refreshed case for change for services against the five evaluation criteria, taking into account research, 1-1 interviews with Trusts and Clinical Working Group discussions

# 2 Background

## 2.1 The Hospital Services Review (HSR) Process

In 2016, the South Yorkshire and Bassetlaw (SYB) healthcare system published its Sustainability and Transformation Plan (STP). While SYB has some excellent hospital services, the STP identified concerns about the long term sustainability of the acute sector in South Yorkshire and Bassetlaw. Key challenges identified were mounting demand, workforce pressures, and inequalities across the region in patients' access to and outcomes of care.

Following the STP, the SYB system, together with Mid Yorkshire and North Derbyshire (MY and ND), agreed to undertake a Hospital Services Review (HSR) to look at options for improving long term sustainability.[2]

### 2.1.1 Identifying the services highlighted in the Review

The HSR found that a number of acute services across SYBMYND were facing significant sustainability challenges. The HSR identified those services which were facing the most acute challenges, and selected five significantly challenged services as the focus of the Review:

- Urgent and Emergency Care *(1st least sustainable)*
- Gastroenterology and Endoscopy *(2nd least sustainable)*
- Stroke (the acute pathway, supporting HASU) *(4th least sustainable)*
- Acute Paediatrics (Care of the Acutely Ill Child) *(11th least sustainable)*
- Maternity *(Neonatology was 15th least sustainable)*

Maternity was included because of its interdependencies with paediatrics and neonatology.

### 2.1.2 Recommendations and the Strategic Outline Case

The HSR published its final report in May 2018, and the commissioners and providers responded in a Strategic Outline Case in October 2018 which agreed the following direction for South Yorkshire and Bassetlaw, and Chesterfield (Mid Yorkshire is following a different strategy as part of a different STP area):

- **Shared working between acute providers:** Hosted Networks, a Workforce Hub and an Innovation Hub will be set up to support shared working.
- **Service transformation:** The system will look at improving services within their current configurations through transformation.
- **Reconfiguration:** If Transformation does not go far enough, changes to the clinical model will be considered:

[2] The findings of the assessment are published in the Stage 1A Report of the HSR, available at: https://www.healthandcaretogethersyb.co.uk/application/files/7515/0903/4254/Hospital_Services_1a_Report.pdf

- **Paediatrics**: The system will consider changing 1 or 2 inpatient paediatric units into Short Stay Paediatric Assessment Units (SSPAUs)
- **Maternity**: Where inpatient paediatrics is changing, the system will look at changing obstetrics services into Standalone Midwifery Led Units (SMLUs), and also explore clinical models that would allow a site to retain obstetrics even if it no longer had 24/7 inpatient paediatrics.
- **Gastrointestinal bleeds**: The system will look at formalising the protocols for out of hours transfers from sites which cannot offer 24/7 GI bleed rotas.

# 3 The case for change: across all services

In considering the next steps for the system, the ICS has revisited the original case for change, to identify whether any of the challenges identified at the beginning of the HSR have been resolved or exacerbated, or any new challenges have emerged.

## 3.1 Challenges in the NHS at national level

### 3.1.1 Workforce

- The NHS employed over one million staff as of July 2018.
- There have been more than 100,000 vacancies reported by Trusts, a number that is expected to rise over the coming years.
- 2018 was the second consecutive year during which the number of applications and acceptances to nursing degrees in England has fallen, this is in large part attributed to the changes in funding offered to nursing trainees. Additionally, c. 24% of those starting a nursing degree either did not graduate in the given time frame, or failed the course.
- The number of hospital based doctors has increased since 2017 (this varies by specialty).[3]
- Attrition rates within the NHS have continued to increase since 2008.
- Staff face increasing pressures at work - the NHS England staff survey conducted in 2017 found that close to 4/10 staff (38%) had experienced work-related stress over the last 12 months, a 2% increase on the previous year.[4]

### 3.1.2 Financial Pressures

- The NHS is under growing financial pressure. Between 2010/11 and 2014/15, health spending increased by an average of 1.2 per cent a year in real terms and increases are set to continue at a similar rate until the end of this Parliament.
- The £20bn announced for the NHS is not anticipated to fully close the projected funding shortfall, being spread out over 5 years to 2023/24.
- This will mean an average increase on the NHS's budget of around 3.4% a year in real terms. When this increase is considered in the context of the whole Department of Health budget, the Nuffield Trust think tank has said that this is increase is more likely to be around 3% a year.[5]
- The Institute for Fiscal Studies (IFS), have said that increases of at least 4% a year on average are needed in order to meet the NHS's needs and see any improvement in its services.[6]

[3] The Health Foundation, NHS staffing trends, 2018
[4] NHSE, NHS staff survey, 2018
[5] Nuffield Trust, Funding settlement a big step forward, 2018
[6] Institute for Fiscal Studies, What does the NHS funding announcement mean for health spending in England?, 2018

### 3.1.3 Demand pressures

- Between 2003/4 and 2015/16, the number of attendances at major A&Es increased by 18 per cent, from 12.7 million to 15 million. Admissions via major A&E departments rose by 65 per cent over the period, from 2.5 million in 2003/4 to 4.1 million in 2015/16.

- One reason for the growth in hospital activity is population growth - between 2003 and 2015, the population of England increased by 10 per cent, from 49.9 million in 2003 to 54.8 million in 2015.
- Additionally there have been demographic changes - between 2003 and 2015, the number of people aged over 85 has increased by nearly 40 per cent.
- King's Fund research suggests that other factors that may be driving up demand include patients' rising expectations, earlier referrals from GPs for suspected cases of cancer, and advances in technology.[7]

## 3.2 Challenges identified within South Yorkshire and Bassetlaw

The main challenges facing each of the five services in 2017 were identified in the Hospital Services Review through the Clinical Working Groups, engagement with patients and the public, and performance and workforce data provided by the Trusts. The main challenges that emerged were around workforce, unwarranted clinical variation and innovation, and were laid out in published reports.[8]

## 3.3 Public engagement on the challenges

During the Hospital Services Review, the HSR team undertook a number of large public engagement events, as well as sessions in each of the Places in SYB. During the drafting of the SOC, and in public engagement between October 2018 and April 2019, the emphasis was on engaging with people from seldom heard groups, and stakeholders who would be particularly affected by changes to the services identified here, such as mother and toddler groups.

The engagement has been reviewed and recorded by an independent organisation, and all of the reports it has written for the HSR as well as other material from the patient and public engagement are available on the ICS website[9].

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[7] King's Fund, How hospital activity in the NHS in England has changed over time, 2016

[8] A full report of the challenges identified by the HSR is available in the Stage 1B Report available at: https://www.healthandcaretogethersyb.co.uk/application/files/9615/1809/8702/Hospital_Services_Review_1b_report.pdf

[9] All of the reports of public engagement so far can be found under 'all the documents' at https://www.healthandcaretogethersyb.co.uk/what-we-do/working-together-future-proof-services/looking-at-hospital-services. The most recent report covers wider public engagement for the ICS as well as the HSR and is published at https://www.healthandcaretogethersyb.co.uk/application/files/3615/5264/4308/SYB_HSR_engagement_approach_Dec_-_April.pdf

The engagement was used to find out what service users and the public consider important for their local health services and to get their views on the specific models put forward. The views of the public have been used to shape the models, and views on specific models are described throughout the paper.

Some of the key points made on the overall challenges to the NHS are:

- **Quality:** Key priorities for respondents were a consistent quality of care across sites, and the importance of compassionate and caring staff. Many participants cited soft skills as an important factor to consider for the quality of care.
- **Workforce:** Some members of the public had a preference for specialist staff (although some participants spoke highly of experiences with for example nurse practitioners). There was a strong theme that the NHS needed more staff and that staff should be better valued.
- **Affordability:** In considering the evaluation criteria, many members of the public felt that the affordability of services should not be a priority in deciding the future of services, though some felt effective management of funding to avoid wasting money should be a priority.
- **Access:** Access was a major theme across the public engagement. In the engagement phase October 2018-April 2020, 6 in 10 participants expressed a preference for local services. A further 3 in 10 participants mentioned the importance of effective and affordable transport in their local area, in order to access the care they need. This theme was emphasised by the public group on transport, which was set up in response to public feedback on the HSR and the SOC.
- **Interdependencies.** Interdependencies was voted by public respondents to be one of the most important themes to consider when evaluating change. Views were divided between participants who believed that all interdependent services should be provided locally, and those who thought that it was important to have access to all interdependent services but they did not necessarily have to be local.

The ways in which public engagement has shaped the specific options is explored throughout this paper, and is laid out in more detail in Annex F.

# 4 The Case for Change: Care of the Acutely Ill Child

## 4.1 Findings in the original HSR case for change

Acute paediatrics was cited frequently in the Trust interviews and was felt to be the biggest workforce risk across the review footprint by Doncaster and Bassetlaw Trust and a moderate risk by Rotherham and Sheffield Children's Hospital. In an aggregated assessment of the sustainability of services in SYB(ND) CAIC scored 11th. The service was a priority for commissioners, driven by workforce shortages (particularly at consultant and middle grade), which were recognised nationally and by the local Health Education England leads as well as the by the individual Trusts, and low activity levels at some sites (particularly overnight). The CQC had raised concerns about services for children and young people at two trusts.

There was agreement that the HSR would support the recent establishment of the Managed Clinical Network in acute paediatrics and that new models of community based provision should be explored. There was agreement that this service was a high priority for shortlisting.

## 4.2 National paediatrics workforce challenges

While there is slight growth in the number of Paediatric nurses nationally, there are still large gaps in the Paediatric medical workforce nationally, that are more pronounced outside of London. Considering falling national trainee numbers there are concerns that the number of current and future estimate Paediatric trainees will not be able to meet future demand and close current workforce gaps.

In the year to July 2018, the number of nurses and health visitors in children's health grew by 2.2%. Contrastingly, there has been a slight decrease (0.4%) in the number of community nursing support workers for Paediatric care. The number of nurses working in children's care (registered to the Nursing and Midwifery council) has increased from c. 45,000 to c. 51,000 from 2013 to 2018.[10]

Between 2013 and 2015, the UK Paediatric consultant workforce grew from 3718 to 3996, a rise of 7.5%. However, at least 752 WTE extra consultants are required to meet the RCPCH Facing the Future, and specialist services standards. Advanced nurse practitioners are employed by 60% of children's hospital services, in an attempt to meet demand.[11]

## 4.3 Public views on paediatrics

The ICS has undertaken engagement with patients and the public, including with the Youth Forum at Sheffield Children's Hospital whose members come from all over SYB. More detail is at Annex F. Key points around the case for change for paediatric services were:

- Care is often excellent and staff are compassionate and friendly, although very busy.
- The physical environment in some Trusts could be more welcoming for children and their families.

[10] Royal College of Nursing, The UK labour market review, 2018
[11] RCPCH, The Paediatric workforce report, 2018

## 4.4 Metrics used to assess performance

We have conducted a detailed assessment of Trusts, against approximately 30 metrics at Trust level. This is contained in the case for change report for each Trust and in the detailed case for change Appendix (Annex B). Included below is a snapshot view of these metrics at the system level.

### 4.4.1 Quality

We will measure Quality by considering the question: Is quality of care optimised by promoting delivery of national good practice and guidance, and contributing to maintained or improved outcomes?

This takes into consideration the following:

- Are SYB(ND) Trusts able to meet national clinical guidelines and standards?
- Are patients satisfied with the quality of care offered?

It includes the following measures:

- CQC Assessment

  The CQC score looks at safety, effectiveness, care, responsiveness and leadership of a service.

- Facing the Future Standards

  We have looked at the number of the Acute Facing the Future standards each Trust meets, as defined by RCPCH

- Patient feedback

  We have conducted a qualitative evaluation of NHS choices submissions, as well as public engagement during the Hospital Services Review. To quantitatively assess patient feedback for CAIC services across SYB(ND) Trusts, we have calculated an average of the scores achieved in the Children and Young People's (CYP) survey.

### 4.4.2 Workforce

Workforce is measured by considering the question: Does the option ensure there is a sustainable workforce of the right number and skill set?

This takes into consideration the following:

- Do Trusts have sufficient workforce in place to provide a safe service?
- Is the existing workforce satisfied with their workplace environment and workload?
- To what extent do Trusts rely on locum / temporary staff?

This includes the following measures:

- The scale of the workforce gap

  We have tried to evaluate the scale of the gap between the staff currently in post and what would be required. Due to the difficulties in attaining consistent funded establishment values across Trusts, we have had to model the required establishment using assumptions developed by clinicians.

  We have calculated the workforce gaps at each grade between:

- The current staff in post and the number of staff required to sustainably staff units based on assumptions developed and refined with clinicians through a series of Clinical Working Groups;
- The further gap between the number of staff required to sustainably staff units and the Royal College guidelines.

- Staff satisfaction - GMC trainee staff survey

  The General Medical Council (GMC) trainee staff survey asks questions around overall staff satisfaction and workload satisfaction, with both metrics are scored out of 100. A higher score for workload satisfaction indicates a more manageable workload.

#### 4.4.3 Affordability

Affordability is measured by considering the question: Does the option cost no more than the current service?

This takes into consideration the following:

- How much activity do Trusts carry out?
- How efficient are the services the Trusts provide?

This includes the following measures:

- Reference Cost index

  We have used reference cost index (RCI) to assess the affordability of each service at each Trust. RCI is a measure of relative efficiency comparing the actual cost of activities in comparison to the expected cost; an RCI value above 100 means relatively inefficient services, whilst an RCI value below 100 means relatively more efficient services.

- Pay cost modelling

  Using the model described in the workforce section, we have calculated the number of staff required at each grade (and their corresponding pay costs) to sustainably staff units based on assumptions developed and refined with clinicians through a series of Clinical Working Groups.

#### 4.4.4 Interdependencies

Interdependencies are measured by considering the question: Are the necessary supporting services appropriately available?

This takes into consideration the following:

- Are interdependent services that need to be provided available onsite?
- What would the impact be to interdependent services at all Trusts if the clinical model were to change?

This includes the following measures:

- Assessment of CQC scores and provision of key interdependent services

  Paediatrics has a large number of interdependent services, notably Urgent & Emergency Medicine, Paediatrics & Neonatology.

### 4.5 The picture in SYB(ND) currently

The table below summarises Trust performance against the measures described above.

- The quality of CAIC services in SYB(ND) is currently good on most sites, but we are facing some sustainability challenges in our systems. In the most recent CQC assessments, all SYB(ND) Trusts achieved 'Good' Care Quality Commission (CQC) scores for Children and Young People, with the exception of Barnsley, which received a 'Requires improvement' score. This was identified by the Trust as being due to a one-off incident and the issues raised have now been resolved.
- Only one Trust (Barnsley) is currently meeting all 10 Facing the Future (FTF) standards. Two trusts (Rotherham and Chesterfield) are meeting 7 standards, and the remainder meet 8 (Doncaster and Bassetlaw) and 9 (Sheffield Children's Hospital) FTF standards, respectively. The most common Facing the Future standards Trusts are struggling to meet involve workforce considerations and are listed below:
  - FTF Standard 1: Consultant is present at peak times, 7 days a week
  - FTF Standard 3: Every child is seen by a consultant Paediatrician within 14 hours of admission
  - FTF Standard 8: All training rotas made up of 10+ WTE posts, all compliant with EU and UK working regulations
- CAIC is also currently included on the risk register for most Trusts including Doncaster and Bassetlaw, Rotherham (concerning an inability to identify and treat deteriorating children waiting in the UECC area), Barnsley (concerning an inability to recruit Paediatric nurses into vacancies on ward 37; and governance, leadership and relationships within the team and service) and Sheffield (concerning an inability to fill junior posts).
- Patient feedback for Paediatrics across SYB(ND) is very good.
- Staff feedback is more variable. GMC trainee staff satisfaction scores for workload (an average of 45/100 across Trusts in SYB(ND). During the Clinical Working Groups staff referred to recent occasions when study leave had been cancelled across the organisation. Staff also report significant levels of substantive staff working extra shifts. These shifts are not recorded in agency or staff bank data and so were not captured in the data collection done for the Hospital Services programme; it was therefore not possible to identify the extent of this.
- Rotherham has significantly higher reference costs than the other Trusts. The Trust believes this to be because community services are included within its reference costs.

Key: Lower than trust average / Higher than trust average

| | Trust Average | Barnsley | Chesterfield | Doncaster | Bassetlaw | Rotherham | SCH |
|---|---|---|---|---|---|---|---|
| **Quality** | | | | | | | |
| CQC Children & Young People score *(In most recent assessment)* | | Requires Improvement | Good | Good | Good | Good | Good |
| CQC Urgent and Emergency Services score *(In most recent assessment)* | | Good | Good | Requires Improvement | Requires Improvement | Inadequate | Good |
| FTF Standards *(No. achieved or mostly achieved; out of 10)* | 8 | 10 | 7 | 8 | 8 | 7 | 9 |
| Patient feedback *(Children & Young People survey score)* | 8.8 | 8.4 | 8.8 | 8.9 | 8.9 | 8.9 | 8.6 |
| **Workforce** | | | | | | | |
| Number of additional Consultants required to meet demand *(Based on modelling and assumptions generated with clinicians)* | 1.3 | 0.0 | 0.0 | 1.0 | 5.0 | 0.7 | 0.0 |
| Number of additional Middle grade doctors required to meet demand *(Based on modelling and assumptions generated with clinicians)* | 6.3 | 4.4 | 6.1 | 3.9 | 9.9 | 7.4 | 11.2 |
| Number of additional Junior grade doctors required to meet demand *(Based on modelling and assumptions generated with clinicians)* | 6.1 | 4.0 | 5.5 | 3.5 | 10.5 | 7.0 | 5.6 |
| Number of additional Nurses (Band 7+) required to meet demand *(Based on modelling and assumptions generated with clinicians)* | 1.8 | 1.9 | 2.5 | 2.6 | 0.7 | 1.5 | -3.0 |
| Number of additional Nurses (Band 5-6) required to meet demand *(Based on modelling and assumptions generated with clinicians)* | 16.0 | 13.1 | 13.8 | 29.5 | 14.5 | 9.2 | 16.6 |
| Number of additional Nurses (Band 1-4) required to meet demand *(Based on modelling and assumptions generated with clinicians)* | 5.4 | 8.2 | 9.1 | 5.9 | 2.3 | 1.6 | 17.3 |
| Overall workplace satisfaction *(Based on GMC trainee staff scores; out of 100)* | 78.2 | 73.5 | 79.0 | 68.7 | 68.7 | 65.1 | 90.5 |
| Overall workload satisfaction *(Based on GMC trainee staff scores; out of 100)* | 45.3 | 46.6 | 48.8 | 37.9 | 37.9 | 47.5 | 45.6 |
| **Affordability** | | | | | | | |
| Paediatrics Reference Cost Index *(Index above 100 is relatively inefficient, below 100 is relatively efficient)* | 108 | 106 | 104 | 86 | 86 | 197 | 69 |
| **Interdependencies** | | | | | | | |
| CQC Urgent and Emergency Services score *(In most recent assessment)* | | Good | Good | Requires Improvement | Requires Improvement | Inadequate | Good |
| CQC Children & Young People score *(In most recent assessment)* | | Requires Improvement | Good | Good | Good | Good | Good |
| Level of Neonatology provision | | Level 2 | Level 2 | Level 2 | Level 2 | Level 2 | Level 3 |

Figure 1: A summary of Trust evaluation metrics, Note: workforce gap data excludes locum staff in place[12]

### 4.5.1 The current situation at Bassetlaw

During 2016, a shortage of specialist paediatric medical and nursing staff adversely affected provision of overnight services at Bassetlaw Hospital for a number of months, and despite efforts to recruit to vacancies, these were not successful. The situation was exacerbated suddenly by several staff leaving at the end of the year. As a result, the Trust felt that it could not safely continue to provide inpatient paediatric services at Bassetlaw.

[12] Latest publically available data from CQC, NHS Children and Young People's Survey, Reference Cost Index data; Facing the Future data based on Trust self evaluation; workforce data based on workforce modelling using assumptions from clinicians

Following discussion with the Bassetlaw Overview and Scrutiny Committee the Paediatric Ward at Bassetlaw Hospital changed in January 2017 to provide an enhanced day time urgent assessment and treatment service, seven days a week.

Although the overnight service could not be maintained, acute paediatrics were enhanced and are available from 8am to 10pm, seven days a week, creating a 'consultant-led Paediatric Assessment Unit'. Any children requiring an overnight stay are transferred to neighbouring Doncaster Royal Infirmary (DRI). Urgent transport for the children who do require an overnight stay is available, and is being jointly commissioned by Bassetlaw Clinical Commissioning Group (CCG) and the Trust

The new model of care is consistent with Royal College of Paediatric and Child Health guidance.

At the time of the change, the number of children who required overnight stay had fallen in recent years with the ward, A3, caring for an average of six children. Data shows that the number of patients transferred per week from Bassetlaw to Doncaster has risen from an average of 6 to an average of 15. Almost 85% of all patients stay one night or less and most children will benefit from an enhanced assessment and treatment service.

The closure of overnight Paediatric services at Bassetlaw remains on the risk register for Doncaster and Bassetlaw. It is closely monitored to ensure the safety of services, with a number of controls and assurances in place, namely:

- Controls:
    - Consultant led paediatric assessment unit in place
    - Arrangements for transferring overnight stays to DRI
    - Communication with CCG and HOSC
    - Arrangements with Sheffield Children's Hospital
    - Ongoing paediatric nurse recruitment
- Actions to address:
    - Regular recruitment exercises
    - Review of paediatric competencies for ED - Additional training for Adult Nurses in Bassetlaw ED
    - Continue to advertise nursing posts
    - Paediatrics being reviewed as part of Hospital Services review

## 4.6 Future demand for Care of the Acutely Ill Child services

### 4.6.1 Current activity

Through discussions with Clinical Working Groups (CWGs) and paediatric Medical Directors, we have ascertained that there are an increasing number of GP referrals to SSPAUs across SYB(ND), with one Trust estimating c. 70% of their SSPAU admissions are from GP referrals. This indicates there is a large proportion of paediatric patients who could be assessed and treated in the community, but are instead being directed to SSPAUs, which are already stretched in terms of activity and workforce. Rotherham has a very low number of SSPAU admissions, which may be due to the success of their paediatric community care programmes.

The same discussions have highlighted the increased proportion of complex cases being admitted for acute paediatric care, predominantly due to public health factors such as obesity and deprivation leading to increased comorbidities. However, using the case studies of Mid Yorkshire and Bassetlaw who have changed their Inpatient Units to SSPAUs, the number of patients who may actually require overnight stay tend to be low.

The activity levels across each Trust in SYB(ND) for CAIC services are shown in Figure 1, using the metrics of non-elective IP admissions for 2018/2019 and average length of stay.

| | Barnsley | Bassetlaw | Chesterfield | Doncaster | Rotherham | SCH |
|---|---|---|---|---|---|---|
| Population under 18y/o (2017/18) | 52,858 | 24,530 | 53,563 | 69,325 | 60,070 | 123,891 |
| Total Paediatric admissions (2017/18) | 6,658 | 1,330 | 4,573 | 11,185 | 5,320 | 13,569 |
| Number of admissions with LOS <1 day | 4,202 | 1,134 | 2,376 | 7,757 | 3,637 | - |
| Average length of stay (days) | 2.1 | 2.1 | 2.3 | 2.6 | 2.2 | 3.8 |

Figure 2: CAIC activity levels and under 18 y/o population data across SYB(ND)[13,14]

### 4.6.2 Demand for future services

Overall, the demand for acute paediatric services is expected to increase over the next five years. Based on the population growth (ONS) and non-demographic growth assumptions, we expect demand for paediatric services to grow by 2.7% on average in the next five years.

Currently, there is a sufficient under 18 population to sustain appropriate levels of patient flow to facilitate training in SYB(ND) hospitals to ensure the workforce remain proficient in paediatric care.

The graph below (Figure 3) shows the predicted inpatient unit and SSPAU admission levels on the left axis, with the percentage change year on year shown on the right axis.

The demand figures for Bassetlaw have been tested against a number of different scenarios around population growth. The under 18 population of Bassetlaw is currently noticeably smaller than the other SYB(ND) Trusts (due to being smaller in size, and having an ageing demographic). However, Bassetlaw is anticipating significant growth over the next two decades. The draft Bassetlaw Development Plan[15] calls 6,630 new homes to be built in the area by 2035. The majority of these homes are intended to provide housing for local people: the Bassetlaw Plan states that 306 of the 390 homes which are being created each year will be needed to

[13] SYB(ND), Trust data returns, 2019
[14] NHS, CCG Population data, 2019
[15] Bassetlaw Council, The Draft Bassetlaw Local Plan, 2019. https://www.bassetlaw.gov.uk/media/3820/draft-bp-pt1-web-version.pdf

meet demographic growth in the existing population, suggesting that around 84 houses per year will be created to attract new population.

Whilst the precise impact of housing developments on paediatric services cannot be precisely quantified, it is known that a relatively small population of children require hospital care, and the impact will be marginal. The modelling that has been done of a range of different scenarios indicates that this is not expected to result in a 'step change' in demand in Bassetlaw.

### 4.6.3 Future workforce

Using the HEE workforce growth assumptions, we expect the workforce to grow, on average, in the next 5 years (Figure 4):

- 1.3% p.a. for junior doctors
- 5.3% p.a. for paediatric nursing staff

Although the number of paediatric nurses is expected to grow faster than the number of paediatric admissions (c.5% p.a. growth in nursing staff vs. and expected c.3% growth in activity), given the current shortage of paediatric nurses, this may not be enough to ensure appropriate staffing. Moreover, although this increase will help to alleviate some of the workforce issues currently experienced in SYB(ND), the rate of growth will not match the growth in demand when current workforce shortfalls are taken into account.

This risks creating a decline in the quality of paediatric care provided across SYB(ND), if no action is taken to counter insufficient staffing across the region.

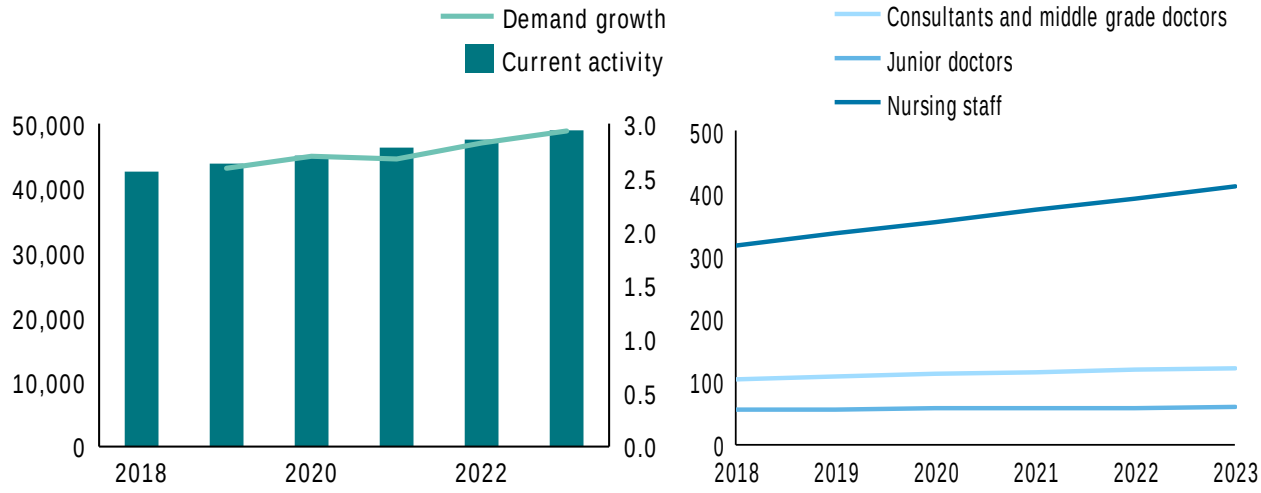



Figure 3: Predicted growth in demand over the next 5 years for CAIC services[16]




Figure 4: Predicted increase in CAIC workforce over the next 5 years[17]

[16] Based on ONS population growth assumptions
[17] Based on data provided by HSE

The implementation of Better Newborn Care guidelines, if implemented, could cause further workforce pressures in acute Paediatrics. The guidelines state that for L1 and L2 Neonatal units, a junior doctor must be immediately available for neonatal care, which will necessitate a separate rota to paediatrics. Busier neonatal units will require a separate middle grade rota, whilst the busiest units will require a separate consultant rota (as is the case currently). The splitting of the rota which currently covers both paediatrics and neonatology would, if it is agreed by commissioners, further exacerbate the junior and middle grade doctor shortages experienced in paediatrics across SYB(ND).

# 5 The Case for Change: Maternity

## 5.1 Findings in the original HSR case for change

Maternity was included in the HSR because of its interdependencies with paediatrics and because it was a high priority for commissioners. There were a number of workforce shortages across the footprint and some requirements from the national strategy had not been met. At the time, the CQC rated Maternity at three of the acute sites, across two trusts, as 'Requires improvement'.

In an aggregated assessment of the sustainability of services in SYB(ND) CAIC scored 11th and Neonatology scored 15th.

## 5.2 National maternity workforce challenges

The midwifery workforce is aging and close to the pension age of 55 nationally, leading to an impending shortfall in experienced staff. The number of Midwives increased by just 0.9% in the year to July 2018. There has also been a 0.2% decrease in the number of community nursing support workers for Maternity care. Additionally, the average attrition rate from Midwifery degrees is 21%. The number of midwives nationally is not increasing at a rate fast enough to meet changes to guidance introduced through the Continuity of Carer guidelines.

The medical workforce is also under pressure. The Maternity audit in 2017 found that 88% of Maternity units had gaps in the rota for middle grade Obstetricians, with 83% of Maternity units requiring locum staff to cover their middle grade rota.[18] With a large proportion of the Maternity workforce being female, more could also be done to provide alternative and more supportive working arrangements for staff as they progress through their careers.

## 5.3 Public views on the Case for Change

The ICS has undertaken significant amounts of public engagement with women who use maternity services and their families, both through the Hospital Services Programme and through the Local Maternity System. More detail is at Annex F. Key points around the Case for Change were:

- Many women reported excellent experiences and good care
- The main concern that was raised by women was that staff were very busy. Some patients reported a change of staff or too few staff present during labour, particularly amongst midwives.

## 5.4 Metrics used to assess performance

We have conducted a detailed assessment of Trusts, against approximately 30 metrics at Trust level, is contained in the case for change report for each Trust and in the detailed case for

[18] RCOG, Workforce report, 2017

change in Appendix B. Included below is a snapshot view of these metrics at the system level.

#### 5.4.1 Quality

We will measure Quality by considering the question: Is quality of care optimised by promoting delivery of national good practice and guidance, and contributing to maintained or improved outcomes?

This takes into consideration the following:

- Are SYB(ND) Trusts able to meet national clinical guidelines and standards?
- Are patients satisfied with the quality of care offered?

It includes the following measures:

- CQC Assessment

  The CQC score looks at safety, effectiveness, care, responsiveness and leadership of a service.

- Patient feedback

  We have used the NHS Friends and Family test for Maternity to assess how patients perceive the quality of the Maternity services at each Trust. The scores (% of people who would recommend the service) are broken down into antenatal care, care during birth, postnatal ward care and postnatal community care.

#### 5.4.2 Workforce

Workforce is measured by considering the question: Does the option ensure there is a sustainable workforce of the right number and skill set?

This takes into consideration the following:

- Do Trusts have sufficient workforce in place to provide a safe service?
- Is the existing workforce satisfied with their workplace environment and workload?
- To what extent do Trusts rely on locum / temporary staff?

This includes the following measures:

- The scale of the workforce gap

  We have tried to evaluate the scale of the gap between the staff currently in post and what would be required. Due to the difficulties in attaining consistent funded establishment values across Trusts, we have had to model the required establishment using assumptions developed by clinicians.

  We have calculated the workforce gaps at each grade between:

  - The current staff in post and the number of staff required to sustainably staff units based on assumptions developed and refined with clinicians through a series of Clinical Working Groups
  - The further gap between the number of staff required to sustainably staff units and the Royal College guidelines

- Staff satisfaction - GMC trainee staff survey

  The General Medical Council (GMC) trainee staff survey asks questions around overall staff satisfaction and workload satisfaction, with both metrics are scored out of 100. A higher score for workload satisfaction indicates a more manageable workload.

### 5.4.3 Affordability

Affordability is measured by considering the question: Does the option cost no more than the current service?

This takes into consideration the following:

- How much activity do Trusts carry out?
- How efficient are the services the Trusts provide?

This includes the following measures:

- Reference Cost index

  We have used reference cost index (RCI) to assess the affordability of each service at each Trust. RCI is a measure of relative efficiency comparing the actual cost of activities in comparison to the expected cost; an RCI value above 100 means relatively inefficient services, whilst an RCI value below 100 means relatively more efficient services.

- Pay cost modelling

  Using the model described in the workforce section, we have calculated the number of staff required at each grade (and their corresponding pay costs) to sustainably staff units based on assumptions developed and refined with clinicians through a series of Clinical Working Groups.

### 5.4.4 Interdependencies

Interdependencies are measured by considering the question: Are the necessary supporting services appropriately available?

This takes into consideration the following:

- Are interdependent services that need to be provided available onsite?
- What would the impact be to interdependent services at all Trusts if the clinical model were to change?

This includes the following measures:

- Assessment of CQC scores and provision of key interdependent services

  Paediatrics has a large number of interdependent services, notably Urgent & Emergency Medicine, Maternity & Neonatology.

## 5.5 The picture in SYB(ND) currently

The table below summarises Trust performance against the measures described above.

- The quality of Maternity services in SYB(ND) is currently good on most sites, but we are facing some sustainability challenges in our systems. Bassetlaw is of particular concern, as it is struggling to maintain a 24/7 Anaesthetics service which is a key interdependency for Maternity (only 3 out of 8 middle grade anaesthetist posts are filled ). Doncaster & Bassetlaw and Rotherham both have '*Requires improvement'* CQC scores for Maternity.
- Patient feedback for Maternity across SYB(ND) is excellent, but GMC trainee staff satisfaction scores for workload (an average of 49/100 across Trusts in SYB(ND) and evidence around the extra shifts staff work suggest that the quality of the service is very dependent on staff members working overtime and going the extra mile to provide a good quality of care.

- The CQC scores for Maternity[19] are varied across SYB(ND). Sheffield Teaching achieved an *'Outstanding'* score, Barnsley and Chesterfield achieved a *'Good'* score, whilst Doncaster & Bassetlaw and Rotherham achieved a *'Requires improvement'* score.
- Considering the CQC reports, Doncaster & Bassetlaw's CQC score was due to workforce shortages. Similarly, Rotherham's score referred to the fact that midwives were frequently deployed from other areas to support the delivery suite, and there had been a reduction in specialist midwives to meet the needs of vulnerable women.
- There is currently a shortfall in workforce across the system for Maternity. As with Paediatric care, it has been noted that the excellent patient feedback received is heavily dependent upon permanent staff going the extra mile to provide a good quality of care, through working overtime to cover gaps in the rota.
- Many Trusts have expressed their concern around the difficulty in recruiting Midwives and middle grade doctors, which has led to spend on locum staff in Maternity departments across SYB(ND). Additionally, larger Trusts have inevitably developed efficiencies of scale, making them more cost effective overall.
- One major piece of guidance which could significantly disrupt the sustainability of the status quo is Better New born Care. This guidance requires that neonatology and paediatrics services have separate mid-grade rotas, rather than relying on a shared mid-grade rota as is currently the case in every SYB(ND) site (other than Sheffield Teaching Hospitals and Doncaster).

[19] CQC, Inspection reports, 2016 - 2019

| Key: | Lower than trust average |
|---|---|
| | Higher than trust average |

| | Trust Average | Barnsley | Chesterfield | Doncaster | Bassetlaw | Rotherham | STH |
|---|---|---|---|---|---|---|---|
| **Quality** | | | | | | | |
| CQC Maternity Services score *(In most recent assessment)* | | Good | Good | Requires Improvement | Requires Improvement | Requires Improvement | Outstanding |
| Patient feedback *(NHS Friends and Family Test; Average score)* | 98% | 97% | 99% | 98% | 98% | 99% | 96% |
| **Workforce** | | | | | | | |
| Number of additional Consultants required to meet demand *(Based on modelling and assumptions generated with clinicians)* | 4.6 | 2.0 | 1.1 | 3.4 | 0.5 | 3.4 | 12.5 |
| Number of additional Middle grade doctors required to meet demand *(Based on modelling and assumptions generated with clinicians)* | 3.3 | 0.1 | 2.7 | 3.2 | 3.0 | 1.8 | 5.9 |
| Number of additional Junior grade doctors required to meet demand *(Based on modelling and assumptions generated with clinicians)* | 1.5 | -0.6 | 1.0 | 0.9 | 3.0 | 1.5 | 1.7 |
| Number of additional Nurses (Band 7+) required to meet demand *(Based on modelling and assumptions generated with clinicians)* | 2.9 | -8.2 | 3.5 | 2.9 | -2.0 | 7.5 | 11.1 |
| Number of additional Nurses (Band 5-6) required to meet demand *(Based on modelling and assumptions generated with clinicians)* | 12.3 | 3.7 | -5.0 | -1.9 | 11.8 | 2.9 | 49.9 |
| Number of additional Nurses (Band 1-4) required to meet demand *(Based on modelling and assumptions generated with clinicians)* | 5.3 | 5.3 | 2.1 | 7.3 | 5.3 | 5.2 | 1.3 |
| Overall workplace satisfaction *(Based on GMC trainee staff scores; out of 100)* | 72.3 | 68.2 | 67.9 | 74.5 | 74.5 | 72.7 | 78.3 |
| Overall workload satisfaction *(Based on GMC trainee staff scores; out of 100)* | 48.6 | 56.9 | 58.9 | 41.4 | 41.1 | 43.8 | 42.4 |
| **Affordability** | | | | | | | |
| Obstetrics Reference Cost Index *(Index above 100 is relatively inefficient, below 100 is relatively efficient)* | 106 | 107 | 96 | 112 | 112 | 118 | 88 |
| **Interdependencies** | | | | | | | |
| CQC Urgent and Emergency Services score *(In most recent assessment)* | | Good | Good | Requires Improvement | Requires Improvement | Inadequate | Good |
| CQC Children & Young People score *(In most recent assessment)* | | Requires Improvement | Good | Good | Good | Good | Good |
| Level of Neonatology provision | | Level 2 | Level 2 | Level 2 | Level 2 | Level 2 | Level 3 |

Figure 5: A summary of Trust evaluation metrics, Note: workforce gap data excludes locum staff in place[20]

## 5.6 Future growth in Maternity services

Some Maternity Medical Directors stated that the overall activity levels across SYB(ND) are decreasing. Despite this overall decrease in activity, there continues to be an increase in demand for consultant-led services due to a larger proportion of expected high-risk pregnancies (up to c. 65% for some Trusts). High-risk pregnancies are usually due to public health factors such as obesity or smoking at the time of delivery. The trend of increasing demand due to public health factors is seen across services within SYB(ND).

The activity levels across each Trust in SYB(ND) for Maternity services are shown below in Figure 4, showing the total number of births for 2018/2019 and the average length of stay:

| | Barnsley | Chesterfield | Doncaster | Bassetlaw | Rotherham | Sheffield Teaching |
|---|---|---|---|---|---|---|

[20] Latest publically available data from CQC, NHS Friends and Family Test, Reference Cost Index data; workforce data based on workforce modelling using assumptions from clinicians

| | | | | | | |
|---|---|---|---|---|---|---|
| Average yearly change in birth rate (since 2013/14) | +0.9% | +0.1% | -1.7% | | -0.7% | -0.6% |
| Activity levels (number of births 2018/19) | 2842 | 2719 | 3216 | 1488 | 2697 | 6667 |
| Proportion of expected high-risk births | 65% | 35% | N/A | N/A | 65% | 60% |
| Average length of stay (days) | 2.1 | 2.0 | 2.4 | 2.2 | 2.3 | 2.6 |

*Figure 6: Maternity activity levels across SYB(ND)*[21]

Overall, the demand for maternity services is expected to increase over the next five years. Based on the population growth (ONS) and non-demographic growth assumptions, we expect the number of births to grow by 2% on average in the next five years.

We have assumed that the additional houses being built at Bassetlaw, of which 84per year are intended to encourage population growth over and above demographic growth in the area, will account for a small increase in births but not at levels that could affect the direction of travel laid out in this report.

The graph below (Figure 7) shows the predicted Maternity admission levels on the left axis, with the percentage change in admissions year on year shown on the right axis. The number of Midwives is expected to grow at 0.8% p.a., which is a slower growth rate than the growth rate of Maternity admissions; therefore there is likely to be a shortfall in maternity staffing over the next five years. Although some SYB(ND) Trusts are seeing a decrease in overall activity levels, any increase in the proportion of women who require consultant-led services during their birth, may lead to increased pressures on the consultant workforce.

Using the HEE workforce growth assumptions, we expect the workforce to grow, on average, in the next 5 years (Figure 8):

- 0.8% p.a. for midwifery
- 1.3% p.a. for junior doctors

Although this increase will help to alleviate some of the workforce issues currently experienced in SYB(ND), the rate of growth does not match the growth in demand; this also does not take into account current workforce shortages.

[21] SYB(ND), Trust data returns, 2019

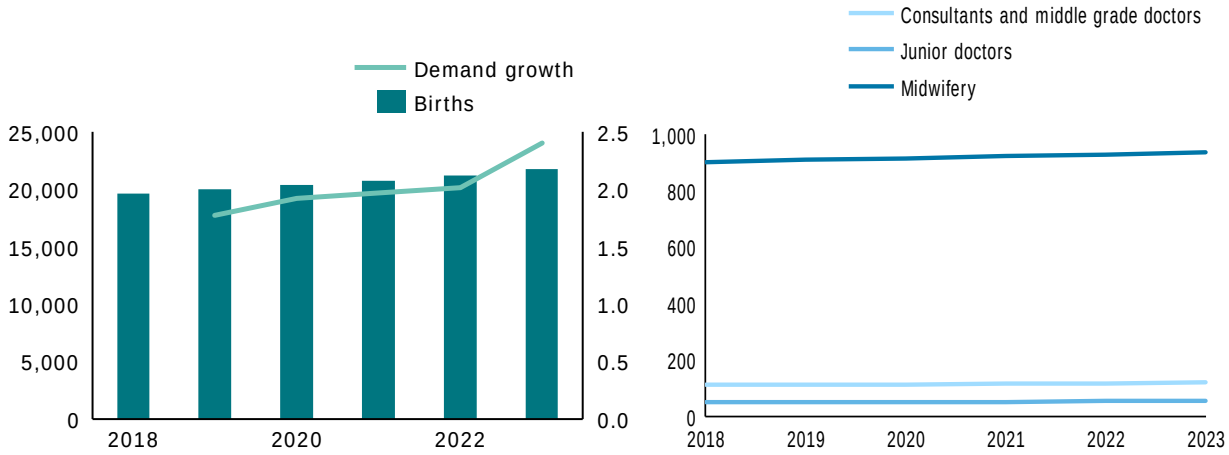






Figure 7: Predicted growth in demand over the next 5 years for Maternity services[22]

Figure 8: Predicted increase in Maternity workforce over the next 5 years[23]

There are also significant concerns around the ageing midwife workforce, and the declining number of midwifery trainees. Continuity of Carer guidelines are also expected to have an impact on the maternity workforce. The guidelines necessitate a different way of working for midwives, who may be on call up to 2 or 3 times a week and teams of midwives will work with the same women throughout their pregnancy, increasing the need for community midwifery. Medical directors for maternity have concerns that the Continuity of Carer targets could significantly destabilise the maternity workforce, due to the increased requirement for midwives, as well as the potential effects of different ways of working might have on midwifery retention rates.

[22] Based on population growth assumptions
[23] Based on data provided by HSE

# 6 The Case for Change: Gastroenterology and Endoscopy

## 6.1 Findings in the original HSR case for change

The scope of this service includes urgent and emergency gastroenterology (GI bleed services and the structure of acute rotas) as well as elective endoscopy services.

The service was raised as a sustainability concern by three Trusts (Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, Sheffield Children's NHS Foundation Trust, Rotherham NHS Foundation Trust) primarily due to difficulties with staffing the service, with some GI bleed services run entirely by locum staff. It is also a service on which many other hospital services rely, particularly because it has close links with the emergency / acute medical rota, and previous attempts to look at GI bleeds services in isolation (via the Working Together Vanguard) have struggled because they impinge upon acute rotas. In an aggregated assessment of the sustainability of services in SYB(ND) Gastroenterology scored 4th. The inclusion of emergency medicine as part of the review, provided an opportunity to revisit this work and incorporate the clinical co-dependencies.

Endoscopy is also a priority for Commissioners and trusts, driven by workforce shortages, a growing workload and consequent capacity issues. Commissioners also recognised the importance of the service in respect of the link to early access in cancer pathways and an extension of screening programmes in local out of hospital pathways.

## 6.2 National gastroenterology workforce challenges

There are challenges with growing the gastroenterology workforce to meet guidance from the RCP around the number of gastroenterologists required to match population levels. Additionally, to add to this challenge, the workforce faces growing levels of demand from increased screening requirements and referrals from Primary care.

As of September 2017, there were c. 1500 substantive gastroenterologists and hepatologists in the UK, a 1.6% expansion from 2016. The mean expansion rate is unchanged during the last 10 years. Additionally, 54% of advertised consultant posts in 2016 to 2017 were unfilled suggesting expansion is less than it could be.[24]

## 6.3 Feedback from public engagement

The ICS team engaged with the public and patients around gastroenterology services. The main points that were made around the Case for Change were:

- Concerns around communications and information for patients. In engagement with seldom heard groups, including people from minority ethnic groups, two respondents reported difficulties in communicating with staff which, they reported, had led to patients being discharged without a clear diagnosis or treatment.

[24] British Society of Gastroenterology, Workforce report, 2018

- A significant number of gastroenterology patients are suffering from liver disease associated with alcohol addiction. Some patients referred to a lack of support in managing their addiction or understanding their circumstances during their hospital stay.

More detail on the response to the public engagement is in Annex F.

## 6.4 Metrics used to assess performance

We have conducted a detailed assessment of Trusts, against a number of metrics at Trust level, which is contained in the case for change report for each Trust and in the detailed case for change Appendix (Annex B). Included below is a snapshot view of these metrics at the system level.

### 6.4.1 Quality

We will measure Quality by considering the question: Is quality of care optimised by promoting delivery of national good practice and guidance, and contributing to maintained or improved outcomes?

This takes into consideration the following:

- Are SYB(ND) Trusts able to meet national clinical guidelines and standards?
- Are patients satisfied with the quality of care offered?

It includes the following measures:

- CQC Assessment

  The CQC score looks at safety, effectiveness, care, responsiveness and leadership of a service.

- JAG Accreditation

  We have noted which Trusts meet the criteria for JAG accreditation. JAG Accreditation means that an endoscopy service has displayed competence in delivery against a set of safety criteria.

- Patient feedback

  We have conducted a qualitative evaluation of NHS choices submissions, as well as public consultation during the Hospital Services Review.

### 6.4.2 Workforce

Workforce is measured by considering the question: Does the option ensure there is a sustainable workforce of the right number and skill set?

This takes into consideration the following:

- Do Trusts have sufficient workforce in place to provide a safe service?
- Is the existing workforce satisfied with their workplace environment and workload?
- To what extent do Trusts rely on locum / temporary staff?

This includes the following measures:

- Fill ratios

  We have considered the fill ratios of Gastroenterology posts based on the approximation by the British Society of Gastroenterology who have recommended 1 Gastroenterologist for every 42,000 members of the population

- Staff satisfaction - GMC trainee staff survey

The General Medical Council (GMC) trainee staff survey asks questions around overall staff satisfaction and workload satisfaction, with both metrics are scored out of 100. A higher score for workload satisfaction indicates a more manageable workload.

#### 6.4.3 Affordability

Affordability is measured by considering the question: Does the option cost no more than the current service?

This takes into consideration the following:

- How much activity do Trusts carry out?
- How efficient are the services the Trusts provide?

This includes the following measures:

- Reference Cost index

  We have used reference cost index (RCI) to assess the affordability of each service at each Trust. RCI is a measure of relative efficiency comparing the actual cost of activities in comparison to the expected cost; an RCI value above 100 means relatively inefficient services, whilst an RCI value below 100 means relatively more efficient services.

#### 6.4.4 Interdependencies

Interdependencies are measured by considering the question: Are the necessary supporting services appropriately available, or are concerns with gastroenterology and endoscopy impacting on other services?

This takes into consideration the following:

- Are interdependent services that need to be provided available onsite?
- What would the impact be to interdependent services at all Trusts if the clinical model were to change?

This includes the following measures:

- Assessment of CQC scores and provision of key interdependent services

  Gastroenterology has a large number of interdependent services, notably Urgent & Emergency Medicine.

### 6.5 The picture in SYB(ND) currently

The table below summarises Trust performance against the measures described above.

- The quality of Gastroenterology and Endoscopy services in SYB(ND) is currently good on most sites, but are facing increasing pressures and strain. Rotherham is of particular concern, as at the beginning of the review there were no permanent Gastroenterologists working at the Trust, with all work being carried out by locum staff. Since then, the Trust, working with Barnsley, has successfully recruited two permanent Gastroenterologists, and are in talks with Barnsley to develop a formalised partnership. However, Rotherham still has a '*Requires improvement*' CQC score for Medical care (including Gastroenterology).
- Patient feedback for Gastroenterology across SYB(ND) is excellent, but staff satisfaction scores for overall satisfaction and workload suggest that the quality of the service is very dependent on staff members putting in extra work to ensure a good quality of care is provided.

- There are substantial workforce shortages for Gastroenterology services across SYB(ND) on particular sites and for Out Of Hour Gastrointestinal Bleed (OOH GI Bleed) Services. The required number of staff is calculated on a basis of having 1 Consultant Gastroenterologist for every 42,000 people in the population (based on the RCP guideline[25]). We have calculated "fill ratios" comparing the staff in post to the numbers required based on the RCP guidelines.
- Fill ratios for Out Of Hours Gastroenterology services highlight that there are shortages in the number of consultants, when compared to the same RCP guideline. The fill ratios indicate that Rotherham and Chesterfield do not have the required number of Gastroenterologists available to work on OOH Gastrointestinal Bleeding (a main cause for concern) both having a fill ratio of only 0.6, vs an average across the other three Trusts of 1.1.
- The Clinical Working Groups have expressed significant concern around the future sustainability of the workforce, due to the low numbers of trainees rising through the ranks. Many CWG participants expressed their concern around the lack of permanent Gastroenterologists at Rotherham and how this shortage was creating further demand at all other SYB(ND) sites, due to the central location of the Rotherham site within South Yorkshire.

Key: Lower than trust average / Higher than trust average

| | Trust Average | Barnsley | Chesterfield | Doncaster | Bassetlaw | Rotherham | STH |
|---|---|---|---|---|---|---|---|
| **Quality** | | | | | | | |
| CQC Medical Care (incl. Gastroenterology) score *(In most recent assessment)* | | Good | Good | Good | Good | Requires Improvement | Good |
| JAG Accreditation status | | Criteria met | Criteria met | Criteria met | Criteria met | Criteria met | Criteria met |
| Patient feedback *(NHS Choices Survey; Average score)* | 99% | 100% | 100% | 100% | 100% | 94% | |
| **Workforce** | | | | | | | |
| Fill ratio for in hours Gastroenterology Services *(based on requirement for 1 Consultant for every 42,000 people; 1 indicates a perfect fill ratio; below 1 indicates a poor fill ratio)* | 1.5 | 1.0 | 1.3 | 2.0 | 2.0 | 1.4 | 1.4 |
| Fill ratio for Out of Hour GI Bleed Services *(based on requirement for 1 Consultant for every 42,000 people 1 indicates a perfect fill ratio; below 1 indicates a poor fill ratio)* | 0.9 | 1.0 | 0.6 | 0.9 | 0.9 | 0.6 | 1.3 |
| Overall workplace satisfaction *(Based on GMC trainee staff scores for Acute Medicine; out of 100)* | 71.6 | 64.5 | 73.7 | 83.5 | 83.5 | 69.2 | 55.2 |
| Overall workload satisfaction *(Based on GMC trainee staff scores for Acute Medicine; out of 100)* | 40.4 | 42.2 | 34.9 | 47.8 | 47.8 | 37.8 | 31.9 |
| **Affordability** | | | | | | | |
| Gastro Reference Cost Index *(Index above 100 is relatively inefficient, below 100 is relatively efficient)* | 109 | 90 | 115 | 126 | 126 | 107 | 89 |
| **Interdependencies** | | | | | | | |
| CQC Urgent and Emergency Services score *(In most recent assessment)* | | Good | Good | Requires Improvement | Requires Improvement | Inadequate | Good |

[25] RCP, Consultant physicians working for patients, 2011

Figure 9: A summary of Trust evaluation metrics[26]

## 6.6 Future demand for Gastroenterology services

The demand for Gastroenterology has significantly increased over the past few years, with one Trust experiencing threefold increase in demand in as many years. The reasons for this large increase are believed by SYB clinicians to be the following:

- The bowel cancer screening programme has increased the demand for endoscopy services[27]
- An ageing population will typically require more Gastroenterology services
- The drop in threshold for referrals from GPs has led to a huge surge in demand for endoscopy services over the past couple of years

Gastroenterologists expect that the demand for Gastroenterology services will only continue to increase in the next five years. If the threshold for bowel cancer screening becomes lower, this will create another large increase in demand for the service in SYB(ND)[28]. Some Gastroenterologists have commented that removing bowel cancer screening from the scope of Gastroenterology services would make the service's workload significantly more manageable.

Additionally, GPs are becoming increasingly risk averse, which also leads to increased referrals for Gastroenterology services. It is also predicted that the occurrence of cancer will increase over the next 5 years, leading to increased requirement for Endoscopy services[29].

[26] Latest publically available data from CQC, NHS Choices, Reference Cost Index, GMC trainee survey data; workforce data based on analysis using population data and RCP guidance. The Doncaster and Bassetlaw services are the same servce, ie Bassetlaw out of hours GI bleeds go to DRI.

[27] Shenbaragaj et al, *Endoscopy in 2017: a national survey of practice in the UK*. BMJ, 2018. https://fg.bmj.com/content/10/1/7

[28] See guidance from the Joint Advisory Group on GI Endoscopy, including JAG Briefing 18/6. https://www.thejag.org.uk/CMS/UploadedDocuments/Scheme/Scheme1/180830%20-%20document%20-%20increasing%20demand%20and%20waiting%20times%20-%20FINAL.pdf

[29] Maddams et al, *Projections of cancer prevalence in the United Kingdom, 2010-2040*, British Journal of Cancer, 2012. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3461160/

# 7 The Case for Change: Summary of pressures on individual sites

The specific challenges within individual services contribute to an overall sense of the pressures that the Trusts are facing across the Board.

The HSR recognises that, across services, quality is currently good. SYB is performing well against the majority of quality metrics such as the A&E waiting times, and in a recent review meeting with national regulators was found to be one of the best performing systems nationally across the board. Individual trusts are national leaders in some specialties. This good performance is the result of significant hard work by staff across the system, and excellent service management in some areas.

While SYB has much to be proud of, there are nevertheless significant pressures, and going forward, trends in demand, financial pressure and the predicted shortage of medical and nursing workforce globally, continue to point to significant challenges facing the system as a whole as well as individual trusts.

This section sums up, in brief, the key challenges that the HSR has identified in each of the Trusts, in relation to the services in the HSR.

## 7.1 Barnsley Hospital NHS Foundation Trust

- The CQC score for Paediatrics was 'Requires improvement' in the most recent inspection, however this may have been due to a one-off incident.
- Barnsley achieved all 10 of RCPCH's Facing the Future (FTF) standards in 2018, and were used as an example of an excellent CAIC service in the latest national FTF report.
- There has recently been a shortage of Paediatrics nurses due to retirement and maternity leave – this means that only 18 out of 22 beds can be used.
- The hospital has recently acquired funding for refurbishment of its A&E department which will allow for the co-location of its Paediatric Assessment Unit in the A&E village, easing pressures on staffing by allowing them to double up A&E paediatric nurses in the A&E.
- The department has a steady workforce who are loyal and have several specialist capabilities, helping the department to achieve a *Good* CQC score for its Maternity services.

## 7.2 Chesterfield Royal Hospital Trust

- In order to meet Facing the Future standard 6 (Access to the opinion of a Consultant Paediatrician throughout open hours) additional Consultant capacity would be required.
- Chesterfield aims to develop a recruitment program to address the middle grade doctor shortage. It has also developed a 'Resident Consultant' position made up of more "junior" Consultants (less than 5 years in grade) to support the overnight middle grade rota.
- There is some pressure on space for outpatient clinics.
- The workforce for CAIC is very stable and robust, with no large recruitment issues seen. Medical trainees typically apply for permanent positions at the Trust due to the good quality of care provided. There are 0.9 WTE vacancies for band 1-4 nurses and 0.5 WTE vacancies for band 5-6 nurses.
- The department has a steady workforce who are reliable and loyal. The trust believes medical staff actively apply to the Maternity unit due to the excellent level of care they provide.

## 7.3 Doncaster Royal Infirmary

- Doncaster & Bassetlaw are struggling to maintain a sustainable Paediatrics and Maternity rota across both sites, placing significant strain on their workforce.
- Doncaster & Bassetlaw has the lowest Paediatric workload satisfaction GMC junior doctor survey score across SYB(ND) at 37.9 compared to an average of 44.1.*
- The CQC score for A&E services for Doncaster and Bassetlaw remains at *Requires improvement* in 2019, partially due to insufficient Paediatric nurse presence.
- Doncaster did not receive national funding for the backlog maintenance that it required, and is looking at other ways to fund necessary changes to the women and children's hospital. Changes are likely to be needed with or without new activity.

## 7.4 Bassetlaw District General Hospital

- Bassetlaw closed its paediatrics unit to admissions overnight in January 2017 due to a lack of nursing staff. This happened quickly through a number of staff retiring and leaving, and it has since proven very difficult to replace these staff.
- Prior to the changes, Bassetlaw transferred about 4 patients a week to Doncaster; since the change in service this has been around 15 patients per week.
- Feedback following the change in pathway has been generally positive. There has been no detriment to clinical outcomes at Bassetlaw and no complaints related to the new model of care.
- The Trust currently cannot reliably maintain a Maternity service overnight due to insufficient numbers of middle grade doctors on the Anaesthetics rota at Bassetlaw (only 3 of 8 positions filled).
- There are large vacancies across Neonatology at Bassetlaw.
- The service struggles with capacity and workforce issues – patients have had to be diverted to neighbouring hospitals on multiple occasions over past year.

## 7.5 Rotherham NHS Foundation Trust

- Rotherham has started to make some changes and address CQC concerns, improving its Children and Young Person's CQC score to 'Good'. The Trust's Maternity score is 'Requires Improvement' and Urgent and Emergency Care Services CQC scores remain at 'Inadequate' although Rotherham reports that the concern around paediatric nurses in A&E has now been addressed.
- Rotherham experiences significant difficulty in hiring medical trainees; they believe this is because many trainees in the region apply to Sheffield due to the attraction of a larger city and a hospital with more specialties.
- The CQC score for Rotherham's Maternity services was *Requires improvement* in 2019 which the Trust is seeking to improve.
- Rotherham received the lowest score in the 3 categories of the NHS Maternity survey in SYB(ND), looking at labour & birth, staff and post birth hospital care.

## 7.6 Sheffield Children's Hospital NHS Foundation Trust

- Sheffield Children's Hospital has more sustainable levels of staffing across most departments than the DGHs.

- Sheffield is working collaboratively across SYB(ND) and with Leeds Teaching Hospitals to mitigate workforce shortages where possible.
- The key difficulties that SCH faces include staffing departments with trainees, given the six month cycle for trainees which limits the ability to plan the workforce.
- While most departments are staffed sustainably, there is no spare capacity, so there is limited flexibility to deal with absences or leave.
- Sheffield wants to grow its Emergency Department and CAU as they often operate over-capacity.

## 7.7 Sheffield Teaching Hospital NHS Foundation Trust

- As with SCH, STH has more sustainable levels of staffing in its maternity services than the majority of the DGHs.
- Sheffield Teaching Hospital faces significant pressure supporting DGHs across SYB(ND) and receiving a large number of transfers from the wider system.
- As with the rest of SYB(ND), the Trust is apprehensive about the additional Midwifery staff required as part of the implications of the Continuity of Carer guidelines.
- The CQC score for the Sheffield Maternity services was *Outstanding* in 2018.
- The increasing complexity of pregnancies across the region is leading to an increased demand for consultant-led services, despite the overall demand falling.
- Providing continuity of carer will be a big challenge for Sheffield moving forward as this is a different way of working for Midwives, who may be on call 2 to 3 times a week.

Therefore, given the challenges faced by the system, changes will need to be made to the way services are delivered through with Trusts working together to develop appropriate system-wide service Transformation solutions such as developing staff networks and increasing university intakes for essential roles. Where these do not go far enough to solve the challenges raised by the Case for Change, changes to the clinical model through reconfiguration will need to be considered.

# Considering the options going forward

In this section we will consider the following:

- The most appropriate options identified for Paediatric and Maternity services in terms of ways forward to resolve challenges addressed by the case for change
- The most appropriate options identified for Gastroenterology services in terms of ways forward to resolve challenges addressed by the case for change
- How we can monitor for early warning signals going forward

# 8 CAIC and Maternity: the opportunities for change

Working with the SYB(ND) Clinical Working Groups, we have considered options to address the existing and growing challenges in paediatrics and maternity. Given clinical interdependencies, the work has considered the impact of changes to Paediatrics on Neonatology and Maternity Services and vice versa. We have considered 3 levels of change, bearing in mind that different solutions may be appropriate for different sites.

1. Maintain the status quo

   *The status quo was deemed to be unsustainable in the first phases of the Hospital Services Review.*

   If this does not resolve the challenge…

2. Service transformation

   Providing services to patients closer to home or on the same acute sites as they currently receive it, but with new ways of working.

   If this does not resolve the challenge …

3. Change the clinical model of Paediatric services on one or two sites

   Some of the most severely ill children receive services on different, more specialist sites.

   If this does not resolve the challenge …

4. Change the clinical model of both Paediatric and Maternity services on one or two sites

   Some of the most severely ill children and most complex mothers and babies receive services on different, more specialist sites.

## 8.1 Evaluation criteria

In order to assess which of these approaches is appropriate for each site in SYB, we have evaluated the options against five criteria, which were identified through engagement with the public, clinicians and leaders in the SYB system.

- **Workforce**: This criterion considers the ability of the site to attract and sustain an appropriate workforce. This will be partially influenced by local geography and the availability of an appropriate pool of potential staff, and will also be influenced by the potential for shared working across other sites. Some staff groups, such as consultants, can more easily work across sites than others.
- **Quality**: This criterion considers the fact that in order to maintain a good quality of service, the site needs to sustain a level of activity which allows staff to maintain their skills, and to ensure that trainees receive adequate exposure to a range of work. For elective services, patients can be redirected, but the activity levels for urgent care are more likely to be determined by the size of the local population.
- **Access**: Important dimensions of this criterion include the additional travel times for patients and families of making any change, whether there is another site close enough to provide a safe alternative, and whether a particular population will be disadvantaged by changes at a particular site.

- **Affordability**: This criterion considers whether the way services are delivered is affordable and financially sustainable.
- **Interdependencies**: This criterion considers whether interdependent services are of a sufficiently high quality and sustainable.

# 9 CAIC and Maternity: Transformation

The starting point for the Hospital Services Review was to test out how far the Trusts could go in making services more sustainable within the same configuration of acute services.

Reconfiguration carries a number of risks and disadvantages, so the Clinical Working Groups have focused closely on exploring ways that the system can improve sustainability without changing the services that are offered on a particular site. The work on transformation within the HSR has focused on two areas:

- Building infrastructure to support transformation between the Trusts
- Identifying specific proposals or areas of focus for transformation.

## 9.1 Building the infrastructure to support transformation

The Clinical Working Groups identified a number of opportunities to improve services through shared working.

Some infrastructure already exists to support this joint working, including the Managed Clinical Networks for Care of the Acutely Ill Child and Children's Surgery and Anaesthesia, and the statutorily mandated Local Maternity System. (The Operational Delivery Networks, such as the Neonatology ODN, operate on a regional footprint and are outwith the scope of this work.)

However, the Clinical Working Groups said that the existing groups have had varying levels of success, and encountered some common barriers. While the LMS has the weight of statutory requirements behind it, some of the MCNs have struggled to gain sufficiently senior buy in, and to make decisions enforceable across Trusts.

In response to this, the Hospital Services Programme has proposed and is now setting up a series of Hosted Networks, one for each of the 5 services included in the Hospital Services Review. Three levels of the Hosted Networks have been identified:

- Level 1 will focus on shared approaches to workforce, clinical standardisation and innovation;
- Level 2 will involve a higher level of sharing resources across the system;
- Level 3 will consist of a closer relationship with one Trust providing or supporting services on another Trust's site(s).

The system is in the process of developing level 1 networks for maternity, paediatrics, gastroenterology, stroke and Urgent and Emergency Care, and is exploring a level 3 network in paediatrics between two Trusts.

The level 1 networks will be formal collaborations between the Trusts, chaired at Chief Executive (CEO) level, with work programmes signed off at the level of the Health Executive Group (HEG) and with monthly reporting on progress to CEOs at the Acute Federation and ultimately at the HEG. They are intended to have a high profile within the organisations and a senior level of oversight to drive delivery.

The Networks are being resourced with 4 PAs of clinical leadership time, 0.5 of a Network Manager, and a small team of analysts and analytical support to ensure that they have the resources they need to deliver their work programme.

## 9.2 Identifying areas for focus for transformation

The Integrated Care System as a whole covers a large transformation programme, which includes transformation in public health and prevention, mental health, primary care services, community services, the digital agenda and workforce.

This section focuses on the transformation that relates specifically to acute services. It covers

- The work programme in the 'level 1' Hosted Networks
- The work programme in the 'level 3' Hosted Networks
- Other areas of work ongoing within individual Trusts
- Other areas of work ongoing at ICS level.

### 9.2.1 Work programme of the level 1 hosted networks

The work programme of the level 1 Hosted Networks will cover workforce, clinical standardisation and innovation. The work programmes are in the process of being developed, and will not be signed off until the new Clinical Lead is in place and can provide input. However, the main common themes that are emerging are:

- **Workforce planning:** All of the Networks have identified proper workforce planning as one of their key deliverables. At present workforce planning tends to be based on what has been provided historically. Work is ongoing around developing new roles, in specific services or Trusts, but this is not consistent or system-wide. The Networks will work with the Local Workforce Advisory Board to develop workforce planning.
- **Workforce data**: A major challenge is the lack of consistent, shared workforce data. Resources are available to recruit two dedicated workforce analysts and two generalist analysts to support Trusts in building and cleaning the workforce data. One of the proposals included below is for a system-wide collection of 'early warning' data which would include essential metrics such as shifts covered by non-substantive staff.
- **Recruitment and retention**: The networks are already beginning to discuss some shared recruitment activity, and this will be expanded.
- **Clinical standardisation**: Most of the networks are planning to identify some early wins, by identifying specific clinical protocols that can be agreed and implemented across the Trusts. More ambitiously, the Networks have the potential to standardise approaches to shifting care out of hospital, for example developing consistent rehabilitation pathways for stroke, and Hospital@Home models for paediatrics.
- **Innovation**: all of the networks are looking at innovative approaches to services, and how good practice might be spread by benchmarking performance and sharing ideas.

### 9.2.2 Work programme of the level 3 Hosted Networks

The ICS has also discussed mechanisms for closer working. At this point, none of the Trusts are looking to move to a level 2 Hosted Network, which would involve systematic pooling of resources and workforce across the whole of SYB. However, the system is exploring the possibilities of a level 3 network, which would involve one Trust which has a particular strength in a specific service providing or supporting the provision of that service on another Trust's site(s).

Sheffield Children's Hospital and Doncaster and Bassetlaw are working together to explore the possibilities of a level 3 network. The work will look at how SCH might use its specialist expertise and its strong reputation to support paediatric services on the sites of Doncaster Royal Infirmary and Bassetlaw Hospital.

#### 9.2.3 Other areas of work ongoing within individual Trusts

All of the individual Trusts are already pursuing programmes of transformation that are intended to address some of the challenges identified in this report. In particular, action is going forward to address challenges in the paediatric and maternity workforce:

- Barnsley has recently received funding to renovate its Emergency Department. This will allow for the co-location of its Paediatric Assessment Unit with its ED, meaning that the same two paediatric nurses can cover both and the site can meet this CQC standard.
- Rotherham is further developing integrated community pathways working closely with partners across the Place and has reduced reliance on inpatient beds.

These are examples of ways in which it may be possible for the Trusts to address the challenges here within the current acute configuration. In the longer term, new models of care such as Hospital@Home could significantly reduce the need for inpatient beds on hospital sites, although the impact of this on workforce requirements remains to be seen.

#### 9.2.4 Other areas of work ongoing within the ICS

Work is ongoing across the ICS to take forward transformation. Particularly relevant to the issues contained in this report is the work on the digital agenda, workforce, and primary care.

- There is work to develop the digital infrastructure that the system needs to support shared working, although the lack of capital resources available nationally is challenging.
- The ICS has established a new Workforce Hub which brings together the resources currently available in the system to strengthen workforce planning. This is at an early stage but will gradually build the workforce capacity of the system.
- Work is ongoing to develop primary care networks. There is work ongoing in each Place to shift activity closer to home although this will require additional support.

### 9.3 How likely is transformation to address the challenges?

At the session on the 1st April, the Accountable Officers, Chief Executives and Medical Directors of the acute providers considered whether the transformation agenda would go far enough to address the challenges. The group discussed the potential impact on quality and safety, workforce, access, affordability and interdependent services.

The group concluded that at this stage it is not clear whether the work that Trusts are taking forward together and individually will address the scale of the challenge in full.

There is encouraging progress, and some of the evolutionary changes that Trusts are making – such as shifts out of hospital and changes to the configuration of the estate – could help to put the services on a sustainable footing individually. However, given the rapidly changing situation at national level and the dynamic nature of workforce issues the ICS cannot guarantee that action will be able to combat all the challenges of growth in demand and national workforce shortages that are likely to emerge.

In this context, the AOs and CEOs weighed up the risks of taking a transformation approach compared with reconfiguration. As discussed in the next section, reconfiguration of services has the potential to reduce the demand for workforce by consolidating services, while transformation largely retains the current configuration.

The preference of the AOs and CEOs was to fully implement transformation before attempting reconfiguration, unless there was a safety issue on a site. However they felt that if the system was to go down this route, it would need to have the tools to monitor the impact of transformation at a system level, and also to have an early warning system if safety issues were emerging. This is discussed in detail in chapter 15.

In the event of these metrics showing a significant problem, or a major concern emerging unexpectedly, the system will work to address this to ensure the safety of patients.

# 10 CAIC and Maternity: Reconfiguring Services

The Hospital Service Programme has considered the options around reconfiguration of maternity and inpatient paediatrics services.

Reconfiguration was considered because, unlike transformation which continues to provide the same number of units for a particular service across the system, reconfiguration allows for units to be consolidated. This can lead both to a saving in the number of staff needed overall, and to greater resilience in the remaining units which are larger and have a larger rota of staff to draw on in the event of workforce shortages.

The following chapters describe:

- Chapter 10: the models for reconfiguration
- Chapter 11: the advantages and disadvantages of reconfiguring inpatient paediatrics
- Chapter 12: the advantages and disadvantages of reconfiguring maternity

## 10.1 Models that the Hospital Services programme has considered

The HSR recommended that the system should look at 2 possible areas for reconfiguration:

- Changing inpatient paediatric units on one or two sites into Short Stay Paediatric Assessment Units (SSPAUs);
- If necessary, changing the obstetric unit on one or both of those sites into a Standalone Midwifery Led Unit (SMLU).

Concerns about SMLUs raised by the public and clinicians led the Boards and Governing Bodies to ask the Hospital Services Programme to explore options which would enable a site to retain obstetrics even if it no longer had 24/7 inpatient paediatrics onsite. This is described in section 10.2.

## 10.2 Changing Inpatient Paediatric Units on 1 or 2 sites

In this model:

- The inpatient paediatric unit on a site is converted a Short Stay Paediatric Assessment, Unit (SSPAU), open 12, 14 or 16 hours a day
- Obstetric services and neonatology services remain onsite. This is achieved by supporting the neonatology rota with Advanced Neonatal Nurse Practitioners (ANNPs) rather than paediatric middle grade staff and junior doctors

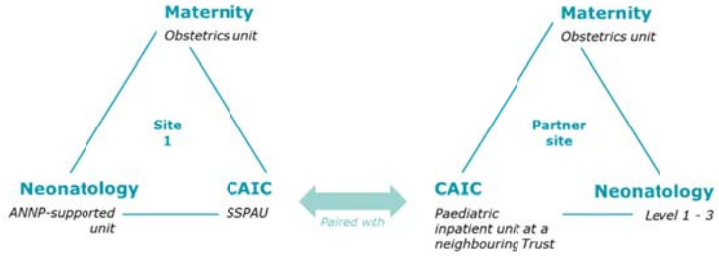



Figure 10: Proposed clinical model on a site where Paediatric Services are unsustainable

In this model, children arriving at the site or picked up by ambulance outside of opening hours are transferred to a paired site overnight, if required, based on clinical judgement. Children are also triaged as appropriate throughout the day if it becomes evident that they will require overnight care.

The model minimises the number of children requiring inpatient care by strengthening care closer to home. A Hospital@Home model operates, with a triage system that diverts children to care in their own home wherever possible, and community services are strengthened.

Where possible, depending on site layout and capital investment, the PAU is co-located with paediatric A&E so that two paediatric nurses in the PAU can also cover the A&E during the day, reducing the number of staff needed to meet CQC requirements.

In order to maintain a neonatal service on the site where CAIC services are found to be unsustainable, the middle and junior grade rotas are supported by the development of Advanced Neonatal Nurse Practitioners (ANNPs).

### 10.2.1 Requirements to make the model work

The model would require investment into out of hospital services, to support as many children as possible to be treated closer to home.

The model also requires work at a cross-system level to recruit and train ANNPs over a period of several years. The planning approach should learn from best practice in other healthcare systems, where promising Band 5 nurses are recruited and given accelerated training and support to get them to ANNP level, rather than relying on an existing workforce of experienced nurses.

Learning from existing sites such as Doncaster where ANNPs are used indicates that in order for this model to be successful it would need to be a system-wide approach, with a critical mass of ANNPs and clear cross-system development and career paths for them.

### 10.2.2 Patient and public feedback on the model

The public engagement included extensive discussion, with a range of different groups, around the option of moving from an inpatient unit to a Short Stay Paediatric Assessment Unit. The engagement included sessions with mothers, at mother and baby groups, and with working parents at some of the major employers in SYB.

More detail on the public engagement and the Hospital Services Programme's response to it is at Annex F.

The key themes that emerged were

- Some parents were concerned above all to ensure that their child received appropriate specialist care, and were willing to travel further to ensure that this happened.
- Some parents felt that all specialist services should be provided on all sites and expressed concern about parents having to travel to units further away, particularly if they had other children who they could not leave. Some respondents from Bassetlaw felt strongly that the inpatient unit should be reinstated.

The public engagement did not include neonatology, since the proposed shift to an ANNP model does not change the care that babies would receive. ANNPs are trained in neonatology to the same level as a junior or mid-grade doctor, with the difference being that they are neonatology specialists rather than paediatric generalists.

## 10.3 Changing inpatient paediatrics services and obstetric services on 1 or 2 sites

Where neither inpatient paediatrics and maternity services (and / or their interdependent services) can be sustained on a site through a system-wide approach, this model involves changing the clinical model of both paediatric and maternity services on one or two sites:

- Changing the inpatient paediatric unit on a site to a SSPAU; and
- changing the obstetrics unit to a Standalone Midwifery Led Unit (SMLU); and
- removing Neonatal services from the site.

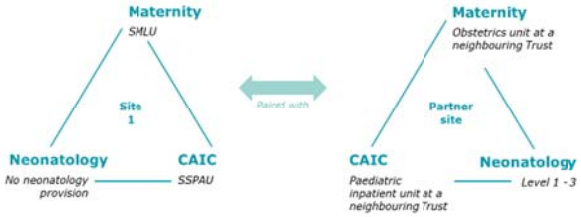



Figure 11: Proposed clinical model on a site where both Maternity and Paediatric Services are unsustainable

The design of the paediatrics service is as per section 10.2

The Midwife-led unit is open 24/7 with no obstetrician involvement, for expected low-risk pregnancies only, where low risk is defined as:

- 37 – 42 weeks of gestation
- expected normal birth
- expected no intervention
- estimated good birth weight
- Mother is non-smoker
- Mother is not obese
- Mother does not have diabetes

24/7 Ambulance transfer service is available in the event of unforeseen complications, with clear transfer protocols and agreements in place with both the ambulance service and the receiving site, to transfer women to a paired site if there appear to be complications.

Antenatal and post-natal services continue to be provided on the SMLU site.

### 10.3.1 Patient and public feedback on the model

There was considerable public engagement around the proposed SMLU model. More detail is at Annex F.

In summary, the views of the public were as follows:

- Some respondents, particularly women who have themselves had midwife-led births, supported a Standalone Midwifery Led Unit.
- Some respondents expressed concern about the safety of the model, if a woman got into difficulties during labour.

- Some respondents raised concerns about midwife led units even alongside an obstetric unit, and suggested that all births should be in obstetric units in the interest of patient safety. These respondents tended also to be opposed to home births.
- Some respondents raised concerns that families would have to travel further away in order to visit.
- Some respondents were concerned that a woman would also have to travel to the further site for ante- and post-natal care, which could be particularly difficult if she had to navigate public transport while pregnant or with a pushchair.

### 10.3.2 Requirements to make the model work

The benefit of a SMLU is that it enables some women in a community to continue to give birth in their local hospital, even if that hospital cannot safely maintain the rotas of obstetric, anaesthetic or neonatology staff that would be necessary to provide obstetrics.

The SMLU model has been identified in the national report Better Births as being safe, and evidence from NICE guidance[30] indicates that the outcomes in SMLUs tend to be better than in obstetric units or Alongside MLUs. This is dependent on the correct triage protocols being in place, to direct patients to the appropriate setting.

The main concern around the SMLU model is that it is able to accept only a proportion of patients (those who are low risk); and beyond this, there is a likelihood that some women who would be eligible for a SMLU will prefer to give birth on a site with an obstetric unit.

A site running a SMLU will therefore need to recognise that it may have a higher cost per birth than an obstetric unit; but this must be considered in the context of the wider costs to the site and the safety risks of trying to support an unsustainable unit, and the service limitations of there being no maternity services available on a site.

[30]NICE, Intrapartum Care for Women and Babies, 2014. https://www.nice.org.uk/guidance/CG190

# 11 The advantages and disadvantages of making changes to paediatrics

The Hospital Services team have undertaken detailed analysis of the models proposed above. The models have been assessed against the five evaluation criteria for the HSR, which were agreed in discussion with patients and the public; representatives from seldom heard groups; clinicians; and system leaders:

- Quality and safety: qualitative assessment
- Workforce: quantitative, site-specific modelling
- Access: quantitative, site-specific modelling of travel times
- Affordability: quantitative, site-specific modelling of costs
- Interdependencies: qualitative assessment.

The detailed methodology and results are laid out in the annexes, with key findings summarised below.

## 11.1 Quality and safety

Changing a challenged, understaffed service into a SSPAU, with the most seriously ill patients being seen in a larger specialist unit, can have a demonstrable effect on improving quality. An example of improvement in quality of care through moving to a SSPAU from a very fragile inpatient paediatrics service can be seen at Bassetlaw. Clinicians consider that the Bassetlaw service has been sustainable since the changes made in January 2017, with no detriment to clinical outcomes and no complaints related to the new model of care.

Moving to an SSPAU model requires a number of safety and quality protocols to be in place, to ensure that any child arriving on the site who is seriously ill can be stabilised and rapidly transferred.

### 11.1.1 Quality and safety of services at Bassetlaw

The model of care currently being provided at Bassetlaw is consistent with guidance from the Royal College of Paediatrics and Child Health.

Data shows that the number of patients transferred per week from Bassetlaw to Doncaster has risen from an average of 6 to an average of 15. Almost 85% of all patients stay one night or less and most children will benefit from an enhanced assessment and treatment service.

The closure of overnight Paediatric services at Bassetlaw remains on the risk register for Doncaster and Bassetlaw, with a number of ongoing monitoring processes in place. The service is providing a higher quality of service, as measured by appropriate levels of staffing, than was that case prior to the change.

### 11.1.2 Discussion at 1st April session

The AOs, CEOs and Medical Directors weighed the relative quality and safety implications of changing the clinical model, against the implications of not changing it.

- **Safety of the SSPAU model:** the SSPAU model is accepted as being a safe way to run services, provided that the necessary transfer protocols and support are in place, and it is accepted as being the appropriate model in some circumstances.

- **Current concerns:** The CEOs and Medical Directors who attended the session on the 1st April were of the view that, while there were obvious sustainability challenges in the system, there were no current safety concerns on any of the SYB sites.

  Bassetlaw had addressed potential safety concerns by making the changes in January 2017, and now had a good quality service, as a result of moving to the SSPAU model.

  The group discussed whether they believed that the availability of workforce had been, or could be, addressed to the point where Bassetlaw would be able to return to an inpatient paediatrics unit without encountering the same quality and safety concerns as had arisen previously. The detail of the workforce discussion is included in the next section; but in summary, in the context of the local population and increasing national pressures, Doncaster and Bassetlaw acute providers and commissioners do not believe that the additional workforce necessary to make services safe in a 24/7 inpatient paediatrics unit will be likely to become available.

  The review has also looked at the growth of activity over the short to medium term. The population of Bassetlaw is intended to rise over the next 20 years, but the impact of this on activity levels in maternity and paediatrics is expected to be relatively small. The challenges arising from low activity levels at Bassetlaw will be partially addressed but Bassetlaw is likely to continue to be one of the smaller units in SYB.

  Doncaster and Bassetlaw are looking to work with Sheffield Children's Hospital in a level 3 network, to strengthen services, to optimise the SSPAU model

  Some of the sites (Rotherham and Doncaster) have been identified by the CQC as having some quality concerns in particular around paediatric nurses in A&E. However Rotherham felt that the issues identified had been addressed or were in the process of being addressed.

  Barnsley received a Requires Improvement rating for its paediatrics but believes that it has addressed the issues, which related to a specific incident at the time of the inspection.

- **Risk of destabilising the workforce**: Against this, the CEOs and Medical Directors felt that there was a risk that moving to consultation on reconfiguration might destabilise sites by causing staff to look for employment elsewhere.

- **Bassetlaw**: The exception to this was Bassetlaw where safety issues had arisen through difficulties in recruiting adequate numbers of paediatrics staff.

The AOs, CEOs and Medical Directors therefore believed that the immediate and medium term safety and quality issues would be better served by focusing on transformation rather than reconfiguration.

The exception to this was Bassetlaw, where the group took the view on quality and safety grounds that Bassetlaw CCG should be invited to consider that it is unlikely that it will be possible to re-introduce overnight inpatient paediatric beds, and whether any further options, which improve the patients' experience are possible. This could be pursued as a part of the level 3 hosted network model with Sheffield Children's Hospital.

## 11.2 Workforce

### 11.2.1 Workforce impact of changing the clinical model

The Clinical Working Groups helped to identify how changing the clinical model results in savings to the number of workforce required for both Paediatrics and Maternity, and by grade:

- Paediatrics SSPAU model:
  - Consultants: The number of consultants does not reduce if an inpatient unit becomes an SSPAU, since the same number of consultants are needed to provide day time

cover, and the difference is that they no longer have to cover an on-call overnight rota.

- Middle grade and junior doctors: The number of middle grade and junior doctors reduces because they need to be present on site for a shorter duration of time
- Nurses: The number of nurses reduces with the number of beds. On a regional level, any reduction in the number of nurses is due to patients leaving SYB for care.

- Maternity SMLU model:
  - Consultants: Consultants are no longer required to provide care at an SMLU
  - Middle grade and junior doctors: Middle grade and Junior doctors are no longer required to provide care at an SMLU
  - Midwives: The number of midwives reduces with the number of births that are transferred to other sites due to higher complexity. 1 registered midwife is required for every 28 births. On a regional level, any reduction in the number of midwives is due to patients leaving SYB for care.

### 11.2.2 How the workforce changes were calculated

The modelling had three elements:

1. **Collecting the data**: The Hospital Services team have worked with clinicians across all of the sites to identify their current numbers of staff in post. This data was correct and signed off by Medical Directors as of 2nd April 2019; given the changing nature of workforce data, it will continue to fluctuate but changes are likely to be marginal.

   The HS team also collected data on agency and staff bank usage. Please note that the HS team were not able to collect consistent data from all trusts on the amount of additional shifts worked by substantive staff, so this is not included. Clinicians have challenged the low level of bank and agency shown here, and have suggested that a significant number of additional hours are worked by substantive staff working additional shifts.

2. **Impact on individual sites**: The HS team modelled the number of staff who would be required on each site if the clinical model changed from inpatient paediatrics to a SSPAU on that site. The team did not model the impact of moving to an SSPAU at Sheffield Children's Hospital, which was designated as a fixed site. The explanation of how SCH was identified as fixed can be found in annex D.

3. **Impact on the system as a whole**: The team also then modelled the total, net impact on the system as a whole. The model assumes that patients would transfer to the hospital that is the next closest to their home (see section 11.3). This would result in some other sites becoming larger, needing to expand their numbers of nurses, and in some cases (if they are at a tipping point) to expand their number of consultants. Some activity is also likely to flow out of South Yorkshire and Bassetlaw, as patients' next closest hospital would be over the border.

### 11.2.3 Impact on individual sites

The following table shows the total number of staff currently on each site, and the number that would be needed if the model changed from inpatient unit to a SSPAU.

The detailed slides of the data are attached in Annex A.

| Barnsley | Bassetlaw | Chesterfield | Doncaster | Rotherham |
|---|---|---|---|---|

| | Current | New | Current | New[31] | Current | New | Current | New | Current | New |
|---|---|---|---|---|---|---|---|---|---|---|
| Consultants | 8.0 | 8.2 | 3.0 | 8.2 | 8.2 | 8.2 | 11.8 | 8.2 | 9.6 | 8.2 |
| Mid Grades | 10.5 | 7.4 | 5.0 | 7.4 | 8.8 | 7.4 | 11.0 | 7.4 | 7.5 | 7.4 |
| Junior doctors | 10.5 | 7.3 | 4.0 | 7.3 | 9.0 | 7.3 | 11.0 | 7.3 | 7.5 | 7.3 |
| Nurses | 37.5 | 17.3 | 17.2 | 17.3 | 35.2 | 17.3 | 57.4 | 21.7 | 39.7 | 17.3 |
| **TOTAL** | 66.5 | 40.3 | 29.2 | 40.3 | 61.2 | 40.3 | 91.2 | 44.6 | 64.3 | 40.3 |
| **Change in number of posts needed** | | *26.2* | | *-11.1* | | *20.9* | | *46.6* | | *24.0* |

Figure 12: Current workforce and modelled potential workforce under an SSPAU model[32]

### 11.2.4 Impact on the system as a whole

The Hospital Services team modelled the impact of making all the possible permutations of changes, for changing services at one site and changing two sites. This results in 30 possible permutations. The full breakdown of all the possible changes is laid out in the annex.

For illustrative purposes, this table shows the potential range of impacts for the system: the smallest to the largest potential saving for the system.

| | **Impact of changing one site** | | **System-wide impact of changing 2 sites** | |
|---|---|---|---|---|
| | Impact of option involving minimum change | Impact of option involving maximum change | Impact of option involving minimum change | Impact of option involving maximum change |
| Consultants | Require additional 5.2 WTE | Reduce by 3.6 WTE | Require additional 5.2 WTE | Reduce by 3.4 WTE |
| Mid Grades | Require additional 5.6 WTE | Reduce by 3.6 WTE | Require additional 1.1 WTE | Reduce by 6.6 WTE |
| Junior doctors | Require additional 3.3 WTE | Reduce by 3.7 WTE | Require additional 1.5 WTE | Reduce by 7.0 WTE |
| Nurses | Require additional 0.1 WTE | Reduce by 35.7 WTE | Reduce by 17.7 WTE | Reduce by 55.9 WTE |
| **Change in number of posts needed on** | Require additional 11.1 WTE | Reduce by 46.6 WTE | Reduce by 9.8 WTE | Reduce by 72.8 WTE |

[31] Bassetlaw is shown as needing more staff than is currently the case because the existing staffing levels are below those identified as optimal by the Clinical Working Groups

[32] Based on trust submitted data-returns and workforce modelling conducted based on assumptions developed by clinicians

| | | | | |
|---|---|---|---|---|
| **individual sites** | | | | |

Figure 13: Potential system-wide WTE savings if one or two sites change to an SSPAU[33]

### 11.2.5 Comparison with the number of staff needed in the system

One of the main tasks that the Hospital Services team asked the Clinical Working Groups to carry out was to identify how many staff they felt that the system would need, in order to deliver a sustainable workforce.

This request emerged out of comments from system leaders and clinicians during the Hospital Services Review. The HSR compared the number of staff who are currently in post with the number that would be needed in order to meet Royal College guidelines.

During the HSR, and the production of the Strategic Outline Case, the Hospital Services team received feedback that the Royal College guidelines were seen as being generous, and highly ambitious given national pressures on staffing. While they were considered to be best practice system leaders and clinicians believed that a safe and sustainable service could be delivered without meeting them.

The Hospital Services team therefore worked with the Clinical Working Groups, over a period of four months, to identify what a realistic number of staff would look like for a sustainable workforce for the system. The attendees of the CWGs were asked to identify how many staff would be needed, to have a workforce where

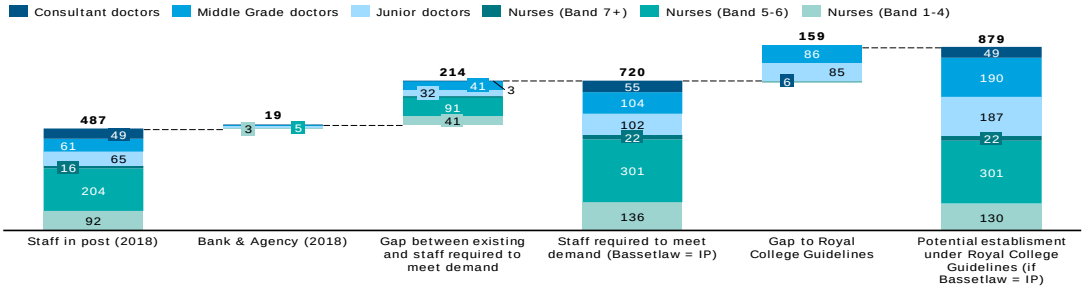
- all shifts could be covered by substantive staff within their contracted working hours
- all staff were able to take their annual statutory and mandatory training
- all staff were able to take their annual leave, and study leave where relevant.

The methodology and the number of staff that was identified by the Clinical Working Group as necessary to meet these requirements is laid out in detail at Annex A.

The following bar chart shows

- the total number of staff currently in the system for paediatrics;
- the number that would be needed to meet the ‘sustainable workforce’ identified by the CWGs;
- the number that would be needed to meet the Royal College Guidelines; and
- how far the change to the model on one or two sites might take you towards closing the gap.

[33] Based on workforce modelling conducted based on assumptions developed by clinicians




| | Staff in post | Agency & Bank | Gap between staff in post and staff required to meet demand | Staff required to meet demand | Gap to Royal College Guidelines | Potential establishment under Royal College guidelines |
|---|---|---|---|---|---|---|
| Consultant doctors | 49 | 4 | 3 | 55 | - 6 | 49 |
| Middle Grade doctors | 61 | 2 | 41 | 104 | 86 | 190 |
| Junior doctors | 65 | 5 | 32 | 102 | 85 | 187 |
| Nurses (Band 7+) | 16 | 0 | 6 | 22 | 0 | 22 |
| Nurses (Band 5-6) | 204 | 5 | 91 | 301 | 0 | 301 |
| Nurses (Band 1-4) | 92 | 3 | 41 | 136 | -6 | 130 |

Figure 14: Workforce numbers showing the number of staff in post, agency & bank staff, staff required to meet demand under the current configuration and the Royal College guidelines[34]

Note that clinicians have suggested that at least part of the gap shown here is currently filled by substantive staff working extra shifts; however the data to test this has not been available.

### 11.2.6 Discussion at the session on 1st April

The AOs, CEOs and MDs discussed the potential workforce impacts of changing the clinical models as laid out above.

- **Extent of the workforce challenge**: The group discussed how urgent the current challenge in the paediatric workforce is. While the group agreed that paediatrics is facing a significant challenge, and national projections show a continued shortage of paediatric nurses and consultants, they did not feel that paediatrics was currently the most significant workforce challenge that the system was facing.

  The group also felt that none of the individual sites had serious enough workforce challenges to require immediate changes that would reduce the number of workforce needed on a particular site. However the shortfalls identified above suggested that it would be difficult to return Bassetlaw to an inpatient paediatric unit.

- **Bassetlaw**: The modelling above suggested that in order to move back to a model of inpatient paediatrics, Bassetlaw would require a significant number of additional staff.

  The group discussed the options available at Bassetlaw, testing out whether there would be a way to find these additional staff:

  - **Increasing the recruitment of staff**. Since January 2017 Bassetlaw has continued to try to recruit workforce, but has found it challenging. The Trust is exploring shared

[34] SYB(ND), Trust data returns, 2019

working with Sheffield Children's Hospital; there may be ways to make posts at Bassetlaw more attractive, for example by offering the opportunity to work on rotation in the specialist hospital. Improving the reputation of the unit, through the link with SCH, could also be attractive.

However, while this is likely to be attractive for those individuals and grades of staff who are mobile across sites, staff told us during the Clinical Working Groups that many staff, particularly at lower grades, prefer to work on one site, usually close to home. While the SCH link might be attractive for some staff, it was unlikely to address challenges for all staff.

One of the contributing factors to staffing difficulties at Bassetlaw is the difficulty of developing a large enough pool of local staff, given Bassetlaw's geographical position and relatively low population. The availability of working-age, economically active adults in Bassetlaw – which could potentially include healthcare staff - is one of the issues being tackled by the Bassetlaw Development Plan. However, the Development Plan is anticipated to increase the population gradually up to 2035; combined with the lead in times to train new staff, the Trust does not anticipate that the workforce availability in the short to medium term will be sufficient to address the challenges. It is possible that in the longer term, the increase in population might improve the situation to the point that sufficient staff are available.

- **Working across sites**. Attendees discussed whether, under the transformation agenda for SYB, staff might work across the Doncaster and Bassetlaw sites. This is being developed but is effective largely at consultant level; it generally has little impact on the need for nurses, since nurses are usually required to be present onsite full time.
- **Transferring staff between sites**. The group explored whether it would be possible to transfer staff from sites which were comparatively well staffed to support Bassetlaw. However, all of the sites in SYB are facing shortfalls of their own. Since Bassetlaw is the smallest site in SYB (and is likely to continue as such at least in the medium term), concern was expressed about the relative numbers of patients who would be affected if the workforce on a larger site were reduced in order to transfer them to a smaller site.

For all sites other than Bassetlaw, the group felt that they would wish to concentrate on improving the workforce through transformation, with an emphasis on improving recruitment, and making changes to the clinical model (such as co-locating the PAU and A&E, and shifting activity out of hospital) which would ease some areas of the workforce pressures.

In Bassetlaw, transformation would need to be taken forward, but there were also concerns about reconfiguration. The group felt that the SSPAU model was sustainable with the current workforce but that returning to an inpatient paediatric model was unlikely to be.

## 11.3 Affordability

The Hospital Services team have considered the impact on affordability, both quantitatively and qualitatively.

Key areas of potential costs include:

- Potential savings from creating larger, more efficient units
- Capital costs from the need to develop new, larger units.

**Savings**

*Workforce:*

The analysis noted that the reduction in number of staff is small at the level of the system, although it can have a significant impact on a particular site. The savings on workforce are therefore likely to be small.

The modelling identified that the gap between the current substantive staff, and the number of staff that would be necessary to meet the 'sustainable' levels of staff identified by the Clinical Working Groups, was around £10m p.a.

*Activity levels:*

The analysis also looked at whether the increase in activity would result in more efficient services. The modelling at Annex A identifies the impact of activity changes from different models of care. The financial impact of different models depends on the one hand on whether consolidating demand results in reduced workforce costs, and on the other hand whether it generates additional capital costs.

The team have also considered the impact of demographic and non-demographic change. In particular, the group considered the implications for Bassetlaw. Bassetlaw is currently a small unit, and the review has considered whether the increase in activity that is likely to result from new housing in the Bassetlaw area will substantially increase the demand for paediatrics services. The impact of new housing at Bassetlaw is 84 houses a year over and above the normal demographic growth that all the SYB Trusts are likely to see (around an extra 192 residents each year, over and above the baseline population growth).

**Capital costs**

The modelling considered the level of capital investment that would be required to support these changes. The main site where capital investment would be required in order to support changes to paediatrics was at Doncaster, where refurbishment of the current women and children's facilities is part of an ongoing programme for which national support is being sought. A number of the other sites, including Sheffield Children's Hospital and Barnsley identified spare bed capacity that could be used if they were to receive additional paediatric activity.

#### 11.3.1 Discussion on the 1st April

The AOs, CEOs and MDs noted that in the short to medium term, changes to the clinical model would be unlikely to result in significant savings.

They felt that there was not a strong financial argument for reconfiguration, but neither were there significant financial barriers.

## 11.4 Access

One of the issues that was raised most frequently by members of the public throughout the public engagement and in the Citizen's Panel was the importance of access to sites, particularly travel times for patients and their families.

The ICS set up two groups, of professionals working in transport-related organisations, and of members of the public drawn from across the geography of the ICS, to explore the issues around access and in particular around transport.

The input from these groups helped to identify access-related issues such as the cost and availability of parking on hospital sites, public transport use for patients with limited mobility (in particular the needs of patients who use wheelchairs), and the timing of appointments.

These issues will be explored in further detail if there is a decision to proceed with reconfiguration at any site. They have already been addressed at Bassetlaw, at which Bassetlaw

CCG and the Trust share the costs of an additional ambulance to be on standby in case of a patient needing transfer to Doncaster Royal Infirmary.

### 11.4.1 Modelling of travel times data

The Hospital Services team has engaged with the professional and public groups identified above; with Yorkshire Ambulance Services and the East Midlands Ambulance Service; and with Public Health England, to undertake modelling of travel times between Trusts. The approach has been discussed with the public travel and transport group; if any CCG decides to proceed with reconfiguration, there will need to be further detailed discussion with this group.

Travel times by private car and public transport were analysed using data from Google maps, which automatically identifies the quickest route between sites:

- **Time**: On advice from the travel and transport professional group, the Hospital Services team analysed the travel times from all SYB(ND) population Lower Super Output Area (LSOA) to the nearest, second nearest and third nearest hospital sites at four times of day (8am morning rush hour, 12 noon middle of the day, 5pm evening rush hour, and 1am in the middle of the night). The nearest trust was calculated by the site which was quickest to reach; in some cases this means that patients are not counted as transferring to their geographically nearest Trust.
- **Routes**: Using Google data, the analysis identified the time that it would take for a patient to travel to the hospital site closest to their home. It also considered the time it would take to travel to the patient's second and third closest sites (where closeness is measured in time taken to reach) from their home. We used this data to consider the relative increase in travel times from a patient's home to their second closest site if their closest site were no longer available.
- **Equalities**: We have then overlaid this data with the Index of Multiple Deprivation (IMD) level data for each LSOA that shows the relative income decile each LSOA sits in. Using this, we have compared the travel times and potential travel time increases for the most and least deprived populations to ensure that the lowest income populations are not made disproportionately worse off by any changes.

The analysis is laid out in detail in annex A. The map below summarises, in one graphic, the average change in travel times for patients in SYB. Note that for summary purposes this averages across different times of day.

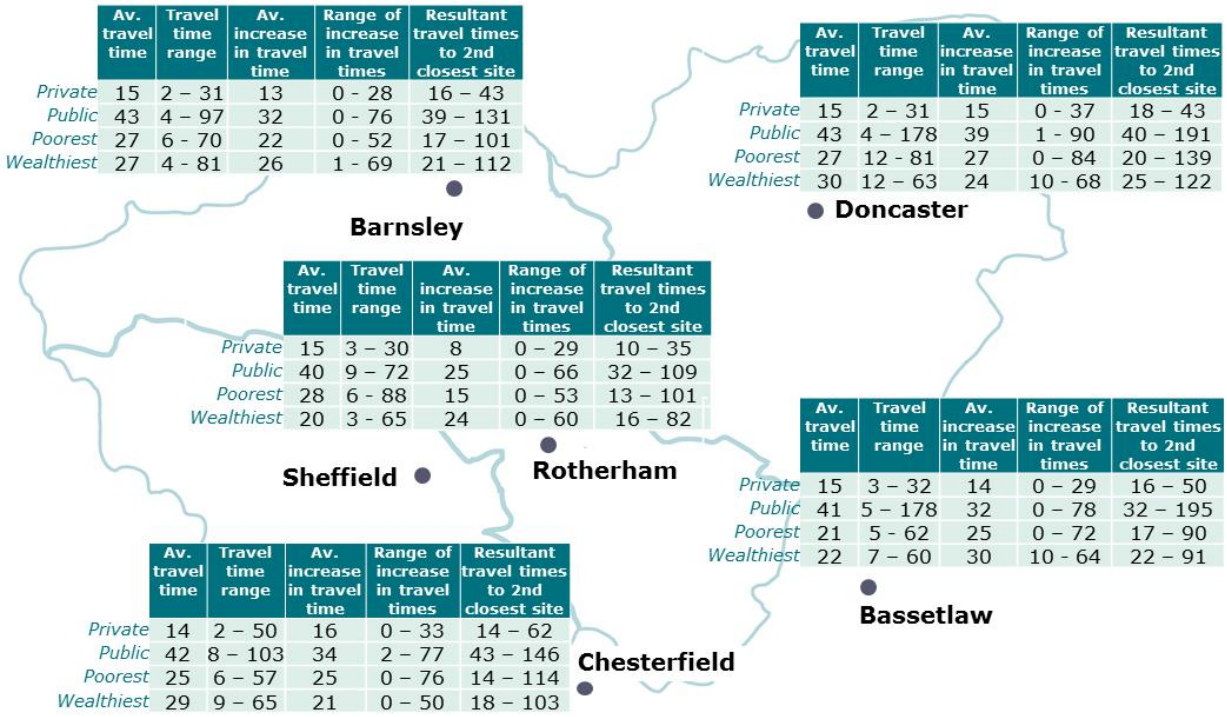



Figure 15: Map of SYB(ND) showing travel time metrics for all SYB(ND) Trusts[35]

The travel time analysis has not at this point modelled exact ambulance travel times, as this would require additional, specialised modelling. However the ambulance services have their own approximate average travel times. The Hospital Services team has used some average times used by Embrace to assess journey time.

A number of conclusions emerged from this analysis, in conversation with the Clinical Working Groups; the patient group on travel and transport; and the expert group:

- The minimum increase in travel times is no change to travel time, where a patient lives equidistant between two sites. The maximum increase in travel times is for patients living in Doncaster who cannot access private transport.
- The chart above illustrates that most patients are able to access their closest Trust within two hours. However the public transport travel times are typically over double that of private travel times.
- On average, the absolute increase of travel times tends to be less for patients from lower income groups than from wealthier groups; this reflects the fact that the majority of poorer people live in urban areas, and so are closer to hospitals and transport routes, while a significant proportion of those people living in rural areas are from higher income groups.

[35] Google travel times, Data extracts, 2018

- However, there are a number of people on lower incomes living in rural areas. We recognise that the impact of changes in travel times will be felt most strongly by these groups, who will be furthest from public transport.

### 11.4.2 Modelling of patient flows

The Hospital Services has also undertaken some initial modelling of where in the system patients would travel to, if services were to change on a site or sites.

There are multiple ways of modelling patient flows:

1. Patients travelling from their own home by private transport, and choosing to go direct to their next nearest hospital;
2. Patients travelling from their own home by ambulance, and being transferred to a destination determined by clinical protocols, which may or may not be the next nearest site;
3. Patients travelling to their nearest hospital, and then being transferred to another site, determined by clinical protocols, which may or may not be the next nearest site.

In reality, the situation would be a mix of these. The Hospital Services team has so far modelled 1). If reconfiguration is taken forward, further detailed modelling will be done with the ambulance services to model 2), and to develop the clinical protocols for transfer for model 3).

Therefore the analysis of patient flows is incomplete at this point, so elements of the modelling (such as the impact on activity levels) could change significantly depending on the clinical partnerships that emerge. For example, a Trust might choose to form a partnership with a Trust further away, which has spare capacity or offers a different service portfolio, rather than its nearest neighbour.

As such, the analysis carried out so far is indicative, and the results are not expected to represent what would happen in reality. If reconfiguration were to be agreed as the way forward, further modelling would be done building on the analysis done so far.

### 11.4.3 Discussions at the session on 1st April

The AOs and CEOs expressed their preference was for providing care as close to home as possible which suggested transformation rather than reconfiguration if this could be made safe.

## 11.5 Interdependencies

The Hospital Services team has also considered the impact on interdependent services. The most important of these is the interdependency with obstetrics, which has been addressed through the proposed model using Advanced Neonatal Nurse Practitioners.

The ANNP model has been used successfully in some trusts around the country. Doncaster currently uses ANNPs to support its neonatology services, and Lincoln have worked with the Royal College of Paediatrics and Child Health to agree a safe ANNP-supported model.

A further interdependency is that with paediatrics staff working in A&E. National guidance requires 2 paediatric nurses to be working in A&E at all times. This has proven challenging across SYB owing to a national shortage of paediatrics nurses. It is being addressed in Barnsley by co-locating the SSPAU with the A&E, allowing the same staff to cover both services.

#### 11.5.1 Discussions at the session on 1st April

The AOs and Chief Executives raised concerns that it would be difficult to recruit sufficient ANNPs, and that there would be competition with existing recruitment to traditional staff roles. However they felt that there might be space to develop advanced roles alongside traditional roles as part of the transformation agenda.

## 11.6 Summary

Overall, the AOs and CEOs' preference was to take forward transformation as opposed to reconfiguration at this stage. Transformation should include new approaches such as co-locating A&Es and SSPAUs, and shifting activity out of hospital, which might partially help to reduce workforce pressures, and the development of new roles.

However, the AOs and CEOs recognised that there was a risk that transformation might not go far enough, or fast enough, to address the emerging challenges in the system. They therefore said that the system would need to develop an approach to monitoring the effectiveness of transformation, and to identifying any concerns with performance before these could become significant.

This monitoring and 'early warning' approach is discussed in chapter 15.

CCG Governing Bodies are asked to consider the analysis laid out above, and consider whether they agree with the view taken by the AOs and CEOs. Governing Bodies are asked to consider the medium term advantages and disadvantages, as well as the long term sustainability of the system.

# 12 The advantages and disadvantages of making changes to obstetrics

The Hospital Services Programme considered whether it would be necessary to make changes to obstetrics on any site in South Yorkshire and Bassetlaw.

The modelling looked at the implications of making changes on all sites, other than the specialist maternity unit at Sheffield Teaching Hospital which was identified as a fixed site.

Feedback from Governing Bodies and Boards was that a Standalone Midwifery Led Unit should be considered only if obstetrics, or its interdependent services, could not be provided safely on the site. Obstetrics is being provided safely on most sites so there was not a detailed discussion of this option at the session on 1st April.

## 12.1 Quality and safety

National evidence, from NICE (2014) and the national report *Better Births*, has found that Standalone Midwifery Led Units are safe, and in fact have better reported outcomes than obstetric-led units, provided that the right triage and transfer protocols are in place.

However, feedback from CCG Governing Bodies and Trust Boards, at the time of publication of the Strategic Outline Case, pointed to concerns around the sustainability and cost-effectiveness of the Standalone Midwifery Led Unit model. Some SMLUs across the country have found that the number of women choosing to attend them has dropped to the point that the unit becomes unsustainable.

Some members of the public also raised concerns about how safe and how desirable the model would be, although some members of the public (particularly women who had themselves had midwife-led births) were supportive.

For this reason, the Hospital Services Programme focused on developing a model that would allow obstetrics to remain on a site even if the site no longer provided 24/7 inpatient paediatrics. A Standalone Midwifery Led Unit would only be considered if obstetrics, and / or its interdependent services of neonatology and anaesthetics, could not be provided safely on the site.

Thus a SMLU model would only be considered if it was a safer alternative than maintaining an obstetrics unit on the site.

### 12.1.1 Safety of SYB services

The Hospital Services Programme found that the obstetrics workforce on most sites looked relatively well staffed (see section 12.2 below).

In review meetings with the Trusts, most Trusts reported that their interdependent services (neonatology and anaesthetics) were also able to staff themselves to safe levels.

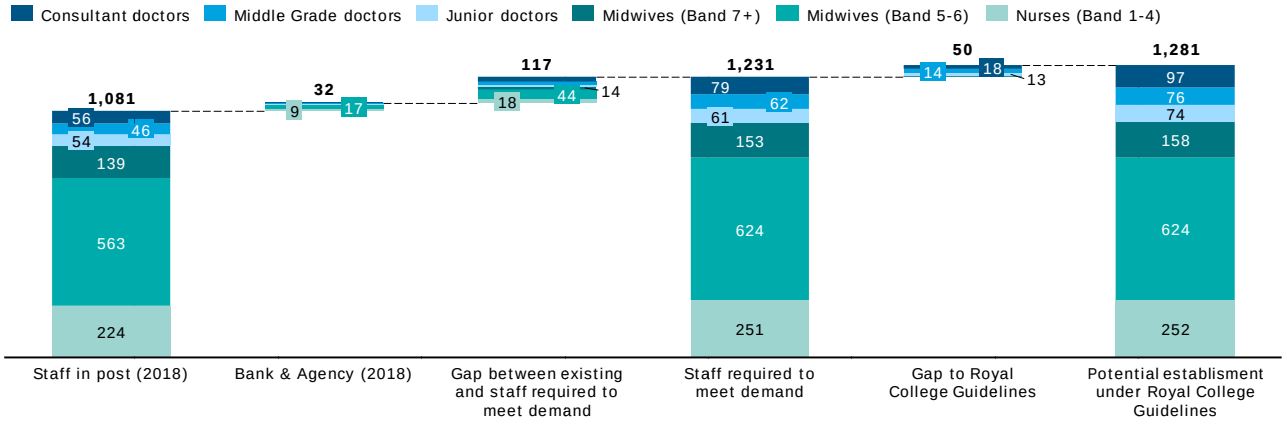
The exception to this was Bassetlaw, which is encountering difficulties in sustaining rotas for anaesthetics on the Bassetlaw site, with only 3 out of 8 posts filled. Doncaster and Bassetlaw are working with commissioners to consider a range of options around how anaesthetics might be made safe on the site.

## 12.2 Workforce

The majority of Trust are currently staffing their maternity services as closely as possible to the national guidelines:

- All of the Trusts are meeting guidance on the number of hours of consultant presence required for their size of unit;
- All of the Trusts are achieving the national guidance on 1 midwife to every 28 births.

The bar chart below shows the current staff in post compared with the numbers necessary to deliver a sustainable workforce and to deliver the Royal College guidelines in full.




| | Staff in post | Agency & Bank | Gap between staff in post and staff required to meet demand | Staff required to meet demand | Gap to Royal College Guidelines | Potential establishment under Royal College guidelines |
|---|---|---|---|---|---|---|
| Consultant doctors | 56 | 0 | 23 | 79 | 18 | 97 |
| Middle Grade doctors | 46 | 4 | 13 | 62 | 14 | 76 |
| Junior ("SHO") doctors | 54 | 1 | 6 | 61 | 13 | 74 |
| Midwives (Band 7+) | 139 | 1 | 14 | 153 | 5 | 158 |
| Midwives (Band 5-6) | 563 | 17 | 44 | 624 | 0 | 624 |
| Nurses (Band 1-4) | 224 | 9 | 18 | 251 | 1 | 252 |

Figure 16: Workforce numbers showing the number of staff in post, agency & bank staff, staff required to meet demand under the current configuration and the Royal College guidelines[36]

## 12.3 Affordability

Affordability represents a significant challenge to any reconfiguration of maternity services, since moving to a SMLU requires significant volumes of activity to move to another site:

### 12.3.1 Capital costs

The majority of maternity units in the system are running at or near full capacity, meaning that transferring large volumes of activity would require new capital build at the site.

Doncaster and Bassetlaw are facing particular challenges to their estate, which has a significant amount of backlog maintenance. The ICS is currently working with DBTH to identify how the system might support DBTH in gaining access to national funding to address its backlog

[36] SYB(ND), Trust data returns, 2019

maintenance issues, and improve the estate for women and children's services on the Doncaster Royal Infirmary site.

### 12.3.2 Financial sustainability of a Standalone MLU

The Hospital Services team looked at the volume of maternity activity which might remain on a site if it shifted from offering an obstetrics service to a SMLU.

| | Barnsley | Bassetlaw | Chesterfield | Doncaster | Rotherham |
|---|---|---|---|---|---|
| Total current number of births (18/19) | 2842 | 1488 | 2719 | 3216 | 2697 |
| High risk women not eligible for SMLU | 1622 | 1126 | 1931 | 2526 | 1853 |
| Total number of births lost by transitioning from OLU to SMLU (assuming 30% of eligible women choose SMLU) | *(2516)* | *(1391)* | *(2509)* | *(3032)* | *(2472)* |
| Estimated number of births if an SMLU | 326 | 97 | 210 | 184 | 225 |
| Expected intrapartum transfers from SMLU at site to neighbouring Trusts | *(81)* | *(24)* | *(53)* | *(46)* | *(56)* |

Figure 17: Activity numbers and modelling to develop assumptions around potential SSPAU activity

The small number of births identified here clearly represents a financial challenge, as the volumes of activity need to be sufficient to maintain a viable rota of midwives. However this needs to be offset against the costs of for example maintaining locum rotas in other interdependent specialties or obstetrics, if there are challenges in maintaining those services.

The Bassetlaw maternity service is likely to see a small increase in demand as a result of the new housing that is being built in Bassetlaw (see Annex F). However the numbers are unlikely to make a significant difference to the levels of demand.

## 12.4 Access

Members of the public identified access as a key concern around changes to maternity services. They raised concerns about pregnant women having to travel further for ante- and post-natal appointments, and the risk of women having to be transferred during a birth.

### 12.4.1 Travelling for ante- and post-natal services

Under the model, ante- and post-natal services would continue to be provided on the SMLU site, including outreach clinics with consultants, so the model could be designed in a way to minimise any additional travel for pregnant women.

### 12.4.2 Transfer during a birth

Triage protocols ensure that patients who can be identified as being at risk have already been transferred to the obstetric-led unit.

In the event that unforeseeable complications develop during labour, existing SMLUs around the country have developed a range of safeguards which include having ambulances on standby.

## 12.5 Interdependencies

Obstetric services are interdependent with

- anaesthetics, which must be provided 24/7 in case a woman requires a caesarean section;
- neonatology services, in case the baby gets into difficulties and requires rescuscitation.

Neither of these is provided alongside a SMLU, since the women giving birth in a SMLU are those very low risk women and babies which have been identified of having minimal risk of needing either service.

### 12.5.1 Interdependencies in South Yorkshire and Bassetlaw

Bassetlaw is currently struggling to recruit sufficient staff to support a 24/7 anaesthetics rota; only 3 out of 8 middle-grade posts are currently filled with substantive employees.

## 12.6 Summary

Overall, SYB obstetrics services appear to be safe and sustainable. The main sustainability challenge is the interdependent services at Bassetlaw.

Doncaster and Bassetlaw are currently working with commissioners, and with Sheffield Children's Hospital, to explore options to support anaesthetics and neonatology, including the configuration of services.

# 13 Gastroenterology and Endoscopy: the opportunities for change

The gastroenterology family of services is relatively diverse. The Clinical Working Group explored several areas, which are facing different challenges and require different solutions:

- Elective endoscopy;
- General (medical) gastroenterology; and
- Out of hours services for gastrointestinal bleeding.

## 13.1 Elective Endoscopy

Elective endoscopy is a service which needs to be provided on all sites, as an essential diagnostic tool to support the wider system. Endoscopy is a crucial diagnostic element within pathways for patients with suspected upper and lower GI cancers, and therefore plays a vital role for the system in achievement of access standards for those. Endoscopy is also a major plank of screening programmes which mitigate the flow of patients onto active cancer pathways.

Endoscopy capacity was frequently raised by the Clinical Working Group as an area of potential concern. Capacity issues can be predicated both upon workforce and upon physical capacity to absorb more work. Endoscopy services are subject to stringent accreditation processes via JAG and are heavily influenced by capital issues, both in terms of estate and equipment.

The system therefore considered approaches that could support the service through transformation and shared working, particularly through the Hosted Network. The Endoscopy Review recently undertaken by the ICS (and looking at endoscopy alongside reviews of other diagnostic services) will be a major asset to the Hosted Network, and the HN will be responsible for developing and overseeing implementation work in response to the recommendations of the Endoscopy Review. The work programme for this area within the Hosted Network is being developed, but should include:

- A response to, and building upon, the cross-system review of endoscopy workforce and capacity, with the aim of making better use of spare capacity within the system if / where this exists. The Endoscopy Review is due to publish in summer 2019.
- Development of a co-ordinated approach to train additional non-medical endoscopists. The Endoscopy Review is likely to recommend the creation of a multi-professional Endoscopy Training Academy, building upon the model developed for reporting radiographers.
- Further consideration, recommended by the Endoscopy Review, of potential for shared procurement of endoscopy equipment, enabling financial savings whilst also further facilitating the adoption of common clinical practices.

## 13.2 General Medical Gastroenterology

General medical gastroenterology services, both inpatient / non-elective and outpatient, will be retained on every site. However, this is set within a context of workforce shortages for gastroenterologists; work over the last 5 years (for the Working Together Vanguard) and for the Hospital Services Review suggests that the consultant staffing situation can be relatively volatile, with the picture changing from year to year.

Close cooperation is being established between Barnsley and Rotherham to develop a resilient and sustainable medical gastroenterology service at both sites. Prior to this relatively recent

collaboration, Rotherham had for some time been entirely reliant upon locum consultant cover to deliver its gastroenterology service.

Feedback from other Trusts to the Clinical Working Group had suggested that there was pressure on e.g. general gastroenterology outpatient waiting lists, potentially exacerbated by the requirement for specialist outpatient services (e.g. hepatology, nutrition) and the capacity to run all of these in parallel.

The work programme for this area within the Hosted Network is being developed, but should include:

- A cross-system review of workforce and capacity, to augment the work already undertaken around endoscopy and GI Bleeds. Links to acute medical rotas and the situation in outpatient settings should be included in this work.
- Over time, a view of the ability and necessary steps to take forward the separation of General Internal Medicine and Gastroenterology rotas should be formed.
- Supporting Trusts to form bilateral partnerships e.g. building upon the work between Barnsley and Rotherham.

## 13.3 Out of hours GI Bleeds

At present, not every site across SYB(ND) is able to provide a 24/7 or Out of Hours GI Bleeds service. Currently, both Rotherham and Bassetlaw have transfer protocols in place to send patients to Doncaster if they need urgent GI bleed services out of hours. There remains some uncertainty as to whether Doncaster themselves are always able to provide out of hours access to expertise in managing GI bleeds.

Whilst the ability of individual sites to provide cover has changed over time with fluctuating consultant establishments, overall this has been the situation in SYB(ND) for at least five years, and suggests inequity in treatment and potentially in outcomes for some of our patients.

At present, alongside the agreements within DBTH and between Doncaster and Rotherham, there are in practice also a significant number of (essentially ad hoc) transfers into STH, which maintains a 24/7 consultant gastroenterology rota.

The Hospital Services team reviewed the options of

- Attempting to establish 24/7 GI bleed services on all sites; or
- Formalising and strengthening the a model of protocol-driven transfer between sites.

An analysis of the options against the HSR evaluation criteria is as follows:

### 13.3.1 Advantages and disadvantages of service change

| | Establish 24/7 GI bleed services on all sites | OOH protocol-driven transfer between sites |
|---|---|---|
| Quality | X Some sites have recently received '*requires improvement*' CQC scores<br><br>X Workforce issues can restrict the access to expert intervention | √ Clinical outcomes should be preserved or improved as all patients access expert opinion and intervention |
| Workforce | X Providing sufficient expert workforce to cover 24/7 rotas at some sites is not possible due to recruitment issues and workforce gaps<br><br>X Bleed services should be consultant-led, and out of hours services largely | √ This model fits demand to workforce (which is feasible), rather than vice versa (which is not) |

| | | |
|---|---|---|
| | consultant-delivered; therefore not feasible to rely solely on a wider pool of clinical endoscopists | |
| Affordability | X High locum staff spend at some sites due to substantive workforce unaffordability is financially unsustainable | √ Locum costs at unsustainable sites could be reduced<br>X Costs associated with ambulance transfers may increase |
| Access | √ Patients would access care at all sites; i.e. transfers would be minimised or removed | X Some patients may need to travel further for GI Bleed services at some times of the week<br>√ Patients are guaranteed to have access to expert OOH services |
| Interdependencies | √ Interdependent services (e.g. general surgery, TIPS, & IR where they exist on that site) would be unaffected | √ Interdependent services (e.g. general surgery, TIPS, & IR where they exist on that site) would be unaffected. TIPS and IR would be highly unlikely to be present on sites which cannot maintain a 24/7 rota |

Figure 18: Table showing an assessment of the advantages and disadvantages of changes to the GI Bleeds OOH clinical model vs retaining presence on all sites

Based upon this, and upon the relatively small numbers of patients likely to be affected (see below), the Clinical Working Group considered that the safest and most efficient model would be to continue with the current model of transferring patients out of hours, but to develop more formalised transfer protocols to support these services.

### 13.3.2 Proposed standardised model for transfer of patients

We therefore propose the following clinical model where the Gastroenterology Hosted Network (in partnership with transport services) will develop Clinical Pathways and associated Standard Operating Procedures for the following:

- The transfer of urgent bleed patients from a site without rota cover to a predetermined site with cover:
    - Pairings will be agreed via the HN and reviewed on an annual basis
    - The Standard Operating Procedure (SOP) should include provision for short-notice / unexpected rota gaps
    - This should ensure that there is never a situation where a site is uncovered either under its own resources or via a pairing / transfer arrangement

- The stabilisation and transfer of highly complex bleed patients:
    - This may include those requiring interventional radiology support or other pre-defined cohorts (NB: increasingly bleeds can be stabilised without IR, the number requiring IR is anticipated to be very low)
    - Patients will be transferred to one or more predetermined specialist sites who can offer the appropriate therapeutic input

If a site is not deemed 24/7 bleed rota compliant (“Site 1” as in Figure 19, below):

- They will provide the comprehensive bleed service at their own site, working to the HN Clinical Pathway, in a predictable and published pattern, to the greatest extent possible
- This should avoid over-ambitious assessments of their own capacity; the HN will be the final arbiter on this
- Where not covered internally, they will adopt the SOPs for transfer of urgent bleed patients, working with a predetermined partner site
- They will utilise the transfer protocol for complex patients if they are not able to provide the relevant highly specialist care

If a site is deemed 24/7 bleed rota compliant ("Site 2" as in Figure 19, below):

- They will provide the comprehensive bleed service at their own site, working to the HN Clinical Pathway
- The site/ Trust may act as the partner for a site without a compliant rota under a pairing arrangement
- They will utilise the transfer protocol for complex patients if they are not able to provide the relevant highly specialist care

The HN will act as the first-line arbiter for disputes, will run the regular rota review process, will review and sign off guidelines and SOPs on a scheduled basis, and will provide an audit mechanism for the regional out of hours bleeds service.

Sites will be paired as in Figure 15 below, with patients transferred from a site without bleeds cover to a pre-determined site with cover, according to pre-agreed protocols and based on clinical judgement, once stabilised.




**No, or Intermittent, OOH Bleeds Service**

***Unit that is not able to offer a 24/7 bleeds service in a stable or predictable way***

***Retains bleeds patients locally ONLY when there is local expert cover according to a predictable, published rota***

***Transfers at times without published rota cover***

**24/7 365 Bleeds Service**

***Consultant led unit that is open 24 hours a day, seven days a week***

*Figure 19: An illustration of the proposed changes to the OOH GI Bleeds clinical model through the pairing of sites*

### 13.3.3 Number of patients likely to be affected by this

Numbers are affected are likely to be low. Our hospitals see around 36 new GI bleed cases per week, but only around a quarter of these (9 to 10 patients) present out of hours. Data on GI bleeds activity is limited due to the low volumes, and most of our Trusts do have cover most of the time, so only a relatively small proportion of these will transfer.

In one short 2014 study undertaken by SYB(ND) Trusts, only one patient per week presented out of hours without bleed cover – but this was only for a fortnight and one Trust did not send

data. We believe that two to three patient transfers a week is the maximum likely, based upon the best current data, and based upon conversations with the Clinical Working Group.

Our proposed new model is not likely to increase these numbers. It is important to recognise that most patients presenting out of hours without bleeds on call will transfer anyway. Our proposal just aims to strengthen the safeguards around this.

#### 13.3.4 Public consultation

The proposals above in many ways simply codify and streamline existing practice. Transfers will now be governed by clear clinical protocols (including scoring) and by standard operating procedures, and will be overseen by the Hosted Network.

Proportionate staff and patient engagement will be necessary going forward and a final decision on whether to proceed with engagement or consultation would need to be taken in discussion with the Joint Health Overview and Scrutiny Committee.

# 14 Equalities implications

The equalities implications have been considered throughout the work that has been done to address the models.

The key points made by attendees are summarised below. A more detailed analysis of how the equalities issues have been addressed is included at Annex F.

## 14.1 Engagement with the seldom heard groups

During 2018 and 2019, there has been engagement with representatives from a wide range of seldom heard groups, including BME groups, LGBT groups, members of the Deaf community, people with disabilities, travellers, asylum seekers and others. A full, independent report of this engagement is published on the ICS website.

The concerns that were raised by these groups have been fed back to the Clinical Working Groups, and have been considered throughout the project.

## 14.2 Implications for different equalities groups

A full Equalities Impact Assessment would need to be taken forward by any CCG which was looking to take forward reconfiguration. The current report has therefore not carried out a formal EIA. However, equalities issues have been considered during the report, and the key issues which have emerged are summarised below.

### 14.2.1 Pregnancy and maternity

The services considered here (maternity and paediatrics) are likely to impact most significantly on women. The ICS has spoken with a number of mother and toddler groups in order to identify specific issues. Key concerns, which have shaped the conclusions of the report, included concerns raised by women who struggled to visit a child in hospital while other children were at home requiring care.

### 14.2.2 Age

Most of the services discussed in this report are focused on younger people, but changes to GI bleeds services would be likely to impact more on older people. The public travel and transport group discussed the challenges for older family members in visiting a site further away.

### 14.2.3 Disability

People with disabilities reported that the key issue was around access, particularly for those who used public or community transport.

Access went beyond transport issues: respondents from the Deaf community referred to the shortage of translators for Sign Language while respondents with autism and learning difficulties described information received from the hospital as being difficult to interpret.

### 14.2.4 Race

The majority of the issues reported by people from ethnic minority groups tended to be around the quality of care and the way in which care was delivered. A number of respondents described communication difficulties and a shortage of translators, while a few reported specific stereotypes: some women of Indian and Asian heritage, for example, warned against cultural stereotypes that assume that Asian families will want to care for family members at home.

#### 14.2.5 Religion or belief

The public engagement included groups of men and women from a range of religions, including groups of older Muslim women. Several of the group members reported finding it difficult to access healthcare, largely because of language and cultural barriers.

#### 14.2.1 Sexual orientation and gender identity

LGBT respondents similarly focused on the delivery of services and the attitudes of healthcare staff, rather than on the design of services. Some reported specific negative experiences although most were positive.

#### 14.2.2 Lower socioeconomic groups

Although socioeconomic disadvantage is not identified as one of the protected characteristics, public respondents made the point that changes in access would impact particularly on the poorest since they are least likely to have private cars.

# 15 Monitoring and early warning signals

## 15.1 Objectives of monitoring

During discussions of whether the system should pursue transformation or reconfiguration, one of the key points raised was that if the system is to focus on transformation rather than reconfiguration, it must be able to identify whether transformation is being successful, or whether any more immediate action needs to be taken.

The AOs, CEOs, and Chairs of the acute providers asked that the Hospital Services team consider how the system might put in place a monitoring and 'early warning' process. This would aim to capture:

- Whether the work on transformation is having an impact on improving services; AND
- Whether there are any serious issues emerging in these services which might necessitate more immediate action.

This work needs to be seen in the context of wider monitoring of performance in the ICS.

## 15.2 Context

The NHS is currently at a moment of transition. Legally, the system is still working within the structure created by the Health and Care Act 2012 in which each Trust operated individually and was legally accountable only for its own performance to its commissioners and regulators.

However, while the legal accountabilities remain in place, the NHS is beginning to move towards a more system-based way of working, with the aim of incentivising trusts to work together in the interest of patients rather than separately.

In this structure, commissioners and providers across the ICS footprint are expected to hold each other mutually accountable, and performance is beginning to be assessed at a cross-system level, as well as for individual organisations. Thus poor performance on quality, or a financial shortfall, in one Trust will appear on the scorecard for the system as a whole, the system as a whole will be held responsible for working together to address the issues, and ultimately all partners will be penalised for poor performance by some members.

As the largest ICS in England, and one of the most advanced, SYB is at the forefront of developing this.

One element of this mutual accountability is the development of a shared approach to monitoring, and a greater degree of transparency around the performance of individual Trusts.

## 15.3 Current monitoring

### 15.3.1 Monitoring at individual organisational level

At present data on quality and performance is largely reviewed by Trusts Boards and CCG Governing Bodies, scrutinising the performance of their own organisation or CCG footprint. Papers are taken at public meetings and are available online.

### 15.3.2 Monitoring at system level

While most monitoring in the system is at organisational level, the system is beginning to see some cross-system working:

- **The Quality Surveillance Group**. This multi-agency group (which consists of commissioners, local authorities, voluntary and patient representative organisations, but excludes providers) meets monthly and reviews any concerns about the quality of care in each Place in SYB. Each meeting receives:
    - a report on quality outcomes, compiled at regional level;
    - a narrative update on any quality issues that are known to be emerging at any individual Place.

  The quality metrics that are considered by this group are exclusively performance based, such as performance against national targets. If an issue is identified for escalation it goes to a quality review meeting at which a report is taken which looks at wider issues such as workforce constraints, leadership issues, or financial concerns.
- **Quality Group**. The system is in the process of setting up a Quality Group which will review performance and other key indicators at a system level, and will include providers. The design of this group is at an early stage.
- **Local Workforce Advisory Group**. The LWAB has a remit to oversee workforce issues across SYB, and receives updates on specific pieces of work, but does not currently monitor performance on workforce on a regular basis.
- **Integrated Assurance Framework**. Work is underway to develop a framework for assurance across the system, including developing a forward look to develop upcoming risks.

## 15.4 Developing the current approach into monitoring

The request from the CEOs, AOs and acute provider Chairs is to identify whether specific initiatives in the transformation programme are having an effect; and to identify risks in these services before they arise.

The monitoring identified above has some limitations in this regard:

- Much of the data that is currently collected at a system level is based on the system performance indicators; is general rather than service-specific; and / or is retrospective;
- The more nuanced, service-specific data that Trusts collect is largely not shared at a system level.
- In particular, there is currently no systematic collection of data relating to workforce at a system level.

We suggest the following approach:

- We should identify no more than five key metrics for each specialty which would be collected and shared on a bimonthly basis. Initially these would be collected and shared within the Hosted Networks; as the Quality Group develops, they might be monitored within that group.
- Ideally these metrics should be metrics which both enable us to identify whether the transformation work in the HSR specialties is achieving its objective, and whether the service is facing risks which could deteriorate into safety concerns.
- The Hosted Networks, with support from the ICS, should be asked to take the lead on developing these metrics.

Examples of the types of metrics that the system might be asked to collect and share include:

- The number of shifts in the specialty which the Trust has needed to fill other than by substantive staff working their core hours, over the last 2 months

- The number of trainees in a Trust who choose to take up a permanent post in it.
- Number of times that patients have been transferred to another Trust outside of the processes or hours agreed in transfer protocols between Trusts.

# Conclusions and Next Steps

In this section we will consider the following:

- Conclusions drawn by AOs and CEOs in terms of the way forward as presented in this report

- Next steps for Governing Bodies and the process of public consultation once decisions have been made

# 16 Conclusions

AOs and CEOs discussed the evidence contained in this report on the 21st of March April. AOs and CEOs, upon evaluating all of the evidence provided by the HSR, con where there is not an immediate safety concern, their preference would be that Trar should be the first area of focus to change and develop services. This approach sho options such as co-locating A&E and SSPAU, and developing out of hospital services help to reduce workforce pressures.

In future, if there are safety concerns or if clinical models change, for example SSPAU co-location and increased community services reduces the need for an in-p reconfiguration may become a viable option that can be revisited.

To this end, the system should develop an approach to monitoring the impact of trar at a system level, with 'early warning' metrics to identify concerns around sustain will form part of the wider ICS approach to monitoring performance.

In summary:

- **Inpatient paediatrics**: the AOs and CEOs preferred that a transformation a change be taken, focusing on system-wide Transformation across services to workforce and as a result improve the quality of services and ensure th remain future-proof in the face of declining workforce numbers and growing d

  The exception to this was Bassetlaw, where the AOs and CEOs believed that s Transformation will not be able to go far enough to address support the reins Paediatric services overnight, without destabilising other Trusts in the syste currently performing well.

- **Maternity**: When considering key interdependencies, the Governing Body into the options for higher risk women to give birth at Doncaster Royal Inf explore whether neonatology and anaesthetics rota can be maintained susta at Bassetlaw.

- **Gastroenterology**: across Gastroenterology and Endoscopy, we recommer Hosted Networks should focus on key priorities such as understanding d capacity and workforce solutions.

  For Out of Hours GI Bleeds, it is proposed that the Hosted Network should ta any work on the development of out of hours protocols, developing a form what is currently common practice through shared working with the HNs.

## 16.1 Decision for Governing Bodies

Governing Bodies are asked to consider whether they agree with the conclusions rea AOs and CEOs above. In particular, they are asked whether they agree that an a focusing on transformation, and considering reconfiguration only if there is an immed safety issues, is appropriate in addressing the long term sustainability of acute servi If transformation fails to address the workforce issues in the medium to reconfiguration may have to be reconsidered.

They are also asked to agree the approach to monitoring the progress of transforr metrics for early warning on sustainability issues, that is laid out in chapter 15

Governing Bodies have agreed during their July meetings to delegate resp the direction of travel laid out in this report to the Joint Committee of C Groups (JCCCG).

# South Yorkshire and Bassetlaw Integrated Care System

# Hospital Services Programme

# Governing Body Note Annex A: Modelling outputs

May 2019

# Outline


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# Workforce:

# Paediatrics

# Workforce:

# Paediatrics - Methodology

# We have looked at current staffing levels on each site, and how this might be affected by changing the staffing model

In the following slides we describe:

- How many staff are currently substantively employed at each site
- How this compares with the number of staff that would make up a sustainable workforce
- The impact that changing the clinical model would have in terms of changing the staff needed on that site, if the changed units were staffed at a sustainable level.

The impact on the system as a whole depends on where the activity would be sent to (see last section of this presentation) but an indicative analysis of the scale of reduction, at a system level, is discussed in this section on changes on 1 or 2 sites.

It is important to note that should the system be unable to afford an investment in staffing numbers to meet a sustainable establishment then changing the clinical model from the current staff in post baseline, could help reduce the demand for workforce, and support more sustainable workforce models on fewer sites.

# The paediatric Clinical Working Group identified how many staff would be needed for a sustainable paeds rota

## Consultants

The number of consultants does not reduce if IP unit becomes an SSPAU

## Middle grade and junior doctors

The number of middle grade and junior doctors reduces because they need to be present on site for a shorter duration of time

## Nurses

The number of nurses reduces with the number of beds.

On a regional level, any reduction in the number of nurses is due to patients leaving SYB for care.

*ASSUMPTIONS (FOR REFERENCE ONLY):*

We asked clinicians to identity a **sustainable workforce required to meet current levels of activity.**
They proposed the following assumptions:

- **Consultants:**
  Estimated using the current number of staff in post with filled vacancies
- **Mid Grade and Junior Doctors**:
  One middle grade and one junior doctor is required at all times and the required number of FTEs is calculated based on opening hours. Therefore the fewer the number of opening hours, the fewer doctors you need.

  It is assumed that a mid grade/junior doctor works 25% of their time in a SSPAU, 30% of their time in an Inpatient unit, and 30% of their time in a Neonatal unit.
- **ANNP:** WTE that could reasonably substitute a Middle Grade/ Junior Doctor
  *(i.e. one to one substitution on wards)*
- **Nurses:** WTE per bed
  *(i.e. 2 Paediatrics nurses for up to 8 beds, an additional nurse for every additional 4 beds)*

# Workforce:

# Paediatrics - Outputs

# CAIC workforce in post

WTE by site, Based on 2018/19 workforce numbers as at 1 April 2019

**Staff in post (+ agency and bank staff)**

| | Barnsley | Bassetlaw | Chesterfield | Doncaster | Rotherham | SCH |
|---|---|---|---|---|---|---|
| Consultant doctors | 8.0 | 3.0 (+ 0.6) | 8.2 | 11.8 (+ 1.9) | 9.6 (+ 0.83) | 8.0 |
| Middle Grade doctors | 10.5 (+ 0.3) | 5.0 (+ 0.1) | 8.8 (+ 0.2) | 11.0 (+ 0.1) | 7.5 (+ 0.66) | 20.6 (+ 1.3) |
| Junior doctors | 10.5 (+ 0.5) | 4.0 (+ 1.0) | 9.0 | 11.0 (+ 2.5) | 7.5 (+ 0.47) | 24.7 |
| Nurses (Band 7+) | 1.0 | 1.0 | 0.4 (+ 0.2) | 2.0 | 1.0 | 10.5 |
| Nurses (Band 5-6) | 26.7 (+ 0.1) | 8.2 (+ 0.5) | 25.9 (+ 2.4) | 33.0 (+ 0.6) | 24.9 (+ 1.9) | 85.7 |
| Nurses (Band 1-4) | 9.8 | 8.0 (+ 0.5) | 8.8 (+ 0.9) | 22.3 | 13.8 (+ 2.0) | 28.9 |

Note: All sites, including Bassetlaw, are modelled using 2018/19 data;
Baseline numbers were sent out to Trusts for validation on 08/03 and 25/03

# CAIC sustainable establishment

WTE by site, Based on 2018/19 workforce numbers

## Estimated sustainable establishment for an Inpatient unit

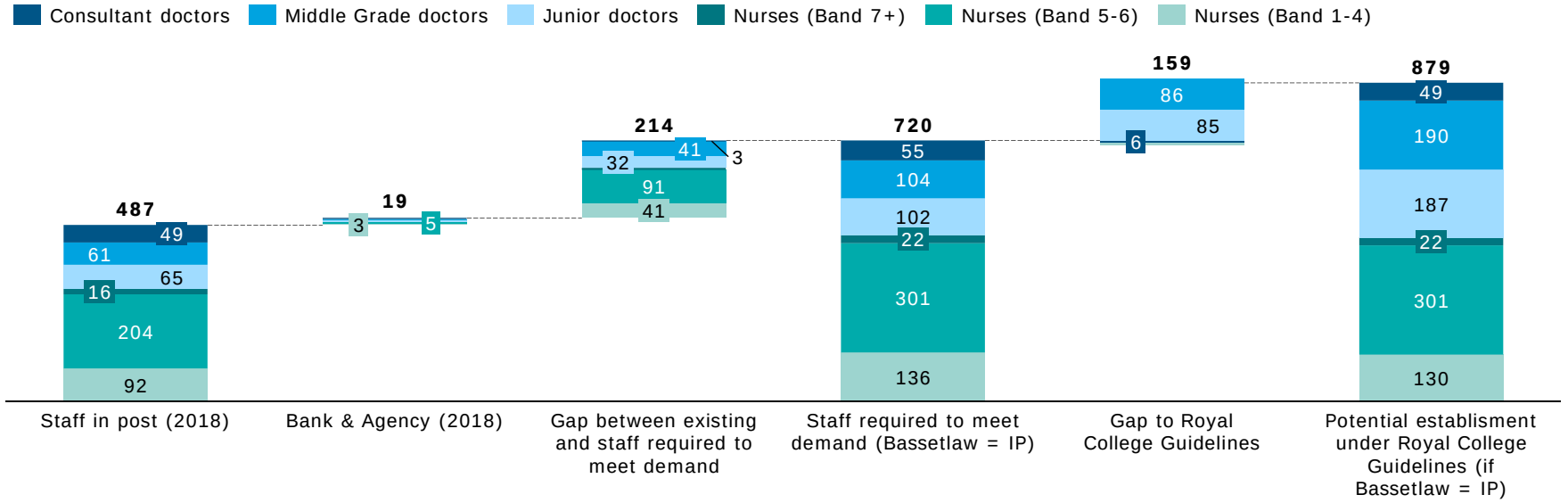
| | Barnsley | Bassetlaw | Chesterfield | Doncaster | Rotherham | SCH |
|---|---|---|---|---|---|---|
| Consultant doctors | 8.0 | 8.0 | 8.2 | 12.8 | 10.3 | 8.0 |
| Middle Grade doctors | 14.9 | 14.9 | 14.9 | 14.9 | 14.9 | 29.8 |
| Junior doctors | 14.5 | 14.5 | 14.5 | 14.5 | 14.5 | 29.0 |
| Nurses (Band 7+) | 2.9 | 1.7 | 2.9 | 4.6 | 2.5 | 7.5 |
| Nurses (Band 5-6) | 39.8 | 22.7 | 39.8 | 62.5 | 34.1 | 102.3 |
| Nurses (Band 1-4) | 18.0 | 10.3 | 18.0 | 28.2 | 15.4 | 46.2 |

Note: All sites, including Bassetlaw, are modelled using 2018/19 data;
All assumptions were developed and iterated across six Clinical Working Groups with clinical and operational managers

# There is currently a shortfall across the system for Paediatrics

## CAIC workforce: Substantive vs Sustainable

*WTE, Based on 2018/19 workforce numbers*




| | Staff in post | Agency & Bank | Gap between staff in post and staff required to meet demand | Staff required to meet demand | Gap to Royal College Guidelines | Potential establishment under Royal College guidelines |
|---|---|---|---|---|---|---|
| Consultant doctors | 49 | 4 | 3 | 55 | - 6 | 49 |
| Middle Grade doctors | 61 | 2 | 41 | 104 | 86 | 190 |
| Junior doctors | 65 | 5 | 32 | 102 | 85 | 187 |
| Nurses (Band 7+) | 16 | 0 | 6 | 22 | 0 | 22 |
| Nurses (Band 5-6) | 204 | 5 | 91 | 301 | 0 | 301 |
| Nurses (Band 1-4) | 92 | 3 | 41 | 136 | -6 | 130 |

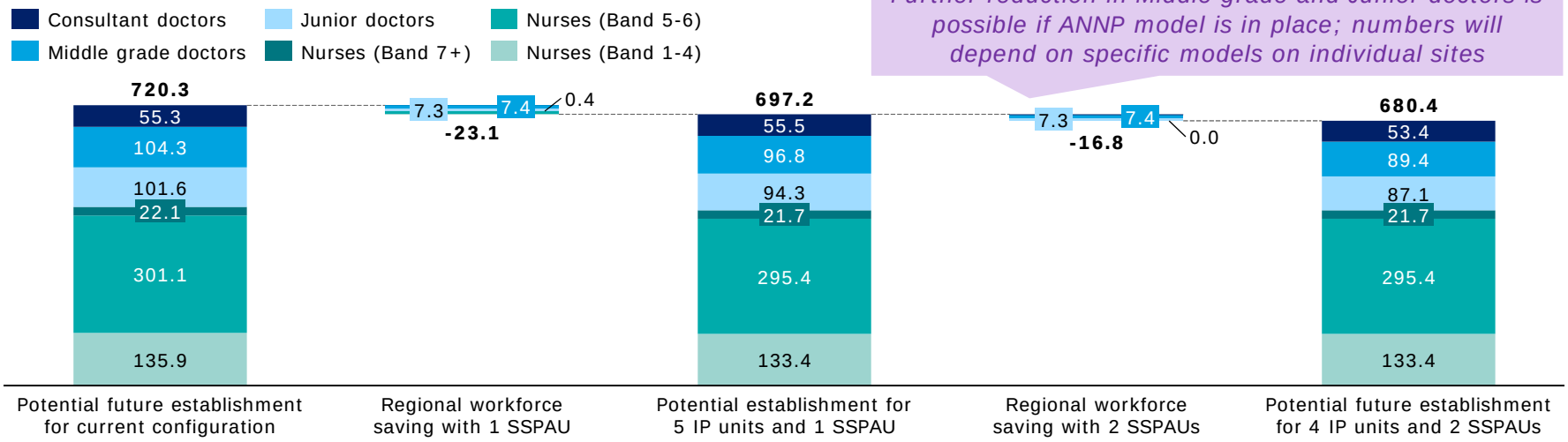


Sources: Trust data returns, 2018/19; Analysis based on Trust-submitted assumptions

# Moving to 1 or 2 PAUs creates a reduction in the demand for middle and junior grade staff

**Illustrative workforce implications of changing Inpatient Paediatric unit(s) to a SSPAU**

*WTE, Based on 2018/19 workforce numbers*




- Changing one or two IP Paediatric units to a SSPAU results in a small workforce change for the region, although has a big impact for an individual site.
- On average, opening 1 SSPAU saves ~7WTEs Middle Grade and Junior ("SHO") doctors. Nursing savings depends on whether any patient move out of area and any beds in SYB can be closed as a result (but Commissioner spend will remain the same under these circumstances)
- Potential establishment for 1 or 2 SSPAUs includes NNU staff cover; however, specific Neonatology arrangements need to be modelled for the preferred option(s) to determine the best use of workforce across the region.
- No assumptions were made around potential changes in clinician behaviour; impact on workforce requirements could be greater if triage becomes more rigorous resulting in a lower number of admissions and a shorter length of stay.



Sources: Trust data returns, 2018/19; Analysis based on Trust-submitted assumptions

# Workforce:

# Maternity - Methodology

# The maternity Clinical Working Group identified how many staff would be needed for a sustainable maternity rota

## Consultants

Consultants are not required to provide care at an SMLU

## Middle grade and junior doctors

Middle grade and Junior doctors are not required to provide care at an SMLU

## Midwives

The number of midwives reduces with the number of births. 1 registered midwife is required for every 28 births.

On a regional level, any reduction in the number of midwives is due to patients leaving SYB for care.

*ASSUMPTIONS (FOR REFERENCE ONLY):*

We asked clinicians to identity a **sustainable workforce required to meet current levels of activity.**
They proposed the following assumptions:

- **Consultants:**
  Number of Obstetricians per unit of activity *(for an Obstetric led unit, assumes 1 Obstetrician per 500 births, plus the required number of Obstetricians to do the existing number of outpatient appointments and elective Caesarean sections, plus 20% extra to cover for antenatal and postnatal wards).* No obstetricians are required for an SMLU.
- **Mid Grade and Junior Doctors**:
  WTE required per unit of Consultants
  Obstetrics: WTE required per unit of Consultants *(c.1:1:1 with a requirement of a minimum of 8 WTEs at all grades to be able to form a rota).* No obstetricians are required for an SMLU.
- **Midwives:** WTE per births
  *(i.e. 1 registered midwife:28 births)*

# Workforce:

# Maternity - Outputs

# Maternity workforce in post

## WTE by site, Based on 2018/19 workforce numbers

### Staff in post (+ agency and bank staff)

| | Barnsley | Bassetlaw | Chesterfield | Doncaster | Rotherham | STH |
|---|---|---|---|---|---|---|
| Consultant doctors | 8.8 | 5.0 | 11.5 | 9.0 | 9.8 | 12.0 [1] |
| Middle Grade doctors | 7.9 (+ 0.3) | 5.0 | 6.6 (+ 1.5) | 6.0 | 8.0 (+ 2.1) | 12.2 |
| Junior doctors | 8.6 (+ 0.1) | 5.0 | 8.0 (+ 0.7) | 8.0 | 8.0 (+ 0.6) | 16.0 |
| Midwives (Band 7+) | 31.2 | 13.9 | 17.8 (+ 0.2) | 22.0 | 14.0 (+ 0.5) | 39.9 |
| Midwives (Band 5-6) | 89.8 (+ 0.4) | 36.6 (+ 1.2) | 91.6 (+ 8.1) | 103.2 (+ 4.3) | 84.4 (+ 3.3) | 157.3 |
| Nurses (Band 1-4) | 32.2 | 14.1 (+ 0.9) | 32.7 (+ 4.5) | 33.4 (+ 1.5) | 29.9 (+ 2.3) | 81.9 |

Note: All sites, including Bassetlaw, are modelled using 2018/19 data;
Baseline numbers were sent out to Trusts for validation on 08/03 and 25/03
1. STH Consultant doctors do not include other specialties e.g. gynaecology, so not always comparable across other trusts

# Maternity sustainable establishment

WTE by site, Based on 2018/19 workforce numbers

## Estimated sustainable establishment for an Obstetrics unit

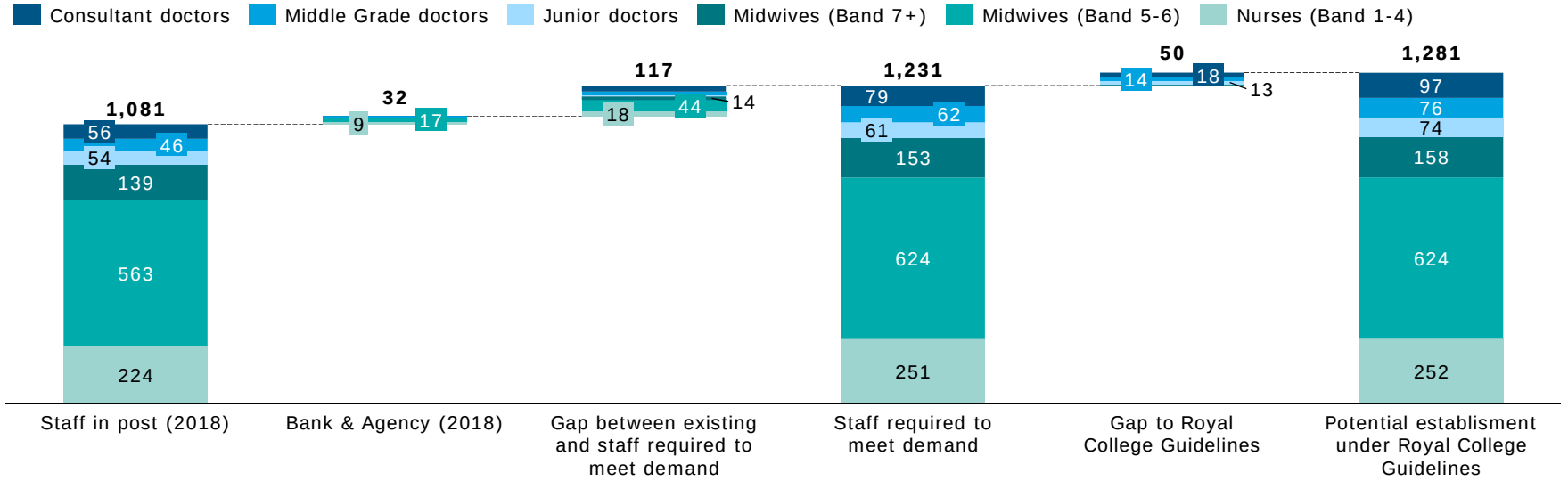
| | Barnsley | Bassetlaw | Chesterfield | Doncaster | Rotherham | STH |
|---|---|---|---|---|---|---|
| Consultant doctors | 10.8 | 5.5 | 12.6 | 12.4 | 13.3 | 24.5 |
| Middle Grade doctors | 8.0 | 8.0 | 9.3 | 9.2 | 9.8 | 18.1 |
| Junior doctors | 8.0 | 8.0 | 9.0 | 8.9 | 9.5 | 17.7 |
| Midwives (Band 7+) | 23.0 | 11.9 | 21.3 | 24.9 | 21.4 | 50.9 |
| Midwives (Band 5-6) | 93.5 | 48.3 | 86.6 | 101.3 | 87.2 | 207.3 |
| Nurses (Band 1-4) | 37.5 | 19.4 | 34.8 | 40.7 | 35.0 | 83.2 |

Note: All sites, including Bassetlaw, are modelled using 2018/19 data;
All assumptions were developed and iterated across six Clinical Working Groups with clinical and operational managers

# There is currently a small shortfall across the system for Maternity

## Maternity workforce: Substantive vs Sustainable

*WTE, Based on 2018/19 workforce numbers*



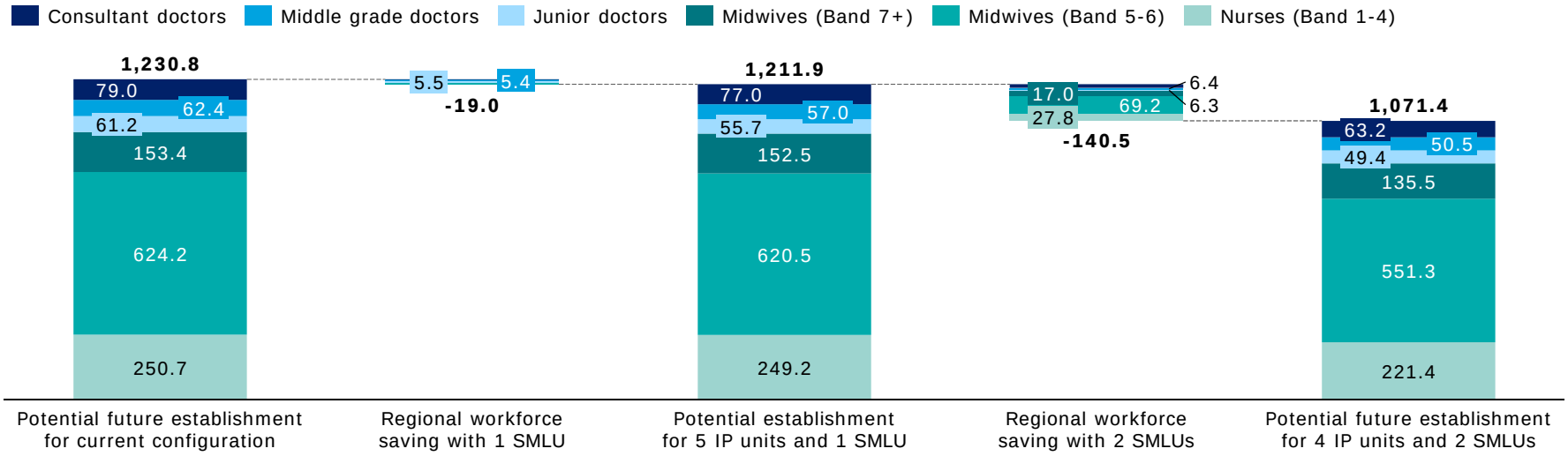

| | Staff in post | Agency & Bank | Gap between staff in post and staff required to meet demand | Staff required to meet demand | Gap to Royal College Guidelines | Potential establishment under Royal College guidelines |
|---|---|---|---|---|---|---|
| Consultant doctors | 56 | 0 | 23 | 79 | 18 | 97 |
| Middle Grade doctors | 46 | 4 | 13 | 62 | 14 | 76 |
| Junior ("SHO") doctors | 54 | 1 | 6 | 61 | 13 | 74 |
| Midwives (Band 7+) | 139 | 1 | 14 | 153 | 5 | 158 |
| Midwives (Band 5-6) | 563 | 17 | 44 | 624 | 0 | 624 |
| Nurses (Band 1-4) | 224 | 9 | 18 | 251 | 1 | 252 |



Sources: Trust data returns, 2018/19; Analysis based on Trust-submitted assumptions

# Moving to 1 or 2 SMLUs creates a reduction in the number of obstetricians but reduction in midwifery staff can only be achieved if patients receive maternity care out of area

**Illustrative workforce implications of changing Inpatient Obstetric unit(s) to a SMLU**
*WTE, Based on 2018/19 workforce numbers*




- Changing one or two Obstetrician led units to a SMLU results in a small workforce change for the region, although has a big impact for an individual site.
- The size of the workforce saving depends on the individual sites chosen for SMLU. Small obstetrician savings can be achieved for the region with any transition from OLU to SMLU; however, midwifery savings for SYB can only be achieved if patients move out of area for care (but Commissioner spend will remain the same under these circumstances).
- In the example above, transitioning one OLU to an SMLU results in a very small obstetrician saving since that particular site only delivers a small number of births. Transitioning two OLUs to SMLUs results in a greater saving, largely driven by patients leaving SYB for to give birth.

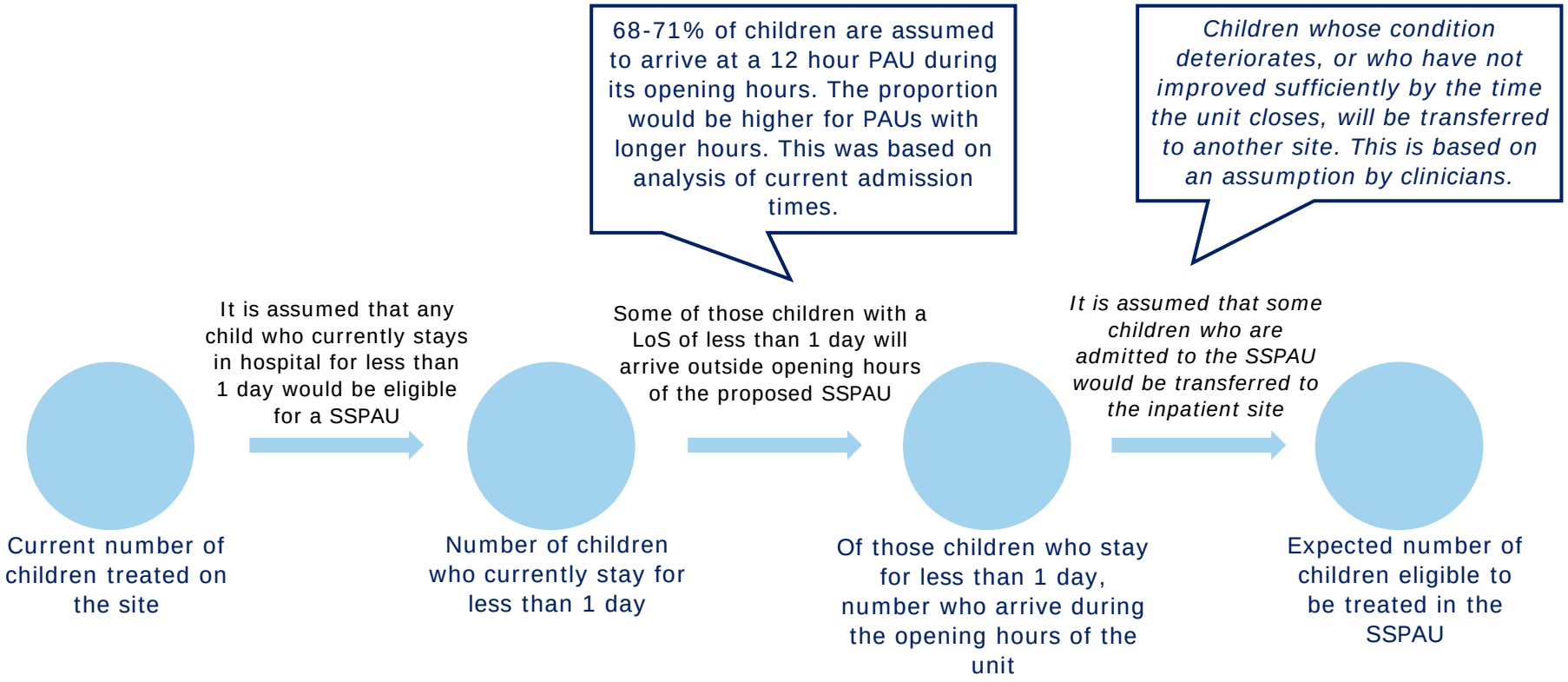


Sources: Trust data returns, 2018/19; Analysis based on Trust-submitted assumptions

# Activity

# In developing modelling around paediatrics, we have included the following

We identified how many of the children currently being treated at a hospital site would remain there, if the inpatient unit became a Paediatric Assessment Unit, and how many would move to another site to receive services



**Activity:**

**Paediatrics outputs**

Number of children affected by changes to the model

# CAIC Activity:

## The following numbers of patients would be affected by changes on specific sites

| | 1 BARNSLEY | 2 BASSETLAW[1] | 3 CHESTERFIELD | 4 DONCASTER | 5 ROTHERHAM |
|---|---|---|---|---|---|
| *Total current Paediatric admissions* | 6,658 | 1,330 | 4,573 | 11,185 | 5,320 |
| *Total activity lost due to patient LOS>0 days* | 2,456 | 196 | 2,197 | 3,428 | 1,683 |
| ***Total activity lost (as not eligible for an SSPAU, or arriving outside of opening hours)*** | ***3,782*** | ***530*** | ***2,884*** | ***5,770*** | ***2,789*** |
| ***Estimated activity that is eligible for a 12 hr SSPAU and arrives within opening hours[2]*** | **2,876** | **800** | **1,689** | **5,415** | **2,531** |
| *Expected transfers of patients admitted to SSPAU to neighbouring Trusts* | 288 | 80 | 169 | 541 | 253 |

Note: [1] Bassetlaw number is shown for 17/18 activity data where Paediatric services are not offered overnight to make sure that patients are not double counted against other units. If we showed 16/17 activity data, total activity lost as not eligible for SSPAU would be 1,444 p.a. instead of 530 shown. We are able to model both 16/17 and 17/18 data; [2] 68-71% of patients are assumed to arrive at SSPAUs across Trusts during opening hours

# Interdependencies – CAIC:

Changes in clinical models may affect the ability to have safe interdependent services

**Changes to services on a site will result in:**

- For Paediatrics:
  - Changes to middle grade Paediatric training
  - Implications to children's surgery:

| | 1 BARNSLEY | 2 BASSETLAW | 3 CHESTERFIELD | 4 DONCASTER | 5 ROTHERHAM |
|---|---|---|---|---|---|
| *Total numbers of elective Paediatric surgery currently* | 1047 | 526 | 571 | 1822 | 1587 |
| *Total number of day case surgery currently* | 967 | 476 | 430 | 1562 | 1363 |
| *Estimated number of children's surgery that will be transferred based on current numbers of elective surgery with LoS > 0 days* | **80** | **50** | **141** | **224** | **260** |

# Key conclusions

- The smallest impact on activity lost to neighbouring sites, (assuming Bassetlaw were operating as a full inpatient paediatric unit), would be at Bassetlaw (530)

- The next smallest impact would be Rotherham (2,789), followed by Chesterfield (2,884). The largest impact across the system would be Doncaster (5,770) and Barnsley (3,782).

- Upon changing to an SSPAU, local evidence suggests changes in clinical behaviour and patient presentation means the actual number of transfers would likely to be lower in practice than the numbers modelled

- This would be particularly true if the SSPAU model was supported by an effective Hospital @ Home model and strengthened community services

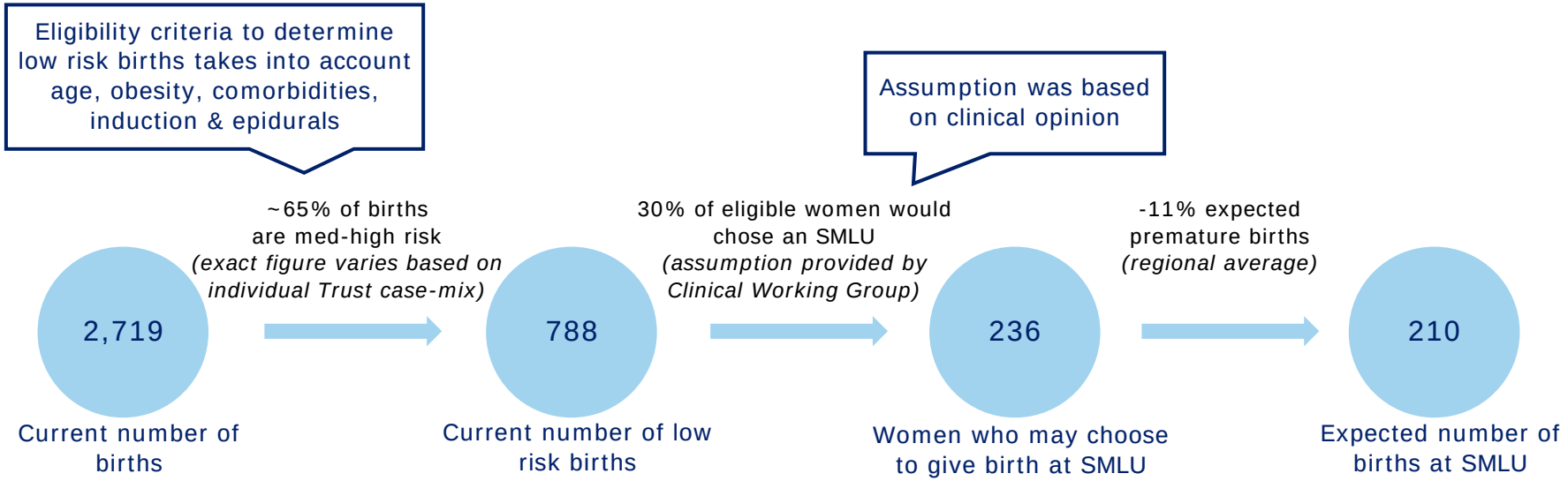
# Activity:

# Maternity methodology

# In developing estimates around activity for Maternity, we have considered the following

We identified how many of the women currently giving birth on a site might both be eligible to give birth in an SMLU on that site, and would choose to do so. To do this we used patient level data, public health data on the health of women in SYB, and a clinically informed assumption of how many women may choose SMLU.

*We have used Chesterfield as an example below to show our methodology:*




Note: [1] Eligibility criteria to determine low risk births takes into account age, obesity, comorbidities, induction & epidurals; [2] It is estimated that, of those who are eligible, 30% of women will choose to give birth at an SMLU

**Activity:**

**Number of births affected by changes to the model**

# Maternity Activity:
## Patients may be affected by individual site changes

| | 1 BARNSLEY | 2 BASSETLAW | 3 CHESTERFIELD | 4 DONCASTER | 5 ROTHERHAM |
|---|---|---|---|---|---|
| *Total current number of births* | 2842 | 1488 | 2719 | 3216 | 2697 |
| *High risk women not eligible for SMLU* | 1622 | 1126 | 1931 | 2526 | 1853 |
| *Total number of births lost by transitioning from OLU to SMLU (assuming 30% of eligible women choose SMLU)* | 2516 | 1391 | 2509 | 3032 | 2472 |
| *Estimated number of births if an SMLU* | 326 | 97 | 210 | 184 | 225 |
| *Expected intrapartum transfers from SMLU at site to neighbouring Trusts* | 81 | 24 | 53 | 46 | 56 |

# Interdependencies – Maternity:

## Changes in clinical models may affect the ability to have safe interdependent services

**Changes to services on a site will result in:**

- For Maternity:
  - A reduction of 1 Anaesthetic rota
  - Implications to Neonatal rotas – to be supported by ANNPs

- The only site which is currently experiencing significant challenges in relation to its neonatal and anaesthetics services, and where there are significant concerns in these services, is Bassetlaw
- We would suggest that any other site which was potentially changing its maternity services should be supported by a neonatal unit supported by ANNPs

# Key conclusions

- We have said that we would only move from an obstetrics unit to a standalone MLU if there were significant concerns about the sustainability of obstetrics or interdependent services on a site
- We can see from the analysis above that SMLUs would be likely to be small on any of the SYB sites, and with this, brings sustainability issues
- It might be possible to increase this by actively promoting the units to women who were eligible to use them. However, these levels of usage are in line with the levels of usage that we tend to see at other SMLUs around the country

# Travel times

# Travel times:

# Methodology

# We have looked at the travel times that patients would face, to get to their next nearest hospital

- One of the greatest concerns from members of the public was travel times, if services were to be provided at another site.
- We have modelled how far patients would have to travel in order to reach their next nearest site.
- It is possible that there might be a clinical decision that a partnership should be with a site other than the next nearest, in which case we would need to do a bespoke piece of modelling in the next stage. However, travel times within SYB(ND) are low by comparison with some health economies.
- The travel and transport groups, and the Clinical Working Groups, agreed that we should not set a specific travel time as 'safe', but should consider each travel time on its own merits, and compare any increase in travel time with the relative increase in quality or workforce sustainability a model could deliver.
- The following slides describe how we have modelled the travel times by public and private transport, at different times of the day.
- Blue light ambulance transfers would need to be modelled in more detail for any smaller number of shortlisted options.

# One of the most important issues to consider under access (as under other criteria) is equality

- If we decide to take forward a shortlist of sites, we will do a full Equalities Impact Assessment
- At this stage, we have looked specifically at the relative impacts that changes would have on the travel times of patients in the highest and lowest income deciles, as is explained on the next slide
- The analysis suggests that in most geographical areas, the groups which would see the greatest increase in travel times are the wealthier groups: this is likely to reflect wealthier people living in affluent rural areas. Overall however the differences are relatively small.

# Population level travel time analysis
## Methodology

An LSOA is a Lower Super Output Area, made up of 4-6 Output Areas (used for census collection) that aggregates areas with similar social characteristics to create groups of c.1500 people or c.500-750 households.

We have pulled data on total travel times by both Public and Private transport from each LSOA to their closest, 2nd closest and 3rd closest Trust at 4 times of the day – 8am, 12 midday, 5pm and 1am, where closeness is defined by how fast a Trust is to reach.

For each time of day, we have considered the range of times it takes to reach peoples' closest trust and the incremental increases in time to reach their 2nd closest trust, if services at the 1st closest trust were no longer available. The results for maternity and paediatrics are slightly different because of the difference in travel times to Sheffield Children's Hospital and Sheffield Teaching Hospital.

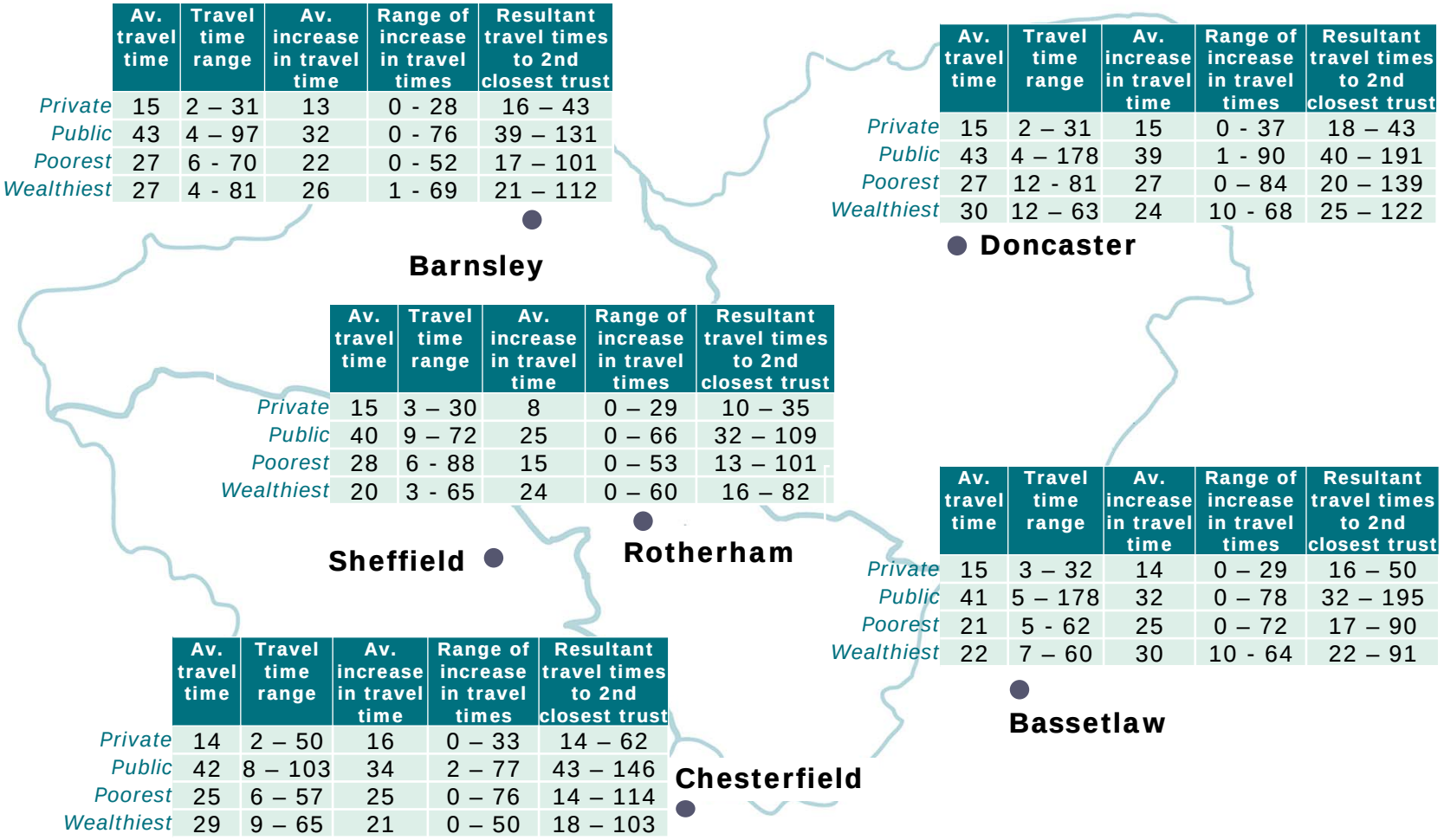
We have then overlaid this data with the Index of Multiple Deprivation (IMD) level data for each LSOA that shows the relative income decile each LSOA sits in. Using this, we have compared the travel times and potential travel time increases for the most and least deprived populations to ensure that the most deprived populations are not made disproportionately worse off by any changes.

# Travel times:

# Outputs

# Population level travel time analysis – Average

## Care of the Acutely Ill Child



| | Av. travel time | Travel time range | Av. increase in travel time | Range of increase in travel times | Resultant travel times to 2nd closest trust |
|---|---|---|---|---|---|
| *Private* | 15 | 2 – 31 | 13 | 0 - 28 | 16 – 43 |
| *Public* | 43 | 4 – 97 | 32 | 0 - 76 | 39 – 131 |
| *Poorest* | 27 | 6 - 70 | 22 | 0 - 52 | 17 – 101 |
| *Wealthiest* | 27 | 4 - 81 | 26 | 1 - 69 | 21 – 112 |

**Barnsley**

| | Av. travel time | Travel time range | Av. increase in travel time | Range of increase in travel times | Resultant travel times to 2nd closest trust |
|---|---|---|---|---|---|
| *Private* | 15 | 2 – 31 | 15 | 0 - 37 | 18 – 43 |
| *Public* | 43 | 4 – 178 | 39 | 1 - 90 | 40 – 191 |
| *Poorest* | 27 | 12 - 81 | 27 | 0 – 84 | 20 – 139 |
| *Wealthiest* | 30 | 12 – 63 | 24 | 10 - 68 | 25 – 122 |

**Doncaster**

| | Av. travel time | Travel time range | Av. increase in travel time | Range of increase in travel times | Resultant travel times to 2nd closest trust |
|---|---|---|---|---|---|
| *Private* | 15 | 3 – 30 | 8 | 0 – 29 | 10 – 35 |
| *Public* | 40 | 9 – 72 | 25 | 0 – 66 | 32 – 109 |
| *Poorest* | 28 | 6 - 88 | 15 | 0 – 53 | 13 – 101 |
| *Wealthiest* | 20 | 3 - 65 | 24 | 0 – 60 | 16 – 82 |

**Sheffield**

**Rotherham**

| | Av. travel time | Travel time range | Av. increase in travel time | Range of increase in travel times | Resultant travel times to 2nd closest trust |
|---|---|---|---|---|---|
| *Private* | 15 | 3 – 32 | 14 | 0 – 29 | 16 – 50 |
| *Public* | 41 | 5 – 178 | 32 | 0 – 78 | 32 – 195 |
| *Poorest* | 21 | 5 - 62 | 25 | 0 – 72 | 17 – 90 |
| *Wealthiest* | 22 | 7 – 60 | 30 | 10 - 64 | 22 – 91 |

**Bassetlaw**

| | Av. travel time | Travel time range | Av. increase in travel time | Range of increase in travel times | Resultant travel times to 2nd closest trust |
|---|---|---|---|---|---|
| *Private* | 14 | 2 – 50 | 16 | 0 – 33 | 14 – 62 |
| *Public* | 42 | 8 – 103 | 34 | 2 – 77 | 43 – 146 |
| *Poorest* | 25 | 6 – 57 | 25 | 0 – 76 | 14 – 114 |
| *Wealthiest* | 29 | 9 – 65 | 21 | 0 – 50 | 18 – 103 |

**Chesterfield**

Source: Google data extract, Deloitte analysis, 2018/19

Note: [1] The 'Av. increase in travel time' value represents the increase in travel time if a patient has to travel to their next closest trust within SYB(ND) if services are no longer available at their closest trust in SYB(ND) – this does not include travel to Trusts outside of the region, so in reality maximum travel times may be slightly shorter; [2] In practice few patients within SYB(ND) will choose to go to Trusts outside of the region such as United Lincolnshire or Mid Yorkshire; [3] Poorest represents the most deprived decile, and Wealthiest represents the least deprived decile, using Index of Multiple Deprivation data

Health and care working together in South Yorkshire and Bassetlaw



# Hospital Services Review

## South Yorkshire, Bassetlaw and North Derbyshire: Considering the case for change

## Governing Body Note: Case for Change Annex

May 2019

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# 1 Introduction

This case for change document acts as an annex to the note to Governing Bodies, which includes all tables, charts and graphs relating to the case for change section. The evaluation metrics are listed under the evaluation criteria described below, and are provided for each services under review (Care of the Acutely Ill Child, Maternity & Gastroenterology).

In developing this, we have considered the following inputs:

- Publically sourced data alluding to the sustainability metrics
- Workforce and activity data provided by Trusts
- Clinical input through the Clinical Working Groups regarding the sustainability metrics to use
- Qualitative information collected from Clinical leads and Medical Directors at Trusts through 1-1 interviews.

# 2 The Case for Change: Care of the Acutely Ill Child

## 2.1 Overall

The quality of CAIC services in SYB(ND) is currently good on most sites, but we are facing some sustainability challenges in our systems. Bassetlaw is of particular concern, having reduced its opening hours from a twenty four hour inpatient unit to no longer being open overnight in 2017 due to staffing challenges. Paediatrics is also currently included on the risk register for most Trusts.

Patient feedback for Paediatrics across SYB(ND) is very good, but staff satisfaction scores for overall satisfaction and workload suggest that the quality of the service is heavily reliant on current staff members working additional shifts and going above and beyond their day to day duties.

A detailed assessment of Trusts, against approximately 30 metrics at Trust level, is contained in the case for change report for each Trust, included below is a snapshot view of these metrics at the system level.

## 2.2 Quality

We will measure Quality by considering the question: *Is quality of care optimised by promoting delivery of national good practice and guidance, and contributing to maintained or improved outcomes?*

This takes into consideration the following:

- Are SYB(ND) Trusts able to meet national clinical guidelines and standards?
- Are patients satisfied with the quality of care offered?

**CQC Assessment**

The table below (Figure 1) shows the Care Quality Commission (CQC) scores for each Trust, including Children and Young People, and Urgent & Emergency services. The CQC score looks at safety, effectiveness, care, responsiveness and leadership of a service.

Overall, most Trusts score *'Good'* and Barnsley Hospital believe their '*Requires improvement'* score may have been in large part due to a one-off event on the day of the inspection. The Trust also highlighted that the CQC report did not suggest a poor quality of care or any clinical weaknesses at Barnsley.

| CAIC CQC Scores | Barnsley *Published Mar '18* | Chesterfield *Published May '17* | Doncaster *Published July '18* | Bassetlaw *Published Jul '18* | Rotherham *Published Jan '19* | Sheffield Children's *Published Oct '16* |
|---|---|---|---|---|---|---|
| CQC Children & Young People | RI Requires Improvement | G Good | G Good | | G Good | G Good |
| CQC Urgent & Emergency Services | G Good | G Good | RI Requires Improvement[2] | | I Inadequate | G Good |

*Figure 1: CQC scores for Children and Young People, and Urgent & Emergency services*[1]

**Facing the Future Standards**

In addition to the CQC score, we also looked at the number of the Facing the Future standards each Trust meets, as defined by RCPCH. The table below (Figure 2) shows the definitions of the standards and how many of the standards each Trust met in 2018. Figure 2 shows that Rotherham, Doncaster & Bassetlaw and Chesterfield are not currently meeting all standards, whilst Sheffield Children's and Barnsley met (or have a plan to meet) all 10 standards.

The most common standards Trusts are struggling to meet involve workforce considerations and are listed below:

- FTF Standard 1: Consultant is present at peak times, 7 days a week
- FTF Standard 3: Every child is seen by a consultant Paediatrician within 14 hours of admission

FTF Standard 8: All training rotas made up of 10+ WTE posts, all compliant with EU and UK working regulations

[1] CQC, Inspection reports, 2016 - 2019

| | | Barnsley | Chesterfield | Doncaster & Bassetlaw | Rotherham | Sheffield Children's |
|---|---|---|---|---|---|---|
| 1 | *Consultant is present at peak times 7 days a week* | ✓ | ✓ | X | X | ✓ |
| 2 | *Every child admitted is seen by a professional within four hours of admission* | ✓ | ✓ | ✓ | ✓ | ✓ |
| 3 | *Every child is seen by a consultant paediatrician within 14 hours of admission* | ✓ | - | X | X | - |
| 4 | *At least two medical handovers led by a consultant paediatrician* | ✓ | ✓ | ✓ | ✓ | ✓ |
| 5 | *Every child with an acute medical problem has their case discussed with a clinician before they are discharged* | ✓ | ✓ | ✓ | ✓ | ✓ |
| 6 | *Access to the opinion of a consultant paediatrician throughout open hours* | ✓ | X | ✓ | ✓ | ✓ |
| 7 | *All inpatient units adopt an attending consultant system, typically in the form of the 'consultant of the week'* | ✓ | ✓ | ✓ | ✓ | ✓ |
| 8 | *All training rotas made up of 10+ WTE posts, all compliant with UK and EU Working Time Regulations* | ✓ | X | ✓ | X | ✓ |
| 9 | *Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties and for all paediatricians* | ✓ | ✓ | ✓ | ✓ | ✓ |
| 10 | *Access to a paediatrician with child protection experience and skills (of at least level 3 safeguarding competencies)* | ✓ | ✓ | ✓ | ✓ | ✓ |

**Key:** ✓ Achieved ✓ Mostly achieved - Plan to achieve X Not achieved

*Figure 2: CAIC Facing the Future standards met by each Trust in SYB(ND)*[2]

**Patient feedback**

Patient feedback for Paediatric services is good, based on qualitative evaluation of NHS choices submissions, as well as public consultation during the Hospital Services Review. NHS choices feedback cited 'caring and reassuring staff' with parents kept 'informed and involved' by Paediatric staff.

To quantitatively assess patient feedback for CAIC services across SYB(ND) Trusts, we calculated an average of the scores achieved in the Children and Young People's (CYP) survey; all Trusts received an average score of 8.4 or more over the 5 questions asked, indicating a very good quality of patient feedback. The average scores for each SYB(ND) Trust are shown in Figure 3:

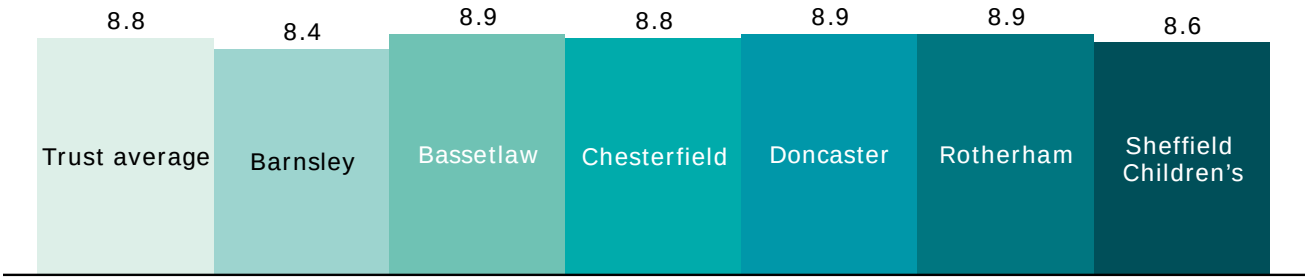



*Figure 3: CAIC average CYP survey score for all SYB(ND) Trusts*[3]

[2] RCPCH, Facing the Future standards, 2018

[3] NHS, Children and Young people's survey, 2016

## 2.3 Workforce

Workforce is measured by considering the question: *Does the option ensure there is a sustainable workforce of the right number and skill set?*

This takes into consideration the following:

- Do Trusts have sufficient workforce in place to provide a safe service?
- Is the existing workforce satisfied with their workplace environment and workload?
- To what extent do Trusts rely on locum / temporary staff?

There is currently a shortfall in workforce across the system for Paediatrics. It has been noted that, the excellent patient feedback received is heavily dependent upon permanent staff going the extra mile to provide a good quality of care, through working overtime to cover gaps in the rota. The Clinical Working Groups have also expressed significant concern around the future sustainability of the workforce, due to the low numbers of trainees rising through the ranks.

Through CWGs we have heard concerns around workforce pressures; although medical staff typically take all of their annual leave, the first leave to be sacrificed in the instance of high demand for a department is study leave. One Trust reported that all study leave for Consultants was cancelled for four months in 2018 due to large outpatient backlogs with Consultant being forced to use their annual leave if they wanted to take study leave, whilst a participant from another Trust mentioned that nurse study leave is only granted if the training was proved to be 'essential', which is difficult to make a case for.

This leads to low staff satisfaction and poor career development opportunities, as well as staff burnout - we have heard qualitatively of many incidences of people being forced to take time out due to work-induced stress and sickness.

We know that despite this, staff within the system are continuing to provide a service that is safe and that is generally good quality. Thus, according to CQC reports, patient care is good in most cases.

**The scale of the workforce gap**

We have tried to evaluate the scale of the gap between the staff currently in post and what would be required. Due to the difficulties in attaining consistent funded establishment values across Trusts, we have had to model the required establishment using assumptions developed by clinicians.

The chart and table below (Figure 4) show the gaps at each grade between:

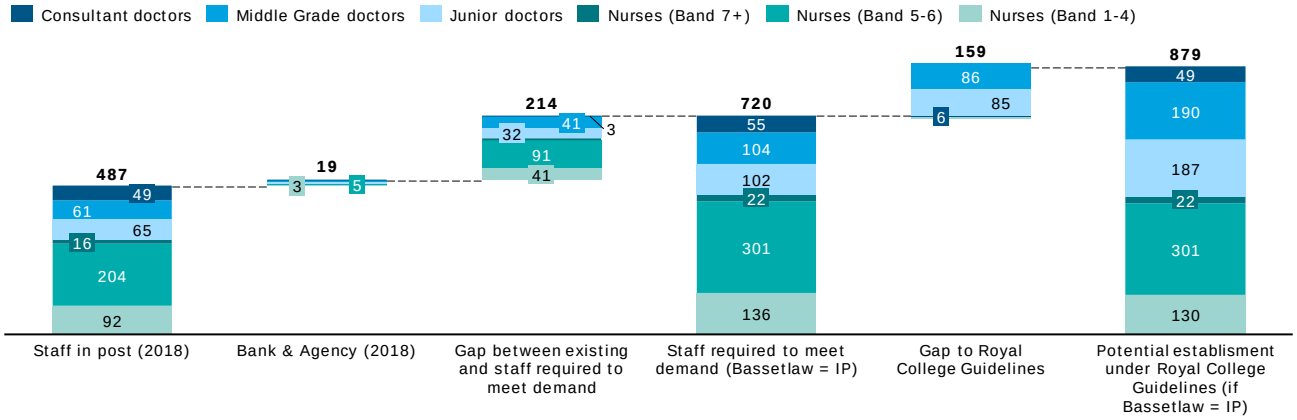
- The current staff in post and the number of staff required to sustainably staff units based on assumptions developed and refined with clinicians through a series of Clinical Working Groups
- The further gap between the number of staff required to sustainably staff units and the Royal College guidelines

The set of workforce assumptions used to develop this analysis (included in Appendix A) were developed through discussions with the Clinical Working Groups (CWGs). These assumptions take into consideration the number of days each staff grade would typically be assigned for annual leave, study leave and other duties outside of their primary acute role e.g. time for clinics as well as inpatient work in DGHs.

There is a gap of 214 WTEs from the current position, across grades, in order to meet the number of staff required to sustainably staff units using the assumption developed. When broken down by grade, the gap illustrates that Trusts struggle to fill middle-grade and junior-grade doctor positions, as well as Paediatric nursing positions, as is seen nationally.

In part, this gap is met with the use of 19 locum staff across SYB(ND). Through discussions with clinicians, we have ascertained that the figures for locum staff numbers received from Trusts are lower than they are in reality, due to a lack of data available and provided. This is likely to be significantly helping to close the gap between existing staff and the staff required to sustainably meet demand. This also suggests that, in reality, Trusts are having to spend significant amounts on locum, agency and bank staff, affecting the affordability of services.

There is then a gap of 159 WTEs from the number of staff required to sustainably meet demand to meeting Royal College staffing guidelines. When broken down by grade, the gap predominantly comprises of middle-grade and junior-grade doctors.




| | Staff in post | Agency & Bank | Gap between staff in post and staff required to meet demand | Staff required to meet demand | Gap to Royal College Guidelines | Potential establishment under Royal College guidelines |
|---|---|---|---|---|---|---|
| Consultant doctors | 49 | 4 | 3 | 55 | - 6 | 49 |
| Middle Grade doctors | 61 | 2 | 41 | 104 | 86 | 190 |
| Junior doctors | 65 | 5 | 32 | 102 | 85 | 187 |
| Nurses (Band 7+) | 16 | 0 | 6 | 22 | 0 | 22 |
| Nurses (Band 5-6) | 204 | 5 | 91 | 301 | 0 | 301 |
| Nurses (Band 1-4) | 92 | 3 | 41 | 136 | -6 | 130 |

*Figure 4: Workforce numbers showing the number of staff in post, agency & bank staff, staff required to meet demand under the current configuration and the Royal College guidelines*[4]

**Workload and Satisfaction**

Nonetheless, the shortfalls shown in the chart above (Figure 4) show that much of the good quality of care provided is being achieved by goodwill of staff. Members of the Clinical Working Group told us that a significant proportion of the shortfall is being made up by staff not taking study leave or taking additional shifts.

This is likely to be contributing to difficulties in recruitment and retention that we are seeing reported across the system. The General Medical Council (GMC) trainee staff survey scores for CAIC are shown below in Figure 5. The scores shown are for overall satisfaction and workload satisfaction, with both metrics are scored out of 100; a higher score for workload satisfaction indicates a more manageable workload.

[4] SYB(ND), Trust data returns, 2019

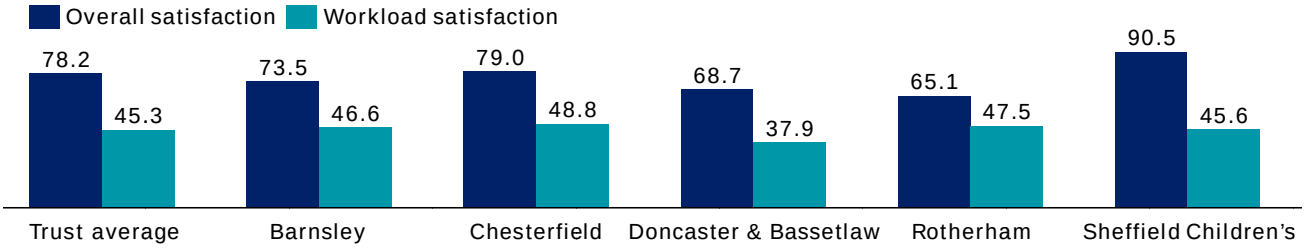



*Figure 5: CAIC GMC trainee staff survey scores for all SYB(ND) Trusts*[5,6]

The overall satisfaction scores (out of 100) range from 65.1 for Rotherham to 90.5 for Sheffield Children's, with a Trust average of 78.2. The workload satisfaction scores (out of 100) start at 37.9 for Rotherham, whilst Chesterfield has the highest score of 48.8, with a Trust average of 45.3. These scores echo the sentiment from the clinical working groups that staff in acute services are often overworked and feel significant workforce pressures in their roles.

## 2.4 Affordability

Affordability is measured by considering the question: *Does the option cost no more than the current service?*

This takes into consideration the following:

- How much activity do Trusts carry out?
- How efficient are the services the Trusts provide?

Interviews with Paediatric Medical Directors across SYB(ND) highlighted the difficulties in recruiting and retaining permanent staff to work in Paediatric departments. Therefore, some Trusts utilise locum staff for their acute Paediatric care, leading to an increased locum staff spend. Additionally, larger Trusts have developed efficiencies of scale, making them more cost effective overall.

We have used reference cost index (RCI) to assess the affordability of each service at each Trust. RCI is a measure of relative efficiency comparing the actual cost of activities in comparison to the expected cost; an RCI value above 100 means relatively inefficient services, whilst an RCI value below 100 means relatively more efficient services. The RCI values for all SYB(ND) Trusts are shown below in Figure 6 for CAIC. Sheffield Children's typically has lower RCI values than other SYB(ND) Trusts due to its large size, whilst Rotherham's very high RCI value could be indicative of high reliance on locum staff for CAIC:

[5] GMC, Staff survey, 2018

[6] Survey questions which make up the workload indicator: 'In this post, how often (if at all) do you work beyond your rostered hours?' 'In this post, how often (if at all) does your working pattern leave you feeling short of sleep when at work?' 'How would you rate the intensity of your work, by day in this post?' 'How would you rate the intensity of your work, by night in this post?'
GMC: High workloads may lead to fatigue and increased likelihood of error. Low scores are an indicator of a post where work intensity and/or long hours may lead to sleep deprivation or exhaustion.

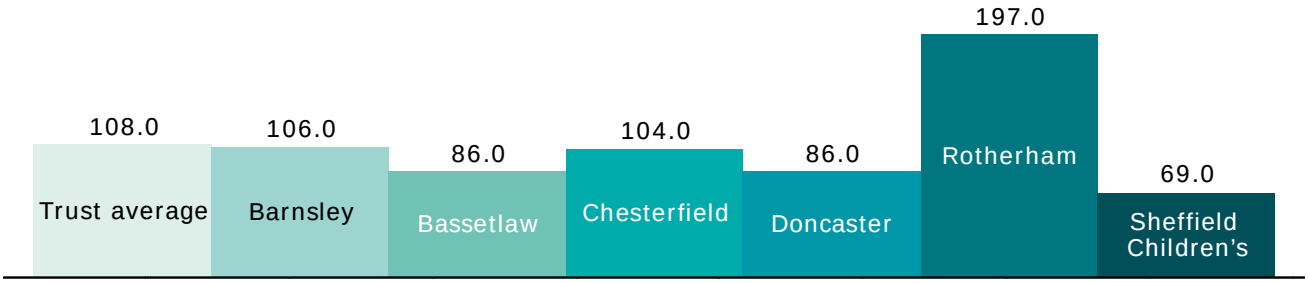



*Figure 6: CAIC RCI values for all SYB(ND) Trusts*[7]

Using the model described in the workforce section (and illustrated in Figure 4), we have calculated the number of staff required at each grade to sustainably staff units based on assumptions developed and refined with clinicians through a series of Clinical Working Groups. Based upon pay costs for each staff grade, an additional ~£10.3m investment p.a. would be required (excluding existing locum staff) in order to fund the supplementary workforce. The largest relative gap in is middle grade doctors as a proportion of staff required; in absolute terms the largest difference is band 5-6 nurses.

In order to close this gap, we are not assuming that we will automatically have to spend more on the service but we are looking to identify any ways in which we may be able to make the service as sustainable as possible within the existing workforce, either by strengthening it through shared working, or if necessary, reducing the demand on workforce from reconfiguration. However it must be noted that while reconfiguration can provide limited savings on one site in terms of overnight Consultant cover, it provides very few workforce savings for the system as a whole.

## 2.5 Interdependencies

Interdependencies are measured by considering the question: *Are the necessary supporting services appropriately available?*

This takes into consideration the following:

- Are interdependent services that need to be provided available onsite?
- What would the impact be to interdependent services at all Trusts if the clinical model were to change?

Paediatrics has a large number of interdependent services, notably Urgent & Emergency Medicine, Maternity & Neonatology. Paediatric doctors currently spend 30% of time in the Neonatology ward. The joint rota between Paediatrics and Neonatology is likely to be split in the future, which will create an even greater demand for middle grade doctors.

Paediatrics also has some interdependencies with A&E i.e. every Emergency department requires two Paediatric nurses who help to manage the inflow of patients with the support of consultant. Rotherham and Doncaster both have *Requires improvement* ratings for their A&E departments, partly as a result of Paediatric staffing issues.

At a system level, essential services are available within SYB(ND) for all but some of the most specialist services, for which there are arrangements on a Yorkshire and the Humber footprint.

[7] NHS, Reference cost indices, 2018

The table below (Figure 9) shows the CQC scores of the interdependent services required for Paediatrics:

| | Barnsley | Bassetlaw | Chesterfield | Doncaster | Rotherham | Sheffield Children's |
|---|---|---|---|---|---|---|
| **Urgent & Emergency Medicine CQC rating:** | G | RI | G | RI | I | G |
| **Maternity – CQC rating:** | G | RI | G | RI | RI | O |
| **Level of Neonatology provision:** | L2 | L2 | L2 | L2 | L2 | L3 |
| Surgery (general surgery) CQC rating: | G | G | - | G | - | - |
| Neonatology – CQC rating: | - | - | - | - | - | G |
| X-ray and diagnostic ultrasound CQC rating: | RI | G | G | G | - | - |
| Acute mental health services CQC rating: | - | - | RI | - | - | RI |

*Figure 9: CQC scores of interdependent services for Paediatrics*[8]

Paediatrics also has some interdependencies with A&E i.e. every Emergency department requires two Paediatric nurses who help to manage the inflow of patients with the support of consultant. We have considered the Children and Young People CQC score alongside the CQC score for Urgent & Emergency services, as this is a key interdependency for CAIC services. All Trusts achieve a *'Good'* score aside from Doncaster & Bassetlaw (who received *'Requires improvement')* and Rotherham (who received an *'Inadequate'* score). Doncaster & Bassetlaw's CQC rating for their A&E departments are partly due to the fact that they could not staff two Paediatric nurses in A&E, 24/7. Similarly the CQC report for Rotherham Urgent and Emergency Services found 'evidence of times when there were insufficient staff on duty in the resuscitation and paediatric emergency departments to ensure patients were safe.'

Similarly, the CQC scores for Maternity are varied across SYB(ND). Sheffield Teaching achieved an *'Outstanding'* score, Barnsley and Chesterfield achieved a *'Good'* score, whilst Doncaster & Bassetlaw and Rotherham achieved a *'Requires improvement'* score. All SYB(ND) Trusts have a L2 Neonatal unit, with the exception of Sheffield Children's which has a L3 unit.

## 2.6 The future of Care of the Acutely Ill Child services

**Current activity**

Through discussions with Clinical Working Groups (CWGs) and Paediatric Medical Directors, we have ascertained that there are an increasing number of GP referrals to SSPAUs across SYB(ND), with one Trust estimating c. 70% of their SSPAU admissions are from GP referrals. This indicates there is a large proportion of Paediatric patients who could be assessed and treated in the community, but are instead being directed to SSPAUs, which are already stretched in terms of activity and workforce. Rotherham has a very low number of SSPAU admissions, highlighting the success of their Paediatric Community Care Programmes.

The same discussions have highlighted the increased proportion of complex cases being admitted for acute Paediatric care, predominantly due to public health factors such as obesity and deprivation leading to increased comorbidities.

[8] CQC, Inspection reports, 2016 - 2019

The activity levels across each Trust in SYB(ND) for CAIC services are shown in Figure 10, using the metrics of non-elective IP admissions for 2018/2019 and average length of stay.

| Activity levels | Barnsley | Bassetlaw | Chesterfield | Doncaster | Rotherham | Sheffield Children's |
|---|---|---|---|---|---|---|
| Population under 18y/o (2017/18) | 52,858 | 24,530 | 53,563 | 69,325 | 60,070 | 123,891 |
| Non-elective IP admissions (2018/19) | 3725 | 1326 | 4573 | 4591 | 2382 | 6580 |
| Average length of stay (days) | 2.1 | 2.1 | 2.3 | 2.6 | 2.2 | 3.8 |

*Figure 10: CAIC activity levels and under 18 y/o population data across SYB(ND)*[9,10]

**Future services**

Overall, the demand for acute Paediatric services is expected to increase over the next 5 years. Based on the population growth (ONS) and non-demographic growth assumptions, we expect demand for Paediatric services to grow by 2.7% on average in the next 5 years.

Currently, there is a sufficient under 18 population to sustain appropriate levels of patient flow to facilitate training in SYB(ND) hospitals to ensure the workforce remain proficient in Paediatric care. The under 18 population of Bassetlaw is noticeably lower than the other SYB(ND) Trusts; if population levels were to fall there may be a risk to the training of staff in Bassetlaw.

The graph below (Figure 11) shows the predicted inpatient unit and SSPAU admission levels on the left axis, with the percentage change year on year shown on the right axis.

Using the HEE workforce growth assumptions, we expect the workforce to grow, on average, in the next 5 years (Figure 12):

- 1.3% p.a. for Junior doctors
- 5.3% p.a. for Paediatric Nursing staff

Although the number of Paediatric nurses is expected to grow faster than the number of Paediatric admissions (5.3% p.a.), given the current shortage of Paediatric nurses, it will not be enough to ensure appropriate staffing. Moreover, although this increase will help to alleviate some of the workforce issues currently experienced in SYB(ND), the rate of growth will not match the growth in demand when current workforce shortfalls are taken into account.

This will likely result in a decline in the quality of Paediatric care provided across SYB(ND), if there is insufficient staffing across the region.

[9] SYB(ND), Trust data returns, 2019
[10] NHS, CCG Population data, 2019

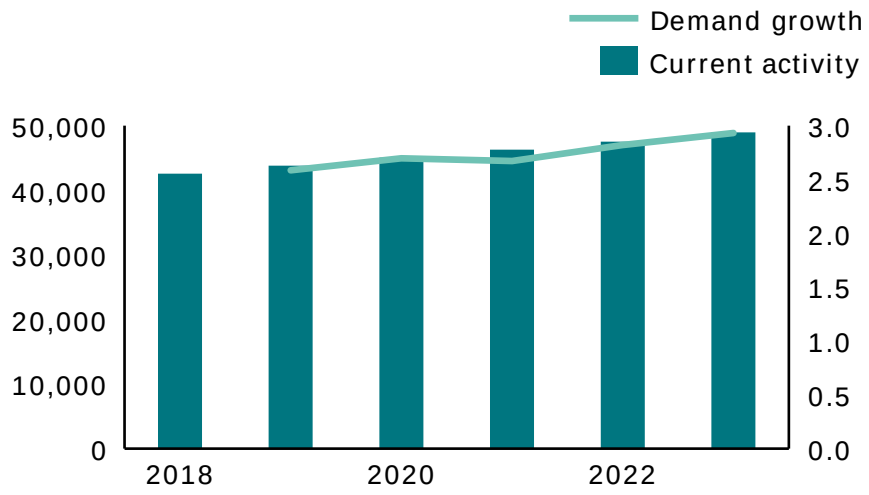



*Figure 11: Predicted growth in demand over the next 5 years for CAIC services*

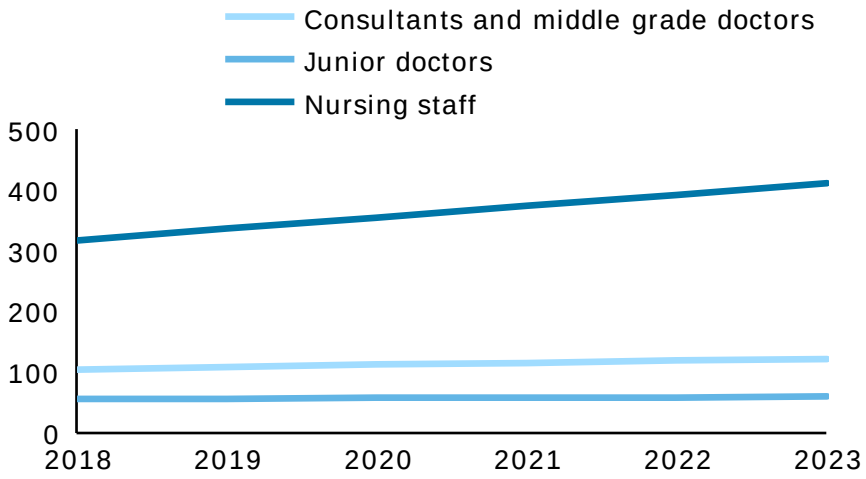



*Figure 12: Predicted increase in CAIC workforce over the next 5 years*

Furthermore, the implementation of Better New born Care guidelines could cause further workforce shortages in acute Paediatrics. For L1 and L2 Neonatal units, a junior doctor must be immediately available for Neonatal care, which will necessitate a separate rota to Paediatrics. Busier Neonatal units will require a separate middle grade rota, whilst the busiest units will require a separate consultant rota (as is the case currently). The splitting of the rota which currently covers both Paediatrics and Neonatology will could further exacerbate the junior and middle grade doctor shortages experienced in Paediatrics across SYB(ND).

# 3 The Case for Change: Maternity

## 3.1 Overall

The quality of Maternity services in SYB(ND) is currently good on most sites, but we are facing some sustainability challenges in our systems. Bassetlaw is of particular concern, as it cannot maintain a 24/7 Anaesthetics service and NHS England are reviewing its Neonatology service. Doncaster & Bassetlaw and Rotherham both have *Requires improvement* CQC scores for Maternity.

Patient feedback for Maternity across SYB(ND) is excellent, but staff satisfaction scores for overall satisfaction and workload suggest that the quality of the service is very dependent on staff members working overtime and going the extra mile to provide a good quality of care.

A detailed assessment of Trusts, against approximately 30 metrics at Trust level, is contained in the case for change report for each Trust, included below is a snapshot view of these metrics at the system level.

## 3.2 Quality

We will measure Quality by considering the question: *Is quality of care optimised by promoting delivery of national good practice and guidance, and contributing to maintained or improved outcomes?*

This takes into consideration the following:

- Are SYB(ND) Trusts able to meet national clinical guidelines and standards?
- Are patients satisfied with the quality of care offered?

**CQC Assessment**

The table below (Figure 13) shows the CQC Maternity scores for each SYB(ND) Trust. The CQC score looks at safety, effectiveness, care, responsiveness and leadership of a service. The CQC scores for Maternity[11] are varied across SYB(ND). Sheffield Teaching achieved an *'Outstanding'* score, Barnsley and Chesterfield achieved a *'Good'* score, whilst Doncaster & Bassetlaw and Rotherham achieved a *'Requires improvement'* score. Considering the CQC reports, Doncaster & Bassetlaw's CQC score was due to workforce shortages, whilst Rotherham's score was in part due to a low rate of safeguarding supervision and a lack of support for community Midwives.

[11] CQC, Inspection reports, 2016 - 2019

| | Barnsley<br>*Published Mar '18* | Chesterfield<br>*Published May '17* | Doncaster<br>*Published July '18* | Bassetlaw<br>*Published Jul '18* | Rotherham<br>*Published Jan '19* | Sheffield Teaching<br>*Published Nov '18* |
|---|---|---|---|---|---|---|
| CQC Maternity | G<br>Good | G<br>Good | RI<br>Requires Improvement | | RI<br>Requires Improvement | O<br>Outstanding |

*Figure 13: CQC scores for Maternity*[12]

**Patient feedback**

NHS choices submissions relating to Maternity indicate a good quality of patient feedback when assessed across SYB(ND), with reference to 'reassuring and supportive staff' who provide 'the highest level of care'. We have also used the NHS Friends and Family test for Maternity to assess how patients perceive the quality of the Maternity services at each Trust. The scores (% of people who would recommend the service) are shown in Figure 14 below. The highest score across SYB(ND) trusts is always for postnatal community care, with a lower average score for care during birth. All scores are above 90%, with the exception of postnatal community care at Mid Yorkshire Hospital NHS Trust.

| Percentage who would recommend | Barnsley | Chesterfield | Doncaster & Bassetlaw | Rotherham | Sheffield Teaching |
|---|---|---|---|---|---|
| Antenatal Care | 100% | 100% | 98% | 100% | 94% |
| Birth | 100% | N/A | 98% | 99% | 96% |
| Postnatal Ward | 92% | 97% | 95% | 97% | 95% |
| Postnatal Community | N/A | 100% | 100% | 100% | 100% |
| **Average** | 97% | 99% | 98% | 99% | 96% |

*Figure 14: Friends & Family test for Maternity for all SYB(ND) Trusts*[13]

[12] CQC, Inspection reports, 2016 - 2019
[13] NHS, Friends and Family test, 2018

## 3.3 Workforce

Workforce is measured by considering the question: *Does the option ensure there is a sustainable workforce of the right number and skill set?*

This takes into consideration the following:

- Do Trusts have sufficient workforce in place to provide a safe service?
- Is the existing workforce satisfied with their workplace environment and workload?
- To what extent do Trusts rely on locum / temporary staff?

There is currently a shortfall in workforce across the system for Maternity. As with Paediatric care, it has been noted that the excellent patient feedback received is heavily dependent upon permanent staff going the extra mile to provide a good quality of care, through working overtime to cover gaps in the rota.

The Clinical Working Groups have also expressed significant concerns around the future sustainability of the workforce, due to the low numbers of trainees rising through the ranks. Many CWG members expressed their concern around the ageing demographic of the Midwifery workforce, many of whom will be coming up for retirement across Trusts over the next five years.

Workforce pressures have also been identified in terms of study leave; although medical staff typically take all of their annual leave, the first leave to be sacrificed in the instance of high demand is study leave, for example Midwives being asked not to take their designated amount of study leave. This leads to low staff satisfaction and poor career development opportunities, as well as staff burnout - we have heard qualitatively of many incidences of people being forced to take time out due to work pressures. Indeed it was mentioned in the CWGs that large numbers of midwives are taking time off work due to work-induced stress or ill-health.

We know that despite this, staff within the system are continuing to provide a service that is safe and that is generally good quality. Thus, according to CQC reports, patient care is good in most cases.

**The scale of the workforce gap**

We have tried to evaluate the scale of the gap between the staff currently in post and what would be required. Due to the difficulties in attaining consistent funded establishment values across Trusts, we have had to model the required establishment using assumptions developed by clinicians.

The chart and table below (Figure 15) show the gaps at each grade between:

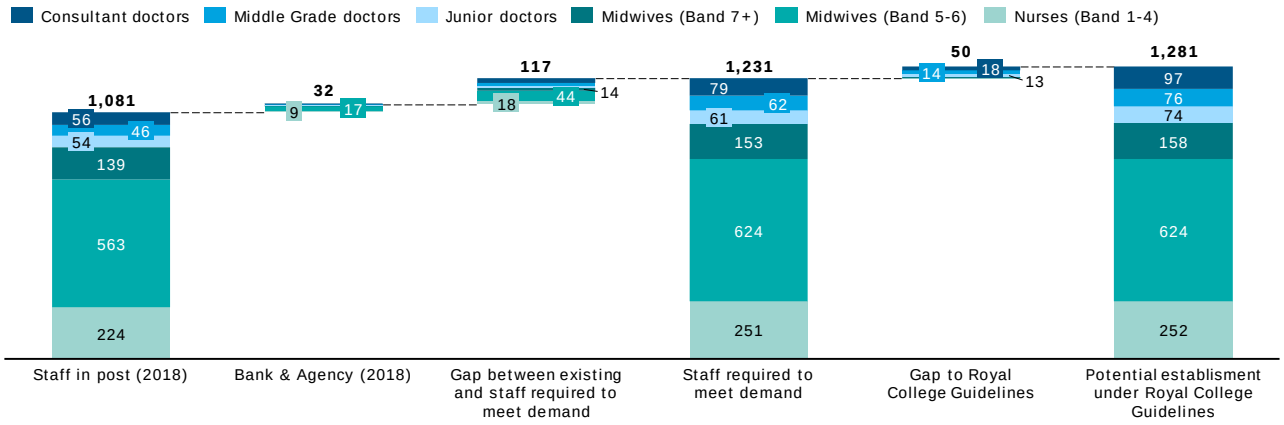
- The current staff in post and the number of staff required to sustainably staff units based on assumptions developed and refined with clinicians through a series of Clinical Working Groups
- The further gap between the number of staff required to sustainably staff units and the Royal College guidelines

The set of workforce assumptions used to develop this analysis are included in the Appendix (Section XX), which were developed through discussions with the Clinical Working Groups (CWGs). These assumptions take into consideration the number of days each staff grade would typically be assigned for annual leave, study leave and other duties outside of their primary acute role e.g. time for clinics as well as inpatient work in DGHs.

There is a gap of 117 WTEs from the current position, across grades, in order to meet the number of staff required to sustainably staff units using the assumption developed. When broken down by grade, the gap illustrates that Trusts struggle to fill consultant and middle-grade doctors positions, as well as Midwifery positions, as is seen nationally.

In part, this gap is met with the use of 32 locum staff across SYB(ND). Through discussions with clinicians, we have ascertained that the figures for locum staff numbers received from Trusts are lower than they are in reality, due to a lack of data available and provided. This is likely to be significantly helping to close the gap between existing staff and the staff required to sustainably meet demand. This also suggests that, in reality, Trusts are having to spend significant amounts on locum, agency and bank staff, affecting the affordability of services.

There is then a gap of 50 WTEs from the number of staff required to sustainably meet demand to meeting Royal College staffing guidelines. When broken down by grade, the gap predominantly comprises of consultant and middle-grade doctors.




| | Staff in post | Agency & Bank | Gap between staff in post and staff required to meet demand | Staff required to meet demand | Gap to Royal College Guidelines | Potential establishment under Royal College guidelines |
|---|---|---|---|---|---|---|
| Consultant doctors | 56 | 0 | 23 | 79 | 18 | 97 |
| Middle Grade doctors | 46 | 4 | 13 | 62 | 14 | 76 |
| Junior ("SHO") doctors | 54 | 1 | 6 | 61 | 13 | 74 |
| Midwives (Band 7+) | 139 | 1 | 14 | 153 | 5 | 158 |
| Midwives (Band 5-6) | 563 | 17 | 44 | 624 | 0 | 624 |
| Nurses (Band 1-4) | 224 | 9 | 18 | 251 | 1 | 252 |

*Figure 15: Workforce numbers showing the number of staff in post, agency & bank staff, staff required to meet demand under the current configuration and the Royal College guidelines*[14]

### Workload and satisfaction

Nonetheless, the shortfalls shown in the chart above show that much of the good quality of care provided is being achieved by goodwill of staff. A significant proportion of the shortfall is being made up by staff not taking study leave or taking additional shifts. Examples of this include study leave being cancelled, and permanent members of medical staff covering gaps in the rota, as opposed to utilising locum, bank or agency staff.

[14] SYB(ND), Trust data returns, 2019

This is likely to be contributing to difficulties in recruitment and retention that we are seeing reported across the system. The General Medical Council (GMC) trainee staff survey scores for Maternity are shown below in Figure 16. The scores shown are for overall satisfaction and workload satisfaction, with both metrics are scored out of 100; a higher score for workload satisfaction indicates a more manageable workload.

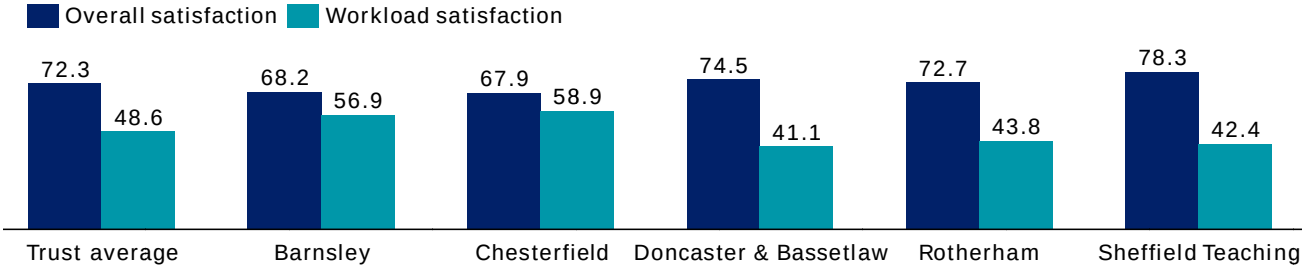



*Figure 16: Maternity GMC trainee staff survey scores for all SYB(ND) Trusts*[15,16]

The overall satisfaction scores (out of 100) range from 67.9 for Chesterfield to 78.3 for Sheffield Teaching, with a Trust average of 72.3. The workload satisfaction scores (out of 100) start at just 41.1 for Doncaster & Bassetlaw, whilst Chesterfield has the highest score of 58.9, with a Trust average of 48.6. These scores echo the sentiment from the clinical working groups that staff in acute services are often overworked and feel significant workforce pressures in their roles.

## 3.4 Affordability

Affordability is measured by considering the question: *Does the option cost no more than the current service?*

This takes into consideration the following:

- How much activity do Trusts carry out?
- How efficient are the services the Trusts provide?

Many Trusts have expressed their concern around the difficulty in recruiting Midwives and middle grade doctors, which has led to spend on locum staff in Maternity departments across SYB(ND). Additionally, larger Trusts have inevitably developed efficiencies of scale, making them more cost effective overall.

We have used reference cost index (RCI) to assess the affordability of each service at each Trust. RCI is a measure of relative efficiency comparing the actual cost of activities in comparison to the expected cost; an RCI value above 100 means relatively inefficient services, whilst an RCI value below 100 means relatively more efficient services. The RCI values for all SYB(ND) Trusts are shown below in Figure 17 for Maternity.

[15] GMC, Staff survey, 2018

[16] Survey questions which make up the workload indicator: 'In this post, how often (if at all) do you work beyond your rostered hours?' 'In this post, how often (if at all) does your working pattern leave you feeling short of sleep when at work?' 'How would you rate the intensity of your work, by day in this post?' 'How would you rate the intensity of your work, by night in this post?'
GMC: High workloads may lead to fatigue and increased likelihood of error. Low scores are an indicator of a post where work intensity and/or long hours may lead to sleep deprivation or exhaustion.

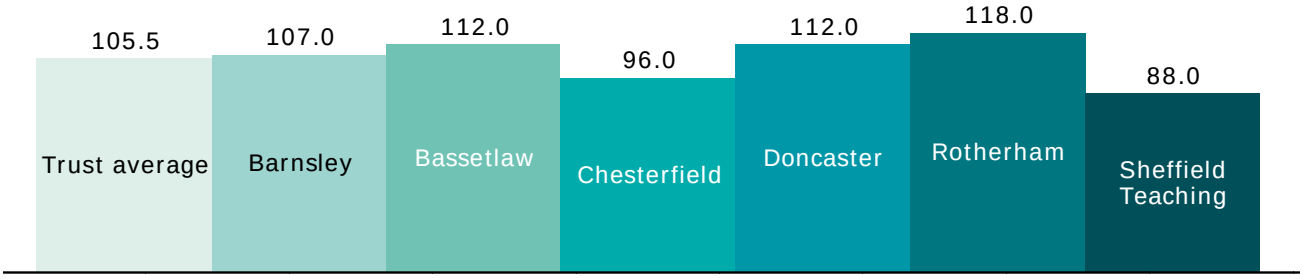



*Figure 17: Maternity RCI values for all SYB(ND) Trusts*[17]

We have calculated the number of staff required at each grade to sustainably staff units based on assumptions developed and refined with clinicians through a series of Clinical Working Groups. Based upon pay costs for each staff grade, an additional ~£11.8m investment p.a. would be required (excluding existing locum staff) in order to fund the supplementary workforce. The largest gap both proportionally, and by total cost, is in consultant doctors.

In order to close this gap, we are not assuming that we will automatically have to spend more on the service but we are looking to identify any ways in which we may be able to make the service as sustainable as possible within the existing workforce, either by strengthening it through shared working, or if necessary, reducing the demand on workforce from reconfiguration. However it must be noted that while reconfiguration can provide limited savings on one site in terms of overnight Consultant cover, it provides very few workforce savings for the system as a whole.

## 3.5 Interdependencies

Interdependencies are measured by considering the question: *Are the necessary supporting services appropriately available?*

This takes into consideration the following:

- Are interdependent services that need to be provided available onsite?
- What would the impact be to interdependent services at all Trusts if the clinical model were to change?

At a system level, essential services are available within SYB(ND) for all but some of the most specialist services, for which there are arrangements on a Yorkshire and the Humber footprint. The table below (Figure 20) shows the CQC scores of the interdependent services required for Maternity:

[17] NHS, Reference cost index, 2018

| | Barnsley | Bassetlaw | Chesterfield | Doncaster | Rotherham | Sheffield Teaching |
|---|---|---|---|---|---|---|
| **Urgent & Emergency Medicine CQC rating:** | G | RI | G | RI | I | G |
| **Children and young people CQC rating:** | RI | G | G | G | G | G |
| **Level of Neonatology provision:** | L2 | L2 | L2 | L2 | L2 | L3 |
| Surgery (general surgery) CQC rating: | G | G | - | G | - | - |
| Neonatology – CQC rating: | - | - | - | - | - | G |
| X-ray and diagnostic ultrasound CQC rating: | RI | G | G | G | - | - |
| Acute mental health services CQC rating: | - | - | RI | - | - | RI |

*Figure 20: CQC scores for Maternity's vital interdependent services*[18]

For Urgent & Emergency medicine, Barnsley, Chesterfield and Sheffield Children's achieved a *'Good'* score, Doncaster & Bassetlaw received a *'Requires improvement'* score, whilst Rotherham received an *'Inadequate'* score.[19]

All SYB(ND) Trusts achieved *'Good'* Care Quality Commission (CQC) scores for Children and Young People[20], with the exception of Barnsley, which received a *'Requires improvement'* score. Barnsley Hospital believe their *'Requires improvement'* score may have been in large part due to a one-off event on the day of the inspection. All SYB(ND) Trusts have a L2 Neonatal unit, with the exception of Sheffield Children's which has a L3 unit.[21]

Bassetlaw is of particular concern, as it cannot currently maintain a 24/7 Anaesthetics service and NHSE are reviewing its Neonatology service. Doncaster & Bassetlaw and Rotherham have *Requires improvement* CQC scores for Maternity. Having said that, most sites can address the interdependencies at present, with significant concerns only at Bassetlaw.

One major piece of guidance which could significantly disrupt the sustainability of the status quo is Better New born Care. This guidance requires that Neonatology and Paediatrics services have separate mid-grade rotas, rather than relying on a shared mid-grade rota as is currently the case in every SYB(ND) site (other than Sheffield Teaching Hospitals and Doncaster).

## 3.6 The future of Maternity services

Some Maternity Medical Directors stated that the overall activity levels across SYB(ND) are decreasing. Despite this overall decrease in activity, there continues to be an increase in demand for consultant-led services due to a larger proportion of expected high-risk pregnancies (up to c. 65% for some Trusts). High-risk pregnancies are usually due to public health factors such as obesity or smoking at the time of delivery. The trend of increasing demand due to public health factors is seen across services within SYB(ND).

Many Trusts commented that although they are able to manage their current level of demand, they would not be able to cope with the extra demand they would face as a result of potential changes to Maternity services elsewhere in SYB(ND) or due to changes to Maternity services outside of the system.

18 CQC, Inspection reports, 2016 - 2019
19 CQC, Inspection reports, 2016 - 2019
20 CQC, Inspection reports, 2016 - 2019
21 CQC, Inspection reports, 2016 - 2019

The activity levels across each Trust in SYB(ND) for Maternity services are shown below in Figure 21, showing the total number of births for 2018/2019 and the average length of stay:

| | Barnsley | Chesterfield | Doncaster | Bassetlaw | Rotherham | Sheffield Teaching |
|---|---|---|---|---|---|---|
| **Average yearly change in birth rate (since 2013/14)** | +0.9% | +0.1% | -1.7% | | -0.7% | -0.6% |
| **Activity levels (number of births 2018/19)** | 2842 | 2719 | 3216 | 1488 | 2697 | 6667 |
| **Proportion of expected high-risk births** | 65% | 35% | N/A | N/A | 65% | 60% |
| **Average length of stay (days)** | 2.1 | 2.0 | 2.4 | 2.2 | 2.3 | 2.6 |

*Figure 21: Maternity activity levels across SYB(ND)*[22]

Overall, the demand for Maternity services is expected to increase over the next five years. Based on the population growth (ONS) and non-demographic growth assumptions, we expect the number of births to grow by 2% on average in the next five years.

The graph below (Figure 22) shows the predicted Maternity admission levels on the left axis, with the percentage change in admissions year on year shown on the right axis. The number of Midwives is expected to grow at 0.8% p.a., which is a slower growth rate than the growth rate of Maternity admissions; therefore there is likely to be insufficient Maternity staffing over the next five years. Although some SYB(ND) Trusts are seeing a decrease in overall activity levels, any increase in the proportion of women who require consultant-led services during their birth, may lead to increased pressures on the consultant workforce.

Using the HEE workforce growth assumptions, we expect the workforce to grow, on average, in the next 5 years (Figure 23):

- 0.8% p.a. for Midwifery
- 1.3% p.a. for Junior doctors

Although this increase will help to alleviate some of the workforce issues currently experienced in SYB(ND), the rate of growth does not match the growth in demand; this also does not take into account current workforce shortages.

[22] SYB(ND), Trust data returns, 2019

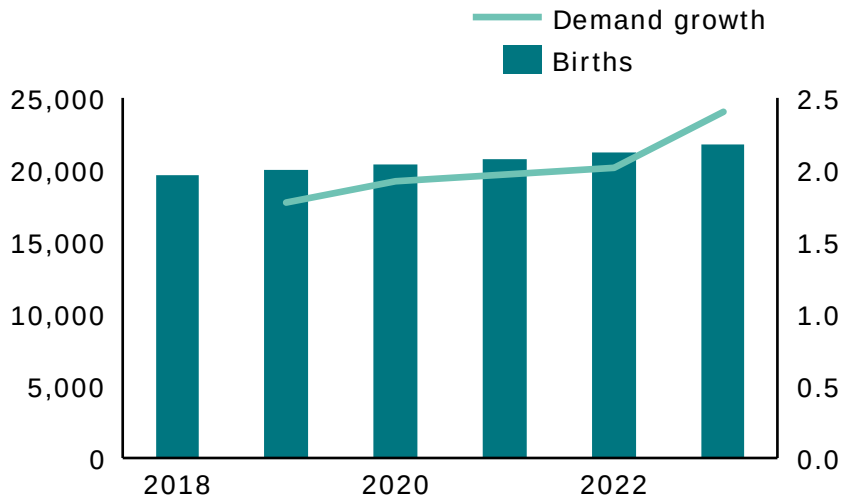



*Figure 22: Predicted growth in demand over the next 5 years for Maternity services*

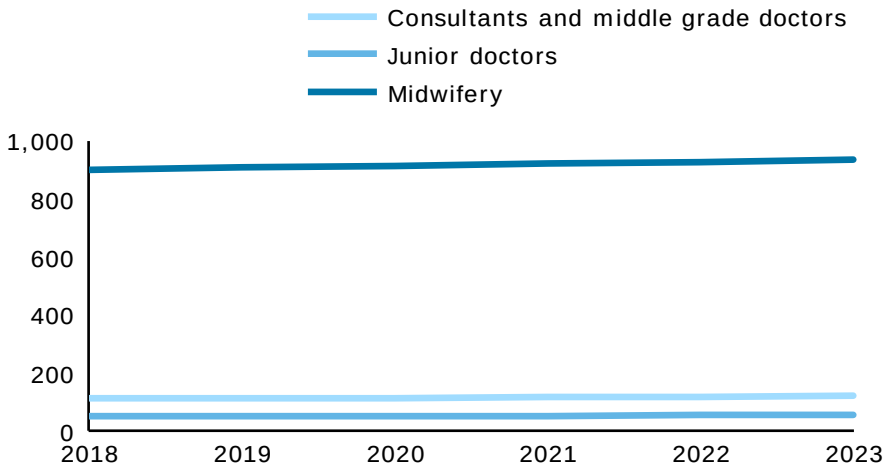



*Figure 23: Predicted increase in Maternity workforce over the next 5 years*

There are also significant concerns around the ageing Midwife workforce, and the declining number of Midwifery trainees. Continuity of Carer guidelines are also expected to have an impact on the Maternity workforce. The guidelines necessitate a different way of working for Midwives, who may be on call up to 2 or 3 times a week and teams of midwives will work with the same women throughout their pregnancy, increasing the need for community midwifery. Medical directors for Maternity have concerns that the Continuity of Carer targets could significantly destabilise the Maternity workforce, due to the increased requirement for Midwives, as well as the potential effects of different ways of working might have on Midwifery retention rates.

# 4 The Case for Change: Gastroenterology and Endoscopy

## 4.1 Overall

The quality of Gastroenterology and Endoscopy services in SYB(ND) is currently good on most sites, but are facing increasing pressures and strain. Rotherham is of particular concern, as at the beginning of the review there were no permanent Gastroenterologists working at the Trust, with all work being carried out by locum staff. Since then, they have successfully recruited two permanent Gastroenterologists, and are in talks with Barnsley to develop a formalised partnership. However, Rotherham still has a *Requires improvement* CQC score for Medical care (including Gastroenterology).

Patient feedback for Gastroenterology across SYB(ND) is excellent, but staff satisfaction scores for overall satisfaction and workload suggest that the quality of the service is very dependent on staff members putting in extra work to ensure a good quality of care is provided.

A detailed assessment of Trusts, against a number of metrics at Trust level, is contained in the case for change report for each Trust, included below is a snapshot view of these metrics at the system level.

## 4.2 Quality

We will measure Quality by considering the question: *Is quality of care optimised by promoting delivery of national good practice and guidance, and contributing to maintained or improved outcomes?*

This takes into consideration the following:

- Are SYB(ND) Trusts able to meet national clinical guidelines and standards?
- Are patients satisfied with the quality of care offered?

**CQC Assessment and JAG Accreditation**

The table below (Figure 24) shows the Care Quality Commission Medical care scores (used as a proxy for Gastroenterology) for each Trust. The CQC score looks at safety, effectiveness, care, responsiveness and leadership of a service. All SYB(ND) Trusts achieved a *'Good'* score for Medical care (used as proxy for Gastroenterology). The exception is Rotherham, which received a *'Requires improvement'* score, which is primarily due to the lack of permanent Gastroenterologists working in the department.[23] The table below also shows the Joint Advisory Group (JAG) Accreditation status for each Trust. JAG Accreditation means that an endoscopy service has displayed competence in delivery against a set of safety criteria.

[23] CQC, Inspection reports, 2016 - 2019

| | Barnsley *Published Mar '18* | Chesterfield *Published May '17* | Doncaster *Published July '18* | Bassetlaw *Published Jul '18* | Rotherham *Published Jan '19* | Sheffield *Published Nov '18* |
|---|---|---|---|---|---|---|
| CQC Medical Care (incl. Gastroenterology) | G Good | G Good | G Good | | RI Requires improvement | G Good |
| JAG Accreditation status | Criteria met | Criteria met | Criteria met | | Criteria met | Criteria met |

*Figure 24: CQC scores for Medical care and JAG Accreditation status*[24]

**Patient feedback**

Patient feedback for Gastroenterology is very good. The NHS Choices survey shows what percentage of patients would recommend the service. The average recommendation rate across SYB(ND) is 98.9%. The scores for each SYB(ND) Trust are shown below in Figure 25:




*Figure 25: NHS Choices scores for Gastroenterology*[25]

## 4.3 Workforce

Workforce is measured by considering the question: *Does the option ensure there is a sustainable workforce of the right number and skill set?*

This takes into consideration the following:

- Do Trusts have sufficient workforce in place to provide a safe service?
- Is the existing workforce satisfied with their workplace environment and workload?
- To what extent do Trusts rely on locum / temporary staff?

There are substantial workforce shortages for Gastroenterology services across SYB(ND) on particular sites and for Out Of Hour Gastrointestinal Bleed (OOH GI Bleed) Services.

The required number of staff is calculated on a basis of having 1 Consultant Gastroenterologist for every 42,000 people in the population (based on the RCP guideline). We have calculated "fill ratios" comparing the staff in post to the numbers required based on the RCP guidelines.

[24] CQC, Inspection reports, 2016 - 2019
[25] NHS Choices, Gastroenterology feedback, 2018

The fill ratios for in hours Gastroenterology services at each Trust (Figure 26) indicate that there are more than the required total number of Gastroenterologists with most sites having a fill ratio range of 1.0 – 2.0. However some of the Gastroenterologists listed as in post may be locum, agency or bank staff:

SUBSTANTIVE POSTS / POSTS REQUIRED = FILL RATIO

FILL RATIOKEY: <0.8 | 0.8 - 0.9 | >0.9

| | Sheffield Teaching | Barnsley | Rotherham | Doncaster & Bassetlaw | Chesterfield |
|---|---|---|---|---|---|
| Population served | 640,000 | 240,000 | 261,000 | 420,000 | 441,000 |
| Gastroenterologists in post (including non substantive) | 22.0 | 6.0 | 9.0 | 20.0 | 5.7 |
| Gastroenterologists required | 15.4 | 5.8 | 6.3 | 10.1 | 10.6 |
| Fill ratio | 1.4 | 1.0 | 1.4 | 2.00 | 0.54 |

*Figure 26: In hours Gastroenterology fill ratios based on RCP guidelines*

However, the equivalent fill ratios for Out Of Hours Gastroenterology services (Figure 27) highlight that there are shortages in the number of consultants, when compared to the same RCP guideline. The fill ratios indicate that Rotherham and Chesterfield do not have the required number of Gastroenterologists available to work on OOH Gastrointestinal Bleeding (a main cause for concern) both having a fill ratio of only 0.6, vs an average across the other three Trusts of 1.1.

SUBSTANTIVE POSTS / POSTS REQUIRED = FILL RATIO

FILL RATIO KEY: <0.8 | 0.8 - 0.9 | >0.9

| | Sheffield Teaching | Barnsley | Rotherham | Doncaster & Bassetlaw | Chesterfield |
|---|---|---|---|---|---|
| Population served | 640,000 | 240,000 | 261,000 | 420,000 | 441,000 |
| Gastroenterologists in post | 20.5 | 6.0 | 4.0 | 9.31 | 6.7 |
| Gastroenterologists required | 15.4 | 5.8 | 6.3 | 10.1 | 10.6 |
| Fill ratio | 1.3 | 1.00 | 0.6 | 0.9 | 0.6 |

*Figure 27: Out of hours GI bleeds fill ratios based on RCP guidelines*

The Clinical Working Groups expressed significant concern around the future sustainability of the workforce, due to the low numbers of trainees rising through the ranks. Many CWG participants expressed their concern around the lack of permanent Gastroenterologists at Rotherham and how this stark shortage was creating further demand at all other SYB(ND) sites, due to the central location of the Rotherham site within South Yorkshire.

However, the shortfalls shown in the table above show that some of this is being achieved by good will of staff and significant pressures. The General Medical Council (GMC) trainee staff survey scores for acute medicine (taken as a proxy for Gastroenterology) are shown below in Figure 28. The scores shown are for overall satisfaction and workload satisfaction, with both metrics are scored out of 100; a higher score for workload satisfaction indicates a more manageable workload when compared to peers nationally:

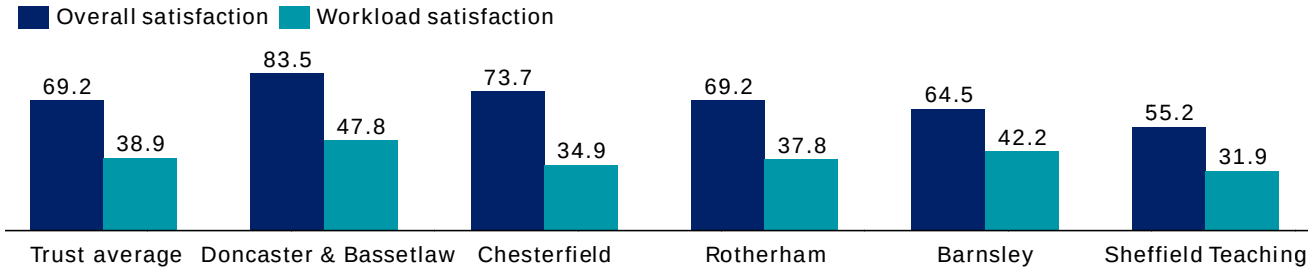



*Figure 28: GMC trainee staff survey scores for Acute medicine for all SYB(ND) Trusts*[26]

## 4.4 Affordability

Affordability is measured by considering the question: *Does the option cost no more than the current service?*

This takes into consideration the following:

- How much activity do Trusts carry out?
- How efficient are the services the Trusts provide?

Due to the difficulties in recruiting permanent staff to work in Gastroenterology departments, some SYB(ND) Trusts have very large locum staff spends. Additionally, larger Trusts have developed efficiencies of scale, making them more cost effective overall.

We have used reference cost index (RCI) to assess the affordability of each service at each Trust. RCI is a measure of relative efficiency comparing the actual cost of activities in comparison to the expected cost; an RCI value above 100 means relatively inefficient services, whilst an RCI value below 100 means relatively more efficient services. The RCI values for all SYB(ND) Trusts are shown below in Figure 29 for Gastroenterology:

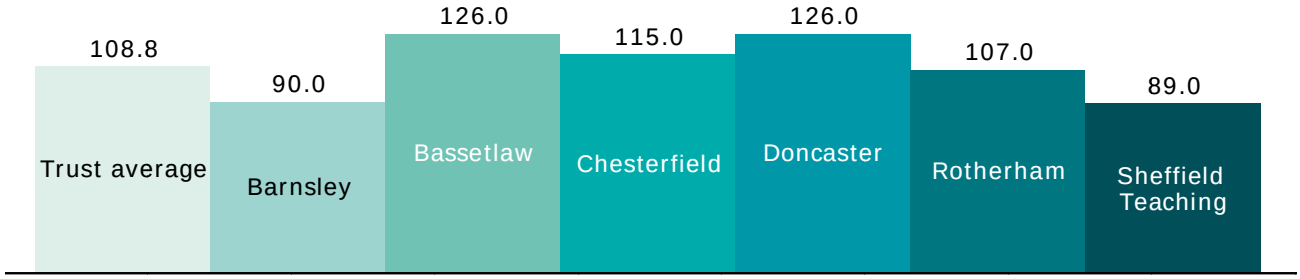



*Figure 29: Gastroenterology RCI values for all SYB(ND) Trusts*[27]

[26] GMC, Staff survey, 2018
[27] NHS, Reference cost indices, 2018

## 4.5 Interdependencies

Interdependencies are measured by considering the question: *Are the necessary supporting services appropriately available?*

This takes into consideration the following:

- Are interdependent services that need to be provided available onsite?
- What would the impact be to interdependent services at all Trusts if the clinical model were to change?

At a system level, essential services are available within SYB(ND) for all but some of the most specialist services, for which there are arrangements on a Yorkshire and the Humber footprint. The table below (Figure 31) shows the CQC scores of the interdependent services required for Gastroenterology:

| | Barnsley | Bassetlaw | Chesterfield | Doncaster | Rotherham | Sheffield Teaching |
|---|---|---|---|---|---|---|
| Medical care CQC rating: | G | G | - | G | RI | G |
| Urgent & Emergency Medicine – CQC rating: | G | RI | G | RI | I | G |

*Figure 31: CQC scores of interdependent services for Gastroenterology*[28]

For Urgent & Emergency medicine, Barnsley, Chesterfield and Sheffield Children's achieved a *'Good'* score, Doncaster & Bassetlaw received a *'Requires improvement'* score, whilst Rotherham received an *'Inadequate'* score.[29]

## 4.6 The future of Gastroenterology services

The demand for Gastroenterology has significantly increased over the past few years, with one Trust experiencing threefold increase in demand in as many years. The reasons for this large increase are believed to be the following:

- The bowel cancer screening programme has increased the demand for endoscopy services
- An ageing population will typically require more Gastroenterology services
- The drop in threshold for referrals from GPs has led to a huge surge in demand for endoscopy services over the past couple of years

Gastroenterologists expect that the demand for Gastroenterology services will only continue to increase in the next five years. If the threshold for bowel cancer screening becomes lower, this will create another large increase in demand for the service in SYB(ND). Some Gastroenterologists have commented that removing bowel cancer screening from the scope of Gastroenterology services would make the service's workload significantly more manageable.

Additionally, GPs are becoming increasingly risk adverse, which also leads to increased referrals for Gastroenterology services. It is also predicted that the occurrence of cancer will increase over the next 5 years, leading to increased requirement for Endoscopy services.

[28] CQC, Inspection reports, 2016 - 2019
[29] CQC, Inspection reports, 2016 - 2019

Hospital Service Review: Report for Governing Bodies

Health and care working together in South Yorkshire and Bassetlaw



# Hospital Services Review

## South Yorkshire, Bassetlaw and North Derbyshire: Considering the case for change

## Governing Bodies Note: Annex C

## Methodology

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# 1 Introduction

This methodology annex has been produced to outline the work that has been produced during Phase II of the Hospital Services Programme, following and building on the publication of the Stage 2 Report in 2018. This document outlines the timeline of key meetings and deliverables produced, including the groups we have consulted with, their membership and purpose. Finally, we have detailed the supplementary reports produced to synthesise knowledge gathered and facilitate decision-making.

# 2 Phase II project timeline

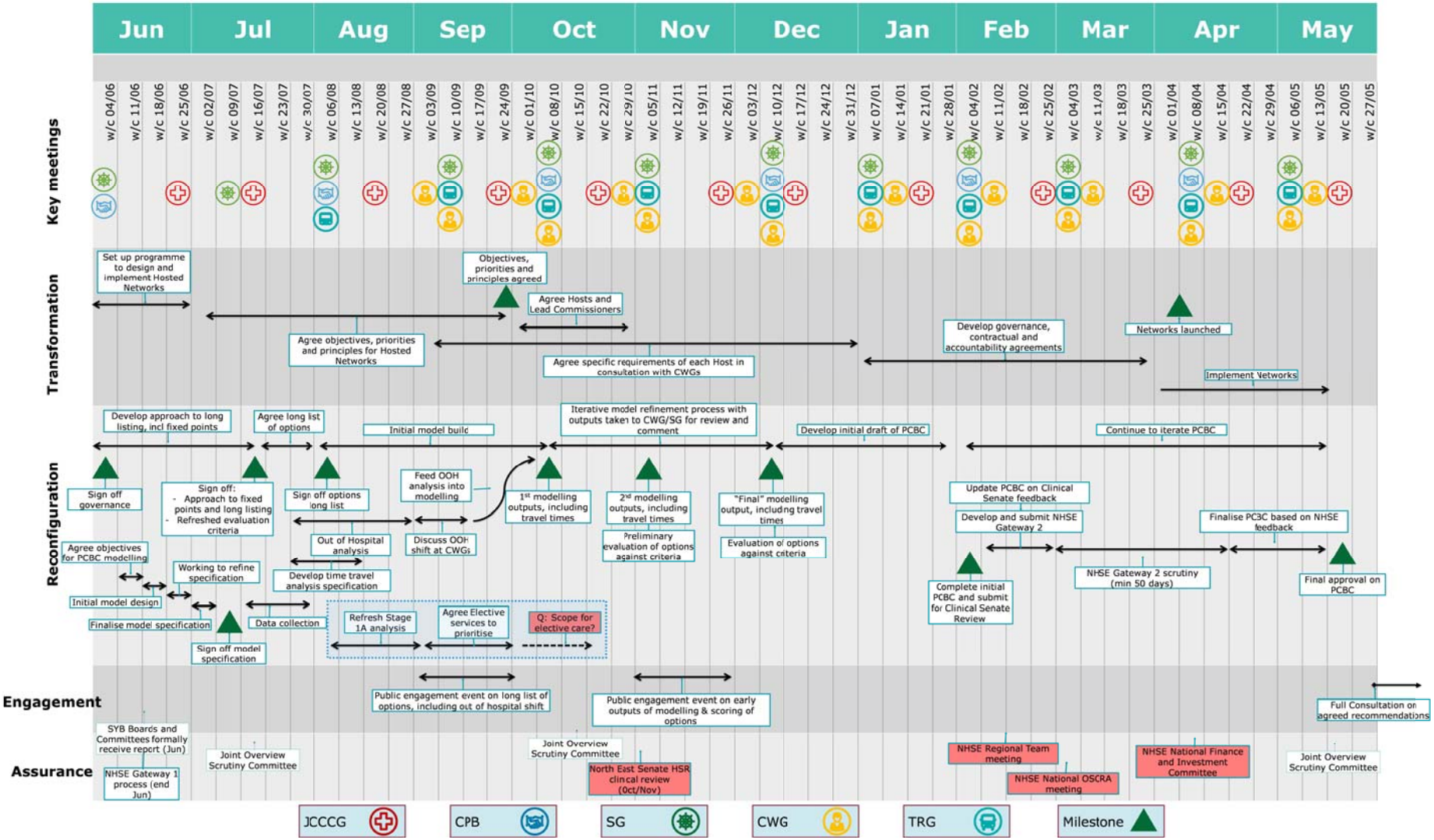



*Figure 1: Project timeline for Phase II of the HSR*

Phase II of the Hospital Services Review was commissioned to follow up on the Strategic Outline Case for the system, developed in Phase I of the review. Phase I of the Hospital Services Review (HSR) was carried out to ensure people across South Yorkshire and Bassetlaw, Mid-Yorkshire and North Derbyshire (SYB(MYND)) were continuing to receive excellent hospital services. It focussed on five hospital based services which were identified during Stage 1A of the Review as facing significant difficulties with workforce and quality, and have a significant impact on the health service as a whole:

- Care of the Acutely Ill Child (CAIC)
- Maternity
- Gastroenterology and Endoscopy
- Urgent and Emergency Care
- Stroke

The recent Strategic Outline Case for the system from Phase I laid out three main proposals tackling some of the problems identified in the Hospital Services Review:

- **Hosted Networks:** Developing the infrastructure to support shared decision-making and cooperation between organisations, supported by a centralised workforce function and Innovation Hub
- **Transformation:** Developing shared standards for clinical pathways supported by new resilient workforce models to ensure patients receive the right care, in the right place, at the right time
- **Changing the clinical model:** Modelling and exploring new, more sustainable options for the delivery of paediatrics, Maternity and out-of-hours gastrointestinal bleeds across SYB(MYND)

Phase II of the Hospital Services Programme commenced in August 2018 and has progressed until the summer of 2019. Figure 1 shows the timelines of the different aspects of work included in Phase II (Transformation, Reconfiguration, Engagement & Assurance), including key meetings and deliverables. Figure 1 also includes the frequency of meetings with key working groups that we have consulted throughout the process.

# 3 Consultation

Throughout Phase II of the Hospital Services Programme, we have consulted with many different groups and bodies, which are outlined in more detail below. They include groups focusing on leadership, clinical direction, finance, HR and transport.

# 4 Hospital services steering group

### 4.1.1 Remit and purpose

The role of the HSR steering group was to provide oversight and strategic direction as the HSR progresses. The steering group acts as the governing body for this large scale project. The steering groups provided oversight of the following HSR activities:

- Development of the Hosted Networks from existing clinical networks
- Implementation of transformation activities, including the development of the Health and Care Institute and Innovation Hub, aimed at reducing unwarranted clinical variation and tackling workforce challenges
- Development of site-specific modelling of acute non-elective services as per reconfiguration recommendations outlined in the Stage 2 report
- Development of modelling of the out-of-hospital shift of activity for each Place
- Modelling and assessment of travel times impact for patients and families
- Development of specific proposals around reconfiguration based on site-specific modelling, transport modelling and CWG input
- Development of proposals on reconfiguration of elective services, as part of the work on the role of the DGH
- Patient, public and staff engagement
- Drafting and submission of the relevant NHS Gateway approval and assurance process documents

### 4.1.2 Frequency of meeting

The steering group met face to face on a monthly basis for the duration of the HSR and also held a WebEx meeting two weeks after each face to face meeting.

### 4.1.3 Membership

The Hospital services steering group was made up of the following individuals:

- Trust representation
  - Medical directors
  - CEOs
  - Directors of strategy and business development
  - Directors of planner and partnerships
  - Operations Directors

- Other representation
  - Lead for system reform
  - Clinical chairs
  - AOs

- ICS lead
- STP Programme Director
- SYB ICS Directors
- HSR Directors and Managers

# 5 Reference Group

### 5.1.1 Remit and purpose

The reference group was set up to review progress on the Hospital Services Review, provide input and feedback on the deliverables produced, and to help guide the strategic thinking moving forward

### 5.1.2 Frequency of meeting

The reference group met on a bi-weekly basis.

### 5.1.3 Membership

The membership of this groups consisted of:

- SYB ICS representatives
- Representatives from each SYB(ND) Trusts, including clinicians and hospital managers

# 6 Hosted Network Consultations

### 6.1.1 Remit and purpose

Workshops were held with leadership and existing networks in the ICS, to test the proposed Hosted Network framework, review the priorities for the Hosted Networks, discuss governance and membership before the Hosted Networks were launched. The purpose, form and function of the Hosted Network was in part developed through these sessions.

### 6.1.2 Frequency of meeting

Three workshops were held during phase II of the Hospital Services Review.

### 6.1.3 Membership

The Hosted Network workshops were attended by:

- Leadership across SYB(ND)
- Members of existing networks e.g. LMS

# 7 Workshop with existing networks

### 7.1.1 Remit and purpose

The workshop with existing networks was held in order to establish how the Hosted Networks would be combined or work alongside existing networks within the SYB(ND) ICS moving forwards. The discussion centred on the structure of the Hosted Network, accountability, the role of the Host and the scope of the network.

### 7.1.2 Frequency of meeting

One workshop was held with the existing networks to help develop the Hosted Network.

### 7.1.3 Membership

The workshop was attended by representatives of existing networks such as the LMS.

# 8 Trust consultation

### 8.1.1 Remit and purpose

Interviews with Trusts were held to help contextualise the case for change, providing additional information to the evaluation metrics suggested by the Clinical Working Groups. Participants answered questions on the biggest challenges their service faced, as well as the key strengths and opportunities for the future.

### 8.1.2 Frequency of meeting

One interview was held with each SYB(ND) Trust.

### 8.1.3 Membership

The interview was attended by Clinical Leads for the three services under review as well as the Medical and Finance Directors.

# 9 Clinical working groups (CWGs)

### 9.1.1 Remit and purpose

The clinical working groups were established to advise on the design of options for transformation of the three services, as part of the Hospital services review.

### 9.1.2 Frequency of meeting

Clinical working groups were held on a monthly basis, with participants being asked to provide local insight as well as expert clinical input. For the three services under review, there were seven CWGs for both Care of the Acutely Ill Child and Maternity, and six for Gastroenterology.

### 9.1.3 Membership

The CWGs comprised of the following individuals:

- **Acute Trusts:** a clinical lead and nurse lead, plus other core specialists e.g. neonatologists; midwives; stroke therapists; assistant healthcare professionals from each Trust
- **CCGs:** a GP lead from each CCG
- **Primary care:** LCS and Federations invited to send a representative from each Place
- **Ambulance services:** one representative from Yorkshire Ambulance Service and East Midlands Ambulance Service per group
- **Community:** one representative from Nottinghamshire healthcare, per group

# 10 HR Directors joint meeting

### 10.1.1 Remit and purpose

This group was devised to discuss all HR and workforce issues across SYB(ND). In addition, there is a teleconference in the months where the HRD meeting is not taking place, to discuss Hospital Services issues that relate to workforce in particular.

### 10.1.2 Frequency of meeting

The HR directors group met on a bimonthly basis.

### 10.1.3 Membership

The HR directors group comprised of the following members; some of the HRDs have specific portfolios for HSP subject areas and therefore sit on the relevant CWGs:

- Maternity – Paul Ferrie, Rotherham
- Care of the Acutely Ill Child – Steven Ned, Sheffield Children's Hospital
- Gastroenterology – Zoe Linton, Chesterfield
- Stroke – Karen Barnard, Doncaster & Bassetlaw Teaching Hospitals
- Urgent & Emergency Care – Mark Gwilliam, Sheffield Teaching Hospitals

# 11 Model owners group

### 11.1.1 Remit and purpose

The model owners group was devised to oversee and support day to day model development. The group was also asked to take ownership of the model going forward, following the end of the programme.

### 11.1.2 Frequency of meeting

The model owners group met on a monthly basis, throughout the development of the model.

### 11.1.3 Membership

The model owners group consisted of:

- Senior sponsors
- A data analyst
- Finance managers

# 12 Modelling steering group

### 12.1.1 Remit and purpose

The modelling steering group was founded to provide input during iterations of the model to ensure that all the relevant outputs were captured in the model specification. The group also advised on the depth of detail required from the model as well as the breadth of the model scope. Finally, the group was also tasked with advising on any other elements of the modelling which might be necessary to inform the PCBC.

### 12.1.2 Frequency of meeting

The modelling steering group met on a monthly basis, throughout the development of the model.

### 12.1.3 Membership

The modelling steering group consisted of:

- Deputy Chief Executive and Chief Operating Officer of Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
- Medical directors
- A senior programme manager
- Strategic finance leads
- Directors of Finance[1]

# 13 Transport advisory group (TAG)

### 13.1.1 Remit and purpose

The Travel Advisory Group (TAG) was created to bring together key stakeholders to improve the experience of travelling to health services in SYB(ND). The group also advised on any transport and travel elements of public engagement. The group also ensured that the travel implications of any proposals for change to services were identified, and the opportunities for improvements and appropriate mitigations of any issues were considered.

### 13.1.2 Frequency of meeting

The group met on a number of times throughout the Hospital Services Review.

### 13.1.3 Membership

The TAG comprised of the following members:

- Representation from the commissioner-led implementation team
- CCG representation
- Acute Hospital Trusts: Travel/Patient Transport Leads
- Yorkshire Ambulance Service
- East Midlands Ambulance Service
- Local Authority Travel Planners
- Local Transport Providers

# 14 Public group on travel and transport (PGTT)

### 14.1.1 Remit and purpose

The public group on travel and transport was created to advise on transport issues affecting patients and the public. They were also asked to provide input on what should be expected from the travel and transport network in the system.

[1] The Directors of Finance also provided a high level overview of the use of Finance data, alongside the Modelling Steering Group

### 14.1.2 Frequency of meeting

This group met on a monthly basis throughout the Hospital Services Review.

### 14.1.3 Membership

The PGTT comprised of the following members:

- Two representatives from each Place: one public transport user and one private transport user
- Chaired by Citizen's Panel representative

# 15 Public consultation

Throughout the Hospital Services Review we have also spoken to a variety of public groups such as mothers groups and family hubs. The purpose of this consultation was to find out what they consider important for their local health services and ultimately guide the strategic thinking behind the services review.

The consultation included questions such as:

- **Quality of care:** *'In your opinion, what's the most important thing for us to consider when we are thinking about quality of care you receive?'*
- **Workforce:** *'What is important about people in hospitals who look after pregnant women, babies and children?'*
- **Access:** *'In your opinion, what's the most important thing for us to consider when we are thinking about access?'*

### 15.1.1 Groups consulted

A comprehensive list of the groups we spoke to is given below. When deciding on groups to engage with, we wanted to speak to a diverse group, in terms of ethnic group, age, race, religion, sexual orientation, employment status, and people with disabilities. There was a particular focus to choose groups with seldom heard members, who are often not provided with representation:

**General**

- SAVTE (Sheffield Association for the Voluntary Teaching of English) AGM
- Rotherfed (Rotherham Federation of Communities)
- Chesterfield PRG group
- Lavender Court TARA, Barnsley
- Sheffield Futures Young Advisors Meeting
- Meeting with the locality managers of Yorkshire Ambulance Service
- Derbyshire MVP
- RDash Listen to Learn Network
- Barnsley MVP
- Shipshape Family Learning
- Harrogate Court TARA, Barnsley

**Barnsley**

- Loundwood family centre
- Penistone
- Athersley

**BCVS**

- Centre for sport and learning
- Harworth lunch club
- Mattersey
- Grove Street
- Joel the Complete Package (a family which supports families through pregnancy and parenting after baby loss)
- The Crossing

**Doncaster**

- Bullcroft Memorial Hall
- Balby Family Hub
- Askern Family Hub
- Mexborough Family Hub
- Central Family Hub
- Moorends Family Hub
- Adwick Family Hub

**SYCF**

- Cathedral Archer Project (1:1 interviews), Sheffield, drugs and alcohol addicts, some in recovery
- Ben's Centre, Sheffield, drugs and alcohol addicts currently still using the substances
- Life in the UK, Rotherham, mixed
- Family Voices, Sheffield, mothers
- YWCA, Rotherham, young mothers
- Rotherham United English Speaking class, Rotherham, migrants / mothers
- Edlington, Doncaster, mixed
- The Light, Sheffield, mothers
- Mexborough Slimming World, Doncaster, mixed, addictions
- JENGA, Barnsley, young mothers

### 15.1.2 Outcomes of the discussions

The outcomes of the discussions with the above groups are summarised below. The key themes raised by participants were concerned with being seen by a specialist, requirement for more staff, a preference for local services and a consistent quality of care across the region:

**Workforce**

- When asked about workforce, 3 in 10 participants mentioned a specific preference for specialist staff

- 1 in 5 felt that generally services required more staff
- 1 in 5 participants also said that there should be a greater emphasis on clinical staff's experience and skills

**Affordability**

- When asked about affordability, 1 in 5 participants believed effective management of funding to avoid wasting money should be a key priority
- A further 1 in 5 participants believed that funding should be invested renovating existing buildings, as opposed to building new ones

**Access**

- When asked about access, a 6 in 10 participants expressed a preference for local services
- A further 3 in 10 participants mentioned the importance of effective and affordable transport in their local area, in order to access the care they need

**Quality of care**

- When asked about quality of care, 2 in 5 participants thought that a consistent quality of care across sites should be a priority
- 3 in 10 participants emphasised the importance of compassionate and caring staff, citing soft skills as an important factor to consider for the quality of care

**Interdependencies**

- When asked about interdependent services, 1 in 5 participants proposed that interdependent services should be offered in one location
- A further 1 in 5 participants suggested that interdependent services should be offered locally

### 15.1.3 Impact on strategic thinking

Using the feedback from public consultation, we have considered the opinions presented through setting up a travel group, developing appropriate clinical models and addressing the variation in the quality of care across the region. The specific actions for each service are explained below:

**Care of the Acutely Ill Child**

- We have developed clinical models which concentrate specialised Paediatric services, to provide greater access to services offered by specialists
- We have established two travel groups with members of the public and representatives from travel providers, to explore concerns around transport to reach acute care sites

**Maternity**

- We have engaged with the Local Maternity System (LMS) to increase the range of choice available to women in SYB(ND)
- We have developed consultant-led Maternity clinical models, due to opinions expressed during public consultation

**Gastroenterology**

- We have prioritised recruitment and retention of staff in Gastroenterology as part of the Hosted Network, based on concerns around staffing levels in Gastroenterology

# 16 Supporting documents

In addition to supporting and guiding the working group discussion s outlined above, throughout Phase II of the HSR we have produced a number of supplementary reports and tools, which are outlined in more detail below.

# 17 Financial model

We have developed a financial model, underpinned by a set of assumptions developed and refined with clinicians through a series of Clinical Working Groups (CWGs). The assumptions include the proportion of time 1 WTE at each staff grade would typically be allocated for annual leave, study leave, and activities outside of their primary clinical role.

Using assumptions focusing on workforce, we have calculated the number of staff required to sustainably staff units, for both Care of the Acutely Ill Child and Maternity. We have calculated these numbers at the regional (SYB(ND)) level as well as individually for each individual Trust. Using these numbers and the number of staff at each grade currently in post, we have calculated the gap between current workforce and the number of staff currently in post and the number of staff required to sustainably staff units.

Using pay cost information provided by SYB(ND) Trusts, we have then been able to calculate the pay cost gap between current expenditure on staff salaries and the cost required to sustainably staff a unit.

We have also used the financial model to calculate the workforce savings, pay cost savings and change in activity levels for any potential change to the clinical model. For Care of the Acutely Ill Child, reconfiguration options were to change one or two Paediatric inpatient units to SSPAUs, and for Maternity the options were to change one or two Obstetrician led units into standalone Midwifery-led units.

The outputs of this model are included in Annex A.

# 18 Case for change

We have looked at the case for change for each Trust, evaluating the three services under review (Care of the Acutely Ill Child, Maternity & Gastroenterology). For each service, these reports include the current provision of services, the key challenges faced and opportunities for the future.

We have assessed each service against five evaluation metrics listed below:

- Quality

- Workforce
- Affordability
- Access
- Interdependencies

Within each evaluation criterion, we have assessed the service against metrics decided through discussions with clinicians over several CWGs.

The case for change is summarised in annex B of the final report.

## 19 Clinical model summit with AOs and CEOs

We produced a presentation for the summit with CEOs and AOs on the 21st March 2019. This presentation included an overview of the current provision of services in SYB(ND), a review of the financial and workforce modelling, the Hosted Networks and the potential reconfiguration options for changing the clinical model for Care of the Acutely Ill Child and Paediatrics.

We included an example of the modelling associated with changing the clinical model for Maternity at one site. This assessed the consequent change in workforce, pay cost and activity upon changing the clinical model, as well as the implications of changing the clinical model on patient travel times to their nearest and next nearest Trust.

We also produced a presentation for the subsequent session with CEOs and AOs on 1st April 2019. This presentation included an overview of workforce transformation, potential changes to the clinical models for Care of the Acutely Ill Child and Maternity, an overview of the current provision of services and conclusions from the financial modelling around changing the clinical model.

## 20 Note to the Governing Bodies

The note to Governing Bodies was produced to provide an overview of the work carried out during Phase II, as well as the conclusions of the two sessions with CEOs and AOs. We provided a view of the current provision of services, the key challenges faced and key opportunities for the future.

We also included a case for change for the SYB(ND) region as a whole, outlining the current quality of the services, as well as the cost this is being delivered at. The case for change also included a review of the sustainability of the services moving forwards.

Finally, we included a summary of the potential options for changing the clinical model, including the opinions of the CEOs and AOs from the two sessions.

**Hospital Services Programme: Report to Governing Bodies**
**Annex E**

# Approach to fixed points

## 1. Purpose

1.1. The Hospital Services Review recommended that the South Yorkshire and Bassetlaw and North Derbyshire (SYB(ND)) system should look at the configuration of hospital services for maternity, paediatrics and emergency out of hours GI bleeds. The Review recommended looking at making changes to the clinical model on 1 or 2 sites for maternity and paediatrics, and moving to having out of hours GI bleed services on 3-4 sites.

1.2. Work was taken forward with the Clinical Working Groups to look at a range of clinical models, and identify the implications of applying these to different sites in SYB(ND).

1.3. In taking forward the modelling, commissioners needed to

- Confirm and agree how options will be assessed against each other (evaluation criteria)
- Agree whether they wished to rule out any sites altogether, and say that the system will definitely not make changes to the clinical model on those sites (fixed points).

1.4. Commissioners were asked to give their views on this in December 2018. All the commissions involved (Barnsley, Bassetlaw, Doncaster, North Derbyshire, Rotherham and Sheffield) agreed the approach outlined below, agreeing to designate Sheffield Children's Hospital as a fixed point for paediatrics, and Sheffield Teaching Hospital for maternity services.

## 2. Evaluation criteria

2.1. The evaluation criteria for the configuration options were developed during the Hospital Services Review, based on prioritisation by system leaders, clinicians, members of the public and people from the seldom heard groups.

2.2. They were reviewed during the autumn 2018 to make sure that issues which had been raised by Governing Bodies, Boards and members of the public in relation to the Hospital Services Review and the Strategic Outline Case were captured within the evaluation criteria.

2.3. A small number of amendments were made which were agreed by Collaborative Partnership Board on 19th October 2018, and reviewed by clinicians in Clinical Working Groups.

2.4. Following agreement by the CPB the evaluation criteria have also been discussed in public forums such as the Travel and Transport Advisory Panel.

2.5. Some very small amendments were made following the CPB e.g. to re-order the points (putting quality at the top, in response to clinician feedback), to clarify some points (e.g. to make it clear that the contribution to closing the financial gap will be assessed on a net basis) and to correct some typographical errors.

2.6. The final agreed set of criteria (figure 2) was agreed by commissioners in January 2019:

*Figure 2: Final agreed evaluation criteria*

| *Criterion* | *Overarching Question* | *Dimensions* |
|---|---|---|
| **Quality** | Does the option optimise the quality of care by promoting delivery of national good practice and guidance, and contribute to maintained or improved outcomes? | • Promoting the delivery of national guidance, such as around safe staffing and evidence-based practice<br>• Extent to which the model promotes sustainable provision of high-quality care for patients receiving their services within SYB<br>• Extent to which the model ensures that patients are not disadvantaged if they need to travel outside of SYB for their care |
| **Workforce** | Does the option ensure there is a sustainable workforce of the right number and skill set? | • Number of staff required compared with likely available workforce<br>• Impact on opportunities for training and skills development<br>• Impact on reliance on locum / temporary staff |
| **Affordability** | Does the option cost no more than the current service? | • Running costs of the system compared with the current<br>• Level of transition costs required<br>• Level of capital costs required<br>• Net contribution of the option to closing the financial gap identified in the STP plan |
| **Access** | Can patients access the right service, in the right place, in the right time? | • Impact on travel times to services by blue light, normal driving times, and public transport, for patients, carers and relatives<br>• Extent to which the model mitigates any risks associated with transferring patients presenting either at home or at another site<br>• Could the option increase health inequalities across SYB e.g. by limiting access for lower socioeconomic groups, their carers and relatives<br>• Extent to which the model keeps outpatient, ambulatory and daycase activity local<br>• Extent to which the model supports shifting care out of acute hospitals closer to home, where appropriate<br>• Extent to which the model is resilient to fluctuations in demand<br>• Extent to which the model supports choice for patients |
| **Interdependencies** | Are the necessary supporting services appropriately available? | • Interdependent services that need to be provided onsite are available onsite<br>• There are formal links to interdependent services that do not have to beprovided onsite |

## 3. Fixed sites

### 3.1. Methodology

3.1.1. In looking at changes to clinical models, there are large numbers of potential clinical models, which could be applied to large numbers of sites.

3.1.2. CCG Accountable Officers said in the November meeting of the ICS Executive Steering Group that they wish to consider a wide range of options, in order to ensure that the process was fair.

3.1.3. However, commissioners also said that they would wish to rule out sites where it is very obvious that there will be no change, to avoid spending time and resource on unworkable options.

3.1.4. It is legally possible as part of the evaluation approach to identify sites where there is wide consensus that the clinical model should not change. These are known as ‘fixed sites.’ Systems can designate fixed sites where the evidence is very clear, and fixing them is “self-evident”.

3.1.5. The Hospital Services programme team reviewed a number of reconfiguration processes around the country. They found several criteria that were frequently used to justify identifying a site as ‘fixed’ (see annex A). These were the levels of

activity, which dictated amongst other things the cost of capital; the number of interdependent services; the condition of the estate; geographical position; and self-selection.

3.1.6. In a meeting of the JCCCG on 28th November, commissioners stated that the criteria that they considered most relevant to South Yorkshire and Bassetlaw, and North Derbyshire, were:

- **Levels of activity, and thus the capital costs** of reproviding services elsewhere. The availability of capital in SYB(ND) is very constrained so options which would involve reproviding services for particularly high numbers of patients should be ruled out. These options would also affect the highest numbers of patients.

- **Interdependencies.** SYB(ND) contains some sites which provide high complexity tertiary services which are interdependent with maternity, paediatrics or gastroenterology. These would also have to be reprovided, further increasing costs and the impact of any move.

3.1.7. Both of these criteria appear within the existing SYB(ND) evaluation criteria, identified above.

3.1.8. Commissioners noted that activity levels were less key for GI bleeds, from a capital perspective. The numbers out of hours were so low that the capital impact would be minimal. We might still wish to avoid options which impacted on greater numbers of patients.

3.1.9. The JCCCG considered whether **geographic location** should be used to fix sites. Commissioners considered that, while access will be an important criterion for evaluating options, there were no sites at present where travel to the nearest alternative site had been considered by commissioners or providers to be clinically unsafe. Therefore it was not considered relevant while setting fixed sites.

3.1.10. The JCCCG noted that the **condition of the current estate** was not a major concern for SYB(ND), and that **self-selection** would not ensure that decisions were taken in the best interests of the population.

3.2. **Recommendations on fixed points**

3.2.1. Annex D shows the analysis of the sites in SYB(ND) against the three evaluation criteria of levels of activity (as a proxy for capital costs), and clinical interdependencies and estates / cost of capital.

3.2.2. Based on the numbers presented in Annex D, there were some sites which stood out clearly from the rest:

- **Maternity**: In 2017-18 Sheffield Teaching Hospitals (the Jessop Wing) had 6,723 births per year, more than twice that of the next largest unit (3,297 at Doncaster Royal Infirmary). In addition it has large numbers of interdependent specialist services which are not provided elsewhere in SYB(ND).

- **Paediatrics**: Sheffield Children's Hospital had 10,043 inpatient stays in 2016-17 (approximated from reference cost data), considerably larger that of the next largest unit at 4,838. The 2017-18 HES data shows a

similar pattern, with 3,404 long stay inpatient stays at SCH compared with 2,313 across the next largest trust (Doncaster and Bassetlaw combined). In addition it has large numbers of interdependent specialist services which are not provided elsewhere in SYB(ND).

- **Out of hours GI bleeds**: On activity, Sheffield Teaching Hospitals and Doncaster Royal Infirmary both treat more GI bleeds than other trusts. STH also undertakes more complex surgeries which may give rise to a GI bleed. However the levels of activity for out of hours emergency bleeds which require transfer are low, and so the Hospital Services Steering Group did not consider that activity was a sufficient driver to fix either site.

  On interdependencies, STH and DRI offer vascular Interventional Radiology out of hours, which was identified by the Steering Group as the main interdependency. Since this was only one interdependent service the Steering Group did not consider it a sufficient driver to fix a site. Therefore we propose not to fix any sites for out of hours GI bleeds.

3.2.3. The CCGs therefore agreed to fix STH for maternity and SCH for paediatrics, and not to fix any sites for GI bleeds.

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# Annex A

## Criteria used to identify fixed sites in other reconfigurations

| ACTIVITY | ESTATES / CAPITAL | GEOGRAPHIC LOCATION | SELF SELECTION |
|---|---|---|---|
| ✓ Initial options selected based on sites' ability to meet **guideline levels of activity** for stroke care (Kent and Medway) | ✓ Some sites fixed due to **significant capital expenditure** required to move the service - c.£100m (Mid & South Essex) | ✓ Fixed sites on the **periphery** of the region for optimal spread of access for patients (NW London)<br><br>✓ Fixed **geographically isolated** hospital as hybrid elective and emergency hospital – 45 and 60 minute drive from alternative sites in Poole and Bournemouth respectively (Dorset) | ✓ Initial options developed by requesting trusts to **submit proposals to host** consolidated elective centre (SE London) |
| x Ruled out options that would not meet **clinical guidelines on safe activity and staffing levels** (Oxfordshire) | x Ruled out sites where the **bed base could not be expanded** due to estates limitations (Cumbria)<br><br>x Ruled out hospitals that **did not have the scale** to provide major acute care – 600-1,000 beds required (NW London)<br><br>x One site assessed as no longer suitable to provide long-term inpatient care due to **poor estates** condition, therefore was a fixed point for closure (Cumbria) | | x Ruled out sites that **did not submit a proposal** to host the consolidated elective centre - assuming to volunteer their service for potential closure/transfer (SE London) |

**CLINICAL INTERDEPENDENCIES**

x Ruled out options where the capital cost of reproviding associated specialist services (plastic surgery, radiotherapy) would be too high (Mid and South Essex)

## Annex D

## Recommendations against the criteria for fixed sites:

Commissioners identified two criteria which were of the greatest relevance when assessing fixed sites:

- Levels of activity, as a proxy for cost of capital
- Interdependencies

### Analysing the activity data

The Hospital Services team have reviewed the activity levels in each trust. Depending on the clinical model, not all of the activity would be transferred; what the activity levels show is the **comparative** sizes of the units and thus the approximate, comparative impact of changing the relative sites.

The comparative size of the units indicates the comparative level of reprovision that would be required. It thus indicates the comparative scale of capital costs that the system would face in reproviding that capacity elsewhere. The specific capital costs have not been modelled at this stage as they would depend on the exact implications on the receiving site.

#### *GI bleeds*

For GI bleeds, the levels below indicate all activity rather than the number of bleeds overnight, but they give an indication of the relative scale of GI bleed activity on the sites.

Capital costs are a less significant issue for GI bleeds since the number of out of hours transfers is low. The Steering Group discussed whether comparative activity levels would still be relevant because of the indication of comparative impact on numbers of patients, but concluded that the numbers were small overall and so this was not a sufficiently 'self-evident' reason for fixing a site.

#### *Paediatrics*

For paediatrics, the analysis presents two years' worth of data in order to capture the comparative size of the units prior to changes to the clinical model being introduced at Bassetlaw. The analysis for the two years is presented using different data (reference costs rather than HES data which was not provided for 2016/17) and has been adjusted to compensate for the change to the Bassetlaw model in January 2017.

The pattern of the comparative sizes of the units remains clear.

### Analysing the data on interdependent services

There are two types of interdependent services:

- Some interdependent services are common to the majority of District General Hospitals, and would have to move or be adjusted if changes were made. For example, most paediatrics services are interdependent with neonatology services since most DGHs currently have a single rota of consultants covering both services. The team proposes that these interdependent services should not be seen as a reason for establishing a fixed site because they are widespread across most sites.

- **There are some interdependent services which are highly specialised**, and are currently provided in only one or two sites in SYB(ND). These have been identified as reasons for establishing a fixed site because they are essential and unusual, and would require specialist reprovision.

## Maternity

*Figure 6: levels of activity in maternity services*

| Activity type | Barnsley | Chesterfield | Bassetlaw | Doncaster | Rotherham | Sheffield Children's | Sheffield Teaching |
|---|---|---|---|---|---|---|---|
| 16/17 Reference Costs ** | 3,012 | 2,845 | 1,507 | 3,391 | 2,678 | N/A | 6,924 |
| 17/18 Reference Costs | 2,937 | 2,772 | 4,767 | | 2,221 | N/A | 6,614 |
| 17/18 HES *** | 2,777 | * | 1,509 | 3,297 | 2,492 | N/A | 6,723 |

Notes: * Data not yet provided; ** Final numbers used for the HSR May 2018 *** Awaiting data validation from trusts

*Figure 7: interdependencies in maternity services*

| | Barnsley | Chesterfield | Bassetlaw | Doncaster | Rotherham | Sheffield Children's | Sheffield Teaching |
|---|---|---|---|---|---|---|---|
| **Specialist / specialised services on-site** | Neonatology Level 2 | Neonatology Level 2 | Neonatology Level 1 | Neonatology Level 2 | Neonatology Level 2 | | Neonatology Level 3 for severely premature babies<br><br>Fetal medicine unit<br><br>Advanced maternal medicine – for example:<br>• Sub-specialist haematology clinics (anti-clotting teams)<br>• Cardiac clinic<br>• Endocrine<br>• Pulmonary vascular service<br>• Intrapartum care of complex patients<br>• Mothers with significant medical co-morbidities e.g. cardio-thoracic |

## *Paediatrics*

*Figure 8: levels of activity in paediatrics services*

| Source of data | Activity type | Barnsley | Chesterfield | Bassetlaw | Doncaster | Rotherham | Sheffield Children's | Sheffield Teaching |
|---|---|---|---|---|---|---|---|---|
| 16/17 Reference Costs ** | All inpatient stays | 3,217 | 4,838 | 1,493 | 4,277 | 3,833 | 10,043 | N/A |
| | Long-stay (IP) | 507 | 883 | 260 | 1,107 | 1,675 | 2,059 | N/A |
| | Short-stay (IP) | 2,710 | 3,955 | 1,233 | 3,170 | 2,158 | 7,985 | N/A |
| 17/18 HES *** | All inpatient stays | 3,490 | * | 1,330 | 4,594 | 2,365 | 6,675 | N/A |
| | Long-stay (IP) | 882 | * | 58 | 1,489 | 824 | 3,404 | N/A |
| | Short-stay (IP) | 2,608 | * | 1,272 | 3,105 | 1,541 | 3,271 | N/A |

Notes: * Data not yet provided; ** Final numbers used for the HSR May 2018 *** Awaiting data validation from trusts

*Figure 9: interdependencies in paediatrics services*

| | Barnsley | Chesterfield | Bassetlaw | Doncaster | Rother-ham | Sheffield Children's | Sheffield Teaching |
|---|---|---|---|---|---|---|---|
| **Specialist / specialised services on-site** | 1 paediatric HDU bed | 2 paediatric HDU beds | | 2 Paediatric HDU beds | 1 paediatric HDU bed | Paediatric Intensive Care Unit<br>Paediatric trauma<br><br>Specialist paediatric services (not provided elsewhere in SYB(ND). For example, specialist:<br>- cardiology<br>- endoscopy<br>- tracheostomy<br>- rigid bronchoscopy<br>- neurosurgery<br>- radiology | N/A |

## *Gastroenterology*

*Figure 10: levels of activity in Gastroenterology services*

| Activity type (all hours) | Barnsley | Chesterfield | Bassetlaw | Doncaster | Rotherham | Sheffield Children's | Sheffield Teaching |
|---|---|---|---|---|---|---|---|
| 16/17 Reference Costs ** | 436 | 517 | 1,049 | | 392 | N/A | 1,132 |
| 17/18 Reference Costs | 383 | 505 | 1,002 | | 373 | N/A | 995 |
| 17/18 HES *** | 252 | * | 104 | 907 | 375 | N/A | 911 |

Notes: * Data not yet provided; ** Final numbers used for the HSR May 2018 *** Awaiting data validation from trusts

*Figure 11: interdependencies in Gastroenterology services*

| Specialist / specialised services on-site | Barnsley | Chesterfield | Bassetlaw | Doncaster | Rotherham | Sheffield Children's | Sheffield Teaching |
|---|---|---|---|---|---|---|---|
| | | Interventional radiology in-hours | | Interventional radiology out of hours | | | Intervention al radiology out of hours |

**Health & Care Working Together South Yorkshire & Bassetlaw**

**Working Together for Hospital Services (South Yorkshire, Bassetlaw & North Derbyshire)**
**Patient/ public engagement plan for November 2018 to April 2019**

## 1. Overview

In July 2017, South Yorkshire and Bassetlaw Integrated Care System (ICS), known as Health and Care Working Together, commissioned an independent review of Hospital Services.

The independent Hospital Services Review Report was published on the 9th May 2018. Following that a Strategic Outline Case was developed, to represent the system's views of the recommendations in the independent report, and to set out which of the recommendations the system would take forward. The Strategic Outline Case was heard in public at all partners' boards and governing bodies in September and October, and collectively agreed at the ICS' Collaborative Partnership Board on the 19th October.

## 2. Engagement to date

From the outset of the commissioning of the Hospital Services Review patient and public engagement has been embedded in the process.

**Phase 1a of the engagement** was to understand from a patient and public perspective what makes a sustainable health service, what is important to them about hospital services and to support the development of a series of principles to inform the work looking at hospital services. This phase took place in August 2017 and included a public event which was advertised through the five regional Healthwatch groups and through wider community organisations such as Voluntary Action organisations. An online survey was also available and patients and the public were encouraged to complete it having been made aware of it via ACS partner networks and communications processes and with a direct mail to those people who attended the event.

A summary document which covers an overview of the engagement; an overview of the feedback and how the feedback was taken into account can be found on our website: https://www.healthandcaretogethersyb.co.uk/application/files/3515/0903/4254/Hospital_Services_Patient_and_Public_Engagement_Report.pdf

**Phase 1b of the engagement** was to receive patient and public input into the development of evaluation criteria that will be used to assess options going forwards (this same engagement criteria is now being used for the narrowing down of options phase). This phase of engagement also engaged with patients and the public to understand their main concerns around the five services (upon which the review focuses) and to ask for their ideas on good practice. This phase of engagement took place between October 2017-February 2018 and in total heard from 1849 members of the public.

A range of methods were used to reach out to patients and the public including:

- An online survey which was promoted via regular social media promotion, promotion in partners' communications mechanisms, web presence, and distribution of the link via existing engagement networks held by Healthwatch and other

voluntary/community/faith sector organisations, the CCGs and the ICS team's own database

- A telephone survey of a random sample of 1000 members of the public who were selected to be as representative as possible of the demographic makeup of South Yorkshire and Bassetlaw
- Sessions with seldom heard groups, arranged with the help of organisations in the voluntary sector. This included face to face sessions with people from seldom heard groups including: young mothers, asylum seekers and refugees, members of ESOL (non-english speaking) groups, members of the deaf and mute community, Pakistani and Somali women, members of the Roma community, members of the LGBT community, young people's groups, elderly people's groups, recovering addicts, current drug and alcohol addicts, members of a support group for people with physical and/ or mental health conditions, and young people from the autistic community
- A public event open to anyone in South Yorkshire and Bassetlaw, attended by 68 people, promoted via regular social media promotion, promotion in partners' communications mechanisms, web presence, and distribution of the link via existing engagement networks held by Healthwatch and other voluntary/community/faith sector organisations, the CCGs and the ICS team's own database
- A session with the Youth Forum of Sheffield Children's NHS Foundation Trust was held to ensure the voices of young patients are heard around services for children and young people
- Face to face drop-in sessions for the public in individual places within the footprint of South Yorkshire and Bassetlaw held in Barnsley on 14 November 2017, Rotherham on 12th December, Bassetlaw on 19th December and Doncaster on 19th December
- Patient discussions in North Derbyshire via sessions with their GP Practice Patient Participation Networks and with their North Derbyshire CCG Patient Reference Group
- Paper-based surveys were also made available at a range of events, by request, and were given out in hospital out-patient department waiting areas, main entrances, and areas convenient for staff, including Sheffield Children's hospital on 20th and 27th November, Rotherham hospital on 29th January and Chesterfield hospital on 23rd January

A summary document which covers an overview of the engagement; an overview of the feedback and how the feedback was taken into account can be found on our website: https://www.healthandcaretogethersyb.co.uk/application/files/4815/2231/8192/15._HSR_Stage_1b_Engagement_Report.pdf

**Phase 2 of the engagement** took place in March 2018 to get input from the public into the proposals being developed for the Stage 2 Report of the Hospital Services Review. In particular, these engagement sessions focused on the proposals around workforce, clinical variation, innovation, governance, and the early analysis around reconfiguration.

The main elements of the Stage 2 engagement were: Discussion with the Citizen Panel around the emerging finding, which took place on 5 March 2018. The Citizen Panel was set up by the ICS to provide input into the process and content of public engagement. As well as providing comments on content, the meeting helped the Review team to develop the materials for the public engagement event on 8h March. Notes from his meeting can be found on our website: https://www.healthandcaretogethersyb.co.uk/get-involved/meet-citizens-panel/meeting-minutes

A public event open to anyone in South Yorkshire and Bassetlaw, which was attended by 60 people from across the footprint on 8th March. Invitations to the event were promoted to

all attendees of the previous public event on 6th December as well as via regular social media promotion, promotion in partners' communications mechanisms, web presence, and distribution of the link via existing engagement networks held by Healthwatch and other voluntary/community/faith sector organisations, the CCGs and the ICS team's own database. The report of the event can be found on our website here

**Phase 3 of the engagement** took place following the publication of the Hospital Services Review report on the 9th May 2018 (and subsequent easy read version of the report). Following the publication of the Report, the partners involved in the HSR were invited to consider their response to the Review and its recommendations. Stakeholders including patients and the public were invited to respond with their views on the full report by 12th July. The opportunity to contribute thoughts on the full report was shared in a press release, via social media, and sent to all of the contacts in the networks held by the South Yorkshire and Bassetlaw ICS and partner organisations, including their staff bulletins. The Boards of the acute trusts, and the Governing Bodies of the Clinical Commissioning Groups, discussed the document in their public meetings. The Joint Health Overview and Scrutiny Committee also discussed the document in public.

The specific written responses to the Hospital Services Review final report have been included in Annex A of the Strategic Outline Case and have, along with the wide range of public views collected during 2017-18, helped to shape the drafting of the Strategic Outline Case. The public feedback received, as well as the review team's response, is detailed in Annex A of the Strategic Outline Case, which can be found on our website here: https://www.healthandcaretogethersyb.co.uk/application/files/7115/3996/5062/31._Strategic_Outline_Case_-_annex_a.pdf .

In order to ensure patients and the public were given enough time to give their responses, engagement did not cease on the 12th July and continued until the end of September. In recognition of the length and complexity of the Hospital Services Review Report materials which highlight the recommendations and key points in the report, and an accompanying easy-read survey were developed.

A range of methods were used to reach out to patients and the public including:

- Face to face workshops, including (this list is not exhaustive): Sheffield Futures young people's groups; prisons service; SAVTE (charity for people for whom English isn't a first language); mother and baby groups; dementia groups; groups for people with physical and mental disabilities; groups for vulnerable women; groups for people with alcohol dependencies, people with a traveller background, asylum seekers, ROMA communities, children and families affected by deprivation, carers (including young carers), the working population, victims of domestic violence, sex workers, people who live in isolated rural communities, deaf community, armed forces/veterans)
- Survey responses being taken to locations including (this list is not exhaustive and is evolving): Workplaces such as Stagecoach, South Yorkshire Fire & Rescue, Distinctions Barnsley; GP practices; PPG Network meetings; National Citizenship Service event; Sheffield University health and social care nursing students lecture
- Communicating to wider audiences at public events such as NHS 70th Birthday celebrations/ AGMs/ local events, handing out leaflets and holding conversations
- Flyers sent to local community centres and libraries

Over 400 people were engaged and gave their thoughts on the report. An engagement report covering all of the engagement that took place between the publication of the final report in May 2018 and the approval of the Strategic Outline Case was published to correspond with the final approval of the Strategic Outline Case. This was to ensure each of

the workstreams taking the work forward from October does so with full understanding of patient and public views on the work thus far. The report can be found on our website: https://www.healthandcaretogethersyb.co.uk/application/files/5615/3996/5160/37._Hospital_Service_Review_Engagement_Report_-_October_2018.pdf

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## 3. Engagement plans November 2018 – April 2019

Health & Care Working Together recognises the need to carry out further engagement using a variety of methodologies between now and the end of April as the review team develops the evaluation criteria, the model and the long list of options. This will ensure that patients, public and staff are provided with information to ensure they understand the process and the criteria against which services are being evaluated.

We recognise the importance of delivering meaningful engagement with the recognition that the information is complex and we need to develop resources which ensure that those participating have a full understanding of the process.

### 3a. Engagement – all aspects of recommendations

Our thoughts are to consider further deliberative events/ focus groups in each place with a focus on ensuring the diversity of our audiences are as abroad as possible. We will work closely with the place-based engagement leads, and local voluntary sector organisations and Healthwatches, in recognition that they are best placed to advise on how best to engage within their local communities.

We propose a simple methodology which will enable:-

- Identified community/voluntary or support groups drawn from each local population to participate in deliberative events/discussions which will ensure they are socialised to the ICS, and the on-going hospital services work and modelling phases. Participants will be able to respond to the modelling proposals as they are identified.
- We propose initially that the focus is on understanding what is most important to our population should there be any reconfiguration of services
- We propose a particular focus on groups with ***relevant experience*** of the services where reconfiguration proposals are put forward

This will allow us to socialise the review and ensure that locally there is an understanding of both the ICs and the review. There have been criticisms that there is a lack of local engagement and that local populations are not aware of the work which is being undertaken. The aim therefore is to ensure that the conversations are broad reaching especially in communities which are rural or isolated. Secondly that they reflect the demographic groups which may be impacted should there be any reconfiguration of services.

### 3b. Engagement – travel and transport specific

In recognition of the importance of travel and transport implications in the hospital services reconfiguration recommendations the modelling of site specific options will include significant work to understand the transport and travel implications.

To support this we are establishing a transport and travel engagement group. The group is being recruited from across South Yorkshire, Bassetlaw and Chesterfield, and will meet to correspond with the meetings of a Transport and Travel Working Group (which features clinicians, service providers, transport colleagues etc). A member of the South Yorkshire &

Bassetlaw Citizens' Panel sits on the Working Group and acts as the go-between from the Working Group to the engagement group ensuring the public voice is embedded.

The group will include two people from each town, one public transport user and one driver, as well as representatives from demographic groups who could be disproportionally affected by any proposed changes. The ask of the group is to:

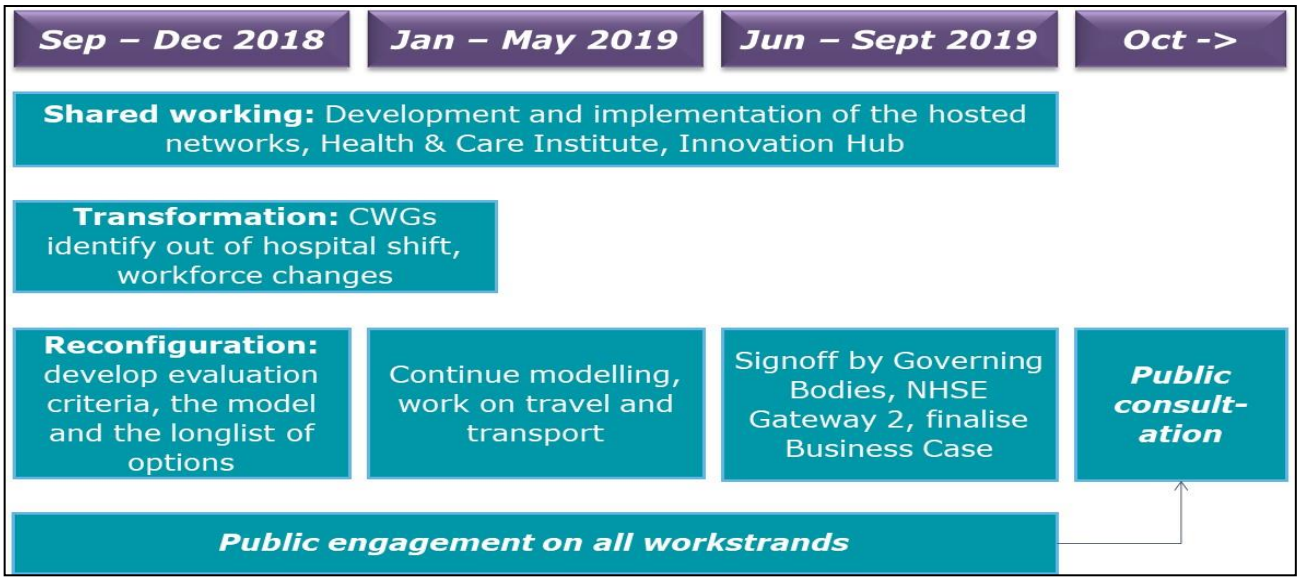
- Consider how patient, carer and family journeys could be impacted by any changes to NHS services
- Bring the voice of their community to discussion – considering how others from their town may be affected
- Feed in ideas for how to improve transport and travel planning and infrastructure around NHS services
- Ensure that information from the NHS in relation to this work is clear and easy to understand
- Test journey times, where possible, to provide realistic insight into the impact of any service changes

## 4. Engagement development

In addition to plans already in place for engagement about the hospital services work, the ICS communications and engagement team is currently undergoing an exercise with NHS England and all South Yorkshire & Bassetlaw partners to develop a co-designed action plan for further developing the partnership's communications and engagement approach. A baseline survey has been disseminated and a Discovery Day with 90+ South Yorkshire and Bassetlaw stakeholders takes place on 22nd November. Should actions be identified that will support better engagement in the hospital services work these will be added to the timeline, and the action plan will strongly inform our hospital services next stage engagement. The draft action plan that is developed on the back of the Discovery Day will be shared with JHOSC members for comment before the final version is circulated to all partners (and the JHOSC).

## 5. Engagement post April 2019

Engagement plans for the period post April 2019 will be developed to reflect the stage of the hospital services work and feedback from the engagement work that has gone before (including that currently taking place). The timeline for the hospital services work currently stands as follows, and we anticipate full public consultation taking place from October 2019.



# Appendix F:
# Public engagement and how we responded to it

The Hospital Services Programme, and the South Yorkshire and Bassetlaw Integrated Care System more generally, have undertaken a significant amount of public engagement on the services, services models and issues included within this report.

The detailed results of the public engagement can be found in a series of independent reports, which are published on the ICS website (under 'Hospital Services Review - all the documents') at https://www.healthandcaretogethersyb.co.uk/index.php/what-we-do/working-together-future-proof-services/looking-at-hospital-services.

This note summarises the responses to some of the key points, which are picked out in the report.

## Feedback on the current system

The engagement was used to find out what service users and the public consider important for their local health services and to get their views on the specific models put forward.

The views of the public have been used to shape the models, and views on specific models are described throughout the paper. Some of the key points made on the overall challenges to the NHS are:

| Theme / issue | You said | We did |
|---|---|---|
| **Quality** | Key priorities for respondents were a consistent quality of care across sites, and the importance of compassionate and caring staff. Many participants cited soft skills as an important factor to consider for the quality of care. | Developing consistent quality of care is one of the main objectives of the Hospital Services Programme. The Hosted Networks will focus on standardisation of clinical standards and on developing a consistent approach across the workforce. |
| **Workforce** | Some members of the public had a preference for specialist staff (although some participants spoke highly of experiences with for example nurse practitioners). Others preferred to receive their care locally even if this meant being treated by less specialist staff. There was a strong theme that the NHS needed more staff and that staff should be better valued. | The HSR looked at access to specialist staff for patients across the system. The aim of the proposals in the Hosted Network (levels 1 and 3) is to improve care for all patients and to strengthen networking between services. There are specific proposals to improve access to specialist care for example for out of hours GI bleeds.<br><br>The ICS is developing a Workforce Hub which is focusing on strengthening recruitment from the local population, developing new roles, and building skills. |

| | | |
|---|---|---|
| **Affordability** | In considering the evaluation criteria, many members of the public felt that the affordability of services should not be a priority in deciding the future of services, though some felt effective management of funding to avoid wasting money should be a priority. | There is a statutory duty on providers and commissioners to achieve financial balance. The affordability of services was considered in this context. Work is ongoing across the ICS to improve the efficiency of services through working together, for example on procurement. |
| **Access** | Access was a major theme across the public engagement. In the engagement phase October 2018-April 2020, 6 in 10 participants expressed a preference for local services. A further 3 in 10 participants mentioned the importance of effective and affordable transport in their local area, in order to access the care they need. This theme was emphasised by the public group on transport, which was set up in response to public feedback on the HSR and the SOC. | In response to concerns around access, the Hospital Service Programme has followed the principle of keeping services local wherever possible. Detailed transport plans will be developed if any service reconfigurations are taken forward. |
| **Interdependencies** | Interdependencies were voted by public respondents to be one of the most important themes to consider when evaluating change. Views were divided between participants who believed that all interdependent services should be provided locally, and those who thought that it was important to have access to all interdependent services but they did not necessarily have to be local. | The work undertaken on the clinical models for neonatology and maternity was intended to address interdependencies, and the assessment of the safety and quality of services has included looking at whether their interdependent services are also safe. |
| **Paediatrics** | • Care is often excellent and staff are compassionate and friendly, although very busy.<br>• The physical environment in some Trusts could be more welcoming for children and their families | The focus of the work on paediatrics was to find ways to strengthen the workforce across the organisations, reducing the pressures.<br>The ICS has an capital strategy for the system as a whole, which is looking at how specific concerns with the estates could be addressed. |
| **Maternity** | • Many women reported excellent experiences and good care<br>• The main concern that was raised by women was that staff were very busy. Some | The ICS work on transformation of maternity services going forward will include recruitment and retention of staff, and developing shared approaches to workforce. |

| | | |
|---|---|---|
| | patients reported a change of staff or too few staff present during labour, particularly amongst midwives. | |
| **Gastroenterology and endoscopy** | • In engagement with seldom heard groups, including people from minority ethnic groups, two respondents reported difficulties in communicating with staff which, they reported, had led to patients being discharged without a clear diagnosis or treatment.<br>• A significant number of gastroenterology patients are suffering from liver disease associated with alcohol addiction. Some patients referred to a lack of support in managing their addiction or understanding their circumstances during their hospital stay. | Both of these points are around the quality of care rather than the design of services, so fall within day to day operational issues. They have been relayed to clinicians in Trusts via the Clinical Working Groups. |

## Feedback on proposed service changes: paediatrics

The public engagement included extensive discussion, with a range of different groups, around the option of moving from an inpatient unit to a Short Stay Paediatric Assessment Unit. The engagement included sessions with mothers, at mother and baby groups, and with working parents at some of the major employers in SYB.

The key themes that emerged are as below:

| You said | We did |
|---|---|
| Some parents were concerned above all to ensure that their child received appropriate specialist care, and were willing to travel further to ensure that this happened.<br><br>On the other hand, some parents felt that all specialist services should be provided on all sites and expressed concern about parents having to travel to units further away, particularly if they had other children who they could not leave. Some respondents from Bassetlaw felt strongly that the inpatient unit should be reinstated. | The ICS has focused on how to ensure that all services are safe and have appropriate access to specialists. The changes at Bassetlaw addressed these issues: through the Paediatric Assessment Unit model, children who need access to higher levels of care are transferred to the inpatient paediatric unit at Doncaster.<br><br>The work between Sheffield Children's Hospital and Doncaster and Bassetlaw, to develop a level 3 Hosted Network, will also consider how children in Doncaster and Bassetlaw have improved access to specialist paediatric care. |

## Feedback on proposed service changes: maternity

Where neither paediatrics and maternity services (and / or their interdependent services) can be sustained on a site through a system-wide approach, this model involves changing the clinical model of both paediatric and maternity services on one or two sites:

- Changing the inpatient paediatric unit on a site to a SSPAU; and
- changing the obstetrics unit to a Standalone Midwifery Led Unit (SMLU); and
- removing Neonatal services from the site.

There was considerable public engagement around the proposed SMLU model. The key points made were:

| You said | We did |
|---|---|
| Some respondents, particularly women who have themselves had midwife-led births, supported a Standalone Midwifery Led Unit | The Hospital Services team noted this view. |
| Some respondents expressed concern about the safety of the model, if a woman got into difficulties during labour, and raised concerns about the risk of women having to be transferred during a birth. | The Hospital Services team looked at the national evidence around the safety of SMLUs. The SMLU model has been identified in the national report Better Births as being safe, and evidence from NICE guidance[1] indicates that the outcomes in SMLUs tend to be better than in obstetric units or Alongside MLUs. This is dependent on the correct triage protocols being in place, to direct patients to the appropriate setting, and proper transfer to convey a woman by ambulance to an obstetric unit if necessary during or after labour. |
| Some respondents raised concerns about midwife led units even alongside an obstetric unit, and suggested that all births should be in obstetric units in the interest of patient safety. These respondents tended also to be opposed to home births. | The national strategy on maternity services, Better Births, lays out the direction of travel to maximise choice for women around where and how to give birth. |
| Some respondents raised concerns that families would have to travel further away in order to visit. | The Hospital Services team discussed this with the travel and transport group. The group discussed the balance between ensuring the safety of services and minimising travel times. |
| Some respondents were concerned that a woman would also have to travel to the further site for ante- and post-natal care, | Under the model, ante- and post-natal services would continue to be provided on the SMLU site, including outreach clinics |

[1]NICE, Intrapartum Care for Women and Babies, 2014. https://www.nice.org.uk/guidance/CG190

| | |
|---|---|
| which could be particularly difficult if she had to navigate public transport while pregnant or with a pushchair. | with consultants, so the model could be designed in a way to minimise any additional travel for pregnant women. |

## Feedback on equalities issues

The ICS has undertaken a programme of engagement with representatives from seldom heard groups, including people from ethnic minorities; women from a variety of backgrounds, and mother and toddler groups; people with physical disabilities including people from the Deaf community; people from the LGBT community; older people; young people; asylum seekers; people from the traveller community; survivors of domestic violence; people with drug and alcohol addictions; and sex workers.

More detail can be found at:
https://www.healthandcaretogethersyb.co.uk/application/files/5615/3996/5160/37._Hospital_Service_Review_Engagement_Report_-_October_2018.pdf

The engagement with these groups was used to inform an analysis of the issues related to each of the protected characteristics. In addition, the report also looked at issues related to socioeconomic disadvantage: this is not one of the protected characteristics, but it was felt to be an important equalities issue in the context of changes to healthcare services.

| Protected characteristic | Issues raised | Response |
|---|---|---|
| Pregnancy and maternity | The services considered in the Hospital Services Programme, maternity and paediatrics, are likely to have the most impact on women. The ICS has spoken with a number of mother and toddler groups in order to identify specific issues.<br><br>Key concerns, which have shaped the conclusions of the report, included access issues. Concerns were raised by women who struggle to visit a child in hospital while other children were at home requiring care. Women also talked about the difficulties of using public transport while pregnant or with a buggy.<br><br>Other women raised issues around choice and the range of maternity services available to them. | In the light of this feedback the Review has recommended keeping paediatrics and maternity services local wherever possible, if this can be done safely and with a good quality service.<br><br>Issues around maternal choice have also been considered in the recommendation to keep obstetrics services open wherever possible. |
| Age | Most of the services discussed in this report are focused on younger people. The Hospital Services Programme engaged with the Youth Forum at | The transformation of services through the paediatrics network, and through the Integrated Care System more widely, is intended to support a shift of care out of |

| | | |
|---|---|---|
| | Sheffield Children's Hospital, which includes young people from across SYB. They spoke about the importance of being able to access the specialist care they needed, but also of wanting to minimise the amount of time they spent in hospital, and the disruption this caused to their lives. Another strong theme was the wish to be more involved in their care.<br><br>Changes to GI bleeds services would be likely to impact more on older people. The public travel and transport group were supportive of the proposals being discussed around GI bleeds, because they are focused on improving access to emergency, life-saving procedures. However they discussed the challenges for older family members in visiting a site further away. | hospital, for example by building community services and the Hospital@Home model. This will minimise the amount of time that chronically ill young people need to spend in hospital, and the disruption to their lives that this causes. The recommendations also look at ensuring that children who need specialist care can access it.<br><br>The travel and transport group suggested that hospitals would need to ensure that transport was provided to support the family members of a patient being transferred out of hours, particularly if they did not have their own transport, and if they were older and frail. This will be considered as part of the development of specific proposals going forward. |
| Disability | People with disabilities reported that the key issue that they encountered was around access, particularly for those who used public or community transport.<br><br>However access went beyond transport issues: respondents from the Deaf community referred to the shortage of translators for Sign Language while respondents with autism and learning difficulties described information received from the hospital as being difficult to interpret. | Representatives of public transport companies reported a number of improvements to buses and trains, with new stock coming onstream: for example, from 2019 buses will be introduced which have 2 wheelchair spaces, while national guidance requires speaking buses to be rolled out to help people with visual impairments.<br><br>The issues around provision of interpreters and communications materials are operational issues, which have been shared with the Trusts. |
| Race | Most of the issues reported by people from ethnic minority groups were around the quality of care and the way in which care was delivered. A number of respondents described communication difficulties and a shortage of translators, while a few reported specific stereotypes: some women of Indian and Asian heritage, for example, warned against cultural stereotypes that assume | The issues around communications and relationships with patients' families are operational issues, which have been shared with the Trusts. |

| | | |
|---|---|---|
| | that Asian families will want to care for family members at home. | |
| Religion or belief | The public engagement included groups of men and women from a range of religions, including groups of older Muslim women. Several of the group members reported finding it difficult to access healthcare, largely because of language and cultural barriers. Again, these issues were more around how specific services were delivered than about how they were designed, and emphasised the vital importance of workforce. | The issues around communications and service delivery are operational issues, which have been shared with the Trusts. |
| Sexual orientation and gender identity | LGBT respondents similarly focused on the delivery of services and the attitudes of healthcare staff, rather than on the design of services. Some reported specific negative experiences although most were positive. | The issues around attitudes and service delivery are operational and cultural issues, which have been shared with the Trusts. |
| Lower socioeconomic groups | Public respondents made the point that changes in access would impact particularly on the poorest. The biggest impact would be anything which required travel to sites further away, since those on the lowest incomes are least likely to have private cars. | The analysis laid out in the report breaks down the implications for people in the highest and lowest income quartiles, analysed by postcode, and this was considered in thinking about the implications of reconfiguration.<br><br>The analysis suggested that the majority of the poorest communities lived in urban areas, which tended to be closer to the hospital sites and be better served by public transport. On average, the rural districts which would be most impacted by changes in travel times tended to be in the higher socioeconomic groups where car ownership was higher. However, we recognise the potential impact on lower income groups living in rural areas, and this would need to be addressed in the design of services if services were being reconfigured. |

| Key to Work Streams | 1. Integrated Wellbeing Support for Bassetlaw People | 2. Right care at the right time | 3. Transport | 4. Comms and Engagement | 5. Sustainable effective services | Information |
|---|---|---|---|---|---|---|

# Bassetlaw Integrated Care Partnership Outcomes Framework

| *Indicator* | *Target* | *Benchmark* | *Actual* | *YTD* | *Trend* | *Trend Interpretation* | *Period* | *Frequency* | *Work Stream* | *Priority* |
|---|---|---|---|---|---|---|---|---|---|---|
| ***A. Reduced Health and Wellbeing Inequalities*** | | | | | | | | | | |
| i.(a) The gap in under 75 Standardised mortality ratios for deaths from Cancer from National Rate | | 0.0 | 17.1 | | | Low / downward trend is better | 2015 17 | 3 year pooled | 1, 2 | Long term |
| i. (b) The gap in under 75 Standardised mortality ratios for deaths from Respiratory Disease from National Rate | | 0.0 | 3.5 | | | Low / downward trend is better | 2015 17 | 3 year pooled | 1, 2 | Long term |
| i. (c )The gap in under 75 Standardised mortality ratios for deaths from Cardiovascular Disease from National Rate | | 0.0 | 1.0 | | | Low / downward trend is better | 2015 17 | 3 year pooled | 1, 2 | Long term |
| ii. Income deprivation | | 14.6% | 13.7% | | | Lower is better | 2015 16 | Annual | 1 | Long term |
| iii. Number long term unemployed supported back into work (no information currently available) | | | | | | | | Annual | 1 | Long term |
| iv. Number of healthy options takeaways providers available in Bassetlaw | | | 20 | | | Higher is better | 2019 | Ad hoc | Information | Immediate |
| v. (a) Children in Reception Year classified as obese | | 9.50% | 11.80% | | | Low / downward trend is better | 2017 18 | Annual | Information | Medium Term |
| v. (b) Children in Year 6 classified as obese | | 20.10% | 22.90% | | | Low / downward trend is better | 2017 18 | Annual | Information | Medium Term |
| vi. Healthy life expectancy at birth (Males) - Bassetlaw place | | 79.6 | 78.7 | | | Higher / Upward trend is better | 2015 17 | 3 year pooled | Information, 2 | Long term |
| vi. Healthy life expectancy at birth (Females) - Bassetlaw place | | 83.1 | 81.9 | | | Higher / Upward trend is better | 2015 17 | 3 year pooled | Information, 2 | Long term |
| vii. % children in out of work families (Nottinghamshire) | | 4.20% | 3.5% | | | Lower is better | 2011 12 | Census | Information | Long term |
| viii. Child Poverty (Children in low income families (under 16s)) | | 17.0% | 16.2% | | | Low / downward trend is better | 2016 17 | Annual | Information | Long term |
| ix. Child development at age 5 | | 60% | 57.9% | | | Higher is better | 2013 14 | Annual | Information | Medium Term |
| x. GCSE achievement (5A*-C inc. Eng & Maths) | | 58% | 68.1% | | | High / Upward trend is better | 2015 16 | Annual | Information | Medium Term |
| xi. % households living in fuel poverty | | 11.1% | 11.4% | | | Low / downward trend is better | 2016 17 | Annual | Information | Long term |
| xii. Overcrowded households (at least 1 room too few) | | 4.8% | 2.2% | | | Lower is better | 2011 12 | Census | Information | Long term |
| xiii. Homelessness (Statutory homelessness: rate per 1,000 households) | | 2.4 | 1.0 | | | Low / downward trend is better | 2017 18 | Annual | 1 | Long term |
| xiv. Reduced social isolation (TBC - work in progress to establish information flows) | | | | | | | | | 3 | Immediate |
| ***B. Improved health and wellbeing outcomes*** | | | | | | | | | | |
| i. Number of people attending activities supported by Active Communities team (meeting 1st April) | 30,189 | | 9,177 | 28,247 | | Higher is better | 2018 19 | Quarterly | 1 | Medium Term |
| ii. General health bad or very bad | | 5.49% | 6.74% | | | Lower is better | 2011 12 | Census | 1, 2 | Long term |
| iii. Low birth weight of term babies | | 2.82% | 3.03% | | | Low / downward trend is better | 2017 18 | Annual | Information | Long term |
| iv. Obese adults | | 62.0% | 66.4% | | | Low / downward trend is better | 2017 18 | Annual | 1 | Medium Term |
| v. Percentage of adults binge drinking on heaviest drinking day (NCC level) | | 16.5% | 15.9% | | | Lower is better | 2011 - 14 | 4 year pooled | 1 | Long term |
| vi. Std Rate of hospital admissions due to (excessive) alcohol consumption (narrow definition) | | 632 | 744 | | | Low / downward trend is better | 2017 18 | Monthly | 5 | Immediate |
| vii. Smoking Prevalence | | 14.9% | 19.6% | | | Low / downward trend is better | 2017 18 | Annual | 1 | Medium Term |
| viii. Healthy eating adults | | 54.8% | 56.5% | | | High / Upward trend is better | 2017 18 | Annual | 1 | Medium Term |
| ix. Cancer 2 week wait compliance | 93% | | 96.6% | 90.2% | | High / Upward trend is better | Mar 19 | Monthly | 2 | Immediate |
| x. Earlier identification of Cancer (Recorded cancers at earlier stage (0 or I) as opposed to stage II, III or IV) | | 52% | 48.1% | 48.0% | | High / Upward trend is better | Q3 2017 18 | Quarterly | 2 | Medium Term |
| xi. A&E 4 hour access target - Bassetlaw Hospital | 95% | | 94.0% | 92.9% | | High / Upward trend is better | Mar 19 | Monthly | 5 | Immediate |
| xii. Incidence of all cancers (New cancer cases (Crude incidence rate: new cases per 100,000 population)) | | 521.0 | 594.0 | 594.0 | | Low / downward trend is better | 2016 17 | Annual | 2 | Long term |
| xiii. Hospital stays for intentional self-harm | | 185.5 | 199.8 | | | Low / downward trend is better | 2017 18 | Annual | 2 | Medium Term |
| xiv. Suicide Rate for Bassetlaw (age-standardised rate per 100,000 population (3 year average) (Persons)) | | 9.6 | 12.3 | | | Low / downward trend is better | 2015 - 17 | Annual | Information, 1 | Medium Term |
| xv. Numbers of patients experienced measured increase in patient activation (TBC) | | | | | | | Apr 20 | Annual | 1 | Immediate |
| xvi. Number of registered volunteers (Bassetlaw) | | 878 | 1,063 | | | Higher is better | 2018-19 | Monthly | 1 | Immediate |
| xvii. Number of social prescriptions issued (Information requested) | | | | | | | 2018-19 | Quarterly | 1 | Immediate |
| ***C. Sustainable effective services*** | | | | | | | | | | |
| i. % stakeholders who believe the CCG involves the public in shaping services | | 56% | 56.0% | | | Higher is better | 2017 18 | Annual | 4 | Medium Term |
| ii. Number of conversations at community events (District Council data only) | | | 1802 | 1802 | | Higher is better | 2018-19 | Annual | 4 | Immediate |

| Key to Work Streams | 1. Integrated Wellbeing Support for Bassetlaw People | 2. Right care at the right time | 3. Transport | 4. Comms and Engagement | 5. Sustainable effective services | Information |
|---|---|---|---|---|---|---|

# Bassetlaw Integrated Care Partnership Outcomes Framework

| *Indicator* | *Target* | *Benchmark* | *Actual* | *YTD* | *Trend* | *Trend Interpretation* | *Period* | *Frequency* | *Work Stream* | *Priority* |
|---|---|---|---|---|---|---|---|---|---|---|
| iii. Quality standard 95% children receiving health and development review at 2.5 years (% of children who received a 2-21/2 year review in the quarter who were at or above the expected level in all five areas of development - NCC) | | 83.3% | 86.2% | | | Higher is better | 2017 18 | Annual | Information | Long term |
| iv. Outpatient DNA Rate (DBTH) | | 7.6% | 8.9% | 10.2% | | Low / downward trend is better | Mar 19 | Monthly | 3, 5 | Immediate |
| v. Outpatient DNA Rate (NHT - in discussion with NHT) | | 12.3% | 13.3% | | | Low / downward trend is better | Mar 19 | Monthly | 3 | TBC |
| vi. Inpatient survey results | | 9.1 | 9.1 | | | Higher is better | 2017 18 | Annual | 4, 5 | Long term |
| vii. % staff recommending trust as a place to work (DBH) | | 64.0% | 58.0% | 58.0% | | High / Upward trend is better | Q2 2018 19 | Quarterly | 4, 5 | Medium Term |
| viii. % staff recommending trust as a place to work (NHT) | | 64.0% | 51.0% | 51.0% | | High / Upward trend is better | Q2 2018 19 | Quarterly | 4, 5 | Medium Term |
| ix. A and E attendances | | 3173 | 3524 | 41557 | | Low / downward trend is better | Mar 19 | Monthly | 2, 4, 5 | Immediate |
| x. A&E attendances 0-4 year olds | | 273 | 345 | 3543 | | Low / downward trend is better | Mar 19 | Monthly | 2, 5 | Immediate |
| xi. Emergency hospital admissions for all causes | | 1038 | 1060 | 13478 | | Low / downward trend is better | Mar 19 | Monthly | 2, 5 | Immediate |
| xii. Prescribing costs (£000) | | £19,890 | £19,454 | | | Lower is better | Mar 19 | Monthly | Information, 2, 5 | Immediate |
| xiii. Friends and family test (DBH - Inpatients at Bassetlaw Hospital) | | 95% | 97.0% | 98.3% | | High / Upward trend is better | Mar 19 | Monthly | 4 | Immediate |
| xiv. Friends and family test (NHT) | | 90% | 90.0% | 89.7% | | High / Upward trend is better | Mar 19 | Monthly | 4 | Immediate |
| xv. Vacancy rates (DBH) - (note WTE posts vacant, not factoring in Locum / Agency cover) | | 5% | 9.1% | | | Lower is better | Mar 19 | Monthly | 5 | Immediate |
| xvi. Vacancy rates (NHT) | | 11.13% | 9.7% | 9.5% | | Low / downward trend is better | Mar 19 | Monthly | 5 | Immediate |
| xvii. Vacancy rates (NCC Adult Social Care) | | 17.2% | 19.0% | | | Lower is better | Aug 18 | Monthly | 5 | Immediate |
| xviii.i Public bus usage (Mattersey - 1 service) | | | 1.39% | | | Higher is better | 09/18-11/18 | Ad hoc | 3 | Immediate |
| xviii.ii Public bus usage (Tuxford - all services, 5 in total) - Council & Stagecoach | | | 0.59% | | | Higher is better | 09/18-11/18 | Ad hoc | 3 | Immediate |
| xviii.iii Public bus usage (Tuxford - all services, 5 in total) - GEM & Marshalls | | | 5.84% | | | Higher is better | Oct 18 | Ad hoc | 3 | Immediate |
| xix. Numbers of Bassetlaw people undertaken independent travel training in previous year (TBC) (No information currently available, being followed up) | | | 0.0% | | | Higher is better | | TBC | 3 | Immediate |
| xx. Numbers of volunteer drivers/ car schemes (for Dial a Trip and BAC) (approximate numbers, subject to change) | | | 73 | | | Higher is better | Mar 19 | Monthly | 3 | Immediate |
| xxi. CCG number of non-emergency passenger transport journeys provided (SC provided) | 20,392 | | 19,389 | 73,342 | | Lower is better | Oct 18 | Monthly | 3 | Immediate |
| ***D. Supporting people to be independent*** | | | | | | | | | | |
| i. Admissions of older adults per 100,000, adult social care | | 555.4 | 572.0 | 572.0 | | Low / downward trend is better | 18/19 | Monthly | 2, 5 | Immediate |
| ii. Older People in Deprivation | | 16.2% | 14.3% | | | Lower is better | 2015 16 | Annual | Information | Medium Term |
| iii. Provides 50 hours or more unpaid care per week | | 2.40% | 3.1% | | | Lower is better | 2011 12 | Census | Information | Long term |
| iv. Pensioners living alone (Older people living alone, % of people aged 65 and over who are living alone) | | 31.5% | 29.6% | | | Lower is better | 2011 12 | Census | Information | Long term |
| v. Rate per 000 hip fractures | | 578 | 578 | | | Low / downward trend is better | 2017 18 | Annual | 2, 5 | Immediate |
| vi. DTOCs - Delayed Bed Days - NCC at DBTH (sum of all responsible organisations) | | 147 | 140 | 1767 | | Low / downward trend is better | Mar-19 | Monthly | 2, 3, 5 | Immediate |
| vi. DTOCs - Delayed Bed Days - NCC at DBTH (sum of NHS responsible Delays) | | 135 | 140 | 1617 | | Low / downward trend is better | Mar-19 | Monthly | 2, 3, 5 | Immediate |
| vi. DTOCs - Delayed Bed Days - NCC at DBTH (sum of Social Care Delays) | | 11 | 0 | 129 | | Low / downward trend is better | Mar-19 | Monthly | 2, 3, 5 | Immediate |
| vi. DTOCs - Delayed Bed Days - NCC at DBTH (sum of Both) | | 2 | 0 | 21 | | Low / downward trend is better | Mar-19 | Monthly | 2, 3, 5 | Immediate |

#Better in Bassetlaw

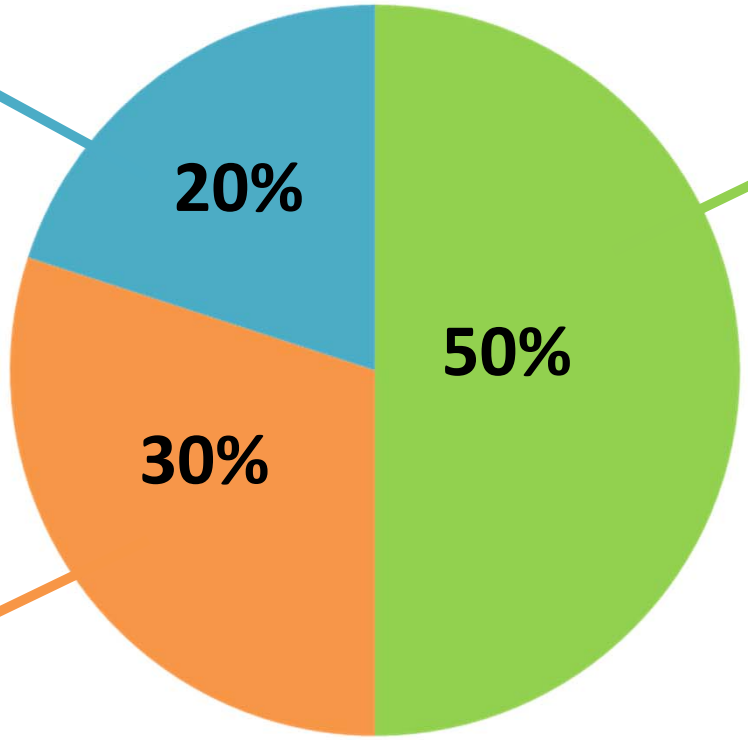
# Bassetlaw Integrated Care Partnership and Place Plan

## DBTH Board, September2019

# Determinants of health

**Clinical care:**
- Access to care
- Quality of care

**Lifestyle:**
- Smoking
- Diet and exercise
- Alcohol and drug use
- Sexual behaviour




**Social, economic and physical environment:**
- Education
- Employment
- Income
- Social and family support
- Community safety
- Air and water quality
- Housing and transit

# Integrated Care Systems and Bassetlaw

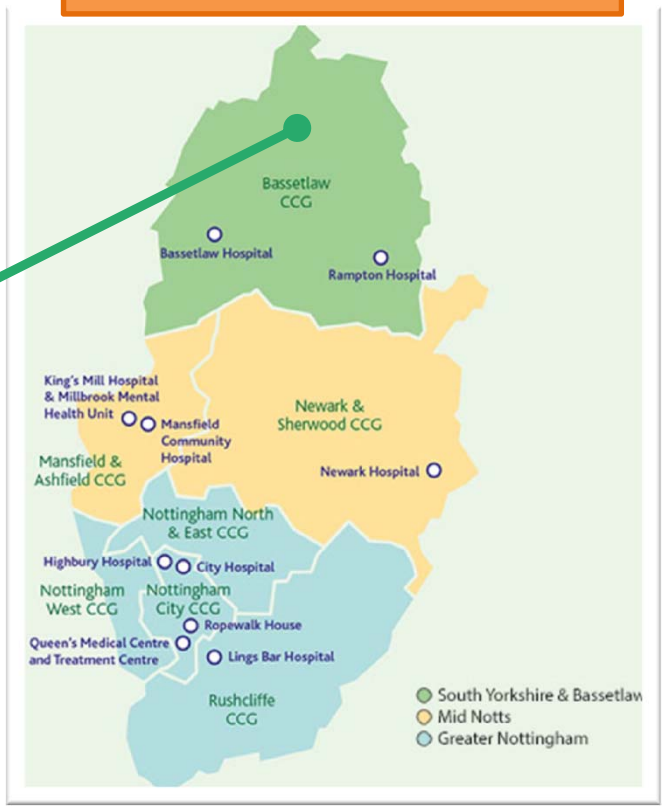
Bassetlaw's unique geography means that it spans two Integrated Care System footprints – South Yorkshire and Bassetlaw, and Nottinghamshire

**South Yorkshire and Bassetlaw ICS**




**The Bassetlaw Place**

**Nottinghamshire ICS**




SYB for hospital services review, and most NHS functions

Nottinghamshire for the Health and Wellbeing Board, public health, social care, mental health and community providers and better care fund.

# Recent Milestones

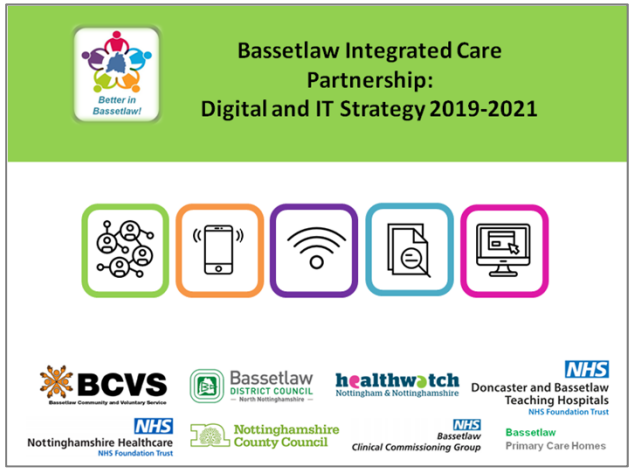
- ‘Better in Bassetlaw Place Plan 2019-2021’ approved by ICP Board, February 2019;
- Miles in May – 31,000 extra miles (report on [www.betterinbassetlaw.co.uk](http://www.betterinbassetlaw.co.uk));
- New PCN contract in place, with three new Clinical Directors (Dr Joel Chapman, Retford and Villages, Dr Richard Davey, Larwood and Bawtry, Dr Deepti Alla, Newgate) plus extended access;
- New social prescribing and community advisor contract/ service in place;
- Outcomes framework established.






# Recent Milestones ctd.

- Website and social media launch;
- Transport info-kiosk bids approved for hospital sites;
- Workforce Strategy approved by Board (work stream chaired by Karen Barnard, DBTH) August 2019;
- Digital & IT Strategy approved by Board (work stream chaired by Steve Jennings-Hough, Nottinghamshire County Council) August 2019;
- Loneliness task group launched June 2019.



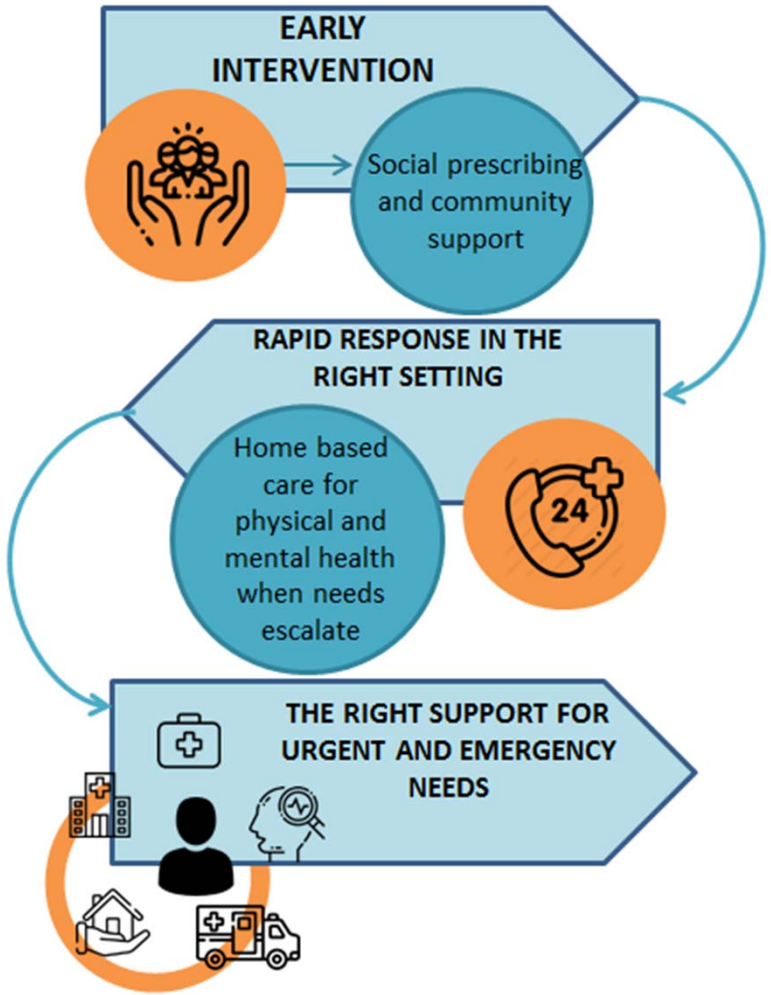



# Recent Milestones ctd.

Bassetlaw Together – new integrated commissioner/provider network to act as the 'engine room' of the ICP, with work streams agreed:

- Urgent and emergency care;
- Home first;
- Frailty;
- Dementia;
- Emotional wellbeing and mental health;
- Integrated community wellbeing support;
- Cancer.

Senior Responsible Owners (SROs) and Project Managers identified from across the partnership.



# In the last year....

**New community services** for pain management, opthamology, audiology and dermatology commissioned

Successful engagement with Bassetlaw schools to attract more young people into NHS careers has resulted in ***many more students taking health and care GCSE*** options

Bassetlaw achieved **the 2nd highest national uptake of annual health *checks*** for adults with LD in 2018/19 at 87%

New **bus routes** to primary care centre in Tuxford

More than **100 cancer patients** supported by Aurora through CCG funded packages

**100%** of Bassetlaw IAPT (improving access to psychological therapies) services treated within 18 weeks, with 80% within 6 weeks.

*It's good to talk!*

Staff in Bassetlaw Hospital can now view patients' **social care records**, resulting in better, more timely care

**Low delayed transfers of care**, following the introduction of the Integrated Discharge Team with community, acute and social care co-located and daily planning meetings have reduced and remained low

**3** Primary Care Networks established, with Integrated Neighbourhood Teams of community health and social care co-located

***31,000***

extra miles run, walked, swam, cycled, rowed and danced by Bassetlaw people through 'Miles in May'.....

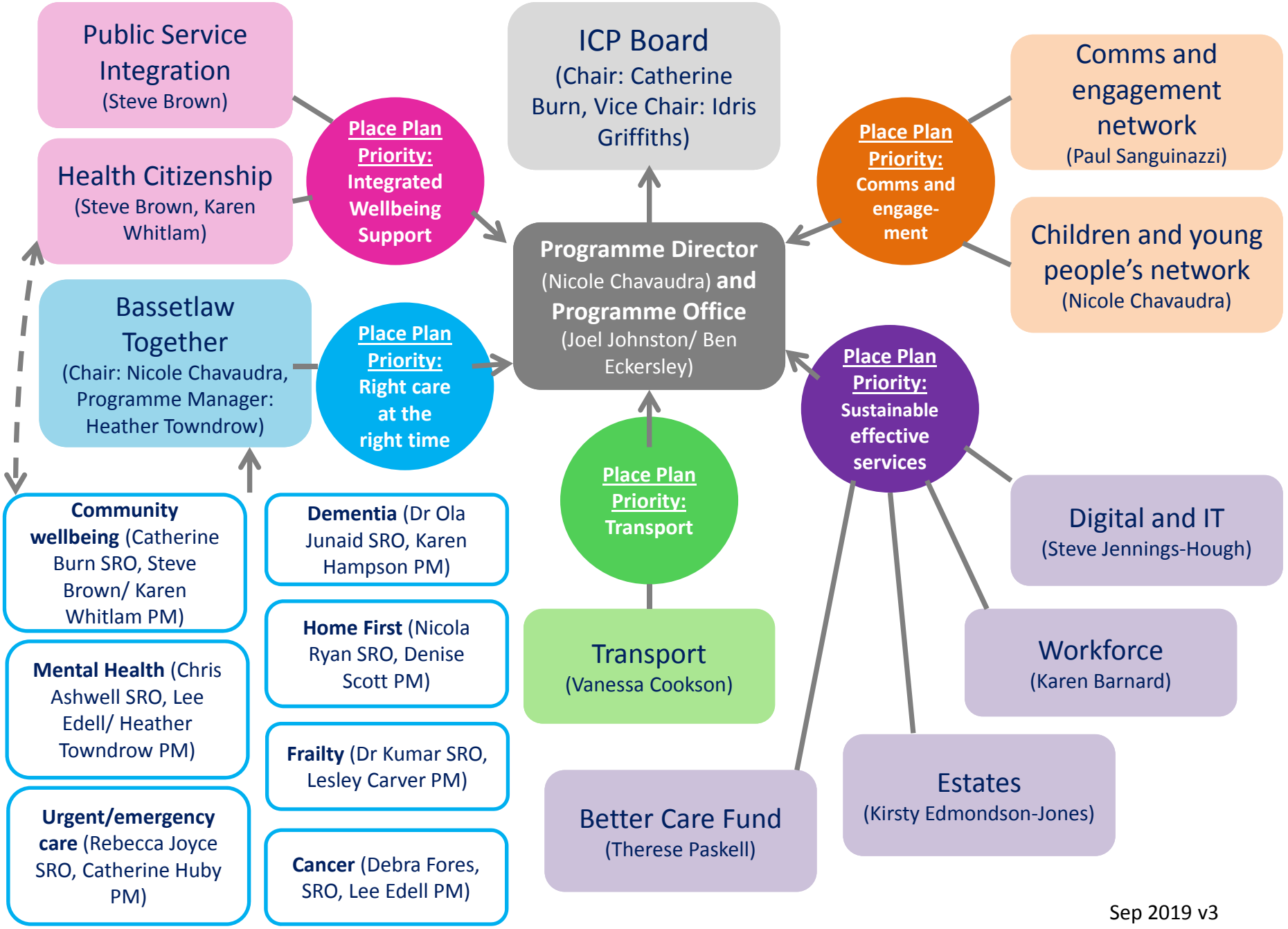
....That is the equivalent of circumnavigating the earth, and part of the way back

The **patient voice** is being better heard through new 'Maternity Voices' partnership work

**41% increase** **in referrals for** young people accessing teenage counselling, with **47 appointments available a week**, in addition to a teenage counsellor in schools,

**369 people**
Supported through social prescribing which has now extended to be available to all Bassetlaw adults

#Better in Bassetlaw


Public Service Integration
(Steve Brown)
Health Citizenship
(Steve Brown, Karen Whitlam)
Bassetlaw Together
(Chair: Nicole Chavaudra, Programme Manager: Heather Towndrow)
Place Plan Priority: Integrated Wellbeing Support
Place Plan Priority: Right care at the right time
ICP Board
(Chair: Catherine Burn, Vice Chair: Idris Griffiths)
Programme Director
(Nicole Chavaudra) and Programme Office
(Joel Johnston/ Ben Eckersley)
Place Plan Priority: Transport
Transport
(Vanessa Cookson)
Place Plan Priority: Comms and engage-ment
Comms and engagement network
(Paul Sanguinazzi)
Children and young people's network
(Nicole Chavaudra)
Place Plan Priority: Sustainable effective services
Digital and IT
(Steve Jennings-Hough)
Workforce
(Karen Barnard)
Estates
(Kirsty Edmondson-Jones)
Better Care Fund
(Therese Paskell)
Community wellbeing (Catherine Burn SRO, Steve Brown/ Karen Whitlam PM)
Mental Health (Chris Ashwell SRO, Lee Edell/ Heather Towndrow PM)
Urgent/emergency care (Rebecca Joyce SRO, Catherine Huby PM)
Dementia (Dr Ola Junaid SRO, Karen Hampson PM)
Home First (Nicola Ryan SRO, Denise Scott PM)
Frailty (Dr Kumar SRO, Lesley Carver PM)
Cancer (Debra Fores, SRO, Lee Edell PM)

Sep 2019 v3

# Coming up

- ***'What Next'*** Careers Event with thousands of Bassetlaw students – 1st November;
- ***Estates and housing*** developments – integrated public sector response to challenges and opportunities from new housing and communities (s106, new communities etc);
- Recap – ***digital information*** prescriptions;
- ***Childhood obesity*** call to action – event November;
- ***Transport Strategy*** refresh, following Transport Summit September 2019 – more active travel focus, more engagement with communities.

# Coming up

- ***'Big Bassetlaw Conversations'*** – better, more integrated and strategic dialogue with Bassetlaw people about health and wellbeing priorities

- ICP Board ***cancer*** deep dive, covering: prevention, early identification, treatment and living with and beyond cancer;

- ***Refill*** campaign – hydration and health, environment, business benefits;

- ***Integrated Wellbeing Service*** commencing April 2020 – all age smoking, weight management and lifestyle change support service;

- ***PCNs*** event, October 2019.

# *Questions and feedback?*


**Nicole Chavaudra**

Programme Director – Bassetlaw Integrated Care Partnership

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@BassetlawICP

Bassetlaw Integrated Care Partnership

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

**C4**

| | | | |
|---|---|---|---|
| **Title** | **Climate and Biodiversity Emergency Motion and Pledge** | | |
| **Report to** | **Board of Directors** | **Date** | **24 September 2019** |
| **Author** | **Richard Parker – Chief Executive** | | |
| **Purpose** | | | Tick one as appropriate |
| | Decision | | X |
| | Assurance | | |
| | Information | | |

**Executive summary containing key messages and issues**

As one of the Team Doncaster Partners, the Trust has been requested to support a recent motion which was debated at Doncaster Metropolitan Borough's Full Council meeting on 19 September 2019.

The motion was:

*The United Nations (UN) Intergovernmental Panel on Climate Change has warned that we have 12 years to make the necessary changes to limit a rise in global temperatures to 1.5C. Failure to act will see a marked increase in sea levels and flooding, extreme and abrupt changes to weather patterns, crop failures, extinctions of plant, insect and animal species and global economic disruption and crisis. The increased frequency and intensity of extreme weather events that we have experienced locally and nationally highlight why this is such an important issue for Team Doncaster to respond to.*

*At the Global Climate Talks in Poland last December, the UK along with over 200 nations agreed action on climate change with a much greater role strongly implied for Local and Regional Authorities like Doncaster Council, in assisting Governments to achieve their carbon emission savings.*

*It should also be noted at the UN Secretary-General António Guterres will host the 2019 Climate Action Summit in New York next Monday 23rd September, to meet the climate challenge. The Summit will showcase a leap in collective national political ambition and reinforce the drive needed to rapidly accelerate action to implement the Paris Agreement.*

*This Council therefore:-*

- *Believes that climate change and sustainability are amongst the biggest issues of the 21st Century, and the effects of manmade and dangerous climate change are already manifestly occurring;*

- *Declares a Climate and Biodiversity Emergency;*

- *Notes that our current international targets are inadequate to respond to the challenge of keeping global temperature rises below 1.5C; and*

- *Notes the Intergovernmental Panel on Climate Change (IPCC) detail that we are already seeing the consequences of a 1°C of global warming through more extreme weather, rising sea levels and diminishing Arctic sea ice, among other worrying changes.*

*We Request that Council:-*

- *Sets a new target and action plan for Doncaster Council to become carbon neutral;*

- *Resolves to work with our partners, other local authorities and the Yorkshire Region on carbon reduction projects, to ensure the UK is able to deliver on its climate commitments;*

- *Resolves to put sustainability, biodiversity and carbon reduction at the heart of this Council's agenda going forward supporting communities, business and individuals locally to make more sustainable choices; and*

- *Calls on the Government to provide the resources and powers so that Doncaster can make its contribution to the UK's Carbon Reduction targets.*

As part of Team Doncaster Partners the Trust has been requested to sign up to the pledge (draft wording):

*'Doncaster wants to play its part in combatting climate change. We represent organisations and agencies in Doncaster. We pledge to support the Borough by doing more for our environment, working together to achieve net-zero carbon emissions'.*

| Key questions posed by the report |
| --- |
| Does the Board of Directors' support the Council motion on Climate and Biodiversity Emergency?<br><br>Does the Board of Directors' approve the signing of the pledge? |
| **How this report contributes to the delivery of the strategic objectives** |
| The Trust will provide the right infrastructure and environment. |
| **How this report impacts on current risks or highlights new risks** |
| Relates to risks on infrastructure, environment and capital resources to maintain and improve. |
| **Recommendation(s) and next steps** |
| The Board is asked to:<br><br>- Support the Council's motion on Climate and Biodiversity Emergency;<br>- Support the signing of the pledge. |

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

**D1**

| | | | |
|---|---|---|---|
| **Title** | **Integrated Performance Report** | | |
| **Report to** | **Board of Directors** | **Date** | **24th September 2019** |
| **Author** | **Rebecca Joyce, Chief Operating Officer**<br>**Sewa Singh, Medical Director**<br>**David Purdue, Director of Nursing, Midwifery and AHPs**<br>**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

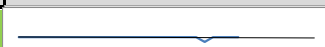
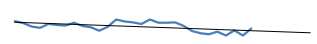
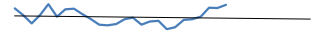
The Quality report highlights the ongoing work with Divisions and external partners to improve patient outcomes and a focus on mortality rates.

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.

| Key questions posed by the report |
| --- |
| Key Questions for the Board are:<br><br>• Is the Trust maintaining performance against agreed trajectories with our CCGs and in the context of national standards?<br>• Is the Trust providing a quality service for the patients?<br>• 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<br><br>**F&P15** Commissioner plans do not come to fruition and do not achieve the required levels of acute service reduction<br><br>**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 | Aug 19 | 95% | 85.6% | 86.3% | 93.6% | 88.1% | -5.5% | 92.0% | 90.56% | -1.4% | *95.0%* | *89.7%* | -5.3% | | | |
| | Max time of 18 weeks from point of referral to treatment- incomplete pathway | Aug-19 | 92% | 89.1% | 85.8% | 90.6% | 85.7% | -4.9% | *90.0%* | *85.7%* | -4.3% | | | | | | |
| | Waiting list size (from 1/4/19) - 18 Weeks referral to treatment -Incomplete Pathways | Aug-19 | .N/A | .N/A | .N/A | 31,423 | 32,811 | 1388 | 31,423 | 32,811 | 1388 | | | | | | |
| | % waiting less than 6 weeks from referral for a diagnostics test | Aug-19 | 99% | 94.6% | 96.5% | 99.0% | 98.7% | -0.3% | *99.0%* | *98.7%* | *-0.3%* | *99.0%* | *99.8%* | *0.8%* | | | |
| Cancer | Two week wait from referral to date first seen: all urgent cancer referrals | Jul-19 | 93.0% | 95.3% | 90.9% | 93.0% | *93.0%* | *0.0%* | 93.0% | *92.5%* | *-0.5%* | 93.0% | *95.3%* | *2.3%* | | | |
| | Two week wait from referral to date first seen: symptomatic breast patients | Jul-19 | 93.0% | 91.9% | 82.4% | 93.0% | *91.0%* | *-2.0%* | 93.0% | *86.0%* | *-7.0%* | 93.0% | *88.0%* | *-5.0%* | | | |
| | 31 day wait for diagnosis to first treatment- all cancers | Jul-19 | 96.0% | 97.5% | 96.5% | 96.0% | *97.9%* | *1.9%* | 96.0% | *99.8%* | *3.8%* | 96.0% | *99.9%* | *3.9%* | | | |
| | 31 day wait for second or subsequent treatment: surgery | Jul-19 | 94.0% | 92.4% | 92.2% | 94.0% | *100.0%* | *6.0%* | 94.0% | *100.0%* | *6.0%* | 94.0% | *100.0%* | *6.0%* | | | |
| | 31 day wait for second or subsequent treatment: anti cancer drug treatments | Jul-19 | 98.0% | 99.5% | 99.2% | 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 | Jul-19 | 85.0% | 81.4% | 77.6% | 84.5% | 84.3% | **-0.2%** | 85.0% | *83.7%* | *-1.3%* | 85.0% | *84.2%* | **-0.8%** | | | |
| | 62 day wait for first treatment from consultant screening service referral | Jul-19 | 90.0% | 88.0% | 85.6% | 90.0% | 75.0% | *-15.0%* | 90.0% | *89.2%* | *-0.8%* | 90.0% | *87.0%* | *-3.0%* | | | |
| Activity | ED Atendances | Aug-19 | N/A | N/A | N/A | | 14053 | | | *71417* | | | | | | | |
| | Daycase Activity - Discharges | Aug-19 | .N/A | .N/A | .N/A | 3,939 | 3,843 | (96) | 20,477 | 20,598 | 121 | | | | | | |
| | Other Elective Activity - Discharges | Aug-19 | .N/A | .N/A | .N/A | 775 | 757 | (18) | 3,423 | 3,760 | 337 | | | | | | |
| | Outpatient new activity (Contracted levels achieved) | Aug-19 | .N/A | .N/A | .N/A | 10,573 | 10,574 | 1 | 56,759 | 56,690 | (69) | | | | | | |
| | Outpatient Follow Up activity (Contracted levels achieved) | Aug-19 | .N/A | .N/A | .N/A | 21,433 | 21,881 | 448 | 115,031 | 117,143 | 2,112 | | | | | | |
| Ambulance Handover Times | Ambulance Handovers Breaches -Number waited <= 15 Minutes | Aug-19 | | | .N/A | 77.6% | 63.65% | -14.0% | | 68.63% | | | | | | | |
| | Ambulance Handovers Breaches -Number waited >15 & <30 Minutes | Aug-19 | | | .N/A | 21.5% | 35.87% | 14.4% | | 30.40% | | | | | | | |
| | Ambulance Handovers Breaches-Number waited >30 & < 60 Minutes | Aug-19 | | | .N/A | 0.9% | 0.44% | -0.5% | | 0.88% | | | | | | | |
| | Ambulance Handovers Breaches -Number waited >60 Minutes | Aug-19 | | | .N/A | 0.0% | 0.03% | 0.0% | | 0.08% | | | | | | | |
| | Proportion of patients scanned within 1 hour of clock start (Trust) | Jun-19 | 48.0% | .N/A | .N/A | 48.0% | *41.7%* | *-6.3%* | 48.0% | *44.8%* | *-3.2%* | 48.0% | *44.5%* | *-3.5%* | | | |
| | Proportion directly admitted to a stroke unit within 4 hours of clock start | Jun-19 | 90.0% | .N/A | .N/A | 90.0% | *52.1%* | *-37.9%* | 75.0% | *53.3%* | *-21.7%* | 75.0% | *50.4%* | *-24.6%* | | | |

| 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 | | | |
| Stroke | Percentage of eligible (according to RCP Guideline minimum threshold) given Thrombolysis (Trust) | Jun-19 | 90.0% | N/A | N/A | 90.0% | *100.0%* | *10.0%* | 90.0% | *100.0%* | *10.0%* | 100.0% | *100.0%* | *0.0%* |  | | |
| | Percentage treated by a stroke skilled Early Supported Discharge team | Jun-19 | 40.0% | .N/A | .N/A | 40.0% | *85.0%* | *45.0%* | 24.0% | *78.2%* | *54.2%* | 24.0% | *76.2%* | *52.2%* |  | | |
| | Percentage discharged given a named person to contact after discharge | Jun-19 | 95.0% | .N/A | .N/A | 95.0% | *95.0%* | *0.0%* | 80.0% | *94.2%* | *14.2%* | 80.0% | *98.5%* | *18.5%* |  | | |
| Theatres & Outpatients | Cancelled Operations (For non-medical reasons) | Aug-19 | | | 1.0% | 0.8% | *0.9%* | *0.1%* | 0.8% | *1.0%* | *0.2%* | 0.8% | *1.0%* | *0.2%* |  | | |
| | Cancelled Operations-28 Day Standard | Aug-19 | | .N/A | .N/A | 0 | *2* | *2* | 0 | *5* | *5* | | | |  | | |
| | Out Patients: DNA Rate | Aug-19 | 7.5% | 6.30% | .N/A | 7.6% | *10.3%* | *2.7%* | 7.6% | *10.2%* | *2.6%* | 7.6% | *10.3%* | *2.7%* |  | | |
| | Out Patients: Hospital Cancellation Rate | Aug-19 | | .N/A | .N/A | 4.5% | *13.8%* | *9.3%* | 4.5% | *13.6%* | *9.1%* | 4.5% | *15.4%* | *10.9%* |  | | |
| | Theatre Utilisation | Aug-19 | | .N/A | .N/A | 87.0% | *70.9%* | *-16.1%* | 87.0% | *72.6%* | | 87.0% | | |  | | |
| | Clinic Utilisation | Aug-19 | | .N/A | .N/A | 95.0% | *87.8%* | *-7.2%* | 95.0% | *89.9%* | | 95.0% | | |  | | |
| Effective | Emergency Readmissions within 30 days (PbR Methodology) | Jul-19 | | .N/A | .N/A | | 3.0% | | | *6.1%* | | | | |  | | |
| | Length of Stay (21 Days) - Number of Patients | Jul-19 | | N/A | N/A | | 54 | | | *54* | | | | | | | |
| | Length of Stay (21 Days) - Number of days | Jul-19 | | N/A | N/A | | 1949 | | | *1949* | | | | | | | |
| | Infection Control C.Diff | Aug-19 | | .N/A | .N/A | 3 | 2 | *-1* | 9 | 17 | *8* | | | |  | | |
| | Infection Control MRSA | Aug-19 | | .N/A | .N/A | 0 | 0 | 0 | 0 | 0 | *0* | | | | **N/A** | | |
| | HSMR (rolling 12 Months) | May-19 | 100 | | | 100.0 | 92.5 | -3.0 | 100.0 | 97.0 | *-3.0* | | | |  | | |
| | HSMR : Non-Elective (rolling 12 Months) | May-19 | 100 | | | | | | 100.0 | 97.0 | *-3.0* | | | |  | | |
| | HSMR : Elective (rolling 12 Months) | May-19 | 100 | | | | | | 100.0 | 93.7 | *-6.3* | | | |  | | |
| Safe | Never Events | Aug-19 | | | | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | |
| | Sis | Aug-19 | | | | | 5 | | | 27 | | | | |  | | |
| | Avoidable Pressure Ulcers Cat 3&4 | Aug-19 | | | | | 0 | | | 24 | | | | | **N/A** | | |
| | Unavoidable Pressure Ulcers Cat 3&4 | Aug-19 | | | | | 0 | | | 3 | | | | | **N/A** | | |
| | Falls that result in a serious Fracture | Aug-19 | | | | | 0 | | | 3 | | | | | N/A | | |

**SPECIFIC THEMES :**

| 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 | | | |
| Fractured Neck of Femur | % of patients achieving Best Practice Tariff Criteria | Aug-19 | | | | | 42.5% | | | 46.8% | | | 46.9% | |  | | |
| | 36 hours to surgery Performance | Aug-19 | | | | | 52.5% | | | 53.2% | | | 54.0% | |  | | |
| | 72 hours to geriatrician assessment Performance | Aug-19 | | | | | 70.0% | | | 87.4% | | | 86.3% | |  | | |
| | % of patients who underwent a falls assessment | Aug-19 | | | | | 72.5% | | | 91.8% | | | 90.4% | |  | | |
| | % of patients receiving a bone protection medication assessment | Aug-19 | | | | | 75.0% | | | 92.2% | | | 90.7% | |  | | |
| | % who underwent a pre-operative AMTS Assessment | Aug-19 | | | | | 67.5% | | | 90.9% | | | 89.2% | |  | | |
| | Mortality-Deaths within 30 days of procedure | Aug-19 | | | | | 7.5% | | | 6.1% | | | 6.9% | |  | | |

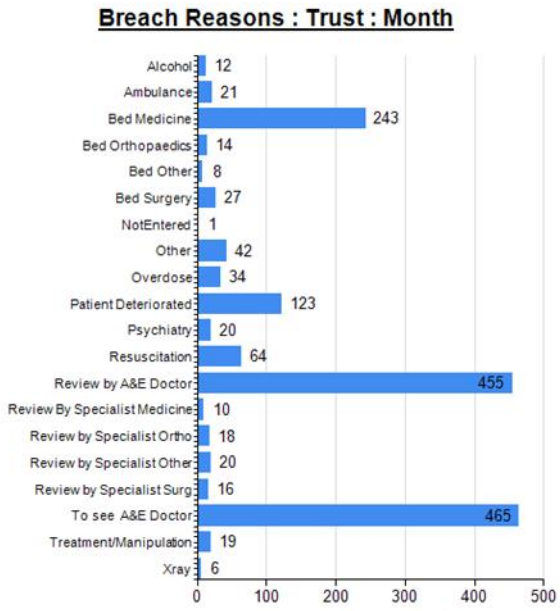
# Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
# PERFORMANCE EXCEPTION REPORT – August 2019

## (A) 4hr Access Target

**Trust**

In August 2019 the Trust achieved performance of 88.12% against the 4hr access standard of 95%, in comparison to 92.5% in August 2018. This is below the locally agreed CCG trajectory of 92.5%.The Trust managed 15782 ED attendances across sites and streams, during August 2019. This is 1618 more patients than in August 2018 seeing an 11%.

1875 patients were not treated within 4 hours – this is 813 more than in August 2018:-




Weekly pathway meetings continue to occur to analyse the Emergency pathway and how we collaborate to support the 4 hour target. The key challenge in the current position is the number of breaches caused by Doctor Waits. Significant work has taken place to fill medical rota gaps in the short term through liaison with HOLT. However, there have been significant gaps in the rota and will continue to be throughout August, including gaps within surgery & orthopaedics, which adds further pressure to the emergency department. This has been escalated to the Executive team. The ED workforce plan includes interviews for 5 CESR doctors and QIMET doctors from Nepal who start in November 2019. This will improve the medical staffing position more sustainably. A full action plan is being developed by the team to address the position and are meeting with the COO and Director of Nursing / Deputy Chief Executive on Friday 19th September.

**Doncaster Royal Infirmary**

In August 2019 DRI achieved performance of 83.46% against the 4hr access standard of 95%, in comparison to 90.27% in August 2018. DRI managed 9333 ED attendances across streams, during August 2019. This is 1002 more patients than in August 2018 seeing an increase of 10%.

**Bassetlaw District General Hospital**

In August 2019 BDGH achieved performance of 92.92% against the 4hr access standard of 95%, in comparison to 93.92% in August 2018

BDGH managed 4672 ED attendances across streams during August 2019. This is 544 more patients than in August 2018 seeing an increase of 11%. On Tuesday 27th August 2019, BDGH saw the highest ever number of patients in the ED with an attendance of 192.

The service have undertaken a review of attendances over the August Bank Holiday weekend and shared with partners.

## Ambulance Breaches

Performance at DBTH is not meeting the local standards agreed with the CCG, except for the standard for patients waiting over 30 minutes and less than 60 minutes. Flow quality improvement work in ED has reduced waits for patients and this has reduced the % of patients waiting over 30 minutes and 60 minutes, with data tracking the improvement as part of the work.

Whilst not meeting all standards, DBTH continues to be the best performer for ambulance handovers in SYB.

## (B) Referral to Treatment (RTT)

The Trust Level month end performance for August 2019 is 85.7% which is 1% lower than July 2019.

Over the last 12 months we have seen a downward trend in performance. Nationally we are currently performing slightly above the national average (86.29%) but below the performance of acute hospital peers within SYB ICS. The Trust is under considerable scrutiny from the ICS.

The following table summarises the position by specialty:

| Specialty Group | Under 18 Weeks | 18 Weeks & Over | Total | Percentage |
|---|---|---|---|---|
| General Surgery | 2375 | 427 | 2802 | 84.8% |
| Urology | 1365 | 281 | 1646 | 82.9% |
| T&O | 5523 | 1123 | 6646 | 83.1% |
| ENT | 2585 | 562 | 3147 | 82.1% |
| Ophthalmology | 2686 | 447 | 3133 | 85.7% |
| Oral Surgery | 1394 | 165 | 1559 | 89.4% |
| General Medicine | 1776 | 479 | 2255 | 78.8% |
| Cardiology | 1826 | 318 | 2144 | 85.2% |
| Dermatology | 1789 | 124 | 1913 | 93.5% |
| Thoracic Medicine | 937 | 134 | 1071 | 87.5% |
| Rheumatology | 785 | 210 | 995 | 78.9% |
| Geriatric Medicine | 212 | 25 | 237 | 89.5% |
| Gynaecology | 1526 | 67 | 1593 | 95.8% |
| Others | 3327 | 343 | 3670 | 90.7% |
| **Trust Total** | **28106** | **4705** | **32811** | **85.7%** |

**Finance and Performance Committee received a deep dive report in September and considerable work continues across the Trust to address this position and recover 92% in year. Significant work is taking place across the Trust to address the position:**

- The development of Gooroo **demand and capacity modelling** to understand what is required to deliver RTT 92% in the context of the wider contract position
- The development of **specialty level actions plans** which have been through three Confirm and Challenge events led by the COO
- The near completion of the **NECs validation process** we undertook in partnership with the CCG which reviewed a number of cohorts of planned care patients. A joint governance process to oversee the outcomes of this work is in place.
- Improvements to how **we train staff** at all levels to develop more consistent approaches to managing RTT, embedding the learning from the data quality NECs audit.
- Increasing our **management capacity and oversight** in this area, with a management restructure being implemented to release the Deputy COO from her divisional duties to focus on this work.
- The introduction of a new **performance assurance framework,** which includes a strengthened focus on RTT both at specialty and Trust wide level.
- Ensuring our routine **data quality checks** pre-emptively pick up validation issues on our waiting lists and avoids the challenges that our NECs validation have highlighted.
- Support from the national **Elective Intensive Support Team** is continuing to build and accelerate our work.

## (C) Diagnostics

The Diagnostics target has not been achieved for August 2019 with 98.7% achievement - 23 breaches beyond achieving the 99% target (98 breaches total).

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

There were 90 trust level breaches, 20 more than last month leading to a marginal decrease in performance. The majority of these breaches were in Urodynamics.

| Exam Type | <6W | >=6W | Total | Performance | Longest Wait |
|---|---|---|---|---|---|
| MRI | 1398 | 4 | 1402 | **99.71%** | |
| CT | 1920 | 12 | 1932 | **99.38%** | |
| Non-Obstetric Ultrasound | 2338 | 0 | 2338 | **100.00%** | |
| Barium Enema | 0 | 0 | 0 | | |
| DEXA | 285 | 2 | 287 | **99.30%** | |
| Audiology | 279 | 16 | 295 | **94.58%** | **TBC** |
| Echo | 223 | 0 | 223 | **100.00%** | |
| Nerve Conduction | 105 | 15 | 120 | **87.50%** | **TBC** |
| Sleep Study | 25 | 0 | 25 | **100.00%** | |
| Urodynamic | 59 | 40 | 99 | **59.60%** | **TBC** |
| Colonoscopy | 306 | 0 | 306 | **100.00%** | |
| Flexible Sigmoidoscopy | 91 | 0 | 91 | **100.00%** | |
| Cystoscopy | 118 | 9 | 127 | **92.91%** | **TBC** |
| Gastroscopy | 313 | 0 | 313 | **100.00%** | |
| **Total** | **7460** | **98** | **7558** | **98.70%** | |

Performance for the Trust, NHS Doncaster and NHS Bassetlaw is outlined below:

| | Waiters <6W | Waiters >=6W | Total | Performance |
|---|---|---|---|---|
| Trust | 7460 | 98 | 7558 | 98.70% |
| NHS Doncaster | 4874 | 58 | 4932 | 98.82% |
| NHS Bassetlaw | 1798 | 27 | 1825 | 98.52% |

**Missed Targets:**

- Urodynamic – 59.6% -40 breaches out of 99 waiters. A meeting took place w/c 9.9.19 to discuss improvements to monitoring and it was agreed a diagnostic PTL would be created for this cohort of patients to achieve a more robust monitoring process.

- Audiology – 94.58% - 16 breaches out of 295 waiters. 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. This is indicative in their overall improved performance position.

- Cystoscopy – 92.91% - 9 breaches out of 127 waiters. The team continue to work on improved monitoring, validation and demand and capacity processes to ensure tight and proactive delivery each month.

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

## (D) Cancer Performance

The following information relates to performance for July 2019. Headlines include:

2 week wait and 31 day position continues to perform well. For breast symptomatic patients, there were 9 patient breaches, all for patient choice reasons. Out challenge continues around the 62 day wait standard:

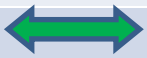
- 62 day breaches performed 2% lower than June data due to a number of pathway breaches reallocated to us as the Inter Provider Transfer (IPT) was sent over after day 38. Within this group, there were 3 complex diagnostic pathways, 2 delayed for medical reasons and 2 patient initiated choice delays to diagnostics/ treatment and 1 pathway delay led to an IPT at day 48.

- For 62 day screening for July had 4 breaches – 2 complex diagnostic pathways and 2 lower GI pathway choice to 1st colonoscopy appointment. August looks set to achieve 90%

- We anticipated improved performance for August against 2 week wait, breast symptomatic and 31 day, although full compliance will continue to be challenging. We expect improvement on the 62 day figures, with benefits from the one stop prostate service and other initiatives.

The tables below provide further breakdown data:

**Cancer Performance – July 2019**

| Standard | Local Performance % | Position from Previous Month |
|---|---|---|
| 31 day | 97.9% |  |
| 62 day – IPT scenario split | 81.4% |  |
| 62 day – 50/50 split | 84.3% |  |
| 62 day – Local Performance only | 91.5% | Local Measure only |
| 62 day – Shared Performance only 50/50 split | 50% | Local Measure only |
| 31 day Sub – Surgery | 100% |  |
| 31 day Sub – Drugs | 100% |  |
| 31 day Sub – Other | 100% |  |
| 62 day Screening | 75% |  |
| 62 day Con Upgrades | 81.3% |  |
| *Day 28 – shadow monitoring* | *82.8%* | FDS testing site – set performance |

**Cancer Performance by Specialty – July 2019**

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

| | 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 | 96% | 94% | 98% | 94% | 85% | 85% | 90% | TBA | TBA |
| Breast | 100% | 100% | | | 96.4% | 93.1% | 88% | 100% | 98.3% |
| Gynaecology | 100% | 100% | | | 75% | 50% | | | 70.3% |
| Haematology | 100% | | 100% | | 87.5% | 87.5% | | 100% | 46.2% |
| Head & Neck | 100% | | | | 50% | 33.3% | | | 90.6% |
| Lower GI | 95.5% | 100% | | | 71.4% | 66.7% | 28.6% | 88.9% | 75.8% |
| Lung | 100% | | | | 71.4% | 61.5% | | 69.2% | 90% |
| Sarcoma | | | | | 33.3% | 0% | | | |
| Skin | 89.5% | | | | 89.7% | 89.7% | | | 88.6% |
| Upper GI | 100% | | | | 57.1% | 42.9% | | | 78.6% |
| Urological | 100% | 100% | | | 87.8% | 90% | | 80% | 73.1% |
| **Overall Performance** | 97.9% | 100% | 100% | | 84.3% | 81.4% | 75% | | 82.8% |

**Cancer Performance Exceptions – July 2019**

| CWT Standard | Tumour Group | Performance against CWT standard | High Level View |
|---|---|---|---|
| Two Week Wait | H&N | 52.1% | **57** Patients – 8 patient choice, 18 administrative delay, 31 elective capacity |
| | Urology | 91.8% | **16** Patients – 6 patient choice, 3 administrative delay - unable to contact patient, 7 Clinic cancellations |
| 31 day | Lower GI | 95.5% | **1** Patient – Patient cancelled on day due to chest infection |
| | Skin | 89.5% | **2** Patients – Elective capacity – clinic and theatre (H&N) |
| 62 day ( using 6 scenario data) | Gynae | 50.0% | **1** Patient –shared care pathway – pathway delays (RP5) and OPD capacity (RHQ) |
| | H&N | 33.3% | **2** Patients –both shared care, complex diagnostic pathways |
| | Lower GI | 66.7% | **4** Patients – 2 shared care – 1 Patient choice, 1 pathway delays. 2 local - 1 complex diagnostic pathway, 1 pathway delay |
| | Lung | 61.5% | **3** Patients – All shared care – 1 treatment delayed for medical reasons, 1 complex diagnostic pathway, 1 delay in histology reporting |
| | Sarcoma | 0% | **1** Patient – local pathway - complex diagnostic pathway |
| | Upper GI | 42.9% | **2** Patients – both Shared care - 1 complex diagnostic pathway. 1 medical reasons |
| 62 day Screening | Lower GI | 28.6% | **3** Patients – 2 local Pathway - delay to diagnosis , 1 Shared Care – medical reasons |
| 62 day Con Upgrade | Lung | 69.2% | **4** Patients – All Shared Care pathways 1 – patient fitness, 3 pathway delays |
| | Urology | 80% | **1** Patient –Shared Care – pathway delay |

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

**62 Day Cancer Performance by CCG – June 2019**

| | 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 – not available* | 62 Day Screening | 62 Day Consultant Upgrades |
|---|---|---|---|---|---|---|---|---|
| Operational Std | 96% | 94% | 98% | 94% | 85% | 85% | 90% | TBA |
| Doncaster CCG | 99.1% | *100%* | *100%* | | 83.56% | | 85.7% | 70% |
| Bassetlaw CCG | 92.5% | *100%* | | | 63.63% | | 0% | |

| | Count of Tumour Type |
|---|---|
| **02Q: Bassetlaw CCG - Total and breakdown** | **8** |
| Gynaecological | 1 |
| Head and Neck | 1 |
| Lower Gastrointestinal | 1 |
| Lung | 2 |
| Skin | 1 |
| Upper Gastrointestinal | 1 |
| Urological (Excluding Testicular) | 1 |
| **02X : Doncaster CCG - Total and breakdown** | **12** |
| Breast | 1 |
| Haematological (Excluding Acute Leukaemia) | 1 |
| Lower Gastrointestinal | 2 |
| Lung | 2 |
| Sarcoma | 1 |
| Skin | 1 |
| Upper Gastrointestinal | 2 |
| Urological (Excluding Testicular) | 2 |
| **15M: Derby and Derbyshire CCG - Total and breakdown** | **1** |
| Urological (Excluding Testicular) | 1 |
| **Grand Total** | **21** |

**Cancer Performance Comments & Action Plans**

See separate internal CCG Cancer Contract Query Document for Urology & ENT.

## (E) Stroke

**Performance June 2019**

The Trust level percentage for Direct Admission to the Stroke Unit was 52.1% against a 90% target. 41.7% of patients were scanned within 1 hour of clock start, against a target of 48%.

A summary of key themes in August from the stroke specialist nurses exception report on stroke performance for both the 4 hour admission and CT scan within 1 hour indicators is presented below.

| Performance Indicator | Key Themes from SNP Mini Audit |
|---|---|
| **CT Scan within 1 Hour** | Delay in assessment and diagnosis in ED – patients presenting at ED being triaged as unwell adults and no scan requested<br><br>Patients not diagnosed with stroke or thought not to have stroke when first presenting, such as dizziness, admissions to FAU.<br><br>Patients not medically stable<br><br>Bassetlaw patients – transport delays to DRI once stroke diagnosis made |
| **4 hour admission to ward 16** | Delay in assessment and diagnosis in ED – patients presenting at ED being triaged as unwell adults and no scan requested<br><br>Patients admitted to FAU / AMU as not initially diagnosed as stroke<br><br>Delays in ambulance transfers from Bassetlaw when patients diagnosed with stroke<br><br>Delay in referral to SNP – during August there were 9 occasions when the referral to SNP was delayed<br><br>Staffing issues / nurses dealing with other poorly patients / high acuity of patients / beds (although this is minimal) |

**Summary**

Reviewing the audit data that the specialist nurses complete for every patient breach, shows the main reason for the poor performance is the delay in assessment and diagnosis on presentation at ED.

During August, there were no breaches due to bed availability and length of stay has improved on the stroke unit. Once patients are referred to/or identified by SNPs the pathway to CT scan and admission onto the stroke unit is well within target times.

Plans to improve performance include:

- Trainee ACPs commenced in post increasing nurse capacity and the plan is for SNPs to be more proactive in ED, which will improve early identification of stroke patients.

- The matron is currently undertaking a deep dive into the pathway delays.

The outcome from the deep dive to feed into a Qii project to improve pathway from ED to stroke unit and CT scan times.

## (F) Cancelled Operations

In August 2019 44 (0.92%) of Trust operations were cancelled.

| CCG Name | CCG Code | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Year to Date |
|---|---|---|---|---|---|---|---|
| TRUST | | 0.83% | 0.98% | 0.91% | 1.47% | 0.92% | 1.03% |
| *Of which Theatre Cancellations* | | *0.39%* | *0.52%* | *0.59%* | *0.96%* | *0.67%* | *0.63%* |
| *Of which Non-Theatre Cancellations* | | *0.43%* | *0.46%* | *0.32%* | *0.51%* | *0.25%* | *0.40%* |
| NHS DONCASTER CCG | 02X | 0.77% | 1.11% | 1.05% | 1.15% | 0.93% | 1.01% |
| *Of which Theatre Cancellations* | | *0.38%* | *0.56%* | *0.65%* | *0.93%* | *0.70%* | *0.65%* |
| *Of which Non-Theatre Cancellations* | | *0.38%* | *0.56%* | *0.40%* | *0.23%* | *0.22%* | *0.36%* |
| NHS BASSETLAW CCG | 02Q | 1.02% | 0.79% | 0.85% | 2.53% | 1.04% | 1.24% |
| *Of which Theatre Cancellations* | | 0.65% | 0.44% | 0.76% | 0.94% | 0.66% | 0.68% |
| *Of which Non-Theatre Cancellations* | | 0.37% | 0.35% | 0.09% | 1.59% | 0.38% | 0.56% |

Non-Clinical Reasons for Cancellations – August 2019 :-

| Row Labels | Main Reason | Sub Reason | ENT | GI | Gynaecology | OMFS | Ophthalmology | Orthopaedics | Podiatry | Urology | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **BDGH** | **Equipment** | Equipment not available | | | | | | 3 | | | 3 |
| | **Insufficient Time** | Late start - AM list over-run | | | | | | 1 | | | 1 |
| | | Problems with previous case | | | 1 | | | | | | 1 |
| | | Late start - Anaesthetist | | 1 | | | | 1 | | | 2 |
| **BDGH Total** | | | | **1** | **1** | | | **5** | | | **7** |
| **DRI** | **Equipment** | Equipment failure | | | | | | 1 | | 2 | 3 |
| | | Equipment not available | 1 | | | | | 2 | | 2 | 5 |
| | **Insufficient Time** | HSDU issue | | 1 | | | | | | | 1 |
| | | Late start - AM list over-run | | 1 | | | | | | | 1 |
| | | Problems with previous case | 1 | 1 | 2 | | | | | | 4 |
| | | Oversubscribed list | | | | | | 1 | | | 1 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Late start - Anaesthetist | | | 2 | | | | | 2 |
| | **No Elective Bed** | N/A | 1 | | | | | | | 1 |
| | **No Staff** | Support staff | | | | 1 | | | | 1 |
| | **Other Urgent Case** | Emergency | | | | | | 1 | | 1 |
| **DRI Total** | | | **3** | **5** | **3** | | **5** | | **4** | **20** |
| **MMH** | **Equipment** | HSDU issue | | | | | | 1 | | 1 |
| | **Insufficient Time** | Problems with previous case | | | | 1 | | | | 1 |

**DNA or Unfit**

29 patients DNA'd and a further 29 were assessed as being unfit on the day of surgery. Most of these cases were due to an unexpected illness or the patient declaring themselves unfit. The division is conducting an investigation as to why so many patients didn't attend and whether those patients declared unfit could have been identified at pre-op. Business Manager for Theatres is currently undertaking a deep dive to look at increasing number of DNA and cancellations due to unfit patients.

**Equipment issues**

13 operations were cancelled due to equipment failure mainly due to problems with missing equipment or damaged packaging meaning the equipment was not sterile.

**Over-runs with the previous case**

13 operations were cancelled due to problems with the previous case. All cases were reviewed and approved in the theatre planning meeting but due to unforeseen clinical difficulties they overran and led to the cancellation of other cases.

**Pre-op**

9 operations were cancelled due to issues with pre-op e.g. the patient had not fasted or not stopped medication

**Non Clinical Cancellations - 28 Day Breaches**

In August 2019, there were 2 cancellations that breached the 28 day target.

| Site | Specialty: | TCI Date: | 28 Day Breach Date: | New Date: | Cancellation Reason: | Breach Reason |
|---|---|---|---|---|---|---|
| DRI | Urology | 31/07/2019 | 27/08/2019 | 03/09/2019 | Lack of equipment | Lack of understanding of breach targets by administrative staff * |
| DRI | Ophthalmology | 15/07/2019 | 12/08/2019 | 19/08/2019 | Lack of Theatre time | Awaiting further information |

*The forthcoming administrative training will include awareness & training around 28 day cancellation breaches for all clinical admin staff.

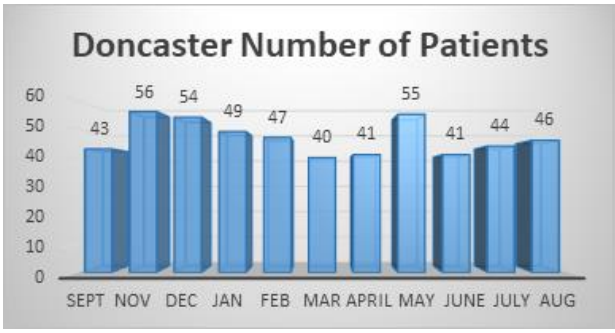
Urology are implementing an internal tracker for all cancelled operations – this should mitigate any further cancelled operation breaches.

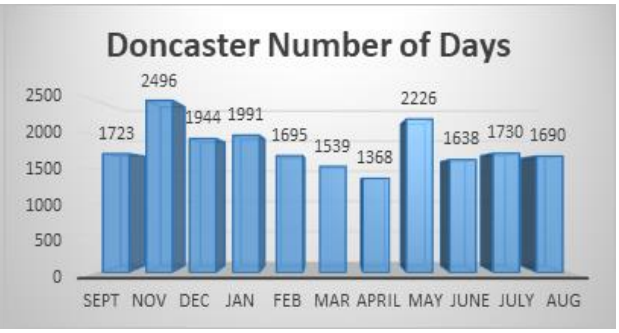
# Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
# PERFORMANCE EXCEPTION REPORT – August 2019

## Length of Stay (21 Days)

From the data recorded at the monthly LOS meeting held on 22 August 2019, there were 46 patients in Doncaster Royal Infirmary with a length of stay of 21 days or more. The total bed days for these 'super stranded patients' was 1690. This equates to an average of 36.7 days per patient. This is a slight reduction in total LOS and the average LOS from July 2019 when the average was 39.3 days per patient.

Many of the high LOS patients are complex with ongoing clinical needs. There is one complex neurological patient with a LOS of over 100 days. He has required an episode of critical care and is now awaiting long term placement.

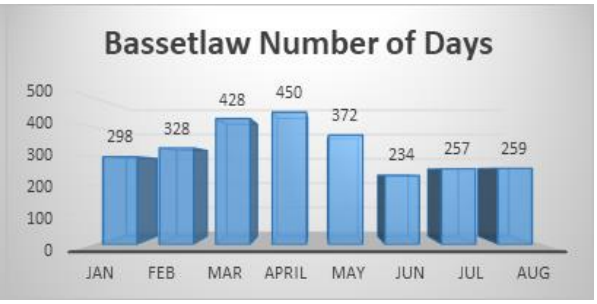



From the data recorded at the LOS meeting held on 21 August 2019, there were 8 patients in Bassetlaw District General Hospital with a length of stay of 21 days or more. The total bed days for these 'super stranded patients' was 259. This equates to an average of 32.3 days per patient. This is a slight increase from July 2019 when the average was 29.2 days per patient.

A recurring theme which contributes to higher LOS at Bassetlaw relates to the absence of a community intravenous (IV) service for patients on long term antibiotics. There is ongoing work with CCG colleagues to identify opportunities to introduce a community IV service.




## Pulmonary Rehabilitation

Due to the way the data is collected and reported, the service feels the current reporting mechanism doesn't truly reflect the service performance. The service, with the Information Team are currently writing a proposal for future performance reporting, which will be available for consideration at the

start of Q2, to ensure any future sharing of data is meaningful and fully reflective of service delivery & achievement of KPIs.

## ERS Utilisation & Appointment Slot Issues

Internal data currently being validated – to be included on future report

# Executive Summary - Safety & Quality - August 2019 (Month 5)

## Mortality: HSMR & Crude Mortality Rate

The Trust's overall rolling 12 month HSMR at the end of May 2019 is 97 with a flattening of the upward trend. Crude mortality has fallen since and we expect that HSMR will show a similar improvement. We are currently reviewing elective mortality to ensure that care delivered was of a good quality

## Fractured Neck of Femur (BPT Performance)

Risk adjusted mortality for patients with a Neck of Femur fracture remains better than expected and Best Practice Tariff was achieved in nearly 60% of patients, which is the national benchmark.

## Serious Incidents

## Children & Young People (Serious Incidents/Incidents/Complaints/Duty of Candour)

There were no Serious Incidents recorded in August within the paediatric service.

**Executive Lead: Mr Sewa Singh**

## Executive Safety Summary

**Launch of World Patient Safety Day**

Over 100 clinicians at Doncaster and Bassetlaw Teaching Hospitals (DBTH) have marked the very first World Safety Day (17 September) with a series of informative workshops, lectures and other learning opportunities.

Coordinated globally by the World Health Organisation (WHO), the event's core message is to ask hospital and healthcare workers to speak up for patient safety, improving practice wherever possible and committing to reducing avoidable harm within clinical settings.

The BDTH event focused on Acute Kidney Injury and how every member of staff can help support patients with this preventable illness.
The Trust used the day to launch the new fluid balance chart which has been devised by a number of consultants and nurses. A number of initiatives have also been launched including #but first a drink, to encourage patients to drink which uses traffic light lids for patient jugs and the pee plotter so staff can easily calculate how much urine patients should be passing.

The new ward accreditation metrics were launched.

## Infection Prevention and Control: MRSA/ C-Diff

MRSA Bacteraemia:
We have continued to achieve a zero tolerance to avoidable MRSA bacteraemia. Our last Healthcare Associated MRSA bacteraemia attributed to the Trust was the 28TH October 2017. This brings us to 670 days with no Trust MRSA bacteraemia
MRSA colonisation:
We introduced, in 2019/20, Post Infection Reviews (PIR) for all Trust acquired MRSA colonisations (patients testing positive after an initial negative admission screen sample). In 2018/19 we reported 17 cases of healthcare acquired MRSA colonisation and we are working to ensure a reduction in that number for 2019/20, at the end of August we reported 6 cases compared to 10 cases for same period in 2018/19.
Clostridioides difficile:
The Trust has a trajectory of not more than 44 cases for 2019/20 financial year with changes as to how cases are assigned as follows: In 2018/19 we achieved a reduction of 49% (with 20 cases out of trajectory of 39), with one lapse in care for entire year.

The challenge this year and onwards is the redefinition of what constitutes healthcare associated and community associated C difficile infection.

Healthcare Onset Healthcare Associated (HOHA): cases detected in the hospital ≥2 days after admission {So far we have 12 cases in this category}.
Community Onset Healthcare Associated (COHA): cases that occur in the community (or within 2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks {we report a total of 5 cases in this category}.
From the reviews none of the cases show a lapse in care.
One of the key areas raised to BCCG is the increase in CDif in the community and of the current 17 cases 10 are from BDGH, last year BDGH only had 20 cases in total.

To achieve this new challenge means going further with good antimicrobial stewardship and effective/proactive management of cases to reduce the incidence of relapse, not only for patients on admission, but for cases discharged into the community. This challenge will be affected with a new vacancy yet to be filled in the consultant pool.
Other measures to help address this include introducing a PCR based testing to identify toxigenic strains so can be given targeted treatment if symptomatic, and rather than batch test the samples daily, to test them as soon as they arrive in the lab to improve clinical liaison and management both in the inpatients and community patients.

## Serious Incidents: Fall resulting in significant harm:

In August there have been no falls resulting in significant harm. Focussed work has been undertaken in the Clinical Decisions Unit at DRI, which has been well received and processes adapted.

## Hospital Acquired Pressure Ulcers:

The changes to reporting has meant the trajectory for this year has been set at 56. There is an exec led review for the all cases of hospital acquired pressure ulcers, learning from the reviews is then shared through the divisions.

## Complaints and Concerns

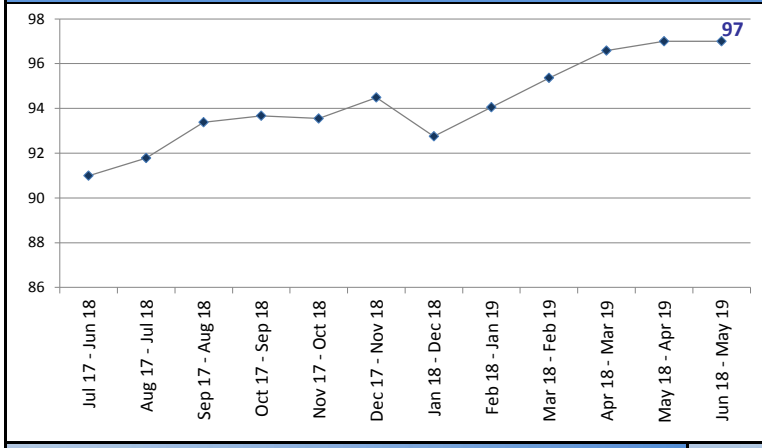
Work to triangulate patient experience feedback for inpatient areas has been completed. The new bedside information book has been complimented by new bedside boards above each inpatient bed, supporting the multi-disciplinary team with essential patient information and co-designed welcome boards outside each ward, support patients and families with communication, using QR codes for more information, reducing the need to store and update leaflets.

A sample of patients have been contacted for feedback on the complaints process and quality of resolution. These results are currently being analysed and will be presented at patient experience and engagement committee.

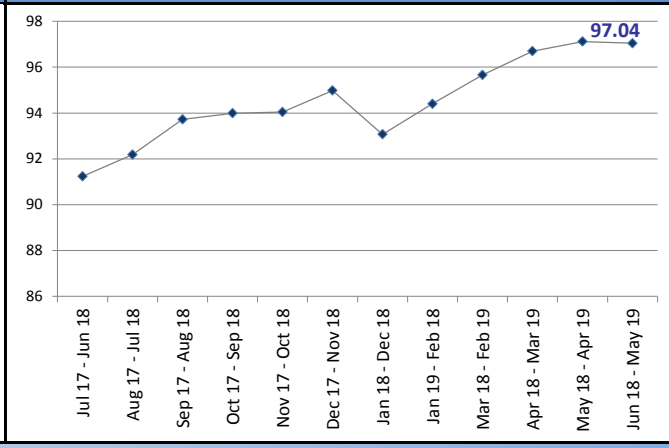
**Executive Lead: David Purdue**

# Hospital Standardised Mortality Ratio (HSMR) - May 2019 (Month 2)

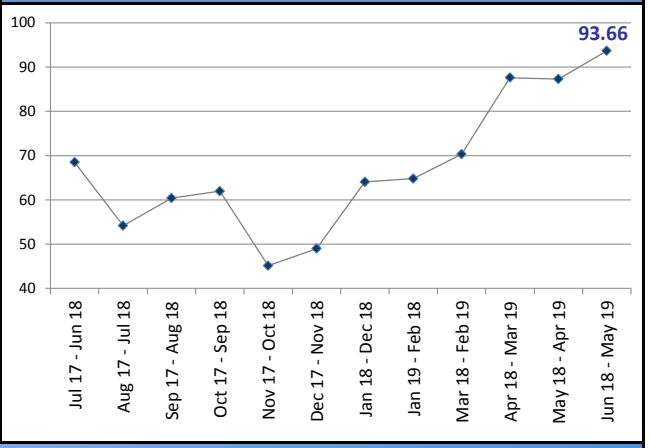
## Overall HSMR (Rolling 12 months)




## HSMR - Non-elective Admission (Rolling 12 months)




## HSMR - Elective Admission (Rolling 12 months)

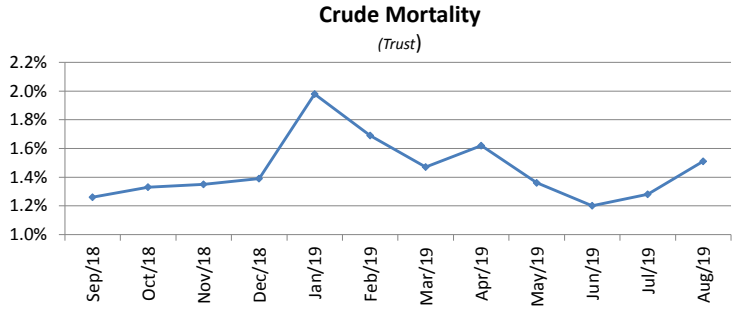


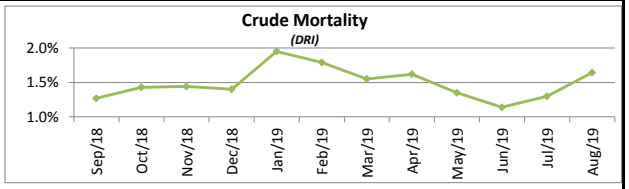

## HSMR Trend (monthly)

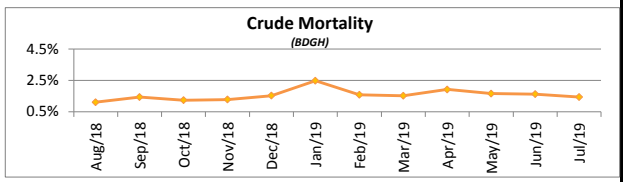
| | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|
| January | 116.80 | 99.21 | 94.86 | 106.54 |
| February | 99.94 | 97.73 | 105.44 | 97.97 |
| March | 90.54 | 97.37 | 88.42 | 101.62 |
| April | 105.91 | 88.50 | 98.90 | 103.77 |
| May | 101.15 | 96.60 | 92.08 | 92.50 |
| June | 80.27 | 93.67 | 90.32 | |
| July | 92.56 | 97.73 | 107.78 | |
| August | 100.27 | 87.52 | 95.03 | |
| September | 90.26 | 95.34 | 90.42 | |
| October | 90.29 | 88.66 | 97.08 | |
| November | 88.98 | 82.30 | 99.42 | |
| December | 82.30 | 93.52 | 80.68 | |

## Crude Mortality (monthly) - Augusy 2019 (Month 5)

*(number of deaths/number of patient discharged)*



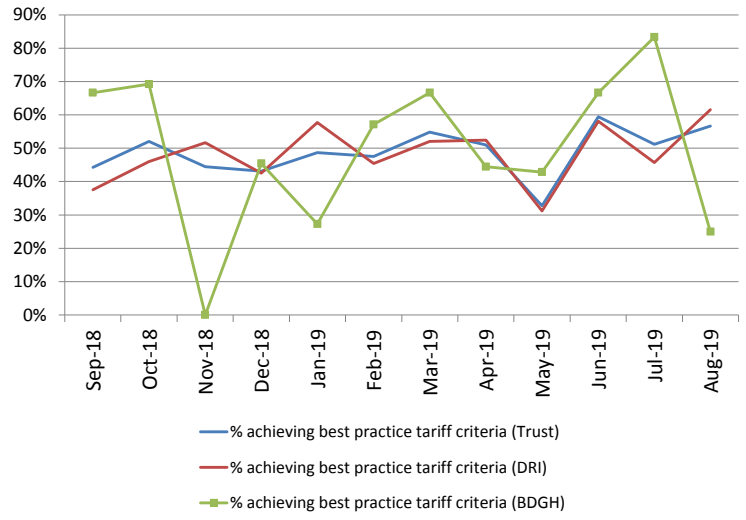



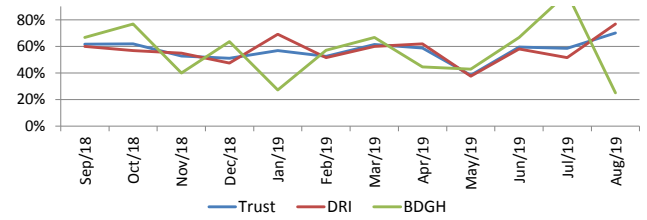

| | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust | 1.26% | 1.33% | 1.35% | 1.36% | 1.98% | 1.69% | 1.47% | 1.62% | 1.36% | 1.20% | 1.28% | 1.51% |
| DRI | 1.27% | 1.43% | 1.44% | 1.45% | 1.95% | 1.79% | 1.55% | 1.62% | 1.36% | 1.14% | 1.30% | 1.64% |
| BDGH | 1.43% | 1.23% | 1.27% | 1.26% | 2.47% | 1.58% | 1.51% | 1.91% | 1.65% | 1.61% | 1.43% | 1.37% |

# NHFD Best Practice Pathway Performance -August 2019 (Month 5)

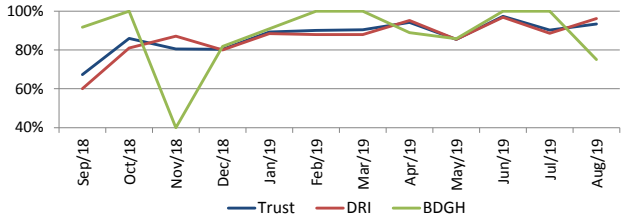
## Best Practice Criteria Performance



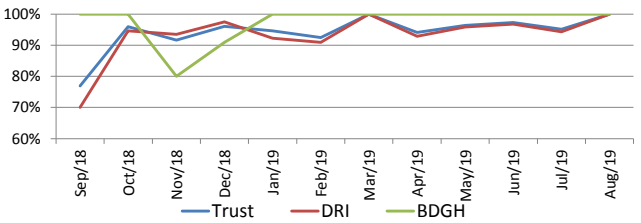

## 36 Hours to Surgery Performance



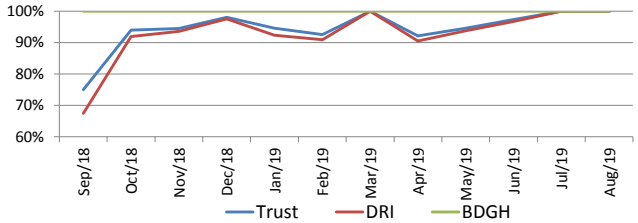

## 72 hours to Geriatrician Assessment Performance



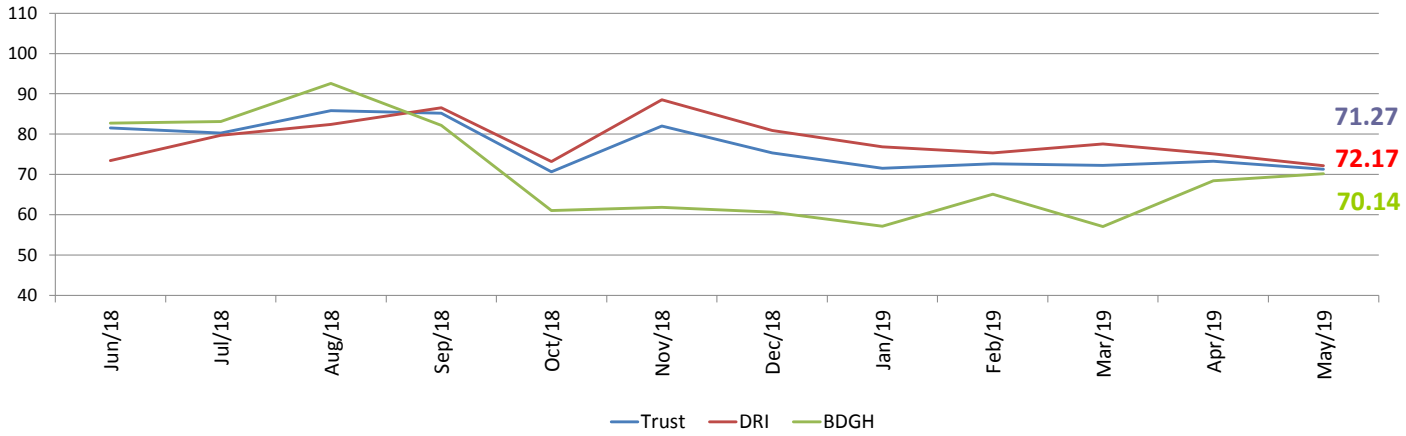

## Bone Protection Medication Assessment




## Falls Assessment Performance




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



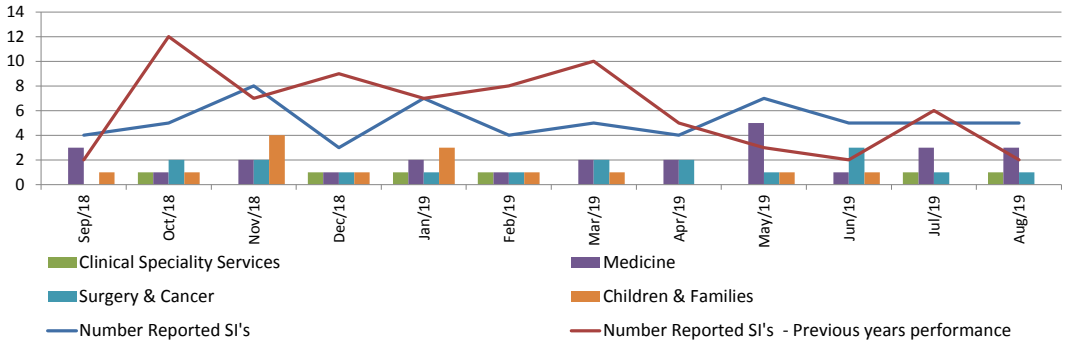
# Serious Incidents - August 2019 (Month 5)

(Data accurate as at 06/09/2019)

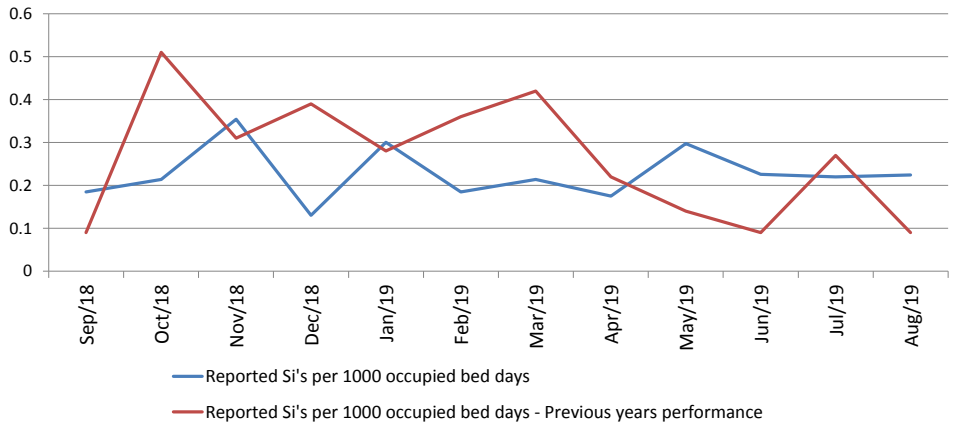
**Please note**: At the time of producing this report the number of serious incidents reported are prior to the RCA process being completed.

## Overall Serious Incidents

### Number Serious Incidents Reported (Trust & Divisions)



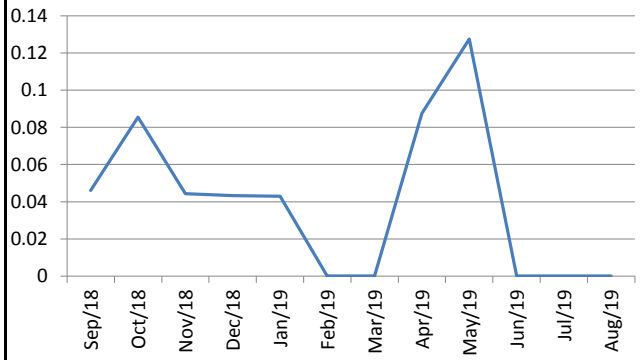

### Serious Incidents per 1000 occupied bed days



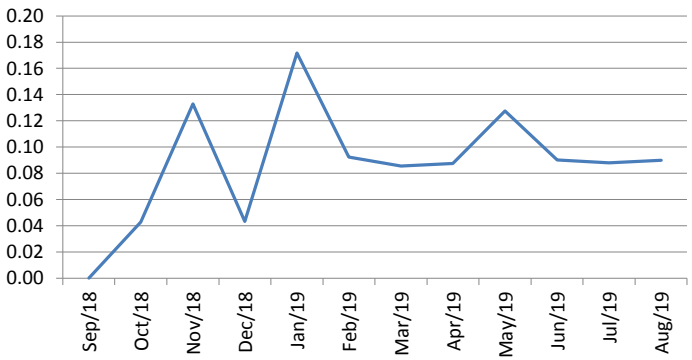

| | | | |
|---|---|---|---|
| Current YTD reported SI's (April-July 19) | 26 | Number reported SI's (Apr-July 18) | 18 |
| Current YTD delogged SI's (April-July19) | 1 | Number delogged SI's (Apr-July 18) | 0 |

## Themes

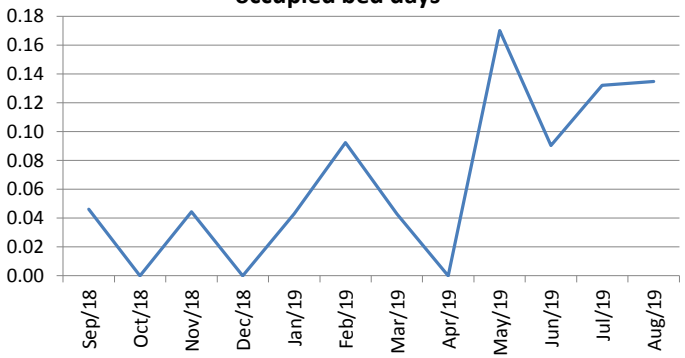
### Serious Falls per 1000 occupied bed days




### Care Issues per 1000 occupied bed days



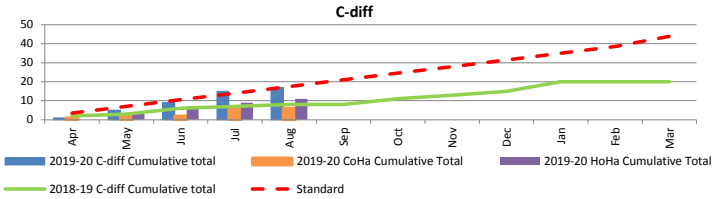

### Pressure Ulcers - Cat 3 & 4 (HAPU) per 1000 occupied bed days

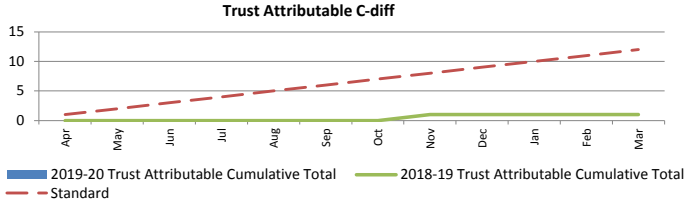


## Infection Control C.Diff - August 2019 (Month 5)
## (Data accurate as at 06/09/2019)

| | Standard | Qtr 1 | Jul | Aug | Sep | Qtr 2 | YTD |
|---|---|---|---|---|---|---|---|
| 2019-20 Infection Control - C-diff | 44 Full Year | 9 | 6 | 2 | | 8 | 17 |
| 2018-19 Infection Control - C-diff | 39 Full Year | 6 | 1 | 1 | | 2 | 8 |
| 2019-20 Trust Attributable | 12 | 0 | 0 | 0 | | 0 | 0 |
| 2018-19 Trust Attributable | 12 | 0 | 0 | 0 | | 0 | 0 |

| | Qtr 1 | Jul | Aug | Sep | Qtr 2 | YTD |
|---|---|---|---|---|---|---|
| HOHA | 7 | 2 | 2 | | 4 | 11 |
| COHA | 2 | 4 | 0 | | 4 | 6 |

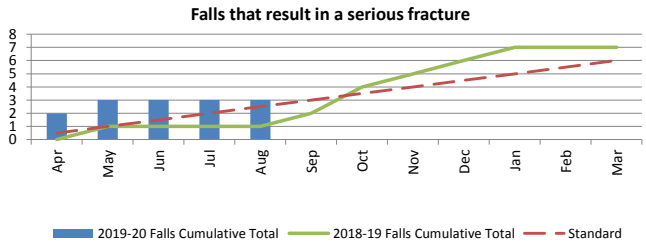



## Pressure Ulcers & Falls that result in a serious fracture - August 2019 (Month 5)
## (Data accurate as at 06/09/2019)

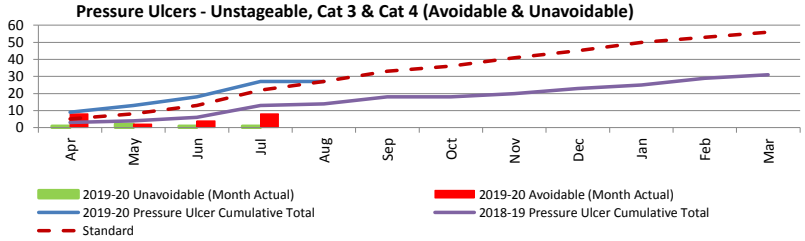
| | Standard | Qtr 1 | Jul | Aug | Sep | Qtr 2 | YTD |
|---|---|---|---|---|---|---|---|
| 2019-20 Serious Falls | 6 Full Year | 3 | 0 | 0 | | 0 | 3 |
| 2018-19 Serious Falls | 10 Full Year | 2 | 0 | 0 | | 0 | 2 |

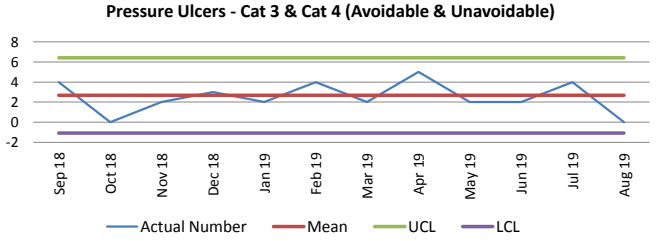
**Please note:** At the time of producing this report the number of serious falls reported are prior to the RCA process being completed.




| | Standard | Apr | May | Jun | Qtr 1 | Jul | Aug | Sep | Qtr 2 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|
| 2019-20 Pressure Ulcers (Unstageable, Cat 3 & Cat 4) | 56 Full Year | 9 | 4 | 5 | 18 | 9 | 0 | | 9 | 27 |
| 2018-19 Pressure Ulcers | 21 Full Year | 3 | 1 | 2 | 6 | 7 | 1 | | 8 | 14 |
| 2019-20 Pressure Ulcers - **UNAVOIDABLE** (Unstageable, Cat 3 & Cat 4) | | 1 | 0 | 1 | 2 | 1 | 0 | | 1 | 3 |
| 2019-20 Pressure Ulcers - **AVOIDABLE** (Unstageable, Cat 3 & Cat 4) | | 8 | 4 | 4 | 16 | 8 | 0 | | 8 | 24 |

**Please note:** At the time of producing this report they are 10 PU's still subject to the RCA process.



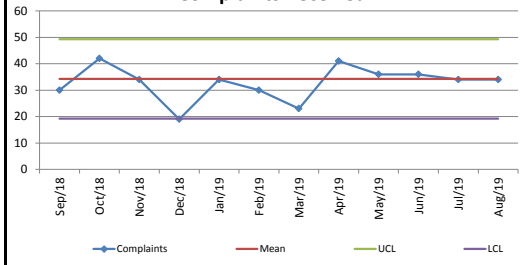



# Complaints & Claims - August 2019 (Month 5)

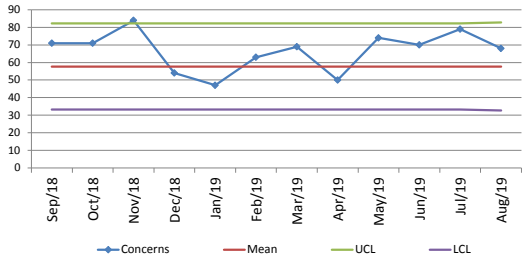
Data accurate as at 06/09/2019

## Complaints

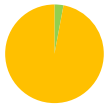
### Complaints Received



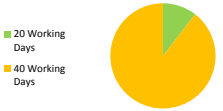

### Concerns Received




### August 2019 Complaints Received Risk Breakdown

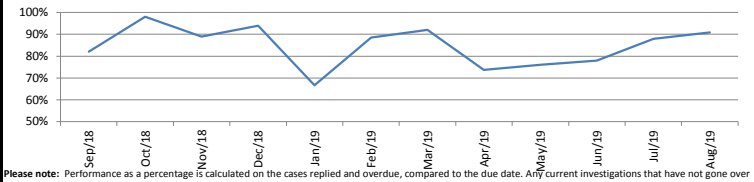


### Year to Date Complaints Received Risk Breakdown




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

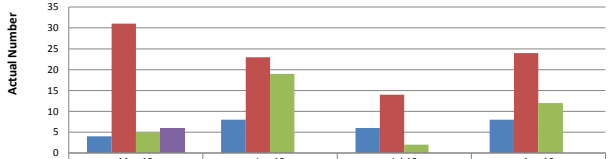
### Complaints Resolution Performance




**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.

## Complaints Closed - Outcome

### Closed Complaints - Outcomes




| | May-19 | Jun-19 | Jul-19 | Aug-19 |
|---|---|---|---|---|
| Complaints Upheld | 4 | 8 | 6 | 8 |
| Complaints Partially upheld | 31 | 23 | 14 | 24 |
| Complaints not upheld | 5 | 19 | 2 | 12 |
| Outcome not reported | 6 | 0 | 0 | 0 |

## Parliamentary Health Service Ombusdman (PHSO)

| Month | Number of cases referred for investigation | Number Currently Outstanding |
|---|---|---|
| Aug-19 | 0 | 4 |

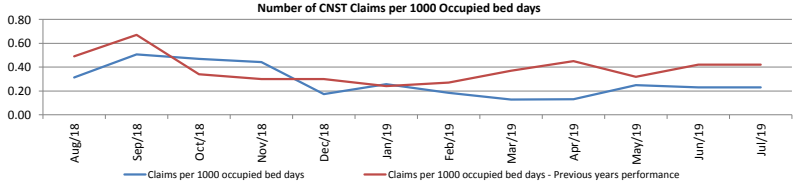
| | Number referred for investigation YTD | Outcomes YTD | |
|---|---|---|---|
| 2017/18 | 7 | Fully / Partially Upheld | 3 |
| | | Not Upheld | 1 |
| | | No further Investigation | 0 |
| | | Case Withdrawn | 0 |
| | | Not Investigated | 3 |
| | | Outstanding | 0 |
| 2018/19 | 9 | Fully / Partially Upheld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

## 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 | 4 | 4 | 10 | 7 | 8 | | | | | | | | 33 |
| | 2018/19 | 10 | 7 | 9 | 6 | 7 | 11 | 11 | 4 | 10 | 6 | 4 | 3 | 88 |
| Liabilities to Third Parties Scheme (LTPS) | 2019/20 | 5 | 4 | 1 | 4 | 0 | | | | | | | | 14 |
| | 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 - August 2019 (Month 5)

(Data accurate as at 13/09/2019)

| | | | | | | Planned v Actual | | Safe | Effective | Caring | Responsive | Well Led |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DIVISION | Ward | WARD | No of | Work- | Quality | CHPPD | Variance | Total score | Total score | Total score | Total | Total score |
| Surgery & Cancer | HD | B5 | 24.0 | | 6.5 | 6.5 | 97% | 3.0 | 0.0 | 1.0 | 3.5 | 2.5 |
| | JW | B6 | 21 | | 9.5 | 6.3 | 93% | 5.0 | 2.0 | 0.5 | 2.5 | 2.0 |
| | AK | St Leger | 35 | | 5.0 | 6.2 | 96% | 0.5 | 1.0 | 1.5 | 1.0 | 2.0 |
| | VB | 1&3 | 23 | | 7.0 | 8.1 | 96% | 2.0 | 1.5 | 1.5 | 2.0 | 2.0 |
| | SB | 20 | 27 | | 6.0 | 5.3 | 107% | 0.0 | 1.0 | 4.0 | 1.5 | 1.0 |
| | RW | 21 | 27 | | 5.0 | 5.1 | 108% | 1.5 | 1.0 | 1.0 | 2.0 | 1.5 |
| | FN | S10 | 20 | | 6.0 | 5.3 | 98% | 1.0 | 0.5 | 1.0 | 2.0 | 3.5 |
| | JP | S11 | 19 | | 6.5 | 6.4 | 108% | 3.0 | 0.0 | 1.0 | 3.0 | 2.5 |
| | HB | S12 | 16 | | 2.0 | 5.9 | 101% | 0.5 | 0.5 | 0.0 | 2.0 | 1.0 |
| | SS | SAW | 21 | | 10.0 | 7.6 | 100% | 3.0 | 0.5 | 4.5 | 2.5 | 2.0 |
| | | | | | | | 100% | | | | | |
| Medicine | SM | A4 | 22 | | 8.0 | 6.8 | 107% | 3.5 | 1.5 | 1.5 | 0.0 | 1.5 |
| | MC | C1 | 16 | | 9.0 | 7.0 | 124% | 3.5 | 3.0 | 1.5 | 2.0 | 1.0 |
| | KD | CCU/C2 | 18 | | 7.0 | 6.4 | 103% | 2.0 | 1.5 | 0.5 | 1.0 | 3.0 |
| | SC | ATC | 21 | | 6.0 | 7.9 | 101% | 2.5 | 1.0 | 0.5 | 2.0 | 2.0 |
| | ZC&KJ | AMU | 40 | | 9.5 | 9.5 | 99% | 5.0 | 1.0 | 1.5 | 2.0 | 2.0 |
| | LB | FAU | 16 | | 5.5 | 8.4 | 100% | 2.0 | 1.0 | 1.0 | 1.0 | 1.5 |
| | JB | 16 | 24 | | 6.5 | 9.1 | 94% | 3.0 | 1.5 | 1.0 | 3.0 | 1.0 |
| | JW | 17 | 16 | | 8.5 | 7.7 | 101% | 1.5 | 2.0 | 3.5 | 2.5 | 1.5 |
| | AB | 18 Haem | 12 | | 3.5 | 7.7 | 106% | 1.0 | 0.5 | 1.0 | 1.0 | 1.0 |
| | LS | 18 CCU | 12 | | 7.5 | 7.2 | 95% | 1.0 | 0.5 | 3.5 | 2.0 | 2.5 |
| | MN | 24 | 24 | | 5.5 | 7.2 | 112% | 1.0 | 1.5 | 1.5 | 2.5 | 1.5 |
| | DF | 25 | 16 | | 7.5 | 10.8 | 151% | 1.5 | 2.5 | 1.5 | 2.5 | 2.0 |
| | TM&JC | Respiratory unit | 52 | | 12.5 | 6.3 | 99% | 5.5 | 2.5 | 2.5 | 2.0 | 2.0 |
| | TM | 32 | 18 | | 11.0 | 7.1 | 104% | 2.0 | 1.0 | 5.0 | 1.5 | 3.0 |
| | LAS | Mallard | 16 | | 3.5 | 8.0 | 100% | 1.5 | 0.0 | 0.5 | 2.0 | 1.5 |
| | RM | Gresley | 32 | | 5.5 | 5.8 | 99% | 1.5 | 2.5 | 0.5 | 1.5 | 1.0 |
| | EW | Rehab 2 | 18 | | 5.0 | 6.0 | 110% | 0.0 | 0.5 | 3.5 | 2.5 | 1.0 |
| | GW | Rehab 1 | 29 | | 7.5 | 5.2 | 113% | 2.5 | 0.5 | 3.0 | 1.5 | 1.5 |
| | | | | | | | 105% | | | | | |
| Clinical Speciality Services | LC | ITU DRI | 20 | | 5.0 | 23.8 | 95% | 1.0 | 0.0 | 3.5 | 1.5 | 0.5 |
| | LW | ITU BDGH | 6 | | 1.0 | 27.7 | 98% | 0.5 | 0.0 | 0.0 | 0.5 | 0.5 |
| | | | | | | | 95% | | | | | |
| Children and Families | CD | SCBU | 8 | | 0.5 | 34.2 | 97% | | | | | 0.5 |
| | IB | NNU | 18 | | 0.5 | 9.6 | 97% | | | | | 0.5 |
| | EJ | CHW | 18 | | 0.5 | 9.7 | 98% | | | | | 0.5 |
| | LM | CHOU | 12 | | 0.0 | 12.2 | 98% | | | | | 0.0 |
| | KR | G5 | 16 | | 9.5 | 6.6 | 89% | 1.0 | 0.5 | 4.5 | 2.5 | 3.5 |
| | TM | M1 | 24 | | 5.0 | 7.6 | 81% | 0.0 | 4.5 | 0.5 | 2.5 | 0.0 |
| | RW | M2 | 18 | | 5.5 | 7.6 | 88% | 0.0 | 4.5 | 0.5 | 2.0 | 0.5 |
| | SR | CDS | 14 | | 2.5 | 26.2 | 86% | 0.5 | 1.5 | 0.0 | 2.0 | 0.5 |
| | KC | A2 | 18 | | 4.5 | 7.6 | 92% | 1.5 | 2.5 | 0.0 | 2.5 | 0.5 |
| | KC | A2L | 6 | | 2.0 | 30.8 | 94% | 0.0 | 0.0 | 1.5 | 2.5 | 0.5 |
| | | | | | | | 91% | | | | | |
| | | | | | | | 101% | | | | | |

The key area this month has been the staffing issues with maternity. Currently we have 30 vacancies across both sites and community.

19 midwifes are due to commence on the 21st of October. This leaves 11 vacancies.

In order to address the vacancies the new registrants have been offered band 3 posts prior to commencing.

Working with the midwives we have advertised core specific roles rather than all rotations to attract midwives who wish to work in specific areas.

There is a robust action plan in place which addresses physical space, processes and recruitment and retention.

# Care Hours Per Patient Day (CHPPD) - August 2019 (Month 5)

**(Data accurate as at 14/09/2019)**

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

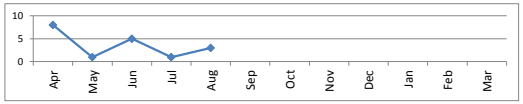
| Site Name | Registered midwives/ nurses | Care Staff | Reg NA | Non Reg NA | Overall |
|---|---|---|---|---|---|
| BASSETLAW HOSPITAL | 4.71 | 3.46 | 0.00 | 0.00 | 8.17 |
| DONCASTER ROYAL INFIRMARY | 4.30 | 3.49 | 0.00 | 0.09 | 7.79 |
| MONTAGU HOSPITAL | 2.17 | 3.32 | 0.00 | 0.00 | 5.49 |
| **TRUST** | 4.24 | 3.47 | 0.00 | 0.07 | 7.71 |

CHPPD is currently being reviewed across all sites. Especially in relation to care staff hours. A full report will to available as part of the overall workforce plan in November.

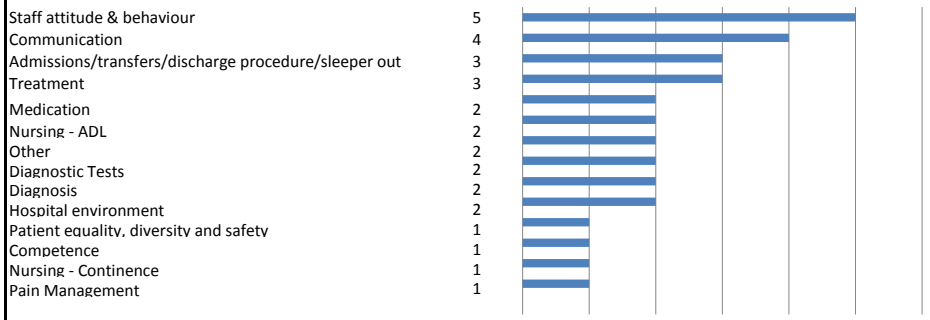
# Childrens & Young People - Quality Metrics
## August 2019 (Month 5)
(Data accurate as at 06/09/2019

## Complaints

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of complaints received - 2019/20 | 8 | 1 | 5 | 1 | 3 | | | | | | | | 18 |
| 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)




The main complaint theme is “Staff Attitude and Behaviour” (16.1%), which breaks down to Abruptness/rudeness (1),Conduct/disposition (1) and Insensitive to needs/unhelpful (1), Inappropriate comments (1) and an allegation of rough patient handling (1). The second joint main complaint theme is around “Communication” (11.1%), which breaks down into Lack of information to relatives (3) and “Admission/Transfer/Discharge procedures” which breaks down into Unacceptable time to wait for appointment (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 | 33 | 29 | | | | | | | | 160 |
| 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 | 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.

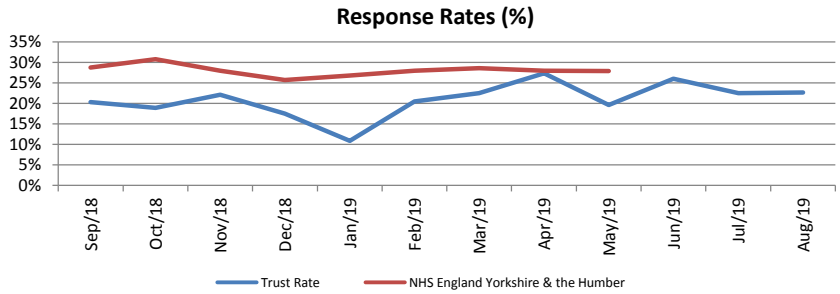
Please note: An incident which has caused moderate, severe or patient death requires DoC to be completed

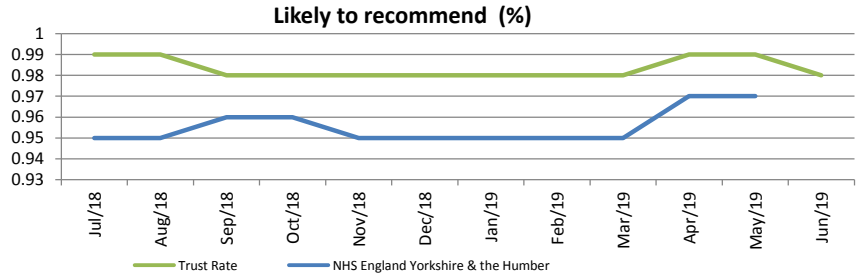
# Friends & Family - August 2019 (Month 5)

**(Data accurate as at 06/9/2019)**

## Inpatients

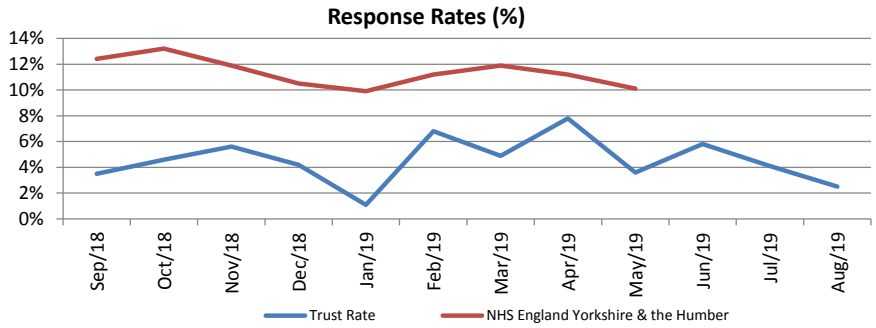
**Please note:** At the time of producing this report no further benchmarking data is available from NHS England.

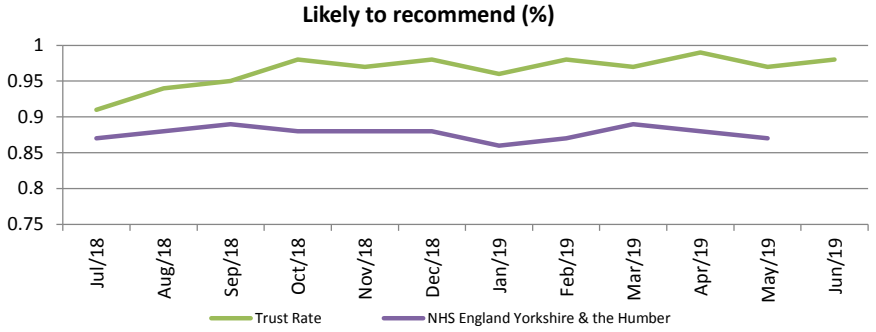



## Accident & Emergency

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



Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

# Executive summary - Workforce - August 2019 (Month 5)

**Sickness absence**

Due to an ESR reporting issue it has not been possible to provide August data - the data provided is therefore July 2019. The rate in July was 4.28% with a cumulative figure of 4.36% which comparable to the same period last year. Absences in excess of 28 days and 6 months both saw a reduction from the previous month.

**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 were aware that some services had to extend the period to take account of services pressures. The data at the end of August indicates that we have achieved 85.69% compliance during the appraisal season and 83.53% compliance on a 12 month rolling period. All areas have been reminded that anyone who has not had an appraisal should be scheduled. We have a target of 90% - in calculating compliance staff on maternity leave, career breaks, external secondments and long term sickness are excluded.

**SET**

SET compliance has seen an ongoing increase and is now at 87.65% as at the end of August 2019 which demonstrates excellent progress. Compliance rates are calculated in the same way as above.

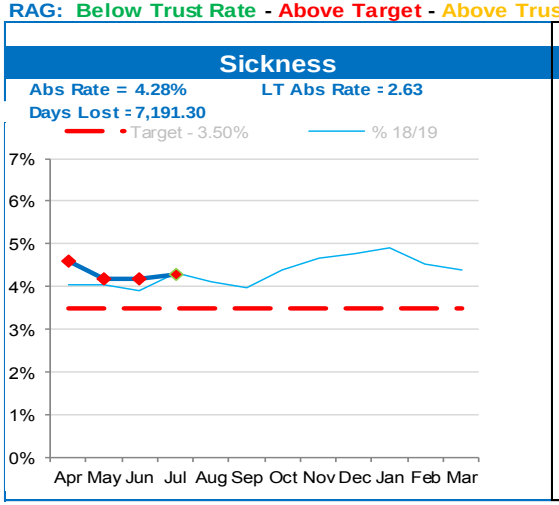
**Staff in post**

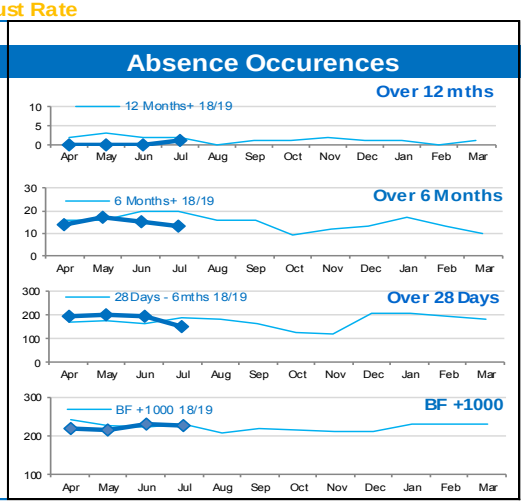
Staff in post by staff group is shown as at month 5 with similar levels of staff in post.

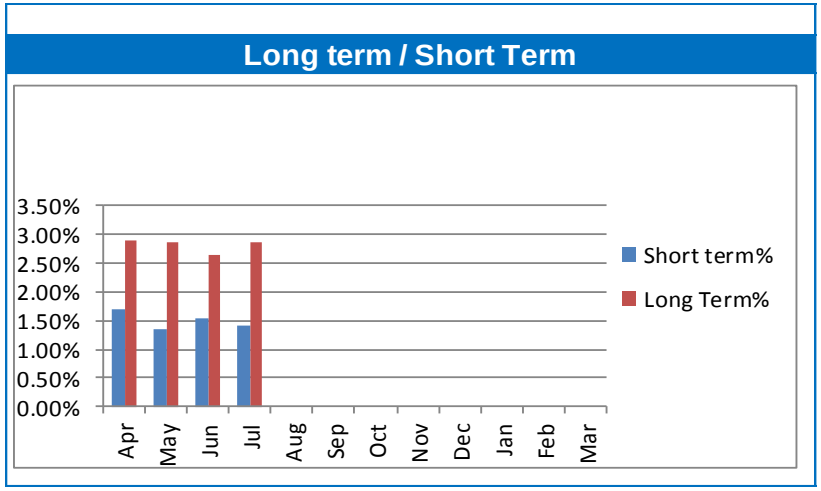
# Workforce: Sickness Absence - July (Month 4)

## CG & Directorate Sickness Absence - July 2019 (Q2)

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



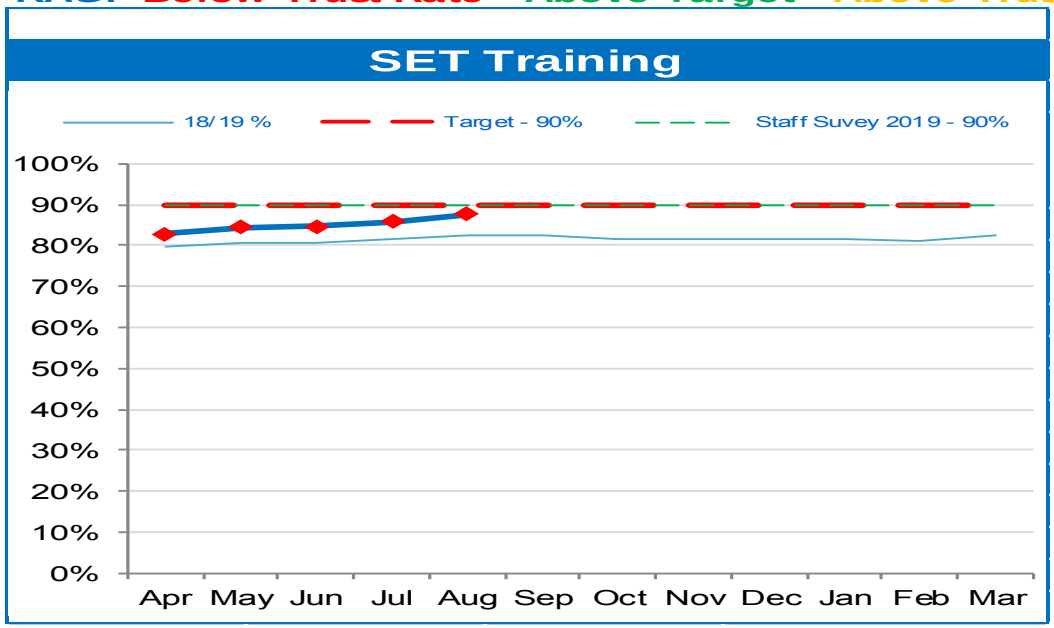

| | Apr-19 | | May-19 | | Jun-19 | | Jul-19 | | Cumulative | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Days Lost | % Rate | Days Lost | % Rate | Days Lost | % Rate | Days Lost | % Rate | Days Lost | % Rate |
| **Doncaster & Bassetlaw Teaching Hospitals NHS FT** | **7472.02** | **4.59%** | **7048.71** | **4.19%** | **6,804.81** | **4.18%** | **7,191.30** | **4.28%** | **28,833.53** | **4.36%** |
| Chief Executive Directorate | 0.00 | 0.00% | 0.00 | 0.00% | 3.00 | 0.57% | 0.00 | 0.00% | **36.00** | **1.75%** |
| Children & Families Division | 1071.72 | 6.17% | 760.56 | 4.22% | 859.39 | 4.93% | 903.82 | 5.02% | **3,702.01** | **5.23%** |
| Clinical Specialist Division | 2022.81 | 4.88% | 2007.09 | 4.62% | 1,703.88 | 4.04% | 1,848.87 | 4.25% | **7,521.45** | **4.40%** |
| Directorate Of Strategy & Improvement | 16.19 | 5.16% | 3.73 | 1.21% | 4.00 | 1.44% | 0.00 | 0.00% | **23.92** | **1.98%** |
| Estates & Facilities | 955.75 | 6.82% | 954.29 | 6.76% | 838.10 | 6.22% | 710.33 | 5.10% | **3,277.07** | **5.90%** |
| Executive Team Board | 54.00 | 2.13% | 40.00 | 1.55% | 81.40 | 3.31% | 65.00 | 2.51% | **255.40** | **2.47%** |
| Finance & Healthcare Contracting Directorate | 13.97 | 0.34% | 10.27 | 0.25% | 86.61 | 2.12% | 99.63 | 2.36% | **314.37** | **1.90%** |
| IT Information & Telecoms Directorate | 30.23 | 1.55% | 32.84 | 1.68% | 20.92 | 1.05% | 1.00 | 0.05% | **90.30** | **1.13%** |
| Medical Director Directorate | 0.00 | 0.00% | 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% | 1,975.55 | 4.51% | **7,192.63** | **4.15%** |
| Nursing Services Directorate | 59.12 | 2.84% | 16.90 | 0.79% | 11.80 | 0.56% | 49.31 | 1.94% | **156.49** | **1.54%** |
| People & Organisational Directorate | 142.80 | 4.36% | 87.52 | 2.52% | 97.35 | 2.84% | 186.33 | 5.27% | **576.11** | **4.20%** |
| Performance Directorate | 288.54 | 5.68% | 285.40 | 5.46% | 259.95 | 4.96% | 205.20 | 3.78% | **1,066.47** | **5.14%** |
| Surgery & Cancer Division | 1069.25 | 4.06% | 1247.56 | 4.57% | 1,134.23 | 4.28% | 1,146.25 | 4.17% | **4,621.32** | **4.28%** |

| | Apr-19 | | May-19 | | Jun-19 | | Jul-19 | | Cumulative | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Days Lost | % Rate | 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%** | **7,191.30** | **4.28%** | **28,833.53** | **4.36%** |
| Add Prof Scientific and Technic | 290.19 | 5.75% | 283.59 | 5.44% | 117.98 | 2.36% | 127.89 | 2.49% | **790.65** | **3.88%** |
| Additional Clinical Services | 2202.11 | 6.27% | 2267.64 | 6.21% | 1,888.27 | 5.31% | 2,245.04 | 6.14% | **8,585.91** | **5.98%** |
| Administrative and Clerical | 1226.32 | 3.90% | 961.43 | 2.94% | 1,134.26 | 3.54% | 1,077.69 | 3.23% | **4,828.59** | **3.72%** |
| Allied Health Professionals | 145.04 | 1.51% | 244.07 | 2.47% | 189.86 | 2.01% | 154.65 | 1.60% | **767.00** | **1.99%** |
| Estates and Ancillary | 984.09 | 6.92% | 1016.50 | 7.13% | 964.81 | 7.09% | 839.83 | 5.99% | **3,623.14** | **6.47%** |
| Healthcare Scientists | 84.80 | 2.34% | 74.84 | 1.99% | 64.35 | 1.77% | 63.25 | 1.69% | **287.05** | **1.94%** |
| Medical and Dental | 275.00 | 1.65% | 276.48 | 1.60% | 345.95 | 2.08% | 309.36 | 1.81% | **1,341.79** | **1.99%** |
| Nursing and Midwifery Registered | 2264.47 | 4.80% | 1924.17 | 3.95% | 2,099.33 | 4.47% | 2,373.58 | 4.91% | **8,609.40** | **4.50%** |
| Students | 0.00 | 0.00% | 0.00 | 0.00% | 0.00 | 0.00% | 0.00 | 0.00% | 0.00 | 0.00% |

# Workforce: SET Training - August (Month 5)

## CG & Directorate SET Training - August 2019 (Q2)

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

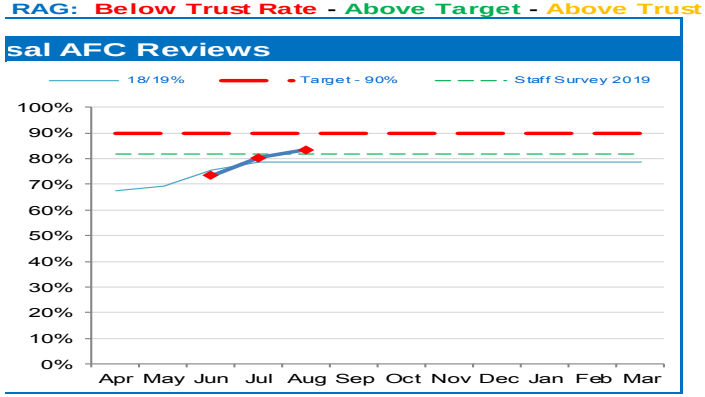



| | % Compliance |
|---|---|
| **Doncaster & Bassetlaw Teaching Hospitals NHS FT** | **87.65%** |
| Chief Executive Directorate | **96.10%** |
| Children & Families Division | **86.66%** |
| Clinical Specialist Division | **89.35%** |
| Directorate Of Strategy & Improvement | **94.81%** |
| Estates & Facilities | **87.38%** |
| Finance & Healthcare Contracting Directorate | **95.88%** |
| IT Information & Telecoms Directorate | **90.73%** |
| Medical Director Directorate | **90.91%** |
| Medicine Division | **86.82%** |
| Nursing Services Directorate | **93.40%** |
| People & Organisational Directorate | **97.25%** |
| Performance Directorate | **85.85%** |
| Surgery & Cancer Division | **84.07%** |

# Workforce: Appraisals -August (Month 5)

## CG & Directorate Appraisals - August 2019 (Q2)

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




### AFC 12 Months (NHSI)

| | % Completed |
|---|---|
| **Doncaster & Bassetlaw Teaching Hospitals NHS FT** | **83.53** |
| Chief Executive Directorate | 92.31 |
| Children & Families Division | 70.42 |
| Clinical Specialist Division | 87.73 |
| Directorate Of Strategy & Improvement | 100.00 |
| Estates & Facilities | 89.27 |
| Finance & Healthcare Contracting Directorate | 98.36 |
| IT Information & Telecoms Directorate | 97.01 |
| Medical Director Directorate | 100.00 |
| Medicine Division | 78.95 |
| Nursing Services Directorate | 91.01 |
| People & Organisational Directorate | 95.19 |
| Performance Directorate | 91.39 |
| Surgery & Cancer Division | 80.96 |

### M&D 12 Months (NHSI)

| | % Completed |
|---|---|
| **Doncaster & Bassetlaw Teaching Hospitals NHS FT** | **65.74** |
| Chief Executive Directorate | 100.00 |
| Children & Families Division | 56.10 |
| Clinical Specialist Division | 69.74 |
| Medical Director Directorate | 66.67 |
| Medicine Division | 73.08 |
| Surgery & Cancer Division | 59.79 |

### M&D 15 Months

| | % Completed |
|---|---|
| **Doncaster & Bassetlaw Teaching Hospitals NHS FT** | **71.56** |
| Chief Executive Directorate | 100.00 |
| Children & Families Division | 60.98 |
| Clinical Specialist Division | 75.00 |
| Medical Director Directorate | 66.67 |
| Medicine Division | 77.88 |
| Surgery & Cancer Division | 66.32 |

# Workforce: Appraisals Seasonal - August (Month 5)

## CG & Directorate Seasonal Appraisals - July 2019 (Q2)

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

| | % Completed |
|---|---|
| **Doncaster & Bassetlaw Teaching Hospitals NHS FT** | **85.69** |
| Chief Executive Directorate | **100.00** |
| Children & Families Division | **69.39** |
| Clinical Specialist Division | **90.93** |
| Directorate Of Strategy & Improvement | **100.00** |
| Estates & Facilities | **81.92** |
| Finance & Healthcare Contracting Directorate | **94.93** |
| IT Information & Telecoms Directorate | **97.18** |
| Medical Director Directorate | **100.00** |
| Medicine Division | **86.00** |
| Nursing Services Directorate | **95.00** |
| People & Organisational Directorate | **100.00** |
| Performance Directorate | **91.45** |
| Surgery & Cancer Division | **83.18** |

# Workforce: Staff in post -August (Month 5)

| | 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** | **Sep-18** | | **Oct-18** | | **Nov-18** | | **Dec-18** | | **Jan-19** | | **Feb-19** | | **Mar-19** | | **Apr-19** | | **May-19** | | **Jun-19** | | **Jul-19** | | **Aug-19** | |
| Add Prof Scientific and Technic | 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 | 165.19 | 183.00 | 167.16 | 184.00 |
| Additional Clinical Services | 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 | 1,182.27 | 1,432.00 | 1,167.33 | 1,418.00 |
| Administrative and Clerical | 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 | 1,076.87 | 1,299.00 | 1,082.98 | 1,306.00 |
| Allied Health Professionals | 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 | 315.25 | 368.00 | 320.09 | 372.00 |
| Estates and Ancillary | 474.36 | 678.00 | 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 | 452.10 | 653.00 | 452.10 | 655.00 |
| Healthcare Scientists | 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 | 120.53 | 137.00 | 121.53 | 138.00 |
| Medical and Dental | 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 | 549.81 | 582.00 | 564.12 | 599.00 |
| Nursing and Midwifery Registered | 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 | 1,560.07 | 1,826.00 | 1,555.97 | 1,821.00 |
| Students | 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 | 0.00 | 0.00 | 0.00 | 0.00 |
| **Grand Total** | **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** | **5,422.09** | **6,482.00** | **5,426.06** | **6,486.00** |

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Title** | People & Organisational Development update – Leadership Development, Staff Experience, Freedom to Speak Up | | |
| **Report to** | Board of Directors | **Date** | September 2019 |
| **Author** | Karen Barnard, Director of People & Organisational Development<br>Jayne Collingwood, Head of Leadership & OD<br>Emma Shaheen, Head of Communications & Engagement<br>Paula Hill, Freedom to Speak Up Guardian | | |

| **Purpose** | | Tick one as appropriate |
|---|---|---|
| | Decision | |
| | Assurance | x |
| | Information | x |

**Executive summary containing key messages and issues**

In our True North statement our ambition is clear **'We aim to be in the top 10% of Trusts for staff feedback in the next five years'** with a break through objective this year of being above average for staff feedback. Instrumental in achieving this objective is the culture of the organisation, how staff feel about working within DBTH and how they are led. This report provides an update on the work of the Leadership & OD team in their first year of operation, progress against the staff survey action plan (and results of quarter one of the staff friends and family test which indicated an improvement in the nine staff engagement questions) and an update on the guidance in relation to freedom to speak up along with the work of the newly appointed Freedom to Speak Up Guardian.

The purpose of the Leadership &OD Team is to enable and facilitate the delivery of our vision 'To be the Safest Trust in England, Outstanding in all that we do', to foster compassionate and inclusive leadership and to achieve this by supporting and developing colleagues to be the best they can be. We recognise that members of Team DBTH are our greatest asset and we are entirely committed to support, enable and empower them to Develop, Belong, Thrive, Here within our organisation. We want to create a positive, inclusive and people-centred culture that engages and inspires all our people, with a clear focus on improvement and equality of opportunity. We want our people to feel connected and a sense of belonging to 'Team DBTH'. The report details the success the team have had in introducing a leadership development programme ranging from soundbites on specific topics through to the Leading to Outstanding programme. These programmes will continue to evolve into next year.

Members of the Board will recall the priorities of our staff survey action plan of:

- Living our Values
- Involvement
- Visibility of leaders
- Wellbeing into Action

- Leading to Outstanding
- Accountability.

The paper details progress against the action plan and the results from the quarter one staff friends and family test – this survey focused on the nine questions that make up the staff engagement score. As a Trust there were improvements against all nine of those questions with the most improved area, aside from receiving care, being 'the ability to make improvements in my area of work' scoring a 12.4% uplift.

Paula Hill has recently joined DBTH as Freedom to Speak Up Guardian – the paper provides and update on refreshed guidance received from the National Guardian's office including a reminder of the remit of the Non Executive and Executive Director leads. Paula is currently developing the FTSU strategy (and refreshing the policy) in consultation with colleagues which will come to Board in November for approval along with the annual report.

**Key questions posed by the report**

Is the Board assured that the update reported will contribute to the achievement of our True North ambition of being above average for staff feedback in 2019/20?

**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. (iii) Increased staff sickness levels

**Recommendation(s) and next steps**

The Board is asked to note and take assurance from this report.

# Leadership Development

**The Doncaster and Bassetlaw Teaching Hospitals Leadership and Organisational Development team was formed in September 2018 and this report provides an opportunity for the Trust to reflect upon the past 12 months and evaluate and summarise the work delivered by the team.**

Throughout the past number of years, we have received feedback from colleagues about the need for a Leadership Development programme, I pleased to reflect upon a successful first, and founding, 12 months for the new team. The Head of Leadership and Organisational Development, Jayne Collingwood, took up the post in September 2018 and as such the Leadership and Organisational Development (L&OD) team was created.

The purpose of the L&OD Team is to enable and facilitate the delivery of our vision 'To be the Safest Trust in England, Outstanding in all that we do', to foster compassionate and inclusive leadership and to achieve this by supporting and developing colleagues to be the best they can be. We recognise that members of Team DBTH are our greatest asset and we are entirely committed to support, enable and empower them to Develop, Belong, Thrive, Here within our organisation. We want to create a positive, inclusive and people-centred culture that engages and inspires all our people, with a clear focus on improvement and equality of opportunity. We want our people to feel connected and a sense of belonging to 'Team DBTH'.

The NHS Long Term plan and the Interim People Plan acknowledge there is compelling evidence that the more engaged our people are, the more effective and productive they are, and most importantly, the higher the quality of care they deliver to patients. The plan sets out the vision for people who work for the NHS and clearly focuses on the actions needed to deliver the vision:

- We need different people in different professions working in different ways.
- Cultural changes are needed to build a workforce that befits a world-class 21st century healthcare system.
- Promotion of positive cultures, to build a pipeline of compassionate and engaging leaders.
- Make the NHS an agile, inclusive and modern employer
- Attract, retain and develop the people we need to deliver the NHS long Term plan.
- Improve technology to organise and plan services differently.
- Enable our people to work to their full potential.

This long term vision for the NHS is the strategic driver which informs and shapes the work of the Leadership and OD Team.

I commend the report appended to this paper to the Board of Directors and wider Trust colleagues about our achievements within this area throughout the past year.

# Staff Survey and Staff Experience Update

In our True North statement our ambition is very clear:

**'We aim to be in the top 10% of Trusts for staff feedback in the next five years'**

This is absolutely critical to our vision to become the safest trust in England, outstanding in all we do. Every member of Team DBTH has a part to play and how every member thinks and feels about working here is incredibly important. Our patients tell us clearly that they want the staff who look after them to be well cared for themselves. This is consistent with, and at the heart of, our DBTH Trust values, 'We Care'.

The National NHS Staff Survey is the best tool at our disposal in order understand whether our staff feel well cared for at work and whether they feel a sense of belonging, describing the culture of the workplace and whether we are living out our 'We Care' values.

The NHS People Plan acknowledges the highly committed and dedicated people working for the NHS who provide an extraordinary range of health and care services for patients and citizens. There is compelling evidence that the more engaged our people, the more effective and productive they are, and most importantly, the higher the quality of care they deliver to our patients. There is a direct correlation between levels of staff engagement and patient mortality rates (Reducing patient mortality in hospitals: The Role of human resource management Michel A. West1*, James P. Gutherie2, Jeremy F. Dawson1 et al 2006).

The results from 2018 National NHS staff survey were shared widely with our leadership teams in order for local level action plans to be developed based on what staff said are the main issues in their local areas. This is in addition to the Trust level action plan.

The results are captured into themes which are equality, diversity & inclusion, health & wellbeing, immediate managers, morale, quality of appraisals, quality of care, safe environment – bullying & harassment, safe environment – violence, safety culture and staff engagement. In March 2019 the Trust Board agreed that the priority areas of focus at Trust level would be:

- Living our Values
- Involvement
- Visibility of leaders
- Wellbeing into Action
- Leading to Outstanding
- Accountability.

The table below presents an update against the Staff Survey Report Action Plan which was presented previously to Board of Directors and QEC.

| Theme | Action | Timescale | Lead | Status Update |
|---|---|---|---|---|
| Living the Values | Induction programme reviewed to incorporate Trust Values | Q1 | Head of Leadership & OD | Complete/ ongoing<br>The We Care Values are an integral part in all Leadership development programmes and a stand-alone soundbite has been dedicated to values and behaviours |
| | Integrate our We Care values into our communication methods to ensure we demonstrate that our values are at the heart of how we lead the Trust | Q1 | Head of Communications | Complete/ ongoing |
| QI | Qi programme of work | Ongoing | Director of Strategy & Improvement | QI is embedded in all our Leadership Programmes such as Leading to Outstanding<br>Over 2,000 staff are trained in our Qi way<br>More than 300 staff are now involved in over 190 improvement projects |
| | Pulse check of staff involved in Qi programmes of improvement (before and after) | Each Quarter | Head of Qi | Ongoing |
| | Include stock set of questions from staff survey in quarterly staff friends and family test in order to gauge the feeling of staff on a regular basis | | Head of Leadership & OD | Results from the last staff FFT there was over a 12% increase in respondents positively stating “I am able to make improvements in my area of work” |

| Theme | Action | Timescale | Lead | Status Update |
|---|---|---|---|---|
| Leading to Outstanding | Implement the Leadership development suite of programmes including the senior leaders programme Leading to Outstanding | Q1 | Head of Leadership & OD,<br>Head of Qi | Leading to Outstanding programme running for Division and Corporate areas with 32 people in the programme. Extremely positive feedback established with programme participants driving and developing the agenda. |
| | Shadow Board programme introduced | Q1 | Head of Leadership & OD | Shadow Board programme opened to competitive application process with an oversubscription. 16 members of senior/ deputy director level colleagues on the programme. Two modules completed looking at strategy, governance, finance and accountability |
| | Moving forward programme for BAME staff | Q3 | Head of Leadership & OD | In planning stages, delivery dates to be agreed |
| Visibility of leaders | All leaders will be required to visit their areas on a regular basis. In addition Executive Directors will undertake a programme of visits to their 'buddy' areas. Feedback will be provided to Management Board on a quarterly basis | Ongoing<br>Quarterly feedback | Divisional & corporate leadership teams<br>Executive Directors | Gemba visits are a key part of Leading to Outstanding programme. Executive Gemba visits taking place as part of Qi executive coaching. Divisions reporting visits to the Gemba as part of the approach to improving staff engagement |
| | Establishment of staff experience groups within divisions and directorates to be complemented with Trust wide group to be chaired by the Chief Executive | Q1<br>Commenced | Leadership teams/ P&OD | Trust wide Staff Engagement Forum established with two meetings taken place at DRI and one at Bassetlaw (the next scheduled in October). Key themes identified and discussed at the forum included acknowledgment and recognition. Specifically retirement, Long service and hygiene factors like breaks, water, facilities, places to eat lunch |

| Theme | Action | Timescale | Lead | Status Update |
|---|---|---|---|---|
| | Fortnightly blog from Chief Executive to share with staff his thoughts and activities | Q1 commenced | Chief Executive | The blog is in place and receives online engagement and positive feedback at the Gemba. The blog has been replicated in the Division of Medicine with podcasts in People & OD and Clinical Specialties |
| Wellbeing into Action | Seek feedback from staff through divisional/directorates on what would make a difference – build this into the workplan for the health and wellbeing committee. | Q1 | Deputy Director of P&OD | Health and Wellbeing Committee inform actions. Key issues highlighted include uniforms (a uniform group lead by a senior member of the nursing team has been set up), naps on shift (we are exploring an organisation wide approach) and hydration (a hydrate, feel great campaign is being rolled out to all staff). |
| | Develop and implement a mental health and wellbeing plan | Q2 | Head of Leadership & OD | Draft plan written |
| | Re-launch staff lottery and access to health and wellbeing fund | Q1 | Communications & Engagement | Staff lottery re-launch undertaken. Process to apply for lottery funding to support health and wellbeing highlighted through gemba walks and promoted through internal communications channels. |
| Accountability | Development of objectives for all staff to be linked to True North breakthrough objectives | Q1 | All leaders<br>Director of P&OD | True North Objectives embedded in Appraisals paperwork to ensure all staff objectives are developed in line with the True North. There is also a Sound bites on this topic |
| | Performance assurance framework to include staff survey related KPIs | Q1 | All divisions/directorates | Accountability meetings re-commenced August 2019 reflecting new performance assurance framework. Discussion around 'People' key component |
| | Feedback from staff experience groups and leadership 'walkabouts' to be reported to Management Board on a quarterly basis | Quarterly | All divisions/directorates | Discussions form part of accountability meetings |

| Theme | Action | Timescale | Lead | Status Update |
|---|---|---|---|---|
| | Development of visual management boards with the support of the Qi team | Q1 | All divisions/directorates | Visual management Boards embedded in some areas and being developed in others |

In addition to the addressing the actions highlighted in the plan above we have taken forward a number of actions to support improvements to staff experience, which include:

**Living the values**

- The We Care values are also now included within the appraisal documentation supporting colleagues to highlight how they live the values and the behaviours associated with them. It also provides managers with support to have conversations about behaviours which are not aligned to the Trust values. We are also in the process of investigating how we can successfully include them within the medial appraisals or job planning process.
- In line with our values we have made strides to be recognised by our patients and colleagues as an LGBTQ+ friendly Trust. Thousands of colleagues have received a rainbow NHS badge in return for their pledge to be inclusive.
- We have rolled out the 'PROUD' campaign encouraging colleagues to discuss what they are proud of on a weekly basis
- Become recognised as a Veteran Aware Trust. This mark of distinction means that patients who have served in the British Armed Forces will be cared for by frontline staff who have received training and education on their specific needs, such as around mental health, and who can signpost them to local support services.

**Visibility of leaders**

- Chief Executive, Richard Parker continues to take part in roving roadshows to visit both support and clinical services in order to understand what they are proud of as well as what some of their challenges are. Simple problems are taken away as actions.
- Both the Chief Executive and Director of People and Organisational Development attend the Staff engagement forum to listen to challenges raised and support the group to identify solutions. Discussions so far have centred around reward and recognition specifically included:
    - Long service awards; the group reached a consensus about an organisation wide approach to recognising NHS Long service and their role in it. A bid to charitable funds is being developed.
    - Retirement; An approach has been agreed to inform CEO of retirees with above 20 years NHS service to ensure people with long service feel valued

**Wellbeing into action**

- A key focus for the coming year is around creating a mentally healthy workplace and the support available for staff suffering from stress, anxiety and depression. The DBTH strategy and action plan is currently in development.
- We were awarded the Platinium Award for our Health and Wellbeing offering from Nottinghamshire County Council
- Further additional well-being actions that have been put in place;
    - Reiki for staff – additional resource has been secured to increase the number of sessions available for staff
    - Feel Great, Hydrate water bottle campaign will be launched shortly
    - Naps on shift – Trust position currently being explored to ensure an organisation wide approach with sound rationale
    - Light weight staff uniforms – A staff uniform group has been established to explore options

- Staff Football tournament will take place on the 22ND September which is positioned as a social event for all of the family
- New staff Talk, Listen, Care (TLC) to go live middle of September (this replaces the CREST service) to support staff following crisis situations

In addition the health and wellbeing committee consider bids that can be funded through staff lottery funds – over the last 12 months funding has been approved for kitchen equipment such as fridges/microwaves/toasters; wellbeing initiatives such as reiki and yoga sessions, water bottles, keyboard for the Trust choir, running vests and benches

**Accountability**

- More of our executive team and senior leaders have a presence on social media and therefore access to our staff groups which 4,500 colleagues are members of. This helps executive team members and senior leaders to understand and respond to issues colleagues are raising in real time.
- Many of the issues raised are environmental issues. Some of the key issues that have been addressed as a direct result of feedback from colleagues (through a range of forums) include:
  - We have improved door locking systems around the basement at DRI in order to support a safer environment for colleagues working late and early, reducing the number of rough sleepers on the hospital site
  - We have worked in partnership with SYP to secure two community officer who will work in and around DRI to make staff and patients feel safer
  - In response to feedback about the environment of the basement corridor for both staff and patients the corridor has been transformed to include images of the seven wonders of the world and under the sea. This has been very positively received by both patients and colleagues alike.

**Reward, recognition and talent management**

- Thank you cards have been rolled out across senior management teams for distribution. There was good discussion at the engagement forum about how the cards should be used to add value for those going above and beyond and to ensure that it doesn't become an exclusive or divisive tool. Positive feedback is being given from those in receipt of the cards and indeed those sending cards.
- The annual Star Awards have had more applications than any other year (300 people approx. 5% staff) and the event has been relocated to a larger location in order to allow more of Team DBTH to attend. In addition divisional awards have been introduced within Surgery & Cancer and Clinical Specialties
- A clear career trajectory has been created visually in order for members of the team across the organisation to identify what the possibilities are in terms of career development enabling them to have the discussion with their line managers.

At a divisional level leadership teams have recognised the importance of being visible within their services receiving and giving feedback – examples include going to the Gemba, the Division of Medicine Way, division specific facebook pages, podcasts and divisional awards.

**Environment**

As an organisation we are keen to listen to staff and to understand how we can improve their working environment, and in turn staff morale. However, results from the most recent staff survey in 2018 showed that in answer to the question "Does your organisation take positive action on Health and

Wellbeing?" there was a decline from 29% to 25%. Whilst it is recognised there are a number of factors which contribute to a positive staff experience and high levels of morale, it was also recognised that working in an environment that reflected the aged estate was often a cause for dissatisfaction for staff. In order to consider any suggestions for improvements which would positively impact both patient and staff experience, a new group, the Charitable Development Committee, was established in November 2018, chaired by the Director of Nursing, Midwifery & AHPs.

In addition to the introduction of this new group, feedback from the Annual Staff Survey and more adhoc feedback, members of the H&WB committee suggested asking staff attending the Health and Wellbeing Fair earlier in the year - "What one thing would improve your wellbeing whilst at work?", as anticipated some items listed included environmental improvements to staff facilities listed below:

**Facilities:**

- More training rooms
- Shower facilities
- Safe cycle storage
- More staff toilets
- Safe car parking
- Changing rooms
- Windows that open
- More staff toilets
- Safe cycle storage at multiple sites
- Turn the heating off in summer
- Easier ways of booking meeting rooms
- Sustainable clinic based education/resource areas
- Staff facilities including showers and toilets that are fit for purpose
- Reduce the cost of car parking also at park and ride which is good but we could do with lighting and less rough walking.

In the first 10 months since its creation the new Charitable Development Group has received upwards of 70 bids for funding, and whilst some have been redirected to other more appropriate funding sources, some that have been approved are suggestions from staff as to how we might improve their working environment. Whilst a number of these bids are for more minor improvements, such as the replacement of warn flooring or blinds, there are also examples of larger schemes that have been approved, such as secure bike storage, additional toilets, improved CCTV and security.

These staff requests are also to be considered in the context of other more significant improvements to facilities benefiting staff which have been made in the last 12 – 18 months. These include the refurbishment of the retail facilities at DRI with the introduction of a Costa Coffee, a Subway and a fully refurbished restaurant. These investments sit alongside the refurbished main entrance at DRI with the removal of the unreliable revolving door and the creation of a 'living wall'. Following staff feedback from BDGH, the Trust is working with Sodexo to develop a Business Case for more retail offers at that site to mirror the vastly improved facilities at DRI. Other schemes include the modernisation and innovative interior designs of three of the East Ward block lifts, which previously had caused significant disruption to staff due to failures. And the most recent example, and the item with the most positive staff comments in DBTH facebook history, is the installation of innovative 3D artwork to the basement corridor which now boasts and 'Under Sea World' and 'Seven Wonders of the World' walkway.

In the coming months further schemes will begin to deliver, such as new bike sheds and CCTV and Lighting at the Park & Ride, and it is hoped that staff will feel invested in and valued as a result.

**Impact and improvement**

The 2019 NHS Staff Survey will be made available to all members of DBTH in October 2019. The indicative results from that survey will not be available until February 2020 at the earliest.

We have however recently received the results of quarter one's Staff Friends and Family Test (FFT) to provide some indication of the impact of the actions in the staff survey action plans.

For the quarter 1 Staff FFT, we decided to concentrate our questions on Staff Engagement and over 1,600 members of Team DBTH completed the short survey, with the Trust registering significantly improved results. Most significantly, 78% of all respondents recommended the Trust as a place to receive care, whilst we also saw a 12% rise in individuals giving the thumps-up to the organisation as a place to work.

In all and across nine categories, the Trust was rated more positively than last year, with the most improved area, aside from receiving care, being 'the ability to make improvements in my area of work' scoring a 12.4% uplift.

The scores for each category can be viewed below and in the subsequent tables:

- Likelihood of recommending organisation to friends and family for care/treatment: 78% (14.3%+)
- Likelihood of recommending organisation to friends and family as a place to work:66% (11.4%+)
- Care of patients /service users is my organisation's top priority: 77.6% (4.9%+)
- I am able to make suggestions to improve the work of my team/department: 73.7% (4%+)
- There are frequent opportunities for me to show initiative in my role: 67.8% (0.2%+)
- I am able to make improvements happen in my area of work: 61.3% (12.4%+)
- I look forward to going to work: 57.2% (3.2%+)
- I am enthusiastic about my job: 74.2% (1.2%+)
- Time passes quickly when I am working: 74.2% (0.6%+).

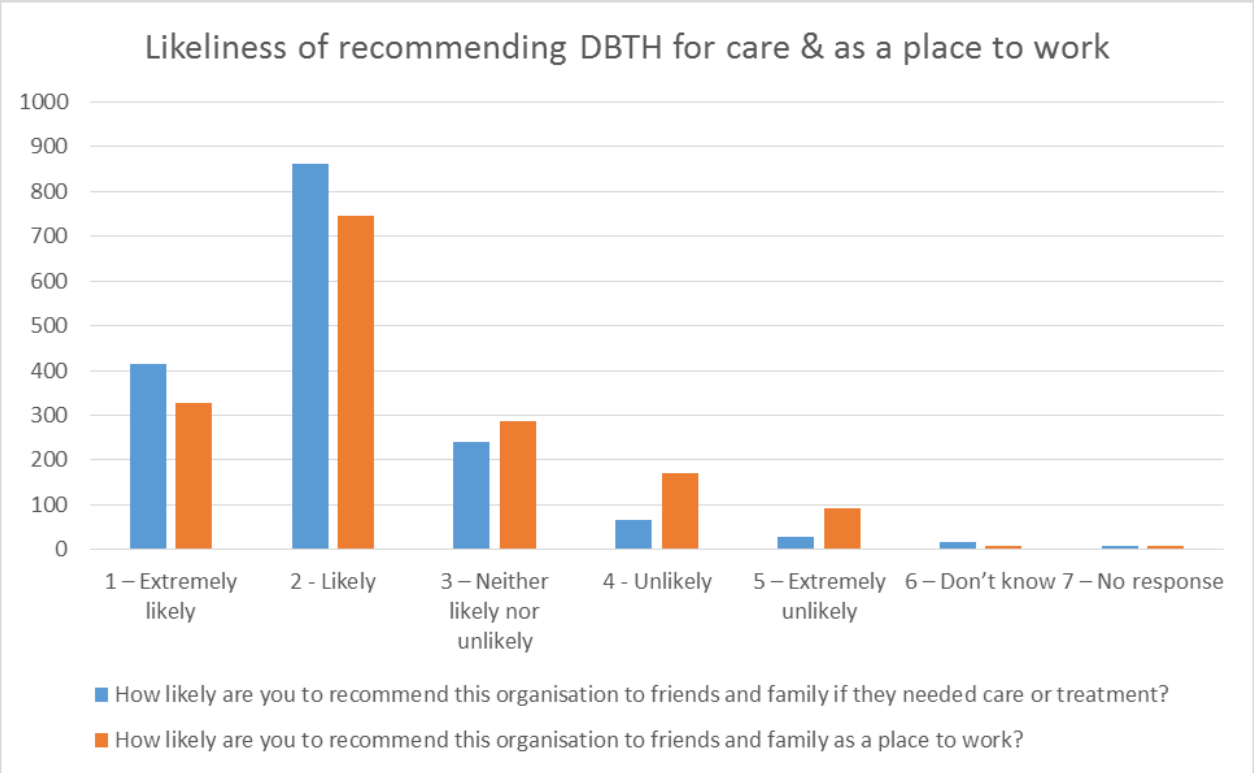
Our Quarter two Staff FFT opened 27 August 2019 and closes on 13 September 2019 and is concentrating on patient safety.

| | 1 – Extremely likely | 2 - Likely | 3 – Neither likely nor unlikely | 4 - Unlikely | 5 – Extremely unlikely | 6 – Don't know | 7 – No response | Total | % who would recommend | Survey results 2018 | Direction of travel |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **How likely are you to recommend this organisation to friends and family if they needed care or treatment?** | 414 | 862 | 241 | 65 | 27 | 18 | 7 | **1627** | 78% | 63.7% | ↑ |
| **How likely are you to recommend this organisation to friends and family as a place to work?** | 326 | 745 | 286 | 170 | 91 | 9 | 7 | **1627** | 66% | 54.6% | ↑ |

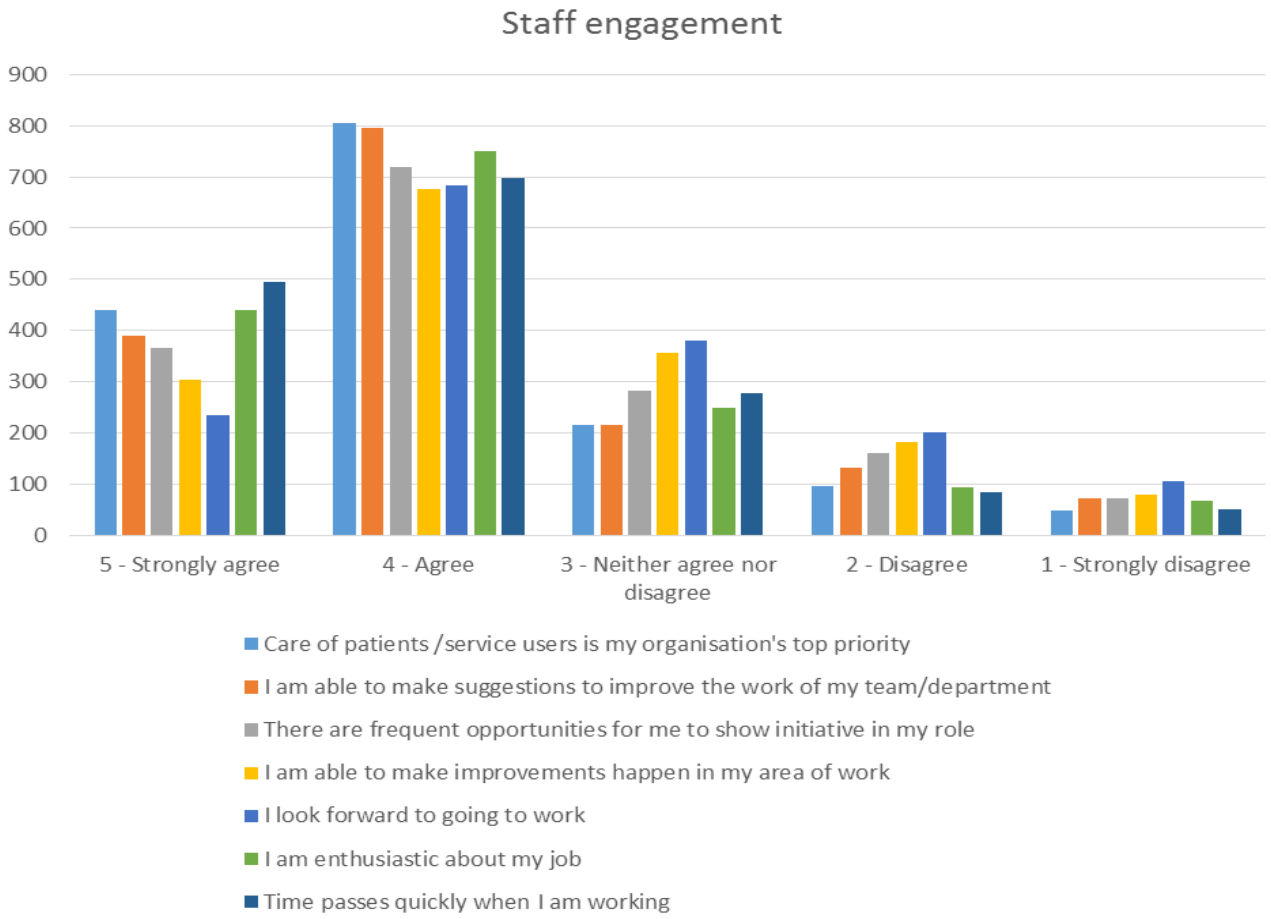
Whilst these results are extremely encouraging it should be noted that there was a lower response rate than the main staff survey.

Whilst across all areas we have seen improvements to the questions about how likely colleagues are to recommend as a place to work there are areas where continued improvement is needed.

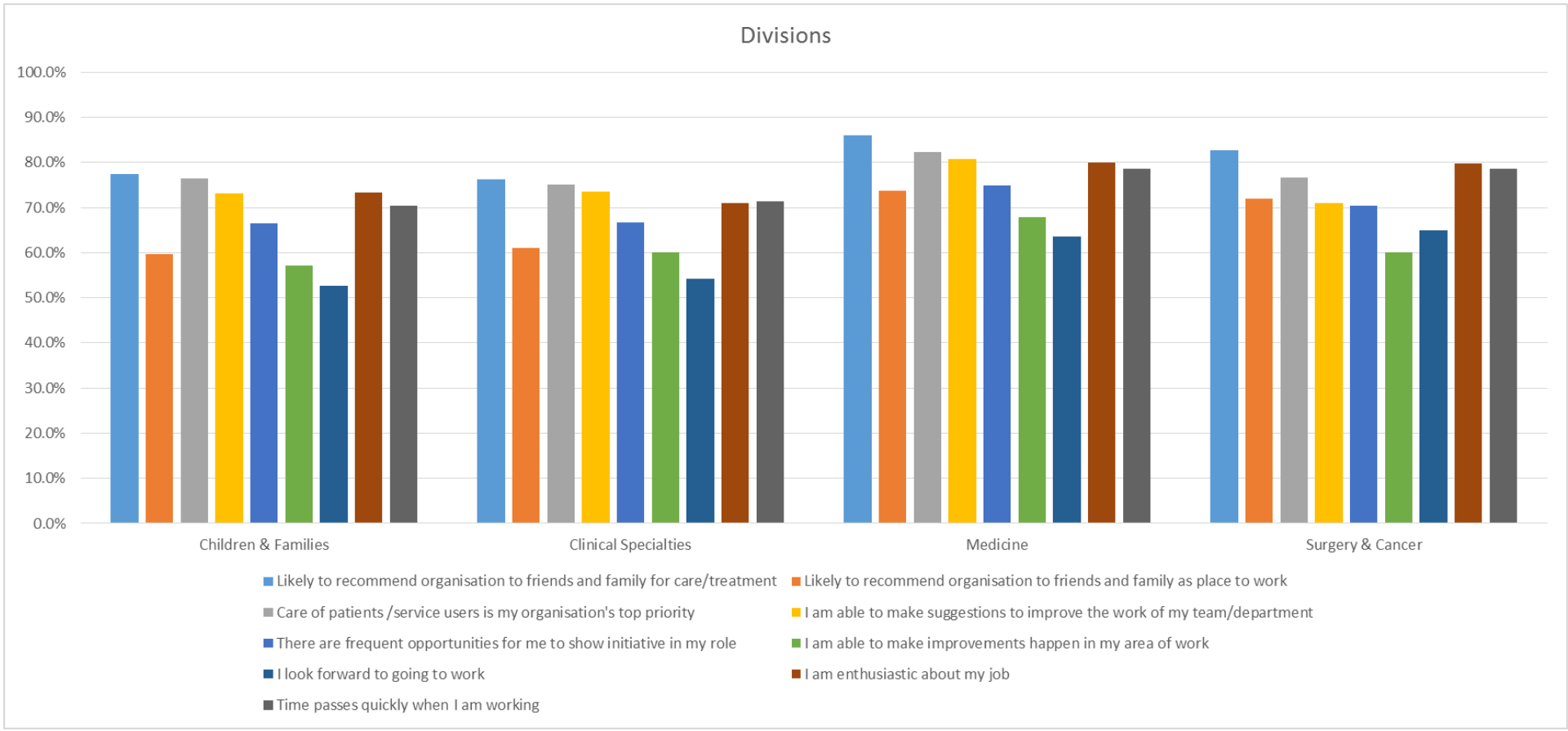
These results support our optimism that we will continue to capitalise on this positive trend through the proactive work on staff engagement, health and well-being and positive actions at both corporate and divisional level to live the 'we care' values within our organisation.

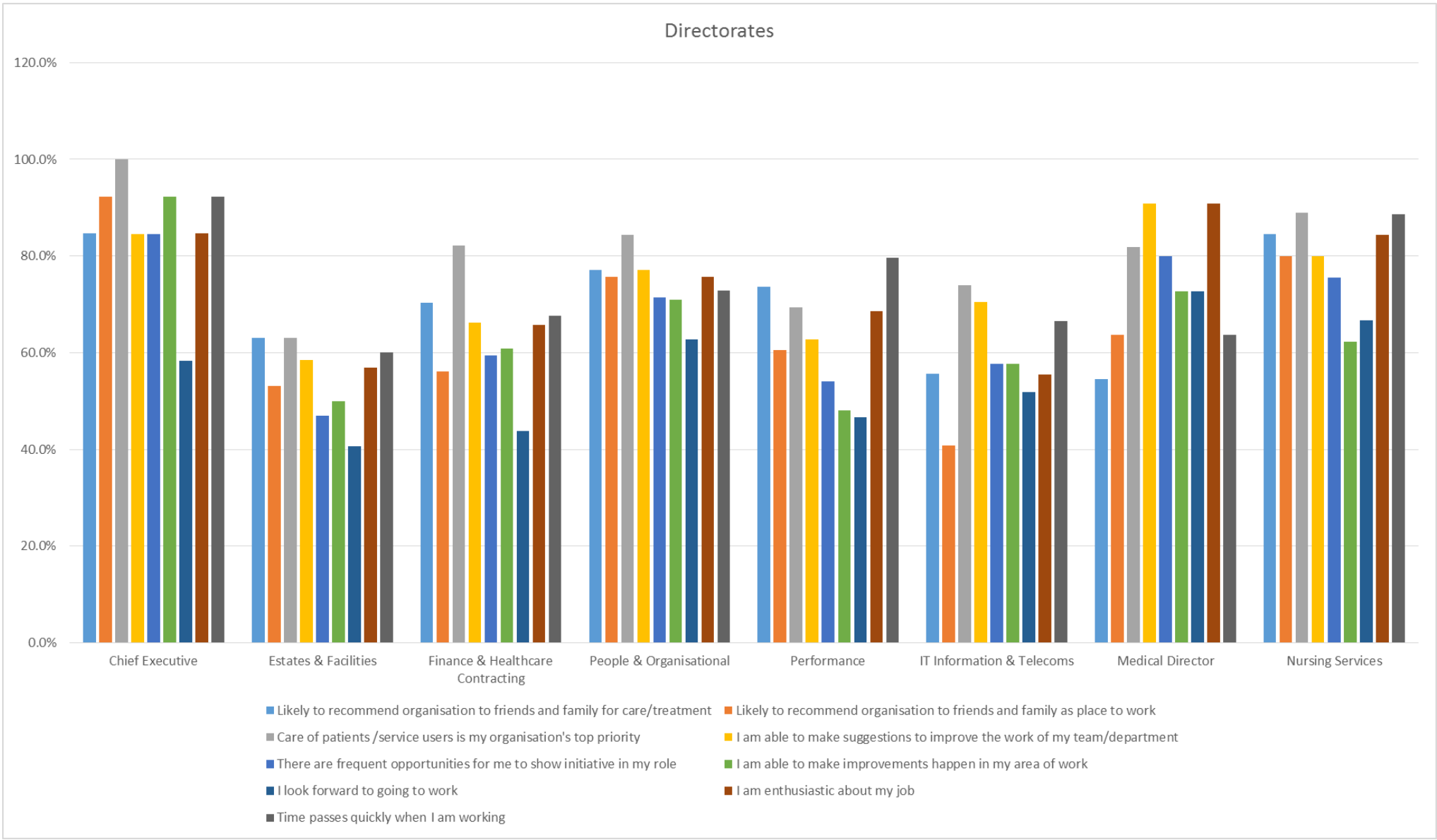



| | 5 - Strongly agree | 4 - Agree | 3 - Neither agree nor disagree | 2 - Disagree | 1 - Strongly disagree | Total | % who would agree | Survey results 2018 | Direction of travel |
|---|---|---|---|---|---|---|---|---|---|
| **Care of patients /service users is my organisation's top priority** | 441 | 805 | 215 | 97 | 48 | **1606** | 77.6% | 72.7% | ↑ |
| **I am able to make suggestions to improve the work of my team/department** | 390 | 795 | 217 | 133 | 72 | **1607** | 73.7% | 69.7% | ↑ |
| **There are frequent opportunities for me to show initiative in my role** | 367 | 719 | 283 | 160 | 73 | **1602** | 67.8% | 67.6% | ↑ |
| **I am able to make improvements happen in my area of work** | 304 | 676 | 357 | 183 | 80 | **1600** | 61.3% | 48.9% | ↑ |
| **I look forward to going to work** | 234 | 683 | 380 | 201 | 106 | **1604** | 57.2% | 54.0% | ↑ |
| **I am enthusiastic about my job** | 440 | 750 | 250 | 94 | 69 | **1603** | 74.2% | 71.0% | ↑ |
| **Time passes quickly when I am working** | 495 | 697 | 278 | 85 | 51 | **1606** | 74.2% | 73.6% | ↑ |


Staff engagement
900
800
700
600
500
400
300
200
100
0
5 - Strongly agree
4 - Agree
3 - Neither agree nor disagree
2 - Disagree
1 - Strongly disagree
Care of patients /service users is my organisation's top priority
I am able to make suggestions to improve the work of my team/department
There are frequent opportunities for me to show initiative in my role
I am able to make improvements happen in my area of work
I look forward to going to work
I am enthusiastic about my job
Time passes quickly when I am working

| | Chief Executive | Children & Families | Clinical Specialties | Estates & Facilities | Finance & Healthcare Contracting | Medicine | People & Organisational | Performance | IT Information & Telecoms | Medical Director | Surgery & Cancer | Nursing Services |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Likely to recommend organisation to friends and family for care/treatment** | 84.6% | 77.3% | 76.3% | 63.1% | 70.3% | 86.0% | 77.1% | 73.7% | 55.6% | 54.5% | 82.7% | 84.4% |
| **Likely to recommend organisation to friends and family as place to work** | 92.3% | 59.7% | 61.1% | 53.1% | 56.2% | 73.8% | 75.7% | 60.5% | 40.7% | 63.6% | 71.9% | 80.0% |
| **Care of patients /service users is my organisation's top priority** | 100.0% | 76.4% | 75.0% | 63.1% | 82.2% | 82.3% | 84.3% | 69.4% | 74.0% | 81.8% | 76.6% | 88.9% |
| **I am able to make suggestions to improve the work of my team/department** | 84.6% | 73.2% | 73.6% | 58.5% | 66.2% | 80.7% | 77.1% | 62.7% | 70.4% | 90.9% | 71.0% | 80.0% |
| **There are frequent opportunities for me to show initiative in my role** | 84.6% | 66.5% | 66.7% | 46.9% | 59.4% | 74.8% | 71.4% | 54.0% | 57.7% | 80.0% | 70.4% | 75.5% |
| **I am able to make improvements happen in my area of work** | 92.3% | 57.2% | 60.0% | 50.0% | 60.8% | 67.8% | 71.0% | 48.0% | 57.7% | 72.7% | 60.0% | 62.2% |
| **I look forward to going to work** | 58.3% | 52.7% | 54.2% | 40.6% | 43.8% | 63.6% | 62.8% | 46.7% | 51.8% | 72.7% | 64.9% | 66.7% |
| **I am enthusiastic about my job** | 84.7% | 73.4% | 71.0% | 56.9% | 65.8% | 80.0% | 75.7% | 68.5% | 55.5% | 90.9% | 79.7% | 84.4% |
| **Time passes quickly when I am working** | 92.3% | 70.5% | 71.3% | 60.0% | 67.6% | 78.6% | 72.8% | 79.7% | 66.6% | 63.7% | 78.5% | 88.6% |


Divisions
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Children & Families
Clinical Specialties
Medicine
Surgery & Cancer
Likely to recommend organisation to friends and family for care/treatment
Likely to recommend organisation to friends and family as place to work
Care of patients /service users is my organisation's top priority
I am able to make suggestions to improve the work of my team/department
There are frequent opportunities for me to show initiative in my role
I am able to make improvements happen in my area of work
I look forward to going to work
I am enthusiastic about my job
Time passes quickly when I am working


Directorates
120.0%
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
Chief Executive
Estates & Facilities
Finance & Healthcare Contracting
People & Organisational
Performance
IT Information & Telecoms
Medical Director
Nursing Services
Likely to recommend organisation to friends and family for care/treatment
Likely to recommend organisation to friends and family as place to work
Care of patients /service users is my organisation's top priority
I am able to make suggestions to improve the work of my team/department
There are frequent opportunities for me to show initiative in my role
I am able to make improvements happen in my area of work
I look forward to going to work
I am enthusiastic about my job
Time passes quickly when I am working

**Freedom to Speak Up**

The National Guardian's Office (NGO) is an independent body sponsored by the Care Quality Commission, NHS Improvement, and NHS England, with a remit for leading a positive culture change in the NHS so that speaking up becomes business as usual.

Freedom to Speak Up Guardians (FTSUG) and the work required to implement their role has been a requirement of the NHS Standard Contract in England since 2016. This role was recommended by Sir Robert Francis QC, in 2015 as part of the 'Freedom to Speak Up' review commissioned by the Secretary of State and chaired by Sir Francis, as a result of the Mid Staffordshire NHS Foundation Trust Public Enquiry 2013.

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust. The Care Quality Commission (CQC) assesses a Trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question.

In 2018 NHS Improvement and the National Guardian's Office published a guide setting out expectations of Boards in relation to Freedom to Speak Up (FTSU) to help Boards create a culture that is responsive to feedback and focused on learning and continual improvement. Given the growth and evolution of the FTSU concept over the past three years, and responding to Freedom to Speak Up Guardians feedback a revised guidance and self-review tool has been published by the NGO in July 2019. These documents acknowledge how Speaking Up should be interwoven into organisational cultures and behaviours. The Guidance is also aligned to the following National publications:

- Sir Robert Francis QC, 'Freedom to Speak Up' review (2015)
- NHS Interim People Plan (NHSI 2019)
- Creating a culture of compassionate and inclusive leadership (NHSI/Kings Fund 2017)
- FTSU Training Needs Analysis (NGO 2019).

The revised guidance moves away from addressing only the knowledge and skills of senior leaders and instead aligns the responsibility with Executive Directors for creating an open, safe, fair and restorative culture where staff are empowered and enabled to speak up. Ensuring that everyone feels they have a voice, control and influence over their work practices, environment and ultimately patient care. The guidance then discusses behaviours and commitment, focussing on how FTSU is strategically placed within the organisation. The previous requirements for senior leaders remain relevant as part of the implementation of the wider cultural change.

In order to address each of the revised requirements appropriately a number of key areas need to be explored and actioned.

Key revised areas for Board consideration are:

- Providing evidence of positive behaviours of Executives and Non-Executives including feedback and evidence of challenge in Board reports
- Inclusion of FTSU and wider cultural aspects in the Board Development Program
- Attendance of those who have spoken up at Board level discussions
- Evidence of FTSU discussions at the public Board of Directors meetings
- Minimum of 6 monthly reporting/ presenting to Board with additional reports through the Executive lead for FTSU
- Evidence that the Freedom to Speak Up Strategy has been developed/revised with all key stakeholders

- Evidence of investment in leadership and development across all staff
- Evidence that all aspects of Speaking Up are encouraged and captured, including discussions held or concerns raised with Governance, Quality Improvement and Human Resources
- The triangulation of all data to support areas where Speaking Up is having a positive effect and where not Speaking Up is being investigated
- A sustained, creative and engaging communication strategy in relation to Speaking Up, including sharing stories about positive experiences and the support that is available
- Information provided to relevant oversight authorities

The specific responsibilities for individual roles remain unchanged other than strengthening the roles of the Director of P&OD in relation to culture change. As a reminder, the Non-Executive lead (undertaken by the Senior Independent Director) is responsible for:

- Role modelling high standards of conduct around FTSU
- Ensuring they are aware of the latest guidance from the NGO
- Challenging the chief executive, executive lead for FTSU and the board to reflect on whether they could do more to create a healthy and effective speaking up culture
- Acting as an alternative source of advice and support for the FTSU Guardian
- Overseeing speaking up matters regarding board members

And the Executive lead:

- Role modelling high standards of conduct around FTSU
- Ensuring they are aware of the latest guidance from the NGO
- Overseeing the creation of the FTSU vision and strategy
- Ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian
- Ensuring the FTSUG has a suitable amount of ringfenced time and other resources and there is cover for planned and unplanned absence
- Ensuring their FTSUG has access to any emotional and psychological support they may need
- Conducting a biennial review of the strategy, policy and process
- Operationalising the learning from speaking up issues
- Ensuring instances where individuals may have suffered detriment for speaking up are promptly and fairly investigated and acted on
- Providing the board with a variety of assurances about the effectiveness of the trust's strategy, policy and process

Following the Trust's self-assessment in 2018 the following actions were agreed:

- Recruitment of a dedicated Freedom to Speak Up Guardian
- The development of a Freedom to Speak Up strategy to include the introduction of divisional FTSU champions to support the Guardian
- The extension of Freedom to Speak Up to the role of the Trust's Diversity & Inclusion group to ensure that any barriers are removed for those in more vulnerable groups

- A refreshed communications plan to ensure staff are familiar with how to raise concerns on an ongoing basis
- Refresh of the leadership development programme to ensure that all managers and leaders across the Trust are aware of the importance of the culture of speaking up and learning from the concerns raised.

Implementing this action plan has seen the recent appointment of a dedicated FTSU Guardian (20 hours per week) to take forward the direction of all of the other above actions. Although independent, the role has robust links to the Head of Leadership and Organisational Development, to enable working together to embed a just culture in which Speaking Up can be seen as business as usual. Work is currently underway to develop and consult on the FTSU strategy, including the development of FTSU forums at each of three main sites. As part of this strategy development many actions have already been/or are being completed including:

- Key representation for the FTSU Strategy group from Governance, QI, Leadership & OD, Education, Estates, IT, communications and operational representation
- Identification of Fairness Champions from each of the divisions, Well-being Service, and the Trust's Equality, Diversity and Inclusion Group
- Revised communication plan
- Learning Needs Analysis leading to a revised FTSU leadership development plan (in line with 2018 action plan and the 2019 revised guidance)
- Revised FTSU Policy to incorporate the change of focus and language required to deliver cultural change. (presentation to Staff Side October 2019)

In addition to this work short term communications and L&D work has taken place to support recruitment to the strategy groups and champion networks. This includes:

- Re-Launch of the FTSU information including revised ward/departmental level information for staff notice boards and information in the weekly Trust publication (Buzz).
- Further communication has been agreed as part of National Speak Up Month in October which sees the use of different language to engage people in Speak Up, using the phrase " I/We support Speaking Up because……."

Speak Up month will also be enhanced by the attendance of a representative from the NGO at a local FTSU awareness and sharing success event on 17th October. The Board will receive an annual update from the Freedom to Speak Up Guardian at its meeting in November along with the FTSU strategy for approval.

Develop Belong Thrive Here at DBTH

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

# Doncaster and Bassetlaw Teaching Hospitals

## Leadership and Organisational Development

## Year one report



We care

# A word from

## **Karen Barnard**, Director of People and Organisational Development



**The Doncaster and Bassetlaw Teaching Hospitals Leadership and Organisational Development team was formed in September 2018 and this report provides an opportunity for the Trust to reflect upon the past 12 months and evaluate and summarise the work delivered by the team.**

Throughout the past number of years, we have received feedback from colleagues about the need for a Leadership Development programme and as Director of People and Organisational Development, I pleased to reflect upon a successful first, and founding, 12 months for the new team.

The Head of Leadership and Organisational Development, Jayne Collingwood, took up the post in September 18 and as such the Leadership and Organisational Development (L&OD) team was created.

The purpose of the L&OD Team is to enable and facilitate the delivery of our vision 'To be the Safest Trust in England, Outstanding in all that we do', to foster compassionate and inclusive leadership and to achieve this by supporting and developing colleagues to be the best they can be.

We recognise that members of Team DBTH are our greatest asset and we are entirely committed to support, enable and empower them to Develop, Belong, Thrive, Here within our organisation.

We want to create a positive, inclusive and people-centred culture that engages and inspires all our people, with a clear focus on improvement and equality of opportunity. We want our people to feel connected and a sense of belonging to 'Team DBTH'.

The NHS Long Term plan and the Interim People Plan acknowledge there is compelling evidence that the more engaged our people are, the more effective and productive they are, and most importantly, the higher the quality of care they deliver to patients. The plan sets out the vision for people who work for the NHS and clearly focuses on the actions needed to deliver the vision:

- We need different people in different professions working in different ways.
- Cultural changes are needed to build a workforce that befits a world-class 21st century healthcare system.
- Promotion of positive cultures, to build a pipeline of compassionate and engaging leaders.
- Make the NHS an agile, inclusive and modern employer
- Attract, retain and develop the people we need to deliver the NHS long Term plan.
- Improve technology to organise and plan services differently.
- Enable our people to work to their full potential.

This long term vision for the NHS is the strategic driver which informs and shapes the work of the Leadership and OD Team.

I commend this report to the Board of Directors and wider Trust colleagues about our achievements within this area throughout the past year.

## Karen Barnard

Director of People and Organisational Development



**The Leadership and Organisational Development Team**

# Our vision: To be the safest trust in england

Outstanding in all that we do




## We care values

**W** e always put the patient first.

**E** veryone counts – we treat each other with courtesy, honesty, respect and dignity.

**C** ommitted to quality and continuously improving patient experience.

**A** lways caring and compassionate.

**R** esponsible and accountable for our actions – taking pride in our work.

**E** ncouraging and valuing our diverse staff and rewarding ability and innovation.

# The team

**One of Team DBTH's newest services, the Leadership and Organisational Development team is made up of the following colleagues.**




**Jayne Collingwood**
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Jayne.Collingwood@nhs.net



**Sean Tuplin**
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Sean.Tuplin@nhs.net



**Kerrie Fletcher**
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kerrie.fletcher@nhs.net



**Linda Shuttleworth**
01302 642561
Linda.Shuttleworth@nhs.net



**Claire Collins**
01302 642561
ClaireCollins@nhs.net


Early on the Leadership and OD team set out their delivery framework which visualised in the diagram below:



**Value our people**
- Inclusive leadership
- Equality and Diversity and Inclusion
- Equality standards including WRES, DES
- Staff survey and FFT
- Staff engagement
- Staff experience

**Create a coaching culture**
- Coaching Capacity and Capability
- Coaching Service
- Coaching Supervision
- Access to coaching
- QI Coaching
- Mentoring

**Develop our leaders**
- Leadership Development*
- DEVELOP, BELONG, THRIVE, HERE Masterclass
- Apprenticeships
- Sound Bites
- Qi Training

**Support our teams**
- Organsational Development Interventions
- Psychometric Instruments
- Talent Management
- Team Development
- Team Interventions



# Leadership & Management Development Programmes

**The Leadership and OD team support and develop 'Team DBTH' leaders to enable them to effectively lead services, lead people, lead change and strive to continuously improve services for patients.**

January 2019 saw the launch of the Leadership Development prospectus at DBTH. The leadership development programmes are Develop, Belong, Thrive and Here. The team work closely with Quality Improvement (QI) to ensure QI methodology is an integral part of all leadership development programmes.

## **Develop**, Belong, Thrive, Here

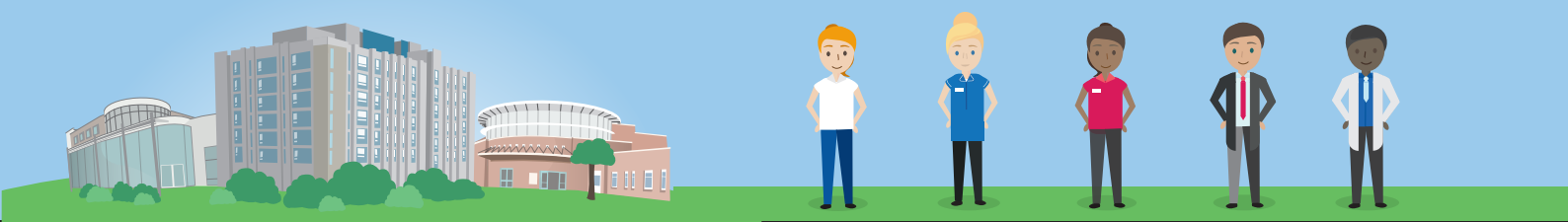
**A four day programme for new managers and leaders in clinical and non-clinical roles at the beginning of their leadership/management careers.**



It is designed to develop participants' leadership and management knowledge and skills to enable them to lead with confidence whilst embedding our 'We Care' values and behaviours. (Develop replaced the previous Management Skills Passport).

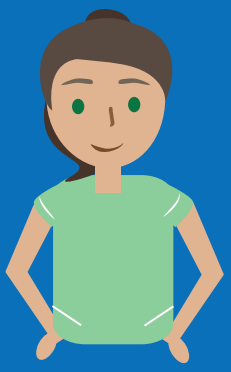
The develop programme began in March and there are three cohorts underway. One cohort has been completed and two are part way through. 23 people have attended the programme thus far. Feedback from participants is captured below:

- 'Finding out about our own leadership style is very useful'.
- Useful group discussions to find out other people opinions'.
- 'Enjoyed the day, we are all leaders'.
- 'All aspects useful, especially finance'.
- 'Since the Develop programme I think differently and act differently in leadership situations'.
- 'I no longer try to do everything myself and empower my team more to take ownership and find solutions'.



# Develop, **Belong**, Thrive, Here

**A two and a half day programme provides middle managers and team leaders with the opportunity to explore how they lead and their personal strengths and areas for development.**



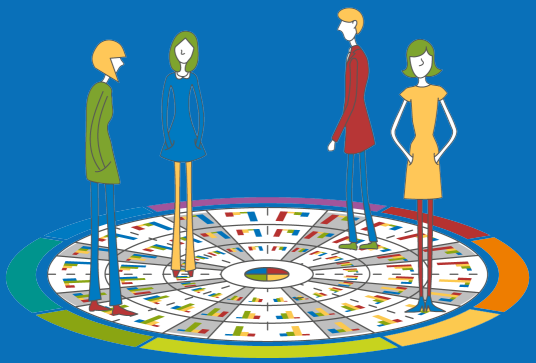
It explores how they lead others and how to flex their leadership style and behaviour to get the best from every interaction.

All participants undertake a Discovery Insights questionnaire and receive a personal Insights report on the programme.

15 participants have completed the programme. Feedback is captured below:

- 'Improved as a leader and I am much clearer about my strengths and weaknesses. The session have enabled me to re-evaluate myself.'
- 'It was most helpful to discuss situations on the ward with others and being offered and offering compassion and support.'
- 'I feel that this series of days has helped improve my confidence in my leadership and made me feel I am entitled to flourish in this role when previously it has felt otherwise.'
- 'It helped me find what kind of leader I am and how to interact with others.'
- 'Insights learning how the different colour energies interact with each other.'
- 'I learned how to improve myself.'
- 'I am actively sign posting other people to these programmes in and outside my own areas.'
- 'I am going to arrange an Insights session for my whole team.'

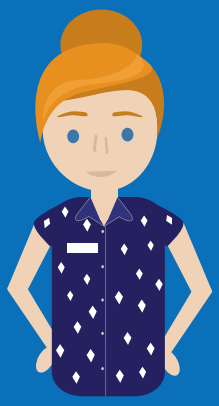
It is pleasing to report that Insights is becoming a recognised leadership tool within our organisation and provides our leaders with a common language to describe leadership behaviours.





# Develop, Belong, **Thrive**, Here

**This two day programme aimed at senior leaders provides the opportunity to explore the importance of staff engagement, own leadership strengths and areas for development through the completion of A Health Care Leadership Model 360 degree feedback report.**



- 'My feedback report has given me a clear focus on what I need to work on in my leadership development'.
- 'I have realised I need to challenge more where behaviours are not in line with our values'.

**The Shadow Board:** This programme is a new programme for DBTH delivered by the Inspiring Leaders Network. We were fortunate to be able to deliver this programme which was funded by the Yorkshire and Humber Leadership Academy. The Shadow Board programme has enabled 16 of our Aspirant Directors to access high level development. The Shadow Board Programme is a short, modular and practical programme providing senior managers and clinicians with an insight into the working of a trust board, directorship and good corporate/clinical governance. The programme aims are to:

- Deepen understanding of Board-level working.
- Prepare for future leadership roles, including aspiring directors.
- Enable further input and insight into existing Board meetings.
- Provide the Trust Board with feedback as a member of staff working in services.
- Increase greater diversity of thought in senior leadership decision making.

The programme launched in June 2019 and will be completed by October 2019. The Leadership and OD Team would like to thank and acknowledge our Non-Executive Director Neil Rhodes for his commitment and support in chairing the DBTH Shadow Board meetings. Neil was able to share his insight and experiences with the group, to enhance their learning and challenge their thinking. Early feedback from programme participants is very positive and a celebratory film will pull together their experiences, so they can be shared more widely.

The Leadership and OD team are hopeful that going forward we will be able to secure funding and invest in another Shadow Board development programme for DBTH.



# Develop, Belong, Thrive, **Here**



**The Masterclass series created an opportunity for all of our senior leaders to' hear' from external high profile leaders/experts who share their knowledge, expertise and experiences on key topics.**

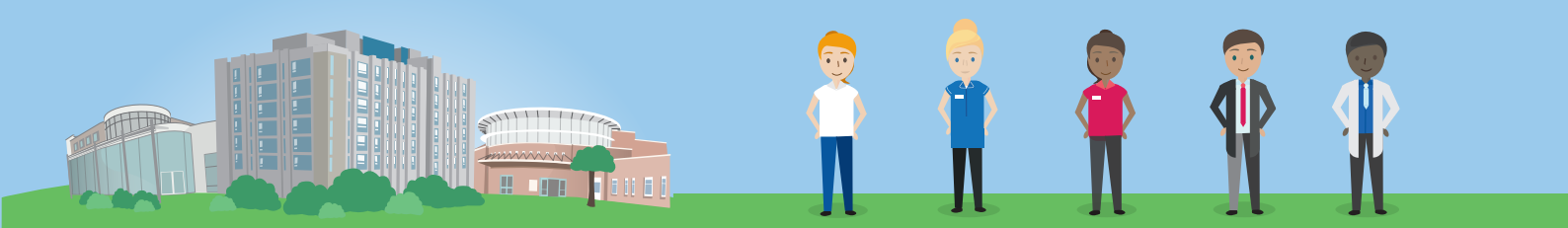
Jonathan Peach delivered the first Masterclass - 'The Art of Being Brilliant' in March 2019. Collected feedback stated: "Very positive, very funny, best presentation I've seen in years. The most inspirational and motivational speaker I have ever seen! Love, loved, loved this! More, more, more Thank you! Inspiring, motivating and brilliant. Keep on organising these frequently. It will encourage us being doctors. Loved the room it was filled with joy!"

Simon Fanshawe OBE delivered Diversity – The New Prescription for the NHS on the 13 June 2019.

Collated feedback stated: "The speaker was amusing and grabbed your attention. He had some valid points and made you think outside of the box. Collected feedback stated: I think we need to look at how we bring down the curtain, to ensure fairness of opportunity for all. It was entertaining and easy to listen to. Excellent delivery and engaging presentation Speaker knew his topic, could quickly relate specific authors/research. Speaker very upbeat and inclusive. Broad view of diversity and benefits. Diversity as a deficit and the business case for diversity. Lively presentation style presenting recruitment pitfalls if wanting equality and appreciation of difference. Informal, humorous style."

**The next Masterclass:** We are looking forward to the next masterclass with Professor Stephen Singleton OBE will deliver "Clinician or Manager: Why is implementing modern improvement science as vital as anything we do?" on creating an improvement culture through collective leadership and the application of improvement science Wednesday 25 September.







# Develop, Belong, Thrive, Here

Sound Bites have enhanced our leadership offer by creating the opportunity for accessible short 90 minute face to face sessions for leaders and managers.



These sessions give clear messages on important topics with a strong focus upon how the leader will apply this to their leadership practice. Sound Bites are offered centrally in the prospectus or are portable and have been delivered within existing team meetings and forums to make it easier for staff. To date we have had 356 people attend soundbites. The current topics available are listed below:

- Stress Awareness
- Personal Resilience
- Quality Appraisals
- Candid Conversations
- Living the We Care Values and Behaviours

Feedback from various sessions has been captured below:

- "It was good to see other members of staff values."
- "Would like more guidance on how to deal with staff who do not display good values."
- "Content was really interesting – enjoyed it, fast paced."
- "Lots of helpful advice and tips."

# Other work

**Leading To Outstanding:** The Leading to Outstanding programme is a recent addition to the leadership prospectus which launched in July. The programme has created an opportunity for Divisional Leadership teams to look at how they create a culture which fosters continuous improvement and the different leadership behaviours and approach we need on our journey to Outstanding. The participants have created an improvement maturity matrix to self-assess where their divisions are currently and where they need to be. They have tested out structured and planned approaches in improvement, introduced improvement methodology in the work place and worked on 'Gemba' visits and visible leadership. This is an organic programme and in response to requests from participants, corporate leaders have now joined the programme. This will facilitate improved working between corporate areas and clinical areas and help to build productive relationships. Presently we have 32 leaders on this programme. Next year this programme will be rolled out to the next tier of leaders.

**Progress:** This is a programme that was introduced to meet the needs of all the administrative staff who have recently been impacted by the review of our clinical administrative processes. The programme is 2.5 days in length and covers leading at DBTH, living our values, building and leading a team and effective and efficient customer care for NHS Staff. 42 members of admin and clerical staff have been invited to participate in the programme which launched in July. Example feedback is captured below:

"I just wanted to say what a brilliant session we have had this afternoon. It was engaging, thought provoking, and gave us an opportunity in a safe environment to examine behaviours and interactions with our patients and colleagues. This enabled us to gain a real in depth understanding of outcomes and improvement for everyone.

I also found the session to be very relevant in terms of our Trust's vision and aspirations. I feel it would be really beneficial for the Trust to invest in our Admin Teams as part of their development to have access to this session. I have to say though that David really made the session and would thoroughly recommend him for any future training in this field to across all levels of staff in our organisation.

Thanks for the opportunity to attend such a brilliantly delivered session. It was the most relevant session I have ever attended in nearly 27 years working in the Trust".

**Leadership & Management Apprenticeships:** This year we have introduced access to Leadership and Management Apprenticeships for existing staff. This offers the opportunity for leaders and managers to develop their leadership skills, knowledge and know-how whilst gaining a recognised professional qualification. We have many experienced leaders within the organisation who are looking for a formal leadership qualification to support their future career and personal development. To date we have 2 people on Apprenticeship programmes (1 person on Leadership and Management Level 5, 1 person on Leadership and Management: Chartered Manager Degree Apprenticeship Level 6) and we want to increase numbers going forward. We also have 4 senior leaders currently enrolling on Masters Degree level programmes for this September. One of these participants is enrolling on the role specific Executive Masters Degree in Facilities Management Degree Apprenticeship.

**Organisational Development – Support our Teams:** The team have worked hard to become visible, accessible and build a positive reputation. We have worked tirelessly to create a culture where our 'We Care' values are lived and embedded and it is 'the way we do things around here'. We have adopted a structured approach to Organisational Development (OD) and requests for interventions are managed to ensure that the appropriate OD intervention is applied and there is maximum opportunity to add value and deliver clear outcomes. It is also worthy of noting that we work closely and corroboratively with your HR People Business Partners who also actively engage in OD support to the divisions and directorates.



# Other work

OD Interventions have included:

- Application of Psychometric instruments for recruitment and development including; Discovery Insights, The Quest Profiler, Lumina sparks
- Leadership Development Feedback tools Healthcare leadership model 360 degree feedback,
- Team Building/development programmes
- Targeted Leadership development Programmes; Shadow Board, Progress
- Coaching
- Mentoring
- Quality Improvement Interventions
- Talk, Listen Care (TLC)
- Sound Bites – on key topics

This year we have offered bespoke support and interventions to support neonatal unit, renal secretaries, palliative care, Governors induction, procurement services, advanced clinical specialities and clinical specialities. The team have also actively supported 'Sharing How we care Conference', Trust Induction, Black History month, Doncaster Pride, Rainbow badge campaign and Preceptor Induction.

**Value our People – Staff Engagement:** The Leadership and OD team also take the strategic lead for our approach to Staff Engagement, Staff Survey and Equality, Diversity and Inclusion. The team recognise that good leadership and positive staff engagement has direct impact upon the quality of patient care.

Good leaders create a positive climate for staff so that they feel valued and experience a sense of belonging to an organisation and a connection with the core business purpose. If staff feel engaged they have the emotional capacity to care for others much better. Our focus this year has been to empower our leaders to listen constantly and carefully in order to learn about the obstacles and hindrances that frustrate front line staff and then work with them to overcome them.

To foster staff engagement the team have lead on a number on initiatives only some of which are highlighted below:

- Set up staff engagement groups across all 3 hospital sites
- Created a space for staff to raise concerns, issues and feedback
- Taken a proactive approach to responding to staff survey results and the Staff Friends and Family test results
- Engaged staff in shaping how we recognise, reward, acknowledge good performance and celebrate long service
- Delivered Health and Well-being events and campaigns to keep our people well
- Launched the new staff support service (replacing CREST) TLC Talk, Listen, Care
- Secured funding from the Health and Well Being Committee to fund additional sessions for the staff Reiki service
- Secured funding from the Health and Well Being Committee to deliver the 'Hydrate, Feel Great' staff wellbeing campaign
- A Staff Football tournament is planned for 22nd September and we have 6 teams in place. This should be a really fun event for staff and sends positive messages around health and wellbeing.

**Summary:** The Leadership and OD team recognise that this is the foundation year for the team and they are very proud of their achievements within the last 12 months.

Going forward the team are optimistic that they are able to build and develop the leadership offer to expand the range and breadth of opportunities available for our leaders, all of which are fundamental in working towards our vision 'The Safest Trust in England, Outstanding in all we do'.



NHS

Doncaster and Bassetlaw Teaching Hospitals

NHS Foundation Trust

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| | | | |
|---|---|---|---|
| **Title** | **BUSINESS CASE: EMERGENCY DEPARTMENT STAFFING** | | |
| **Report to** | **TRUST BOARD** | **Date** | **24TH SEPTEMBER 2019** |
| **Author** | **DR NICK MALLABAND, DIVISIONAL DIRECTOR**<br>**KATE CARVILLE, ASSOCIATE DIRECTOR OF NURSING**<br>**ANDREW THOMAS, PROJECT DIRECTOR** | | |
| **Purpose** | | | Tick one as appropriate |
| | Decision | | X |
| | Assurance | | |
| | Information | | |

| **Executive summary containing key messages and issues** |
|---|
| The attached FBC outlines the need for additional staffing resource within the trust's Emergency Departments (ED).<br><br>The main driver for this need is the increase in both activity and patient acuity over the last. This is despite the successful implementation, working with local commissioners, of a number of schemes to both reduce admissions and stream the activity that does occur to avoid unnecessary ED waits.<br><br>The integrated case outlines the need for staffing increases in three main areas:<br><br>• Medical staffing<br>• Paediatric nursing<br>• General nursing<br><br>Whilst each of these is addressed discretely in individual sections of the attached there are a number of common and overarching themes which the document seeks to draw together.<br><br>Therefore, the case lays out, in one document, the need for the additional staffing resource identified to both ensure patient safety and to ensure the performance against the various targets in maintained. |

| Key questions posed by the papers |
| --- |
| • Does the FBC attached sufficiently make the case for the additional resources requested? |
| **Recommendation(s) and next steps** |
| The trust board is asked to agree the additional funding requested in the attached FBC. |

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

# Business Case : ED Workforce

(Integrated case for Medical, Nursing and Paediatric staffing)

Divisional Director : Nick Mallaband

Lead Managers : Lesley Hammond & Kate Carville

Author : Andy Thomas

**VERSION HISTORY**

| Version | Date Issued | Brief Summary of Change | Author's Name |
|---|---|---|---|
| Draft v1.0 | 11th June 2019 | First Draft Version – Integrated for all staff groups | Andy Thomas |
| Draft v2.0 | 18th June 2019 | Comments by Divisional management team incorporated | Andy Thomas |
| Draft 3.0 | 19th June 2019 | Forwarded to Medical, Nursing & Finance Directors for comment | Andy Thomas |
| Draft 4.0 | 28th August 2019 | Revised based on Directors comments | Andy Thomas |
| | | | |

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# GLOSSARY OF TERMS

| TERM or ABBREVIATION | DESCRIPTION |
|---|---|
| **AfC / A4C** | Agenda for Change |
| **CCG** | Clinical Commissioning Group |
| **ACP** | Advanced Clinical Practitioner |
| **DBTH** | Doncaster & Bassetlaw Teaching Hospitals NHS FT |
| **FAQ** | Frequently asked question |
| **FBC** | Full Business Case |
| **FT** | Foundation Trust |
| **KPI** | Key Performance Indicator |
| **NHSI** | NHS Improvement |
| **NHS** | National Health Service |
| **PbR** | Payment by Results |
| **PA** | Physician's Assistant |
| **BEST** | Tool for estimating required staffing levels based on activity and acuity |
| **ED** | Emergency Department |
| **GP** | General Practitioner |
| **CQC** | Care Quality Commission |
| **WTE** | Whole Time Equivalent |
| **A&E** | Accident & Emergency |
| **RCEM** | Royal College Emergency Medicine |
| **ESR** | Electronic Staffing Record |
| **WAU** | Weighted Activity Units |

## 1. EXECUTIVE SUMMARY

### 1.1 Introduction

Nationally there is a challenge around the increase in patients attending Emergency Departments and a general deterioration of performance against the 4-hour target. The trust's overall performance for 2018/19 being short of the 95% national and 91% local targets.

In October 2018 a survey was completed across Doncaster and Bassetlaw (DBTH) on why patients come to our Emergency Departments. Feedback indicated; people were unable to get a GP appointment and that our patients liked the "one stop shop".

Over the last 4 years we have worked with our partners to stream patients away from the front door. As a Trust we are in line with national average for such streaming of patients. However, despite these efforts, our Emergency Departments have seen a significant and consistent increase in activity year on year. E.g. for 19/20, an additional 8% in emergency attendances.

Additional to the increase in attendances there is also a general increase in the acuity of the patients attending i.e. patients' general degree of sickness is increasing. This inevitably leads to additional draw on resources, particularly medical staffing.

### 1.2 Basis of the Case

This business case identifies the additional resources required to staff the trust's two ED departments to the required standard i.e. in line with agreed national benchmarking given the volume of attendances adjusted by the acuity of the patient mix.

There are three aspects of the staffing increases required:

- Medical
- Paediatric nursing
- General nursing

Whilst the case for these is made separately below there is an obvious an interconnection between the three. However, the details for each staffing group are shown separately as the rationales and methodologies used to generate the modelled staffing levels in each is distinct.

It should however be remembered that the case for each category does not sit independent of the others.

### 1.3 Summary

#### 1.3.1 Medical Staffing

The analysis shows the need to increase staffing levels overall by the following:

- 1.0 wte consultants
- 5.6 wte Physician's Assistants (2.8 wte at each of Doncaster & Bassetlaw sites)
- 2.8 wte ACP
- 3.0 wte SHO's

There is also additional supervision required for these new posts i.e. 0.2 wte.

Given the likely time lag in recruitment etc. it is assumed that funding for these posts will be required for, on average six months, for 2019/20. The full funding then being required for 2020/21.

The additional medical staffing input will also allow rotas to be adjusted to both better reflect the volume of patient arrivals throughout the day and the need for more senior decision makers to be available when breaches of the four-hour target are more prevalent. Indeed, there is an aspiration

within the team to move to a 24/7 ‘shopfloor’ consultant presence. Whilst the staff levels included in this FBC will not achieve this it will make a significant move in that direction.

These changes will enhance care and improve the patient pathway by minimising risk in patient waiting times and overall enhance the quality of care given to patients.

This proposal has been developed with our ED Team who, together, has produced a workforce model that will support the safe, efficient delivery of services by maximising skills and overall productivity. A Qii project looking at patient flow is also in train and has acted as a vehicle to explore and gain feedback on our future needs. It is also a forum where we continue to engage, give and receive feedback from our teams.

This will be the first time we have used Physician’s Assistants in our emergency departments. This will provide a more efficient use the budget, supported by positive feedback and national data.

### 1.3.2 Paediatric Nursing

The CQC inspection in December 2018 highlighted an issue with the level of specialist paediatric nurses available at both the trust’s ED sites. The recommendation of the CQC was that each ED should have 2 paediatric nurses present at all times i.e. 24/7.

The level of additional staffing required aggregates to 11.34wte at a cost of £512k pa. The majority of these posts will be at the Band 5 level with 3.4wte of the total at higher bandings.

This resource input is based on achieving the staffing level required by the CQC as outlined above. The achievement of this will lead to step change in both the quality and patient experience received by users of this service.

### 1.3.3 General Nursing

The BEST tool was used to audit ED staffing levels for February 2018. This highlighted a need to:

- Increase general nursing staffing levels across both ED teams;
- Improve the senior leadership at both sites to better support the current Band 5 staff.

The results from the BEST tool have been taken then further developed by the project team. It has been assessed that actual establishments could be run at 10 – 15% below the figures generated. This will be achieved by active management of the aseasonality of work i.e. skewing training, non-urgent admin, annual leave, etc. into the less busy periods and therefore maximising patient facing activity in the busy periods. This practice may however prove more and more challenging over time as activity increases in previously ‘quieter’ times.

Overall the additional staff level required to achieve the two aims outlined above has been identified as an additional 17.41wte at a cost of £660.0k pa. Within this there is a significant increase in skill mix particularly a movement from Band 5’s to Band 6’s.

### 1.3.4 Overall

Details of the overall costs is shown in section 5. However, in summary, the aggregate costs are estimated to be as follows:

| Item | wte | £'000 pa |
|---|---|---|
| Medical Resource | 12.6 | 756.2 |
| Admin Support | 1.0 | 22.9 |
| Paediatric Nursing | 11.3 | 512.0 |
| General Nursing | 17.4 | 659.7 |
| PAY COSTS | 42.4 | 1,950.8 |
| Training (£1k pa @ wte) | | 42.4 |
| Other Non-Pay (£500k pa @ wte) | | 21.2 |
| **OVERALL TOTAL** | **42.4** | **2,014.4** |

An estimate of £1,000pa per wte has been included for training costs and a further £500pa per wte for other non-pay items.

The additional £2,014.4k quoted above is the FYE of the proposed changes. Due to time lags with recruitment etc. the 2019/20 costs are likely to amount to approximately half of this sum i.e. £1,007.2k

### 1.4 Conclusion

In conclusion the business case requests a significant level of additional staffing and related resources into the trust's ED service. This is required due to cope with increased attendances and the increased complexity of patients.

This investment is required to enable the service to meet the A&E 4 hour wait targets and move towards a CQC assessment of outstanding.

Therefore, the trust board is asked to agree to the request for additional funding for the service.

## 2. STRATEGIC CASE

### 2.1 Activity Increases

There has been a significant increase in activity at both of the trust's ED functions over the past three years. This is shown in the table below:

| Year | Minor | Major | Resus | Paeds | Grand Total |
|---|---|---|---|---|---|
| 2016-17 | 83,119 | 42,618 | 7,151 | 33,695 | 166,583 |
| 2017-18 | 82,405 | 43,709 | 6,607 | 32,836 | 165,557 |
| 2018-19 | 89,127 | 45,213 | 6,552 | 34,276 | 175,168 |
| **Grand Total** | **254,651** | **131,540** | **20,310** | **100,807** | **507,308** |
| 18-19 vs 16-17 | **7.20%** | **6.10%** | **-8.40%** | **1.70%** | **5.20%** |
| 18-19 vs 17-18 | **8.20%** | **3.40%** | **-0.80%** | **4.40%** | **5.80%** |

This can be further split by ED site as follows :

**DRI**

| Year | Minor | Major | Resus | Paeds | Grand Total |
|---|---|---|---|---|---|
| 2016-17 | 46,717 | 28,137 | 5,467 | 18,175 | 98,496 |
| 2017-18 | 47,320 | 28,980 | 5,127 | 18,244 | 99,671 |
| 2018-19 | 51,963 | 29,966 | 5,009 | 19,212 | 106,150 |
| **Grand Total** | **146,000** | **87,083** | **15,603** | **55,631** | **304,317** |
| 18-19 vs 16-17 | **11.20%** | **6.50%** | **-8.40%** | **5.70%** | **7.80%** |
| 18-19 vs 17-18 | **9.80%** | **3.40%** | **-2.30%** | **5.30%** | **6.50%** |

**Bassetlaw**

| Year | Minor | Major | Resus | Paeds | Grand Total |
|---|---|---|---|---|---|
| 2016-17 | 22,137 | 14,481 | 1,681 | 9,539 | 47,838 |
| 2017-18 | 20,830 | 14,729 | 1,478 | 8,797 | 45,834 |
| 2018-19 | 23,443 | 15,246 | 1,541 | 9,326 | 49,556 |
| **Grand Total** | **66,410** | **44,456** | **4,700** | **27,662** | **143,228** |
| 18-19 vs 16-17 | **5.90%** | **5.30%** | **-8.30%** | **-2.20%** | **3.60%** |
| 18-19 vs 17-18 | **12.50%** | **3.50%** | **4.30%** | **6.00%** | **8.10%** |

As can be seen from the above activity has at both ED sites. This trend has been continued for the current year 2019/20 where activity is significantly over plan for April and May.

### 2.2 Acuity Increases

Within this increased activity there has also been a growing level of complexity amount the medical issues presented by patients. This can be assessed by the increase in the average tariff per attendance. This is shown in the table below:

| Year | Total Income | Average Price | Average Price Increase |
|---|---|---|---|
| 2015/16 | 15,909,278 | 116.48 | |
| 2016/17 | 16,632,004 | 125.21 | 6.97% |
| 2017/18 | 18,301,848 | 139.78 | 10.42% |
| 2018/19 | 20,215,536 | 143.08 | 2.30% |

As can be seen average tariff received has increased year on year. This is in excess of the general inflationary uplift.

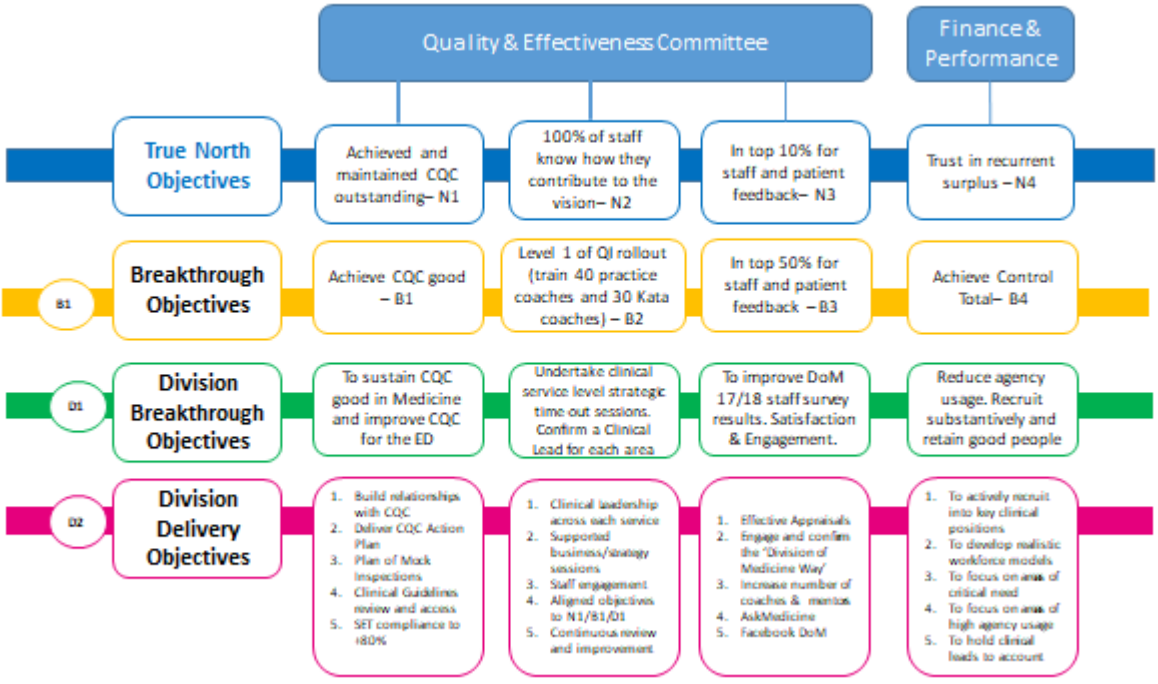
In reality the average tariff received for 'majors', i.e. the sicker patients, will have increased at a greater level than that shown above as the average will have been masked by the increased level of minors.

Given these increased in the demands on the service there is a need to address the capacity of the service. Given the labour intensive nature of the ED service this can only be achieved by additional staffing resources.

### 2.3 Divisional Strategic Objectives

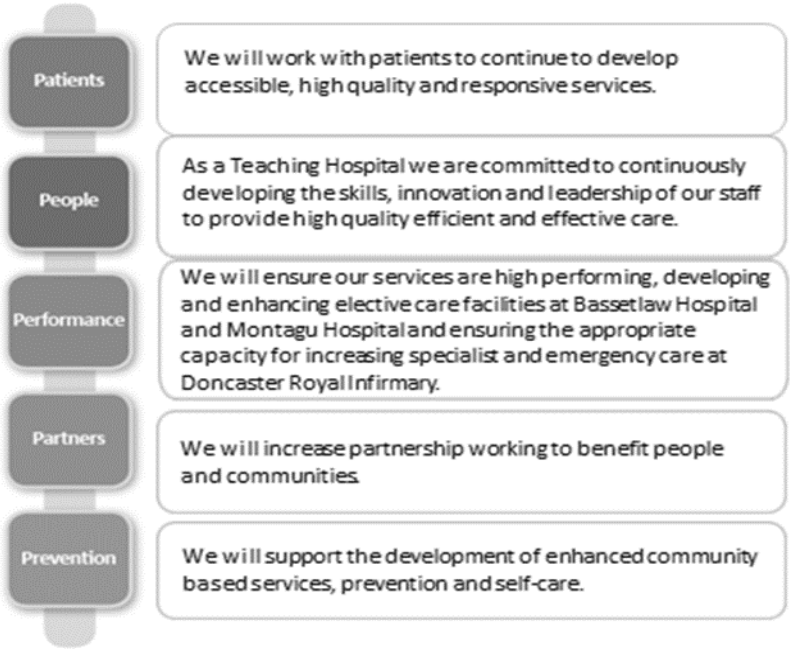
The remodelling of the workforce sits with the internal strategy looking at Urgent and Emergency pathways along with the Doncaster and Bassetlaw place strategies and the urgent and emergency strategy at SYBICS level.

The case also fits with all the trusts True North objectives and the division's breakthrough objectives please see the diagram below.




### 2.4 Trust Strategic Objectives

The trust's strategic objectives are, in summary, shown below:




The gains, both in terms of service quality and patient experience, that it if felt this business case supports will enhance the above objectives.

## 3. ECONOMIC

This section considers the range of options that could deliver the objectives and address the challenges identified in the strategic case. It then seeks to identify the option which best meets these and the existing and future needs of both the service itself and the wider Trust.

Whilst each of the three categories of staffing have unifying themes and rationale for the proposed changes there are some differences in the methodology used to quantify the changes required. Therefore, they have each been dealt with separately below:

### 3.1. MEDICAL STAFFING

Nationally there has been a shortage of middle grade tier doctors to support the workforce. At DBTH we have had a heavy reliance on locums resultant in high costs and inconsistent quality of doctors. Over the last few years we have been working toward reducing the locum work force with initiatives such as overseas development trainees that come over to DBTH for 2 year training programme. This has also resulted in a large uptake of our CESR training. All very positive for the Trust and department.

The increase to emergency attendances has had an impact on doctor waits in our that has increased patient waiting times and impacted on our overall performance. Therefore, we need to work towards increasing and 'future-proofing' our current substantive workforce to ensure we are able to continue providing a safe, effective and resilient service. Alongside Qii work that is currently being carried out around patient flow and new ways of working, we are asking for agreement to support the additional recruitment to our existing workforce team.

To resolve the issues identified above a number of options have been considered so as how to best amend medical staffing.

#### 3.1.1 List of options

The following options have been identified and assessed:

| Option | Description | Risks | Benefits |
|---|---|---|---|
| 1 | Do nothing and continue with current rota, and reliance on locums | Continued failure of 4 hour performance | Income continues to rise with additional attendances |
| | | Retention of staff | |
| 2 | Increase locum work force to meet increased demand | Quality of locum doctors | Small increase in waiting time to see a doctor |
| | | Impact on financial stability | |
| | | Historic poor productivity from some doctors in the cohort | |
| 3 | Increase workforce using consultants, PA, and ANPs | | Reduction in Emergency attendances |
| | | | Senior decision makers at the front door |
| | | | ANP and PA supporting the medical workforce and increasing productivity |
| | | | Improvement in 4 hour performance |
| | | | Improvement in time to see a doctor |

### 3.1.2 Identification of preferred option

Based on the above assessment option 3 has been identified as preferred. I.e. A proportionate increase in ED staffing is required to manage the increase in ED attendances.

Already this year the ED access target has fallen below 90% for the month of April 2019 leading to a significant deterioration in our target when compared to national piers.

If we are to attain CQC outstanding, then we need to invest in our staff to give them the capacity to deal with the increasing ED attendance.

Each of these lines of investment can be implemented relatively independently of each other however, we do not feel we will be able to improve care whilst dealing with the increase in attendance without the whole increase.

We have designed this plan to recruit staff groups that we believe we can attract to the Trust and invest in our future while dealing with the current capacity issues within ED.

The Royal College of Emergency Medicine (RCEM) has already designed a training program to take ACPs from the current SHO level up to a tier 3 level with 3-4 years to training. Investing in this staff group allows us the opportunity to look at replacing expensive ED MG Locums in the future as our workforce matures and grows.

Not only would we like to sustain our current service, but we aspire to improve towards a better CQC rating and an improved 4 hour access target. The output from our GIRFT session was that we were below average for consultant workforce and beds in the hospital. It showed that we were very good value as a department. This is further supported by the model hospital data showing that our ED WAU cost is £2,964 compared to a national average of £3,533. As our last CQC rating was substandard and our current 4 hour access target is falling this would suggest significant investment is needed.

The current RCEM staffing guidelines would suggest that across our two EDs (one classified as small and one as large this should have between 43 and 61 full time consultants. The additional posts identified in this business case would take our budget to 25 WTE consultants therefore still significantly below national guidelines. The actual guidelines are shown as follows :

**Numbers of Consultants and Minimum WTE SDMs**

| Size of Department (attendances/year) | WTE Consultant numbers | WTE SDMs (minimum) |
|---|---|---|
| **Medium** | 18-25 | 30 |
| **Large** | 25-36 | 42 |
| **Very Large** | 34-48 | 60 |

#### i. Consultant staffing

1.0 wte additional consultants contributing additional shop floor sessions per week will be able make a move towards, but not achieve at this stage, the desired '24/7 shopfloor consultant presence'.

#### ii. SHO Staff

- 10 hour shift 7 days per week 2-12 covering the busiest time
- Additional day shift mon-fri to allow leave to be taken without booking agency staff (slight reduction to current agency run rate)
- Further additional day shift Mon, Tues as Monday busy and Tues to cover teaching.

**iii. PAs**

- To start with will be supernumerary (likely 6 months) doing mainly day shifts then move to late/night cover as needed
- New staff group for us we need to invest, good experience reported from other sites

**iv. ACPs**

- 12 hour shifts 7 days per week 12-12 to cover busiest time
- 3 years will remain at band 7 training towards RCEM portfolio that will allow tier 3 MG cover when completed – likely future saving in MG hours.

**v. Admin Support**

- With the increase in staff into the department an increase in admin support will be required

### 3.1.3 Pattern of Patient Arrivals

As the ED service is a demand led service patients arrive throughout the day/night. However, there are significant 'peaks and troughs' in the pattern of arrivals. This is shown in summary below:

| MEASURE | TIME | | | | | | TOTAL |
|---|---|---|---|---|---|---|---|
| | 00 00 to 03 59 | 04 00 to 07 59 | 08 00 to 11 59 | 12 00 to 15 59 | 16 00 to 19 59 | 20 00 to 23 59 | |
| **Arrivals** | 11,842 | 10,057 | 44,264 | 49,741 | 47,585 | 28,016 | 191,505 |
| **Proportion** | **6.2%** | **5.3%** | **23.1%** | **26.0%** | **24.8%** | **14.6%** | **100.0%** |

As can be seen attendances peak during the 12pm – 4pm period and are at their lowest in the early morning (12am – 4am). Whilst staff are rotated accordingly it is not always possible to reflect this given to need to maintain minimum staffing levels at all times.

As can be seen in Appendix 2 these limitations result in a mismatch of patient arrivals and staffing over the period 8am to 2pm. The expansion to the rota that the additional staffing identified will provide will allow this issue to be better addressed.

### 3.1.4 Pattern of 4 Hour Breaches

In line with the varying pattern of patient arrivals there is also a variation in the proportion of patients breaching the four-hour target at varying times throughout the day. This is shown below:

| MEASURE | TIME | | | | | | TOTAL |
|---|---|---|---|---|---|---|---|
| | 00 00 to 03 59 | 04 00 to 07 59 | 08 00 to 11 59 | 12 00 to 15 59 | 16 00 to 19 59 | 20 00 to 23 59 | |
| **Arrivals** | 11,842 | 10,057 | 44,264 | 49,741 | 47,585 | 28,016 | 191,505 |
| **Breaches** | 1,985 | 1,022 | 1,784 | 2,862 | 3,737 | 3,175 | 14,565 |
| **Proportion** | **16.8%** | **10.2%** | **4.0%** | **5.8%** | **7.9%** | **11.3%** | **7.6%** |

As can be seen the proportion of breaches is significantly higher during the period 8pm – 4am than during 4am – 8pm. Indeed, the rate, at 12.4% for the former is more than twice as much as the later at 5.9%.

The increased staff levels proposed will allow greater flexibility for the mix of senior: junior medics to be enhanced during the period to enhance decision making and thereby reduce breaches.

### 3.1.5 Clinical and operational impact:

- This model will provide a safe environment with safer staffing establishment for the number of patients attending the department.
- Reduction in the number of bank and agency staff when establishment is correct.
- Reduction in SI and incidents with improved staffing per patient allowing improved documentation and discharge planning.

## 3.2 PAEDIATRIC NURSING STAFFING

### 3.2.1 Rationale

The CQC inspection in December 2018 highlighted an issue with the paediatric nurses working in both EDs and recommended that both EDs have 2 paediatric nurses 24/7. This requires a staffing level of 5.67wte per site.

The CQC recommended that the paediatric nursing staffing should be developed within both EDs to effectively support the number of children attending the departments. This would mean an increase a further paediatric nurse by 1 x 24/7 and at Bassetlaw of 1 x 24/7 and 1 x 12 hrs. As above the introduction of the band 6 role into the paediatric team on both sites would improve the leadership and responsibility of these staff to improve the services for children in both EDs. These roles would link with the paediatric wards with a rolling rotational programme to maintain and develop skills in working with children. This will also assist in the recruitment of paediatric nurses to both areas.

An increase in nurse staffing will ensure the establishments are correct for monitoring through grip and control meetings. Enable recruitment to the posts and reduce the bank and agency spend for the departments.

### 3.2.2 Bassetlaw

The CQC have requested that the Bass ED be staffed with two paediatric nurse 24/7 to ensure that all children are cared for effectively. This rota change would enable 1wte band 6 nurse to work in the department and be responsible for the development of children's services within ED at Bassetlaw. Working alongside the band 7 lead nurse for paediatrics who covers both EDs the remaining rota will be covered by wte band 5 paediatric nurses. With recruitment being an issue for this role there will be educational development for the band 5 ED nurses to work with children in the absence of a paediatric nurse. This will be a recognised qualification accredited to a local university.

### 3.2.3 Doncaster

The CQC have requested that the DRI ED be staffed with two paediatric nurse 24/7 to ensure that all children are cared for effectively. This rota change would enable band 6 nurses to work over a 12-hour period every day to support the band 5 paediatric nurses. They would also be responsible for the development of children's services within ED, working alongside the band 7 lead nurse for paediatrics who covers both EDs the remaining rota will be covered by wte band 5 paediatric nurses. With recruitment being an issue for this role there will be educational development for the band 5 ED nurses to work with children in the absence of a paediatric nurse. This will be a recognised qualification accredited to a local university.

## 3.3 GENERAL NURSING STAFFING

### 3.3.1 Overall

The BEST tool audit in February 2018 and December 2018 highlighted a need to improve the senior leadership within both Emergency Departments (ED) to support the band 5 and unqualified staff working within the teams. This was discussed with the nursing, medical and managerial teams within the department who agreed with the findings of the BEST audit and the CQC recommendations as this would be best practice for the nursing staffing numbers for the ED.

The current establishments for the ED in both hospitals were introduced in 2014 and have not changed since this time. The departments have seen a continuing yearly increase in patients attending during this period with a 6% increase in the past year. The vacancy rates have lowered, and retention rates have increased through a planned recruitment and development plan for the whole nursing team. This includes the training and qualification of the Band 4 assistant practitioners who function in both departments. The band 3 and band 2 posts have been developed and increased to ensure that patient quality and competencies can be performed satisfactorily.

The BEST tool identified that within the resuscitation and majors teams that there was a high number of band 5 nurses and no leadership within the team. This was the same message coming from the medical and nursing staff within the department. The revised staffing structure has a band 6 nurse identified for resus and majors. This role will support the band 7 co-ordinator who has a helicopter view of the whole department. The role would be to increase the clinical expertise, who can delegate duties, managing these areas with the responsibility of their grade. This will enable them to support and guide the junior nursing staff and unqualified staff working alongside them. This will improve patient safety and quality with a senior person being able to improve communication with the patients and their relatives/ carers.

An increase in nurse staffing will ensure the establishments are correct for monitoring through grip and control meetings. Enable recruitment to the posts and reduce the bank and agency spend for the departments.

### 3.3.2 Bassetlaw

Bassetlaw ED has seen an increase in the number of attendances by 6% over the past year. There is a need for a band 5 to support the unplanned care area of the department to ensure effective triage, streaming and treatment of the patients either to other areas or within the department. The band 5 will be a 12-hour post during the peak afternoon and evening period when the number of walks in patients increase. This post will be responsible for the patient flow through the department and work with the medical team to ensure that patients are seen, treated and discharged in a timely manner.

There is a requirement to introduce a band 6 post into early senior review (ESR) and majors who will be responsible for these areas in terms of patient quality care and treatment in a timely manner. They will be responsible for the support and development of the areas and the nursing team working within the ED.

The BEST tool has been designed to demonstrate Emergency Department (ED) nursing workload based on a combination of the number of patients attending the department, a measure of the patients' nursing dependency and length of stay. Dependency rather than acuity is used as a patient may be very sick, but not actually require much nursing input; their *acuity* would be high, but their nursing *dependency* low. Whereas another patient may not be acutely unwell, but because of other factors (perhaps incontinence, coupled with confusion), will require significant nursing input; low acuity, but high nursing dependency. This staffing tool has been used to evaluate the necessary nurse staffing levels required in the trust's ED function.

February 2018 has been used as an exemplar of a typical busy period. This will therefore identify the maximum staffing level required. However, given the historically lower requirements of nurse staffing in summer months, the project team has identified that actually establishments can be approximately 10% lower. This will require items such as annual leave, training, non-urgent admin, etc. to be undertaken in less busy times so that direct clinical contact can be maximised in busy periods.

The BEST tool for Bassetlaw ED identified the following :

| **ECA BEST TOOL TEST Bassetlaw DGH** | |
|---|---|
| Daily hours required | 273.00 |
| Daily hours + on costs @ 25% | 341.30 |
| Weekly hours | 2,388.80 |
| Whole-time equivalent | 63.70 |
| **Skill level** | **WTE Requirement** |
| Senior Emergency/Emergency Charge Nurses | 6.37 |
| Emergency Nurses | 19.11 |
| Foundation Staff Nurses | 25.48 |
| Clinical Support Workers or Nurse Associates | 12.74 |
| | 63.70 |

As can be seen the tool identified a need for 63.7wte. This is based on February 2018 activity/acuity. However, the exercise has been repeated for May 2019 to produce a similar outcome.

To compare this with the proposed establishments care is required to ensure that a 'like for like' comparison is made. Therefore, the areas not included in the BEST tool calculation, i.e. CDU, FDASS and BDGH streaming, need to be removed to ensure a true comparison. This is shown below:

| | BDGH<br>wte |
|---|---|
| Proposed new establishment | 67.20 |
| Less : CDU staffing | (5.67) |
| Less : FDASS/Streaming staffing | (5.67) |
| Adjusted Establishment | 55.86 |
| BEST tool results | 63.70 |
| Reduction from BEST tool | 7.84 |
| Reduction from BEST tool | 12.3% |

As can be seen the requested staffing level is 12.3% below that generated by the BEST tool. This will be achieved by better seasonal flexing of staffing tasks and levels. This may however prove more difficult over time as significant activity increases are seen in previously 'quieter' times.

### 3.3.3 Doncaster

DRI ED has seen an increase in the number of attendances by 6% over the past year.

Following the review of the BEST data with the senior nurses, medical team and department staff there was a consensus that the department required senior support for the band 5 nurses within the teams of the department. There was a concern that the teams had no leadership and delegation to prioritise the assessments, treatments and communications which leads to disorganised workforce. This is particularly an area of concern with the increase of new staff to the department and newly qualified staff. There is a need to introduce a band 6 post into early senior review (ESR), majors and resus who will be responsible for these areas in terms of patient quality care and treatments in a timely manner. They will be responsible for the support and development of the staff and patient safety, working alongside the band 7 lead nurse and the senior team within ED.

A workforce review would see a decrease in the current in post band 7 and band 5 staff to cover the changes in the role. Please see the financial analysis for the changes in the banding.

Additionally, the CQC have requested that the DRI ED be staffed with two paediatric nurse 24/7 to ensure that all children are cared for effectively. This rota change would enable band 6 nurses to work over a 12-hour period every day to support the band 5 paediatric nurses. They would also be responsible for the development of children's services within ED, working alongside the band 7 lead nurse for paediatrics who covers both EDs the remaining rota will be covered by wte band 5 paediatric nurses. With recruitment being an issue for this role there will be educational development for the band 5 ED nurses to work with children in the absence of a paediatric nurse. This will be a recognised qualification accredited to a local university.

The results of the BEST tool for Doncaster are as follows:

| ECA BEST TOOL TEST DRI | |
|---|---|
| Daily hours required | 548.00 |
| Daily hours + on costs @ 25% | 685.00 |
| Weekly hours | 4,795.00 |
| Whole-time equivalent | 127.90 |
| **Skill level** | **WTE Requirement** |
| Senior Emergency/Emergency Charge Nurses | 12.79 |
| Emergency Nurses | 38.36 |
| Foundation Staff Nurses | 51.15 |
| Clinical Support Workers or Nurse Associates | 25.57 |
| | 127.87 |

As can be seen the tool identified a need for 127.9wte. This is based on February 2019 activity/acuity. However, the exercise has been repeated for May 2019 to produce a similar outcome.

Once again it is necessary to remove CDU and FDASS/Steaming staffing requirements from the requested staffing levels to form a true comparison. This is shown below:

| | DRI wte |
|---|---|
| BEST (February) | 127.90 |
| Plus : CDU | 19.84 |
| Plus : FDASS/Streaming | 22.68 |
| Adjusted BEST Establishment | 170.42 |
| Reduction From Adj BEST | (17.12) |
| New Establishment | 153.30 |
| Proportion BEST Establishment | 90.0% |

As can be seen the overall level of staffing requested is 10.0% below that generated by the BEST tool. As is the case for Bassetlaw (see above) this will be achieved by better management of the seasonal tasks required although this may prove more challenging over time as significant activity increases are seen in previously 'quieter' times.

## 4. COMMERCIAL CASE

### 4.1 Income

The trust receives payments from local commissioners for ED attendances. Therefore, the activity and acuity growth seen will have generated additional income for the trust. This is quantified below:

| Year | Total Income | Average Price Increase |
|---|---|---|
| 2015/16 | 15,909,278 | |
| 2016/17 | 16,632,004 | 4.35% |
| 2017/18 | 18,301,848 | 9.12% |
| 2018/19 | 20,215,536 | 9.47% |

As can be seen the ED service has generated increased income for the trust significantly in excess of the level of general tariff inflation.

It should however be noted that the above income includes a contribution to other services e.g. building costs, hotel services, etc.

### 4.2 Commissioner Reaction

In such cases commissioners do not support service developments due to the concern that any expansion in capacity will need to an 'supply led' increase in activity. However, given the nature of the ED service, this is unlikely to be the case in this instance.

### 4.3 Comparable Cost

The NHS wide 'model hospital' generates costs for each trust's ED services. To adjust for acuity of patients between differing services a unit of activity of 'Weighted Activity Units' (WAU) is used. This shows that the trust is mid-way on the bottom quartile i.e. amongst the lowest cost 25% of providers.

As summary of the output of this nationally recognised benchmarking is show in the table below:

| Provider | Cost per WAU | | Cost per Attendance | |
|---|---|---|---|---|
| | £ | % c/w Peers | £ | % c/w Peers |
| DBTH | 2.964 | 84% | 162 | 91% |
| National Median | 3.533 | 100% | 172 | 96% |
| Peer Median | 3.525 | 100% | 179 | 100% |

As can be seen, in terms of the WAU measure the trust, is 16% cheaper than both the national median and the median of its local peers. Even in terms of basic attendances the trust is 9% cheaper than its local peers.

Therefore, it can be seen that the trust's ED function is an efficient low cost service.

More details of this is shown in Appendix 1.

### 4.4 Service Profitability

The trust's 'PLICs' system generated the following SLR figures for the year to 31st March 2019 for A&E/ED as a speciality:

| | £m |
|---|---|
| Income | 31.2 |
| Direct Costs | (24.3) |
| Indirect Costs | (2.4) |
| **Contribution** | **4.5** |
| Overheads | (5.8) |
| **(Loss)/Profit** | **(1.3)** |

As can be seen above the service generated a significant contribution which was however not sufficient to cover the allocated overheads. Therefore, a net loss was generated overall. It should however be noted that this loss does not include an allocation of the additional funding received from NHSI at the year end. If this was allocated proportionately to services by income, then the A&E/ED service would have generated a comfortable surplus for the year.

### 4.5 Public Perception of the Service

The A&E service is seen by the general public as the 'front door' of the trust's hospital. Indeed, it is via this methodology that the majority of emergency patients enter the trust's facilities.

Therefore, public perception of the quality of the services offered by NHS bodies is generally skewed towards an assessment of this service – both in terms of quality of care and waiting times.

Therefore, an efficient, quality ED service is key to ensuring a positive public perception of the trust's services.

## 5. FINANCIAL CASE

It is inevitable that the significant increase in staffing levels will incur significant additional costs.

In costing these development no additional clinical non-pay costs have been assumed. The rational being that activity will not increase due to the changes, simply the quality of the service and patient experience. Therefore, the only non-pay cost that have been included are an allowance for training cost of £1,000pa per wte and a further £500pa wte for minor equipment. In practice the later may be capitalised as a grouped asset but, for ease of reference, has been assumed to be a revenue cost in this business case.

The current ED sites face significant issues with a lack of physical space. Any changes that may be required relating to this issue have been deemed to be outside the remit of this business case.

### 5.1 Nursing Staffing

The additional staffing identified as required is shown by site in the tables below:

## A&E Bassetlaw

| Grade | Budget WTE | Required staffing wte | WTE Variance | Additional Cost (£) |
|---|---|---|---|---|
| Ancilary band 1 | 1.0 | 1.0 | 0.0 | 0 |
| Nurse band 2 | 5.7 | 5.7 | 0.0 | 0 |
| Nurse band 3 | 8.5 | 11.3 | 2.8 | 85,865 |
| Nurse band 4 | 1.8 | 0.0 | (1.8) | (46,270) |
| Nurse band 5 | 34.0 | 31.2 | (2.8) | (118,454) |
| Nurse band 6 | 5.3 | 14.2 | 8.9 | 462,699 |
| Nurse band 7 | 3.3 | 3.8 | 0.5 | 32,975 |
| **Total** | **59.5** | **67.2** | **7.7** | **416,814** |

## A&E Doncaster (DRI)

| Grade | Budget WTE | Required staffing wte | WTE Variance | Additional Cost |
|---|---|---|---|---|
| Ancilary band 1 | 1.8 | 1.8 | 0.0 | 0 |
| Nurse band 2 | 14.2 | 22.7 | 8.5 | 231,544 |
| Nurse band 3 | 24.8 | 34.0 | 9.2 | 277,600 |
| Nurse band 4 | 3.6 | 5.7 | 2.1 | 61,745 |
| Nurse band 5 | 62.4 | 50.4 | (11.9) | (500,822) |
| Nurse band 6 | 14.2 | 26.6 | 12.5 | 638,684 |
| Nurse band 7 | 11.3 | 12.1 | 0.8 | 46,161 |
| **Total** | **132.2** | **153.3** | **21.1** | **754,912** |

In aggregate the overall changes requested are as follows:

## NURSING OVERALL

| Grade | Budget WTE | Required staffing wte | WTE Variance | Additional Cost |
|---|---|---|---|---|
| Ancilary band 1 | 2.8 | 2.8 | 0.0 | 0 |
| Nurse band 2 | 19.8 | 28.3 | 8.5 | 231,544 |
| Nurse band 3 | 33.3 | 45.4 | 12.0 | 363,465 |
| Nurse band 4 | 5.4 | 5.7 | 0.3 | 15,475 |
| Nurse band 5 | 96.4 | 81.6 | (14.8) | (619,276) |
| Nurse band 6 | 19.4 | 40.8 | 21.4 | 1,101,383 |
| Nurse band 7 | 14.6 | 15.9 | 1.3 | 79,136 |
| **Total** | **191.7** | **220.5** | **28.8** | **1,171,727** |

Due to supervisory responsibilities it is not fully possible to split staff between paediatrics and 'general'. However, an estimate has been made in the table below:

| | WTE Variance | Additional Cost |
|---|---|---|
| **Paediatrics** | 11.34 | 512,000 |
| **General** | 17.41 | 659,727 |
| | **28.75** | **1,171,727** |

As can be seen from the above the overall increase of 28.8wte masks a 14.8wte reduction in Band 5 staff and a 21.4wte increase in Band 6 staff. This move will be achieved by a combination of

upskilling the existing Band 5 staff and natural wastage, therefore there will be no redundancy costs incurred.

The above costings of the revised service have generated via revised rotas based on the CQC recommendations.

### 5.2 Medical Staffing

The additional medical staffing identified as required is as follows:

**MEDICAL OVERALL**

| Grade | WTE Change | Additional Cost |
|---|---|---|
| Consultants | 1.0 | 140,000 |
| Physician's Assistant (BDGH) | 2.8 | 124,738 |
| Physician's Assistant (DRI) | 2.8 | 124,738 |
| ACP (DRI) | 2.8 | 149,374 |
| SHOs | 3.0 | 171,180 |
| Supervision | 0.2 | 23,206 |
| Admin Support | 1.0 | 22,923 |
| **Total** | **13.6** | **756,159** |

The above additional resources will allow the trust's ED functions to provide the quality service complying with NHS performance targets.

These Costs are based on the shift data and productive PA data from the divisional director's workings costed at the average budget of a current vacancy to be consistent with original budget setting process.

### 5.3 Overall Costs

The above costs can be aggregated as follows:

| Item | wte | £'000 pa |
|---|---|---|
| Medical Resource | 12.6 | 756.2 |
| Admin Support | 1.0 | 22.9 |
| Paediatric Nursing | 11.3 | 512.0 |
| General Nursing | 17.4 | 659.7 |
| PAY COSTS | 42.4 | 1,950.8 |
| Training (£1k pa @ wte) | | 42.4 |
| Other Non-Pay (£500k pa @ wte) | | 21.2 |
| **OVERALL TOTAL** | **42.4** | **2,014.4** |

It should be noted that the above are full year costs. Given likely recruitment timescales it is only envisaged that 50% of these total costs will be incurred during 2019/20.

## 6. MANAGEMENT CASE

### 6.1 Implementation

The project team have developed an outline implementation plan. This address both each individual line of the additional staffing identified as well as the changes overall as a whole. Key aspects of this include:

- Consultant recruitment: These posts will we advertised as soon as approval of the business case is agreed. Recruitment for such roles is, however, often difficult. Where it proves impossible to recruit a combination of bank and agency will be used to fill any gaps. However, spending will be limited to the increased budget.
- ACP recruitment – These posts will be advertised immediately with a planned August 2019 start. There are thought to be ACPs already within the trust that are interested in these posts. Such recruitment will inevitably require a further recruitment process to cover any gaps generated in other departments. The rota for this staff group will not be put in place until recruitment is completed.
- PA recruitment: These posts will be advertised once a plan has been developed for their training and supervision. It should be noted that the trust has not used PAs within the ED service previously. Where this staff group cannot be recruited to the relevant rota will not be put in place i.e. the rota will be built as the staff are put in place.
- SHO recruitment: The trust has been successful in recruiting to similar posts over the last year. Therefore, a similar approach will be taken. There is also a plan to devise an “F3 teaching post” that has been developed with the education department.
- Unqualified nurse recruitment: These posts will be advertised and recruited in the usual manner. Bank staff will be used to fill any gaps in establishments.

- Qualified nurses: The significant change proposed for this staffing group is the move from Band 5 posts to band 6. This will largely be achieved by upskilling and upgrading the current workforce. There this is not possible it is likely that there will be a need to recruit to a Band 6 level as Band 5 staff leave the trust.

Therefore, the overall move to the new staffing level will occur over time with changes amongst some staff groups being completed at a different pace than others. Overall it is estimated that these changes will be largely completed by January 2020. Although the additional PA posts are likely to prove the exception to this where it is estimated that only 3 of the additional 6 will be in place at this point.

## 6.2 Risks

### 6.2.1 Overall Risk

Using the trust risk matrix below, the risk score for taking no action in relation to the objective of this Business Case is 16. I.e. a RED risk. This reflects the risk of poor quality patient care and a reduced patient experience.

Again, using the trust's risk matrix below, the risk score following the implementation of the recommendation in relation to the objective of this Business Case is 8. This reflects a reduction in the overall risk level of the above from 'High/Likely' to 'Low/Unlikely'. This does not reduce further as the assessment of the 'consequences' remains at 'Major'.

| | **Consequence** | | | | |
|---|---|---|---|---|---|
| **Likelihood** | Insignificant | Minor | Moderate | Major | Catastrophic |
| Rare | **1** | **2** | **3** | **4** | **5** |
| Low/Unlikely | **2** | **4** | **6** | **8** | **10** |
| Possible | **3** | **6** | **9** | **12** | **15** |
| High/Likely | **4** | **8** | **12** | **16** | **20** |
| Almost Certain | **5** | **10** | **15** | **20** | **25** |

### 6.2.2 Specific Risks

The project team have identified a number of specific risks that relate to the project. These are shown below:

| **Risks** | **Assessment** | | **Overall** | **Mitigation Plan** |
|---|---|---|---|---|
| | **Likelihood** | **Consequence** | | |
| Activity doesn't increase as per contract expectations and reduces from 19/20 activity | 2 | 3 | **6** | If we recruit to substantive from the business case it will enable us to reduce the reliance on locum staffing |

| | | | | |
|---|---|---|---|---|
| Unable to recruit to the staffing model | 3 | 3 | **9** | There is no reason as to why would not be able to recruit to these posts as we are unaware of any short falls nationally for these work group. |
| Not meeting the CQC recommendations for paediatric staffing | 3 | 4 | **12** | Agency staff requested. Adult nurses developing skills and masters level training to deal with paediatric patients. |
| Not achieving safe staffing levels increase in serious incidents | 3 | 4 | **12** | Agency and bank staff are requested to fill the current workforce gaps within the department. |

### 6.3 Quality Impact Assessment

The proposed staffing increase will support the True North objectives of the organisation. The quality of the service will improve by employing substantive workforce that will increase productivity on the shop floor by support the current workforce. Patient experience will improve as the wait to see a clinician and time in the department will reduce.

### 6.4 Equality impact assessment

The project team has completed an equality impact assessment which raises no issues.

### 6.5 Other organisations

Emergency ambulances turnaround times were affected by the performance of the trust's ED function. During 2018/19 there were 815 occasions when non-clinical waits of greater than 15 minutes occurred. The proposed changes here will serve to reduce waiting times and therefore minimise unnecessary ambulance waits.

Whilst this improvement has no financial or direct other effects on the trust is does serve to support a partner in the local health economy.

### 6.6 Benefits realisation

As stated above the benefits to be achieved through the proposed staffing increases will largely be apparent through improvement to the quality of the service and enhanced patient experience. Whilst these are obviously key a number of secondary benefits should also be generated e.g. improved staff retention. These will also ultimately work through to enhance the quality of the service.

The identified quantifiable benefits are shown below:

| Benefit | Measure |
|---|---|
| Reduction in complaints | Datix reports |
| Reduction in time to be seen by a clinician | Symphony Data |
| Reduction in time patients spend department | Symphony data |
| Staff feedback sessions | Survey Monkey benchmarked again March 19 |
| Decreased reliance on bank and agency staff | Reduced spend in that category |
| Increased development and retention of existing band 5/6 workforce | Retention rate of band 5/6 nurses |
| Meeting the performance and quality metric for the department | KPI targets met |

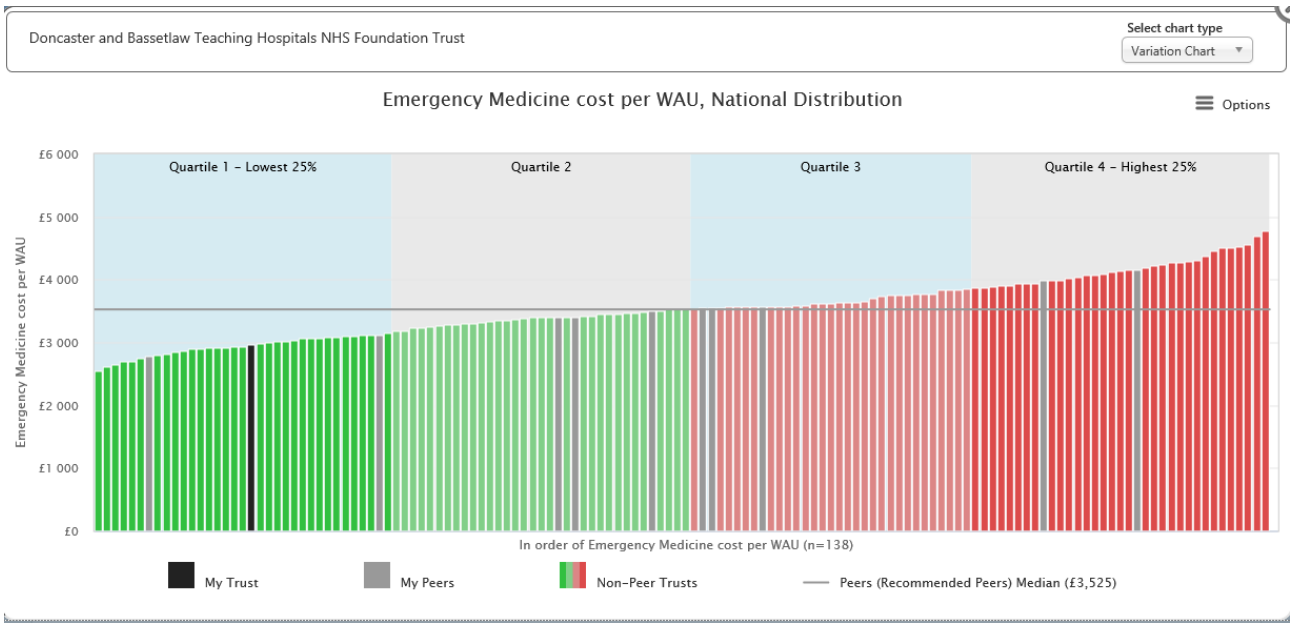
### 6.7 Post project evaluation

The post evaluation process will link in with the various performance matrix that go to divisional team and, at a summary level, the trust board on a monthly basis. This will involve a review of departmental and divisional objectives to assess whether they are being achieved.

The project will be evaluated at the six-month stage after the additional workforce is largely in place i.e. July 2020.

## 7 APPENDICES

**APPENDIX 1 – ED COSTS COMPARED NATIONALLY**



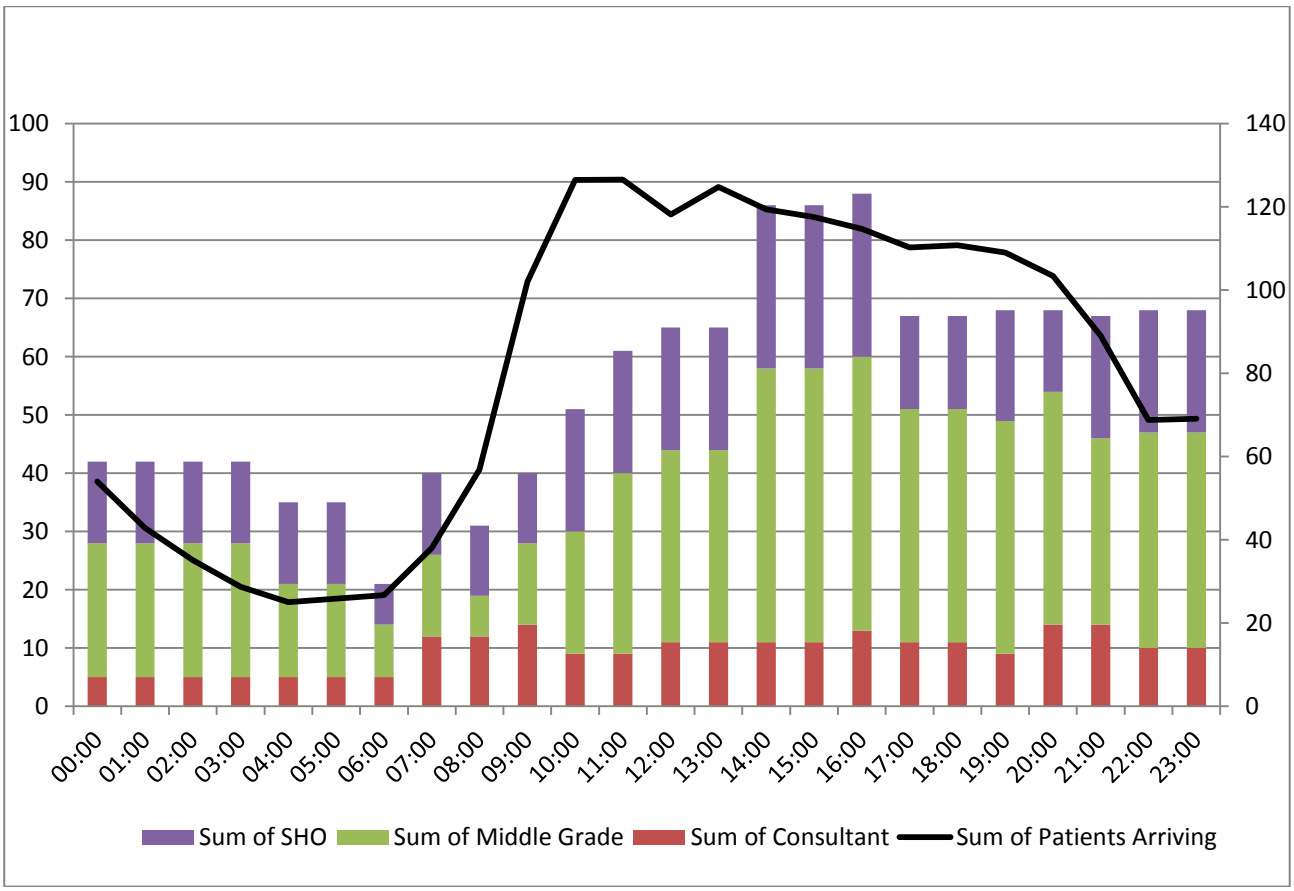

| Clinical Output (WAUs) | Data period | Trust value | Peer median | National median | Chart | Actions |
|---|---|---|---|---|---|---|
| Emergency Medicine WAUs | 2017/18 | 9,507 | 7,773 | 6,332 | | |

| Expenditure | Data period | Trust value | Peer median | National median | Chart | Actions |
|---|---|---|---|---|---|---|
| Expenditure on Emergency Medicine | 2017/18 | £26.86m | £25.02m | £21.29m | | |

| Cost per WAU | Data period | Trust value | Peer median | National median | Chart | Actions |
|---|---|---|---|---|---|---|
| Emergency Medicine cost per WAU | 2017/18 | £2,964 | £3,525 | £3,533 | | |

| Cost per Attendance | Data period | Trust value | Peer median | National median | Chart | Actions |
|---|---|---|---|---|---|---|
| Cost per Attendance | 2017/18 | £162 | £179 | £174 | | |

## APPENDIX 2 - Current ED staffing (Bar chart) Mapped to ED attendances (black line)


100
90
80
70
60
50
40
30
20
10
0
140
120
100
80
60
40
20
0
00:00
01:00
02:00
03:00
04:00
05:00
06:00
07:00
08:00
09:00
10:00
11:00
12:00
13:00
14:00
15:00
16:00
17:00
18:00
19:00
20:00
21:00
22:00
23:00
Sum of SHO
Sum of Middle Grade
Sum of Consultant
Sum of Patients Arriving

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Title** | NHS Pensions update | | |
| **Report to** | Board of Directors | **Date** | September 2019 |
| **Author** | Karen Barnard, Director of People & Organisational Development | | |

| **Purpose** | | Tick one as appropriate |
|---|---|---|
| | Decision | x |
| | Assurance | |
| | Information | |

**Executive summary containing key messages and issues**

Members of the Board will recall earlier discussions about the impact of the lifetime allowance on staff within the NHS Pension Scheme but also the fact that many younger and or lower paid staff were choosing not to be in the pension scheme and whether the Trust should provide an option of receiving a proportion of the employer's contributions should they have taken the decision to opt out of the NHS Pension scheme. More recently Trusts including ourselves have seen an impact on senior clinicians related to the tapered annual allowance which was introduced in 2016 (Since 2016, the annual allowance taper has restricted the amount of tax relief available to those with a threshold income over £110,000, reducing it from £40,000 to £10,000.

However, concerns have been raised these rules have left those in the NHS pension scheme with unexpectedly high tax bills, encouraging some to opt out of the scheme, turn down additional work or leave the health service altogether) – this led to the government consulting on proposals around a 50:50 option, which would allow clinicians to halve their pension contributions in exchange for halving the rate of pension growth. As a result it was determined that we would pause that work. Whilst this consultation was launched it was quickly paused following the publication of the interim NHS People Plan with the intention of further work being undertaken.

**NHS Employers guidance**

In August 2019, the government announced that it would act to introduce pension changes to enable senior clinicians to take on additional clinical activities without incurring unexpected pension tax bills. In the meantime NHS Employers developed guidance for Trusts to support staff who are likely to be affected by these pension tax issues. The purpose of this paper is to consider which, if any, of these options we might wish to pursue.

The guidance outlines several routes we can take during the 2019/20 financial year, to support staff affected by current pension tax policies in the interim (pending the outcome of the government's consultation on changes to the NHS Pension scheme), including:

- taking independent financial advice and guidance

- using existing flexibilities to enable employees to remain in the NHS Pension Scheme
  - managing pensionable pay
  - local clinical excellence awards
  - designing innovative TOIL arrangements
  - use of multiple contracts
  - establishing new organisations for service delivery
- possible arrangements for employees who decide to opt out of the NHS Pension Scheme
  - Opting out of the scheme for a proportion of the scheme year
  - Paying the employer contributions as additional salary.

**Government consultation on revised proposals**

Government publishes fresh proposals amid increasing reports of staff refusing extra work. DHSC says third of consultants and GPs may be less inclined to take on extra shifts because of current pension rules. Subject to consultation response, it is expected that changes will be implemented in time for the start of next tax year. The Department of Health and Social Care have said that it would today set out a range of possible new measures, including allowing GPs, senior nurses and consultants to set their own bespoke pension growth level at the start of each tax year and pay correspondingly lower contributions. This level would be a percentage of the normal scheme contribution in 10 per cent increments – such as 30, 50 or 70 per cent of the full accrual level.

Other proposals include:

- An option to alter pension contributions, including topping up pensions, towards the end of the tax year, when the individual has a clearer idea of their tax situation; and
- Individuals who receive a large pensionable pay rise being able to phase, over several years, the amount by which their new pay contributes to their pension.

The DHSC said it will also develop a tool to help clinicians tailor the new flexibilities to support their own individual circumstances and preferences.

Comments made:

> Danny Mortimer, chief executive of NHS Employers, said in the release that the new proposals *"helpfully acknowledge"* the need for more flexible schemes, *"over and above"* the 50:50 system, to help senior clinicians manage their pension growth within current tax laws. He added: *"The consultation recognises the importance of the work of the Scheme Advisory Board, through which NHS Employers and our trade unions are leading the development of a recommendation on introducing scheme flexibilities for the benefit of all NHS staff. Employers continue to believe the greater scheme flexibilities are needed for all areas of our workforce."*

Health and social care secretary Matt Hancock said the proposal was the government's way of taking a *"decisive step"* in fixing the problem, adding:

> *"To make sure we get this right, however, it is vital we learn from the experiences of our dedicated frontline staff, so I urge them to have their say."*

Responding to the government's new NHS pensions consultation, the Chief Executive of NHS Providers, Chris Hopson said:

> *"It is good to see the government has recognised the importance of addressing the pensions issue as it affects senior clinicians, through this consultation. It is important that this is followed by decisive steps to ensure they are not penalised financially for carrying out much-needed work which makes a huge difference for so many patients. We have played a leading role in raising these concerns and we are pleased to see they are being addressed. However, we are worried that in tackling the concerns of senior clinicians, the continuing pensions difficulties for more junior staff and for NHS managers will be overlooked. It is vital that this does not happen,*

*and we will continue highlight the damaging impact this could have."*

**Consultation questions**

DHSC would like to receive responses on the following consultation questions, including evidence (where available) to support the response:

***The case for pension flexibility***

**Question 1 -** Who do you think pension flexibility should be available to?

- NHS GPs and consultants who may be affected by the annual allowance tax charge
- Other NHS clinicians who may be affected by the annual allowance tax charge
- Non-clinicians in the NHS who may be affected by the annual allowance tax charge
- All members of the NHS workforce, regardless of their tax position
- Other group
- None of the above.

Please provide evidence to support your views.

***Proposed pension flexibility***

**Question 2 -** Do you think the proposal for a more tailored approach to pension accrual is flexible enough for senior clinicians to balance their income, pension growth and tax liability? Please set out the reasons for your answer.

**Question 3 -** If not, in what ways could the proposals be developed further?

**Question 4 -** We're proposing that large pay increases for high-earning staff should only be included in their pensionable income gradually. Do you agree or disagree with this proposal? Please set out the reasons for your answer.

***Improving Scheme Pays***

**Question 5 -** Currently, the NHS Pension Scheme has a notional defined contribution pot (NDC) approach to Scheme Pays deductions. We're proposing to replace this with the debit method. Do you agree or disagree with this proposal? Please set out the reasons for your answer.

***Equality Impact Assessment***

**Question 6 -** What impact, if any, do you think the following will have on people with one or more protected characteristics:

- The proposal to target the flexibility to clinicians who have a reasonable prospect of an annual allowance tax charge
- The proposal to provide flexible accrual to clinicians who have a reasonable prospect of an annual allowance tax charge
- Other proposals in the consultation document e.g. phasing pensionable pay increases and/or commissioning a modeller to help individuals understand their tax liability and flexibility options
- Adopting the debit method for scheme pays.

**Question 7 -** Are there any further equality considerations that the department should be aware of from groups outside the data set?

The consultation will close on 1 November 2019. The link to the full consultation document is:

https://www.gov.uk/government/consultations/nhs-pension-scheme-increased-flexibility

**Key questions posed by the report**

Do members of the Board consider that the Trust should implement any of the flexibilities contained within NHE Employers' guidance?

| 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:<br>i. Increase in temporary expenditure<br>ii. Inability to meet FYFV and Trust strategy<br>iii. Inability to provide viable services.<br>Q&E 6 Failure to improve staff morale leading to:<br>i. Recruitment and retention issues<br>ii. Impact on reputation<br>iii. Increased staff sickness levels. |
| **Recommendation(s) and next steps** |
| Members of the Board are asked to:<br>• consider whether the Trust should implement any of the flexibilities within NHS Employers guidance. The recommendation from the Executive team is that the maximum level of flexibilities should be developed in order to ensure we can minimise the impact on service delivery.<br>• provide feedback on the consultation questions to the Director of P&OD in order that a Trust wide response can be formulated. |

## Introduction

Members of the Board will recall earlier discussions about the impact of the lifetime allowance on staff within the NHS Pension Scheme but also the fact that many younger and or lower paid staff were choosing not to be in the pension scheme and whether the Trust should provide an option of receiving a proportion of the employer's contributions should they have taken the decision to opt out of the NHS Pension scheme. More recently Trusts including ourselves have seen an impact on senior clinicians related to the tapered annual allowance which was introduced in 2016 – this led to the government consulting on proposals around a 50:50 option, which would allow clinicians to halve their pension contributions in exchange for halving the rate of pension growth. As a result it was determined that we would pause that work. Whilst this consultation was launched it was quickly paused following the publication of the interim NHS People Plan with the intention of further work being undertaken.

## NHS Employers guidance

In August 2019, the government announced that it would act to introduce pension changes to enable senior clinicians to take on additional clinical activities without incurring unexpected pension tax bills. In the meantime NHS Employers developed guidance for Trusts to support staff who are likely to be affected by these pension tax issues. The purpose of this paper is to consider which, if any, of these options we might wish to pursue.

The guidance outlines several routes we can take during the 2019/20 financial year, to support staff affected by current pension tax policies in the interim (pending the outcome of the government's consultation on changes to the NHS Pension scheme), including:

- taking independent financial advice and guidance
- using existing flexibilities to enable employees to remain in the NHS Pension Scheme
    - managing pensionable pay
    - local clinical excellence awards
    - designing innovative TOIL arrangements
    - use of multiple contracts
    - establishing new organisations for service delivery
- possible arrangements for employees who decide to opt out of the NHS Pension Scheme.
    - Opting out of the scheme for a proportion of the scheme year
    - Paying the employer contributions as additional salary.

There are increasing reports that NHS employees are turning down additional work, requesting to reduce their working hours and retiring early due to concerns about pension tax. This is having a significant impact on workforce supply, staff retention and service delivery. As a Trust we undertook a survey of Consultants and SAS doctors to which 97 individuals responded (85 Consultants) which indicated that 14% are planning on leaving the scheme (with 35% undecided), 62% are planning to decrease programmed activities, 80% are planning to decline additional sessions and 46% planning to retire early to avoid lifetime allowance tax (35% undecided). The comments provided by clinicians were very emotive as to the impact both the lifetime and annual allowance has had on them as individuals and the service.

While DHSC is not able to mandate employers to implement local arrangements that are complementary or in addition to national contracts and the pension scheme regulations, it recognises that current pensions taxation policies are having a significant impact on workforce capacity in the NHS. Therefore, DHSC is supportive of employers working with their employees and trade union representatives to implement local solutions. As such employers are free to reach their own decisions and agreements with individuals locally, without challenge or scrutiny from DHSC, provided they take

appropriate advice and have assurance that such agreements are lawful and based on strong justifications.

The measures outlined in this guidance can be used during the 2019/20 financial year to support staff and service delivery, ahead of any changes to the NHS Pension Scheme or wider tax system. All local arrangements should be reviewed from April 2020, as new approaches may become appropriate following the implementation of scheme changes. Being a member of the NHS Pension Scheme will be in the best financial interests of most NHS employees, therefore this guidance can be used to support staff who are affected by the tax issues.

## The importance of independent financial advice and guidance

Signposting employees to available advice and guidance may help them to maximise their earnings and make informed decisions about their membership to the NHS Pension Scheme, whilst carrying out additional activity. NHS Employers has compiled a list of organisations that are able to give expert guidance and advice for members of the NHS Pension Scheme. We will make this information available to colleagues.

## Existing flexibilities for employees choosing to remain in the NHS Pension Scheme

***Managing pensionable pay – we have taken advantage of these options other than one off payments.***

Employers have some flexibility in determining what pay is pensionable, depending on the nature and duration of the payment. As pension tax matters are very specific to the varying circumstances of each individual, we would encourage employers to discuss pensionable pay arrangements with staff individually to reach an appropriate agreement. Such agreements should be reviewed regularly to ensure the arrangements remain appropriate for the individual and the employer. Employers may wish to discuss the existing flexibilities around the following payments:

- *Temporary payments* – all temporary payments are non-pensionable.
- *Local payments* – all local payments can be determined as non-pensionable.
- *One-off payments* – employers may wish to explore options to establish one-off payments in recognition of the completion of additional activity.
- *Allowances for undertaking management responsibilities* – these are set locally and can be determined as non-pensionable through agreement with the individual.
- *Overtime* - is non-pensionable.
- *Additional programmed activities (PAs)* – additional PAs (over 10) are non-pensionable. Employers should ensure job planning processes and any supporting documentation clearly sets out that additional PAs are separate to standard PAs and are subject to regular review.
- *Waiting list initiative (WLI) payments* – where the acceptance of WLI payments is voluntary and in addition to contracted hours, WLI payments are non-pensionable.

***Local Clinical Excellence Awards (LCEAs)***

New LCEA payments made from 1 April 2018 for consultants are non-pensionable, because they are non-consolidated payments and are re-earnable. In contrast, existing LCEAs will remain pensionable until at least 2021. Schedule 30 allows employers to review and amend existing LCEA schemes by agreement with their Joint Local Negotiation Committees (JLNCs). There is scope for employers to explore converting existing LCEAs into new LCEAs by individual agreement, so that the payments are non-pensionable to support staff with pension tax issues.

***Designing TOIL arrangements***

Employers may wish to offer staff time off in lieu (TOIL) instead of pay, as this helps to reduce both pensionable income for the purposes of pension growth and the impact of the tapered annual allowance. This approach has limitations in that it does not directly increase the available capacity for service delivery. However, it is a useful tool to help employers redistribute capacity to ease pressures on service during exceptionally busy periods. For example, a consultant may work additional activity to support the trust with additional service pressures over the winter period and take the time back during less critical periods

***Use of multiple contracts***

Employees with multiple contracts of employment can opt out of the NHS Pension Scheme for one or more of their employments. For full-time employees, employers have the option to split the full time contract into two part-time contracts. The distribution of pensionable and non-pensionable pay across both contracts can be varied to manage pension growth. This approach may help employees to reduce the value of pension benefits built up over the year. This option is similar to the approach where employees opt out of the pension scheme for part of the scheme year, referred to as 'hokey cokey'. However, it has the advantage of maintaining death in service and ill-health retirement benefits, although at a slightly lower level, based on the part-time salary. We would recommend employers take a cautious approach to using this option, due to the practical issues it may present with employers having to manage different contracts and the impact that termination of one contract (i.e. due to redundancy or disciplinary purposes) may have on the other contract.

***Establishing new organisations for service delivery***

This approach is not generally supported by DHSC or NHS England and NHS Improvement, due to the issues and complexities set out below.

## Potential arrangements for employees who decide to opt out of the NHS Pension Scheme

***Opting out of the scheme for part of the scheme year***

Some employees are choosing to opt out of the NHS Pension Scheme for a period of time, and then returning to the pension scheme to manage their pension tax position. This is sometimes referred to as 'doing the hokey cokey'. This approach allows individuals to build up a lower value of pension benefits over the scheme year to mitigate annual allowance and lifetime allowance issues.

***Paying the employer contributions as additional salary***

Employers have the option to make an additional pay offer to staff using any unused employer contributions, but employers also have an obligation to ensure that staff are not disincentivised to save for their retirement. Before exercising this option, employers should carefully consider the balance between enabling staff to save for their retirement and current recruitment and retention needs. This option could be appropriate where an employee has chosen to opt out of the NHS Pension Scheme for the whole year or just part of the year or agreed with their employer to convert previously pensionable pay to non-pensionable pay, due to concerns about pension tax charges.

In advance of the introduction of the new pension flexibilities, the payment of unused employer contributions as additional salary may be considered in a number of circumstances such as:

- where an employee has opted out of the NHS Pension Scheme for the full scheme year, for tax reasons.
- during periods where an employee has opted out of the scheme for part of the scheme year, for tax reasons.

- where the employee and employer have agreed that an element of pay is no longer pensionable, for tax reasons.

Employers are under no obligation to take this step, but they may use their discretion to design and agree local policies, working with employees and trade union representatives. Employers should ensure that their policies clarify the following points:

- The employer has the discretion to review, amend or remove the policy at any time through consultation and using appropriate notice periods.
- The arrangement is limited and does not form any contractual entitlement.
- Employees are strongly encouraged to take independent financial advice to assess if ceasing contributions to the NHS Pension Scheme is appropriate. Employers are not able to give advice directly or recommend any particular independent financial adviser.
- In order to request payment of employer contributions in place of pension scheme membership, employees must provide evidence that they are affected (or about to be affected) by the annual allowance or lifetime allowance.
- Employees should be aware of the impact on their death in service and ill-health retirement benefits if they are no longer making payments towards their pension.

The guidance advises employers will also need to consider the position of staff who have already opted out of the NHS Pension Scheme due to tax reasons and whether to include them under any local arrangements. It will be important to carry out an equality impact assessment of any policy and to set out clearly the objective justification if the policy does disproportionately impact on groups with protected characteristics.

## Government consultation on pension arrangements

On 7 August 2019, the government announced it would act to introduce pension changes to enable senior clinicians to take on additional clinical activities without incurring unexpected pension tax bills. The Department of Health and Social Care (DHSC) have launched a consultation on revised proposals to make the NHS Pension Scheme more flexible to allow senior clinicians (i.e. those in a registered clinical profession) to control the growth of their pension benefits. The announcement also confirmed HM Treasury will review the annual allowance taper to support the delivery of public services, such as the NHS. It is intended to support the announcement that gave employers permission to implement a number of optional, temporary measures locally.

## Executive Summary of the proposals

***The challenge of the tapering annual allowance***

The NHS Pension Schemes are among the most generous pension schemes available and are a valuable part of the total reward package for NHS staff. However, for a relatively small but important group of staff, the interaction of the NHS Pension Schemes with the pension tax regime has created significant challenges. The evidence that the Department has demonstrates that the largest groups affected are high-earning consultants and GPs. The effect of this for some high earners is that pension tax could affect either the value of their take home pay or their final pension.

The Lifetime Allowance limits the total amount of tax-free pension savings that an individual can make over their career. The allowance has reduced from £1.8 million in 2011-12 to £1.055 million currently. The tax liability is assessed when the pension is drawn or transferred. Any tax charge is deducted from the value of the pension pot. Therefore, individuals do not pay a lifetime allowance tax charge in cash.

The Annual Allowance limits the amount by which an individual's pension savings can grow tax-free in the year. The allowance has reduced from £255,000 in 2010-11 to £40,000 currently unless a taper mechanism applies in which case it reduces further to potentially a £10,000 minimum. A tax charge is applied to pension savings above the individual's annual allowance.

In April 2016, the government introduced a mechanism to taper the annual allowance for those with the highest incomes. This applies to all individuals whose net income exceeds £110,000 and whose adjusted income (net income plus annual pension growth) exceeds £150,000.

Critically, the threshold income and adjusted income includes all sources of taxable income, including non-pensionable pay for additional sessions above full-time hours worked by many consultants. The result has been to bring increasing numbers of high earners in the NHS within the scope of pension tax charges.

Senior NHS clinicians, particularly consultants and GPs, have a significant degree of flexibility over their workloads and can vary their commitments in the course of the year. Consultants typically volunteer for additional non-pensionable sessions of work, often at short notice, to cover service pressures. This includes undertaking discretionary work to reduce waiting lists and deliver on-call services. In response to concerns about annual allowance tax charges, clinicians are seeking to control their income and pension growth by limiting or even reducing their NHS work to avoid breaching their annual allowance. NHS employers report that consultants are increasingly no longer willing to work additional sessions to reduce waiting lists, fill rota gaps or take on additional supervisory responsibilities. The lost capacity can be difficult to replace especially in clinical specialties where there are already shortages, and expensive as employers can pay a premium for locums to bridge the gap.

The government recognises that the interaction between the NHS pension scheme and the pensions tax regime is driving a behavioural response from NHS clinicians to reduce their work commitments. The Government has also listened to concerns that this behavioural response is, in turn, impacting on frontline NHS service delivery and patient care. In response, the proposals outlined in this consultation seek to address these issues by giving NHS clinicians facing these much greater pension flexibilities.

The taper can create some cliff edges, though this depends on an individual's circumstances. Some commentators argue that the operation of the taper is difficult to predict, particularly when a senior clinician is unsure what level of income that they will earn within a tax year. This uncertainty means that tax charges can occur unexpectedly for individuals. Around a third of NHS consultants and GP practice partners have earnings from the NHS that could potentially lead to them being affected by the tapering annual allowance.

The government is listening to concerns about how the design of the tapered annual allowance affects the delivery of public services. The Chancellor has announced that the Treasury will review how the tapered annual allowance operates in order to support the delivery of public services. Should changes to the tax system be introduced the department may revisit the need for flexibility within the NHS Pension Scheme.

***Paying annual allowance tax charges***

HM Revenue and Customs require pension schemes to provide a Scheme Pays facility, through which some individuals can meet their annual allowance tax charges by choosing to have it deducted (plus interest) from their pension pot at retirement.

The department has maximised the availability of Scheme Pays facility by extending it so that it can be used to settle any annual allowance charge of any value. This is beyond the statutory minimum requirement for Scheme Pays coverage. This means that no one needs to find money up front to pay their pension tax bill.

Under NHS Scheme Pays the pension scheme pays the tax charge on behalf of the member directly to HMRC. This creates a debt that is repaid at retirement where the charge value plus interest is deducted from the member’s pension before it is put into payment. Scheme Pays is available to all members of the NHS Pension Scheme.

However, the current way that the NHS Pension Scheme operates Scheme Pays may not allow a clear insight on how it affects member pensions. The consultation proposes an alternative method that

seeks to provide greater transparency for members. This would involve annual member benefit statements showing the Scheme Pays deduction as a pension debit so that they can see the adjustment to their pension at retirement as it increases with interest each year and compare this with how the accrued pension also increases over time though annual pot revaluation or salary increase.

However, whilst Scheme Pays is an important method for paying tax charges, it does not allow high-earners to manage their pension accrual, and any associated annual allowance charges, in the first place.

***Proposed scheme flexibility***

Some private sector pension schemes offer members the flexibility to tailor the rate at which their pension builds (accrual rate). At present the NHS Pension Scheme does not allow any such flexibility. Instead, in response to concerns about annual allowance tax charges, some clinicians are choosing to reduce their NHS income through declining the additional discretionary work and responsibilities that the NHS relies upon, reducing their hours or opting out of the NHS Pension Scheme.

The department is therefore consulting on proposals to introduce new flexibilities within the NHS Pension Scheme for clinicians whose work patterns mean they have a reasonable prospect of incurring an annual allowance tax charge.

The new proposals offer options that go significantly beyond the previous 50:50 proposal that the BMA and NHS England had originally asked Government to consider but that is now viewed as providing insufficient flexibility. Discussions with the medical profession and employers have highlighted the need for wide-ranging pension flexibility that would offer clinicians the tools to control the amount of tax-free pension saving they build up so that they can manage their tax liability without needing to reduce their workload. Tailoring pension accrual helps manage both the annual and lifetime allowance liability, as slowing down pension growth allows individuals to reach the lifetime allowance limit at a point in time that matches their target retirement age.

The proposed changes to the Scheme would allow such clinicians to:

- Choose before the start of each scheme year (1 April) a personal accrual level and pay correspondingly lower employee contributions. The accrual level chosen would be a percentage of the normal scheme accrual level in 10% increments. For example, 50% accrual with 50% contributions, 30%:30% or 70%:70%.
- Fine tune their pension growth towards the end of the scheme year by updating their chosen accrual level when they are clearer on total earnings. For example, go from 50%:50% to 60%:60%. The updated accrual level would be higher than initial level and have retrospective effect from the start of the scheme year. Contribution arrears from the higher accrual level would be payable by the member and employer before the end of the scheme year.

Where clinicians use the flexibilities to choose a lower accrual level than the full rate, the employer will also pay lower contributions. Employers have the discretion to pay to the member unused employer contributions in these circumstances, although this would be a decision for individual employers. Unused employer contributions could be paid by non-recurrent lump sum at the end of the scheme year after any updating of the chosen accrual level for that year.

One-off substantial increases in pensionable pay can create a spike in pension growth and a higher annual allowance tax charge that is not replicated in the subsequent years. The NHS Pension Scheme Advisory Board have suggested that the amount by which the new pay level contributes towards member pensions could be gradually increased over a number of years to smooth such spikes. The Department proposes to consult on the principle of phasing the ‘pensionability’ of large pay increases for high-earners and invites views on potential ways to give effect this.

The department is concerned that the complex interaction of tax, pay and pensions can take considerable amounts of individual time and resources to manage. To complement the introduction of new pensions flexibilities, the department will work with employers and staff representatives to ensure that all clinicians affected by pensions tax issues or concerns have access to high quality education and information to understand their tax liability and how these new flexibilities can be best used to support individual circumstances and preferences. Guidance and modellers commissioned by the department do not constitute financial advice.

Building on what is already available, the department is planning to commission a modeller to help individuals assess options for using these flexibilities tailored to their personal circumstances. The intention is to support affected clinicians and their employers to agree programmed activities and other contractual commitments equipped with a clear understanding of their pension tax liability and how the flexibilities can be best deployed to deliver the right balance of incentives.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Title** | **Financial Performance – Month 5 – August 2019** | | |
| **Report to** | **Trust Board** | **Date** | **24th September 2019** |
| **Author** | **Alex Crickmar – Deputy Director of Finance**<br>**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 5 (August 2019) was £2,142k which is an adverse variance against plan of £97k (£1,088k deficit including PSF, FRF and MRET which is £97k adverse against plan). The cumulative position to the end of month 5 is a £11,019k deficit (before PSF FRF and MRET), which is £78k adverse to plan (£6,409k deficit including PSF, FRF and MRET which is £78k negative against plan).

In August 2019, CIP savings of £1.4m are reported, against a plan of £1.36m, an over achievement of £33k in month. Year to date the Trust has delivered £3.1m versus plan of £2.9m an over-delivery of £172k.

During the month, the Finance team has prepared a first high level, top down forecast for 2019/20. This indicates that the current worst case scenario shows a £6m gap to achievement of the control total (excluding any impact of lost PSF/FRF), with a range of forecasts between break-even and a £6m gap. There continues to be significant risks to delivery of the Trust's financial control total, including:

- Modelling of required activity to deliver 92% RTT performance has been completed. However finalised, robust capacity plans are still outstanding, especially for the Surgery Division. These are required in order to provide assurance that activity and income will deliver in line with plan for elective and outpatients. This is potentially a £3m risk to delivery of the Trust's control total.
- CIPs - there is currently thought to be a £2m risk to delivery of the £13.2m CIP target. The delivery of CIPs over the next few months will be a key indication of delivery of plans, since the plan is phased to increase significantly over the coming months. In addition to the £2m gap, the delivery of bed savings from the Nerve Centre project (EPR) is currently considered at risk (£0.5m).

- A number of business cases of significant value have been put forward by Divisions which were not included within their original plans (including A&E of c£2m). These cases are under review by the Executive team, and where required will be presented to F&P and Trust Board for sign off.
- Divisions have started to develop their winter plans for 19/20 which are currently indicating a significant cost pressure against plan (c£1.5m). These plans are under review by the COO.
- There could potentially be cost pressures associated with the outcome of the CQC visit and also the impact of Brexit. The value and impact of this though is uncertain at this point in the financial year.
- Aligned to capacity plans, robust monthly 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. Finalisation of SOPs are still required for the Grip and Control and VCF process (now TRAC has been implemented).
- Resolution of the payback of non-recurrent support received from CCGs (£1.7m) and the ICS (£1.5m) in 2018/19.
- 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. A draft of the report has now been received and is under review.
- The Trust is assuming that the outpatient cap penalties will not be incurred in the financial year as part of implementing the joint work undertaken with the CCG reviewing pathways. This is a risk of c£1.5m to the position.

**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 5 (August 2019) was £2,142k which is an adverse variance against plan of £97k (£1,088k deficit including PSF, FRF and MRET which is £97k adverse against plan). The cumulative position to the end of month 5 is a £11,019k deficit (before PSF FRF and MRET), which is £78k adverse to plan (£6,409k deficit including PSF, FRF and MRET which is £78k negative against plan).
- The achievement with regards to the Cost Improvement Programme.
- The forecast financial position and the risks set out in this paper.

# FINANCIAL PERFORMANCE

## P5 August 2019

## DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

### P5 August 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 | 1,099 | 92 A | 6,481 | 70 A | 15,491 |
| Income | (31,690) | (106) F | (163,100) | (1,908) F | (411,669) |
| Donated Asset Income | (11) | 5 A | (72) | 8 A | (195) |
| Operating Expenditure | 32,804 | 265 A | 168,922 | 2,276 A | 407,492 |
| Pay | 22,371 | (449) F | 113,681 | (627) F | 273,143 |
| Non Pay & Reserves | 10,433 | 713 A | 55,241 | 2,903 A | 134,349 |
| Financing costs | 1,039 | (66) F | 5,270 | (298) F | 4,177 |
| **I&E Performance excluding PSF** | **2,142** | **97 A** | **11,019** | **78 A** | **15,296** |
| PSF / FRF / MRET | **(1,054)** | 0 | **(4,610)** | 0 | (15,296) |
| **I&E Performance including PSF** | **1,088** | **97 A** | **6,409** | **78 A** | **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 | 326 | 189 A | 1,017 | 257 A | 7370 |
| Drugs | 114 | (64) F | 686 | (436) F | 861 |
| Clinical Supplies | 1 | 22 A | 6 | 64 A | 347 |
| Non Clinical Supplies | 0 | 0 A | 0 | 0 A | 0 |
| Non Pay Operating Expenses | 667 | 43 A | 1,020 | 90 A | 3685 |
| Income | 287 | (223) F | 345 | (148) F | 937 |
| **Total** | **1,395** | **(33) F** | 3,074 | **(173) F** | **13,200** |

### 3. Statement of Financial Position

| All figures £m | Opening Balance | Closing balance | Movement in year |
|---|---|---|---|
| ***Non Current Assets*** | **206,773** | **207,031** | **258** |
| *Current Assets* | 56,797 | 57,020 | **223** |
| *Current Liabilities* | -57,515 | -60,129 | **-2,614** |
| *Non Current liabilities* | -82,091 | -82,035 | **56** |
| ***Total Assets Employed*** | **123,964** | **121,887** | **-2,077** |
| ***Total Tax Payers Equity*** | **-123,964** | **-121,887** | **2,077** |

### 4. Other

| Performance Indicator | Monthly Performance | | YTD Performance | | Annual |
|---|---|---|---|---|---|
| | Plan £'000 | Actual £'000 | Plan £'000 | Actual £'000 | Plan £'000 |
| Cash Balance | 1,900 | 30,472 | 1,900 | 30,472 | 1,900 |
| Capital Expenditure | 1,254 | 507 | 3,557 | 2,719 | 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. Month 5 Financial Position

The Trust's deficit (before PSF, FRF and MRET) for month 5 (August 2019) was £2,142k which is an adverse variance against plan of £97k (£1,088k deficit including PSF, FRF and MRET which is £97k adverse against plan). The cumulative position to the end of month 5 is a £11,019k deficit (before PSF FRF and MRET), which is £78k adverse to plan (£6,409k deficit including PSF, FRF and MRET which is £78k negative against plan).

The month 5 income position is £106k favourable to plan and £1,908k favourable to plan YTD. The underlying over performance relates to commissioner income, which in month is £114k favourable to plan 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 £357k offset by underperformance in Day cases of £88k. Outpatients were £9k favourable to plan (including outpatient cap adjustment) and non-PbR Drugs were adverse to plan by (£77k) in month. Emergency income was £186k favourable to plan whilst A&E over-performed against plan by £101k in month. Emergency income remains behind plan by £283k year to date.

Non NHS Clinical Income and Other Income is (£74k) ahead of plan in month 5 and (£674k) YTD. The over-achievement in month is related to over achievements against plan in Education and recharges.

| Income Group | Annual Budget | In Month Budget | In Month Actual | In Month Variance | | YTD Budget | YTD Actual | YTD Variance | |
|---|---|---|---|---|---|---|---|---|---|
| Commissioner Income | -337,871 | -26,552 | -26,665 | -114 | F | -136,922 | -137,561 | -639 | F |
| Drugs | -19,606 | -1,655 | -1,574 | 82 | A | -8,041 | -8,637 | -596 | F |
| PSF, FRF and MRET | -15,296 | -1,054 | -1,054 | | A | -4,610 | -4,610 | | A |
| Trading Income | -39,160 | -3,377 | -3,452 | -74 | F | -16,228 | -16,902 | -674 | F |
| **Grand Total** | -411,932 | -32,638 | -32,744 | -106 | F | -165,802 | -167,710 | -1,908 | F |

*Note : The income figure excludes £744k relating to 18/19 post accounts allocation of PSF*

The in-month expenditure position was £265k adverse to plan, of which pay was £449k favourable to plan, non-pay £981k adverse to plan and reserves £268k favourable to plan. The YTD expenditure position at the end of Month 5 is £2.3m adverse to plan (with pay £627k favourable to plan and non-pay £3.7m 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), along with clinical supplies (£0.5m), drugs (£0.6m) and other non-pay (£1.8m) also being overspent.

| Expenditure type | In Month Budget | In Month Actual | In Month Variance | | YTD Budget | YTD Actual | YTD Variance | | Annual Budget |
|---|---|---|---|---|---|---|---|---|---|
| Pay | 22,820 | 22,371 | -449 | F | 114,308 | 113,681 | -627 | F | 272,498 |
| Non-Pay | 9,018 | 9,999 | 981 | A | 48,399 | 52,096 | 3,696 | A | 113,267 |
| Reserves | 701 | 434 | -268 | F | 3,938 | 3,145 | -793 | F | 13,168 |
| **Total Expenditure Position** | 32,539 | 32,804 | 265 | A | 166,645 | 168,922 | 2,276 | A | 398,933 |

Capital expenditure is £838k behind plan YTD with spend of £2.7m against the YTD plan of £3.6m. The in-month capital spend for month 5 was £0.5m against an in-month plan of £1.3m, an underspend in-month of £747k. The main area of underspend is on Estates schemes.

The cash balance at the end of August was £30.5m (July: £30.5m) against a plan of £1.9m. The over performance against plan is as a result of the favourable performance in 18/19, including the achievement of Q4 PSF and 18/19 PSF bonus, both of which were received in July. The cash position was boosted by PDC Dividend receipt of £1.1m for Capital schemes. However, the cash position was impacted by overall receivables increasing by £751k and a £271k loan repayment in the month.

In August 2019, CIP savings of £1.4m are reported, against a plan of £1.36m, an over achievement of £33k in month. Year to date the Trust has delivered £3.1m versus plan of £2.9m an over-delivery of £172k.

During the month, the Finance team has prepared a first high level, top down forecast for 2019/20. This indicates that the current worst case scenario shows a £6m gap to achievement of the control total (excluding any impact of lost PSF/FRF), with a range of forecasts between break-even and a £6m gap. There continues to be significant risks to delivery of the Trust's financial control total, including:

- Modelling of required activity to deliver 92% RTT performance has been completed. However finalised, robust capacity plans are still outstanding, especially for the Surgery Division. These are required in order to provide assurance that activity and income will deliver in line with plan for elective and outpatients. This is potentially a £3m risk to delivery of the Trust's control total.
- CIPs - there is currently thought to be a £2m risk to delivery of the £13.2m CIP target. The delivery of CIPs over the next few months will be a key indication of delivery of plans, since the plan is phased to increase significantly over the coming months. In addition to the £2m gap, the delivery of bed savings from the Nerve Centre project (EPR) is currently considered at risk (£0.5m).
- A number of business cases of significant value have been put forward by Divisions which were not included within their original plans (including A&E of c£2m). These cases are under review by the Executive team, and where required will be presented to F&P and Trust Board for sign off.
- Divisions have started to develop their winter plans for 19/20 which are currently indicating a significant cost pressure against plan (c£1.5m). These plans are under review by the COO.
- There could potentially be cost pressures associated with the outcome of the CQC visit and also the impact of Brexit. The value and impact of this though is uncertain at this point in the financial year.
- Aligned to capacity plans, robust monthly 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. Finalisation of SOPs are still required for the Grip and Control and VCF process (now TRAC has been implemented).
- Resolution of the payback of non-recurrent support received from CCGs (£1.7m) and the ICS (£1.5m) in 2018/19.
- 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. A draft of the report has now been received and is under review.
- The Trust is assuming that the outpatient cap penalties will not be incurred in the financial year as part of implementing the joint work undertaken with the CCG reviewing pathways. This is a risk of c£1.5m to the position.

## 2. Recommendations

The Trust Board is asked to note:

- The Trust's deficit (before PSF, FRF and MRET) for month 5 (August 2019) was £2,142k which is an adverse variance against plan of £97k (£1,088k deficit including PSF, FRF and MRET which is £97k adverse against plan). The cumulative position to the end of month 5 is a £11,019k deficit (before PSF FRF and MRET), which is £78k adverse to plan (£6,409k deficit including PSF, FRF and MRET which is £78k negative against plan).
- The achievement with regards to the Cost Improvement Programme.
- The forecast financial position and the risks set out in this paper.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

**F2**

| | | | |
|---|---|---|---|
| Title | **Use of Trust Seal** | | |
| Report to: | **Board of Directors** | Date: | **24 September 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 |
|---|---|---|---|
| 113 | Property sale: Transfer of whole registered title (TR1) for Health Clinic, Chequer Road. From Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust to Birchwood Daycare Ltd. | Richard Parker<br>Chief Executive | 20 September July 2019 |
| | | Jon Sargeant<br>Director of Finance | |

**Recommendation**

The Board is requested to approve use of the Trust Seal.

## Chair's Log – Quality Effectiveness Committee – August 2019

### Overview

No new escalations to QEC or from QEC to Board. The chair requested that all reports to QEC contained the relevant board assurance framework risk when noting risks on the front sheet.

### Assurance Reports

### Breast Screening Quality Assurance Report

The above report and action plan was presented to the committee by Dr Ward - Director of Breast Screening. There were some excellent outcomes and no immediate concerns were noted. There were some priorities for action over the next three to six months and a full plan with timescales had been developed. The chair requested the following:

- The action plan to be monitored by the Division at least monthly and the support given to develop the workforce plan required;
- The Director of Nursing and Allied Health Professionals to review the role of the Breast Care Nurses in relation to assessment clinics;
- The action plan to be reported back to the Clinical Governance Committee in six months' time for review and then reported to QEC;
- The Medical Director to raise these actions at the next Executive Committee;
- Marie Purdue Director of Strategy and Transformation to initiate a quality improvement project in the department to support the actions and changes that needed to occur.

### Paediatric Nurse Staffing Deep Dive

A full and detailed report was provided outlining the methodologies that had been used to assess the requirements for staffing. It was noted that, whilst there were variations in staffing levels on a day-to-day basis, the establishments were within the required limits. However was acknowledged that there were ongoing issues with recruitment and retain both locally and nationally.

The area of difficulty remained managing peaks in activity and, based on this, a business case was being produced to provide some solutions – this was agreed at the Children and Families Board. This would include 24/7 Band 6 cover in the assessment area to ensure senior decision making and patient flow, review of shifts and a full review of neonatal staffing.

### Medical Appraisal and Revalidation

The Trust had succeeded in fulfilling its statutory requirements for the year 2018/19 and, as of August 2019, 94.8% of Trust medical staff had undergone a revalidation compliant appraisal within the prior year.

**Strategies**

Current action on the National Patient Safety Strategy was discussed and the need for future internal planning agreed. A refreshed Quality Improvement and Innovation Strategy with some minor amendments received approval. Progress was noted on the Research and Development Strategy and the People and Organisational Development Strategy.

**Quality and Safety**

The majority of performance issues were good and had shown some improvements from the last report. The quarterly report on learning from deaths was presented and progress noted. The interviews for the Medical Examiner Officer and Medical Examiner would take place in September 2019, which should alleviate difficulties for the Bereavement Office and a meeting was planned to discuss options. Registration of deaths within five days was currently at 85%. Current areas for focussed improvement were:

- Reducing the number of incidents - further actions had been agreed with Divisions;
- All Divisions had agreed an immediate priority of no overdue serious incidentactions, and other changes to the process;
- The risk register action plan was a key focus for completion;
- Achieving planned staffing levels noting the areas that had had vacancies and sickness absence issues.

Collectively the reports to QEC demonstrated processes were robust and effective but there was a need to continue to monitor in order to improve patient safety and care quality.

Progress has been made on the following:

- Following an NPSA Alert, a training package had been introduced for staff placing nasogastric tubes;
- Phase 3 Bloodhound Business Case Approved;
- Orthopaedic Surgical site infections decreasing;
- Decrease in third and fourth perineal tears in both maternity units;
- Maintenance of zero MRSA bacteraemia.

**Patient Experience an Engagement**

The continuing work on the patient survey was noted particularly in relation to discharge. Whilst complaints response was improving it was agreed that a deep dive would take place at the December 2019 meeting. Further information was requested on how users of the services were involved in service evaluation and improvements.

**Workforce and Education**

An overview of the carer policy was received.

The updated action plan for the staff survey was noted, the Trust figures for turnover retention and vacancy levels were at a good level. SET compliance continued to improve. The feedback from the appraisal sessions was indicating some good quality appraisal conversations.

The Trust continued to experience staffing shortages within the medical and nursing staff groups. However benchmarking would indicate that the Trust appeared to be performing quite well.

Assurance was sought for the next meeting on:

Deprivation of Liberty standards training;
Mental Health Act training;
Prevent training;
Level three safeguarding training.

The previous work on staff well-being continued and a further update requested in the next paper.

Marie Purdue Director of Strategy and Transformation had been invited to the membership.

No further comments.

**Pat Drake**
**Non – Executive Director and Chair – Quality Effectiveness Committee**

**Chair's Log - Finance and Performance Committee 20.09.19**

**Overview**

With a large agenda and some beefy items, the meeting was very full and thorough. Searching discussions took place. I was encouraged by the participation and engagement of executive colleagues across all items, with them playing a full and helpful part in testing colleagues' papers. Although I set it out in more detail below the headlines are –

- As in my last report, delivery against financial profiling is broadly 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 are at the pivotal point in the year with the September meeting. Overall, CIPs are marginally ahead of plan on delivery, but some are raising doubts as to their ability to deliver this year. We are on the case!
- Performance remains broadly acceptable, but there are concerns around A+E performance and RTT. We recommended a business case to Board for A+E, to boost staffing. We held a deep dive around RTT where our weak performance has led to the need for a comprehensive action plan, which F+P quality assured at this meeting.
- A further deep dive was held in relation to the Outpatients CIP and a programme of activity designed to deliver it.
- We gained positive assurance around catering provision and patients' meals, following recent complaints from Governors and I will brief them personally at the next Governors' Council.
- The detailed document set to support the creation of the pharmacy wholly owned subsidiary was approved and commended to Board.
- We received a revised Risk Register and covering paper, having considered the relevant risks with each paper presented to the committee.

**Assurance area – Performance**

**Performance Report**

The Board meeting will receive a separate performance report which will give a more detailed appreciation of the picture.

There was a detailed discussion of A+E pressures that informed later consideration of the A+E business case.

As outlined above, we held a deep dive around RTT where our weak performance has led to the need for a comprehensive action plan, which F+P quality assured at this meeting. It was well received and we have asked for monthly updates to track progress with that action plan.

Rebecca Joyce, supported by Deputy COO Claire Jenkinson and Project Manager Matthew Handley also gave us a very detailed presentation in relation to progress with the Outpatient CIP. A candid picture of lower quartile performance in relation to DNAs was shared.

The paper reminded us that –

… whilst there are examples of good practice, we know as a Trust there is more work to be done:-
- Improve the efficiency of some of our basic outpatient procedures, including clinic utilisation, capturing activity and patient communication.
- Improve our patients' experience of outpatients.
- Transform how we deliver outpatients through new clinical models and modernising outpatients through digital means.
- Develop a collective understanding of our overall outpatient portfolio to better understand variation and priorities for improvement (including, for example, capital investment).
- Develop a strategic direction for outpatient services across the Trust.

Good progress with the programme of activity was evident. The introduction of Dr Doctor texting and associated electronic letters to patients appeared very promising indeed - in the areas where it has been introduced (principally Ophthalmology) DNAs had swiftly been almost halved. We will continue to track this to ensure progress continues and business benefits are driven out.

Kirsty Edmondson gave a presentation summarising issues and the current position with the Sodexo contract. We gained positive assurance around catering provision and patients' meals, following recent complaints from Governors and I will brief them personally at the next Governors' Council.

Patient safety must never be compromised by catering issues and a small number of matters over recent months have been, and must always be, the subject of real focus and improvement. However, to put quality and ordering complaints in context, Sodexo serve just under 20,000 meals per week in the Trust. Even allowing for under-recording, the number of complaints are really low and far better than when provision was in-house. Realistically, there will always be the odd poor meal or mistake in delivery. The overall delivery is now consistently well within KPI parameters. Visitor and Staff facing facilities are also popular and increasingly well used.

**Assurance area – Workforce Management**

This month our exploration of workforce matters was focused. We had a detailed examination of workforce plans to handle the challenges of filling difficult vacancies and the grip and control process for managing the use of temporary staff and agency spend to fill the gap. The presentation was well received and gave confidence that innovative work is being done and managers are working hard to give leadership to the process of controlling temporary staffing spend.

F+P also received, interrogated and commended to Board a business case presented by divisional director Dr Nick Mallaband. In essence, continuing and consistent growth in A+E demand coupled with a shortage of the middle grade doctors we rely on has meant the need to revisit structures. An innovative approach proposes the creation of a further consultant post, together with a raft of other specialist staff –

- 1.0 wte consultants
- 5.6 wte Physician's Assistants (2.8 wte at each of Doncaster & Bassetlaw sites)
- 2.8 wte ACP
- 3.0 wte SHOs

The case is thorough and gives confidence improved patient outcomes can be achieved whilst gaining value for money from the new resources.

**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.

As in my last report, delivery against financial profiling is broadly 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 are at the pivotal point in the year with the September meeting, when the second quarter has been delivered. Overall, CIPs are marginally ahead of plan on delivery, but some are raising doubts as to their ability to deliver this year.

We will now start to routinely consider best worst and most realistic scenarios for year end figures at our meetings as we track towards year end, nudging and steering the components of achieving our control total. Encouragingly, NHSi have confirmed we are no longer required to provide fortnightly finance reports. This vote of confidence will also give our staff welcome breathing space to put more energy into growing and developing the business rather than meeting inspection demand.

Future F+P meetings will now have an even sharper finance focus as we press forward.

Good work has been done by the project team working to deliver the detailed document set to support the creation of the pharmacy wholly owned subsidiary. The key documents (extensive!) were examined in detail by NEDs prior to the meeting and following discussion the overarching summary paper was approved and commended to Board. This is a promising avenue. In addition to taking an important patient service in the shape the outpatient pharmacy into the DBTH family, it also provides a scalable vehicle for future development.

| **Assurance area – Governance and Risk** |
| --- |
| F+P received and noted the current Corporate Risk Register and Board Assurance Framework, noting the recent updates which had brought the risk position up to date. The committee noted that the continued development of the Corporate Risk Register and Board Assurance Framework would be further discussed at the December Board of Directors' meeting.<br><br>Relevant risks had been considered actively with each paper received at the meeting. |
| **Assurance area - Strategy** |
| The committee received the revised Procurement Strategy and Procurement Champion for the Board, Kath Smart was asked to spend time, on our behalf, with procurement, to better understand the detail of the strategy.<br><br>**Neil Rhodes**<br>**Chair – Finance and Performance Committee**<br>**20.9.19** |

| | | | |
|---|---|---|---|
| **Title** | **SUBSIDIARY: UPDATE FOR INFORMATION** | | |
| **Report to** | **TRUST BOARD** | **Date** | **24TH SEPTEMBER 2019** |
| **Author** | **JONATHAN SARGEANT, DIRECTOR OF FINANCE**<br><br>**ANDREW THOMAS, PROJECT DIRECTOR** | | |

| | | |
|---|---|---|
| **Purpose** | | Tick one as appropriate |
| | Decision | |
| | Assurance | |
| | Information | X |

| **Executive summary containing key messages and issues** |
|---|
| Since approval by the Trust Board at its May 2019 meeting work has progressed on the development of a wholly owned subsidiary to provide the trust's Outpatient Pharmacy service. As members will recall the current provider, Well Pharmacy, has given the trust notice that it wished to withdraw from the provision of this service across the NHS.<br><br>Key tasks completed include:<br><br>• Agreement obtained from NHSI to allow us to proceed without further scrutiny<br>• Licensing requirements from GPhC in place<br>• Insurances in place<br>• Process for ordering prescription drug items in place<br>• Standard Operating Procedures (SOP) for clinical processes refreshed to satisfy new requirements of the subsidiary and to generally update and refresh<br>• Contract for services between the subsidiary and trust completed. This includes service specs and KPIs<br>• Formation of a property lease between the trust and subsidiary for the rental of the 'shop' premises<br>• TUPE completed with minor changes to T&Cs<br>• Superintendent Pharmacist in place as clinical head<br>• Staffing rota identified and cover sourced where required<br>• Payroll and pensions solutions in place<br>• Logo developed and signage produced<br>• Transfer agreement, including stocktaking arrangements, in place to manage the handover and subsequent legal arrangements<br>• Finance ledger and ordering system in place<br>• Subsidiary registered for VAT, PAYE, bank accounts, etc.<br>• Company set up and registered at Companies House<br>• Board structure developed with methodologies in place to recruit the initial directors. |

- Contracts between trust support departments (e.g. P&OD, Finance, Estates, etc.,) and the subsidiary completed i.e. 'reverse SLAs'
- Arrangements for other services required in place e.g. telephone, burglar alarm, waste disposal, cash collection, etc.

The proposed hand over date for the service is midnight 27th/28th September 2019. This being selected such that the 'shop' can close over the weekend period to patients to ensure a smooth transfer and that patient safety is not compromised due to work changing signage, removing and installing new IT kit, etc.

Whilst there are no issues that the project team is currently aware of that would cause the go live to need to be delayed the final decision will be made at the Project Board meeting scheduled for the 26th September 2019. Within this the key decision makers being the Directors of P&OD and Finance.

**Key questions posed by the report**

- Has sufficient work been undertaken to ensure that the transfer of the Outpatients Pharmacy service to the subsidiary passed smoothly with no detrimental effects on patient care and safety?

**Recommendation(s) and next steps**

The board is asked to note the above.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

**H1**

| | | | |
|---|---|---|---|
| **Title** | **Chair's and NEDs' Report** | | |
| **Report to** | **Board of Directors** | **Date** | **24 September 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 August and September 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 – September 2019**

## Introductory Meeting with Chair of Rotherham Doncaster and South Humber NHS Foundation Trust



At the start of August I had the pleasure of meeting Alan Lockwood, the newly appointed Chair of Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH). Alan took up his post on 1 July 2019, following the retirement of Lawson Pater. With previous experience as a Deputy Chair and Senior Independent Director Alan brings with him a wealth of NHS experience, alongside a distinguished military career. I look forward to working together in partnership with him.

## Welcome - Paula Hill, Lead Freedom to Speak Up Guardian




Paula joined the Trust in mid-July and as part of her induction I met with her to formally welcome her and to hear about her plans for the role and consider the support we could offer as a Board. The role of the guardian is crucial to support colleagues and the organisation to be a more open and transparent place to work, where colleagues are supported to raise matters of concern. Posters around the site have now been updated to show Paula and her fellow guardians, Roy Underwood and Lorraine Robinson.

## One to One Discussions

During the remainder of the month I was able to meet with a number of colleagues who took the opportunity to brief me on their current key areas of work, those which caused them a challenge and their plans for the coming months. I was able to spend time with Lois Mellor, Head of Midwifery, who shared with me all things maternity and the significant steps they have taken to drive performance and quality improvements across her teams. It's great to hear good news stories!

**Great British Spring Clean 2020**

My final appointment for August saw me fulfilling two of my current roles, as Chair of the Board at DBTH and Chair of Keep Britain Tidy. Following initial discussions with my board members at Doncaster Chamber early consideration had been given to a Doncaster wide approach to support next year's campaign. Hosted by Damian Allen, Interim Chief Executive of Doncaster Metropolitan Borough Council and Mayor Ros Jones I was joined by colleagues from Keep Britain Tidy, Dan Fell, Chief Executive of Doncaster Chamber and other key DMBC team members to consider plans to provide borough wide support. Watch this space for future developments.

**Governor Brief**

Governors were once again welcomed to a full programme on 3 September. Colleagues were briefed on the trust's strategy refresh and received an update from Andrea Bliss, Interim Head of Nursing – Children & Families. Andrea shared a wealth of information, including service provision, patient experience, workforce, improvements, risks and complaints. Governors were invited to ask questions to support their understanding at the end of each session. Due to the unannounced CQC inspection there was a change to the final agenda item and David Purdue will be invited to return at the next suitable opportunity.

**NED Strategy Discussion**

In preparation for the October Board meeting Richard and I met with the NEDs to consider items for the strategy refresh. It was a great opportunity to share initial thoughts and consider a wide range of topics for further discussion with the Board.

**Star Awards 2019**

This celebratory event to recognise trust colleagues and their achievements is always a highlight in the calendar and this year was no exception. Held at a larger venue this year to allow an increased attendance, the event was hosted by BBC Look North's Harry Gration. It was a great opportunity to reflect on all the hard work, dedication and innovation which has taken place over the last twelve months. Our Communications team do a great job in organising this event, so a special thank you to them and of course to our sponsors who generously offer their support.



**NED Reports**

***Neil Rhodes***

Since the last Board meeting Neil has become Board Champion for digital transformation and begun to spend time with the IT Department and on wards to better understand the transformation journey from staff and patient perspectives. He spent a day with Acting Chief Information Officer, Ken Anderson as part of this work on 3 September.

Neil continues to be involved with the Shadow Board Programme and will shortly chair the final session on 23 September.

In the absence of Board and Finance and Performance Committee meetings in August Neil received the formal finance and performance reports on 20 August, from the respective executive directors and considered them in a one to one meeting with the Board Chair shortly afterwards.

Neil took part in a forward look strategy workshop for NEDs led by the Chair and Chief Executive on 9 September. He also takes an interest in work to improve the timeliness and quality of treatment to people visiting from local prisons and is in close touch with the programme leader, Fiona Littlewood, monitoring some promising innovative approaches.

Neil joined colleagues at this year's Star Awards and in the period ahead looks forward to participating in the Annual Members' Meeting on 26 September.

***Pat Drake***

During this period Pat attended and observed a special meeting of the Patient Safety Review Group, the purpose of which was to review and determine the next steps for incident reporting and risk management. She also observed the Clinical Governance Committee and met with Paula Hill, the newly appointed Freedom to Speak Up (FTSU) Guardian in her capacity as FTSU NED.

On 21 August Pat chaired the Quality and Effectiveness Committee and attended the Governor Briefing on 3 September.

A strategy discussion for the NEDs was held on 9 September and Pat attended the World Patient Safety Day and launch of the new fluid balance charts on 17 September.

Finally, Pat attended the Star Awards and September's Finance and Performance Committee.

***Sheena McDonnell***

Despite the traditional summer holiday period there has been lots happening over the last couple of months, Sheena has participated in two sets of consultant interviews for an anaesthetist and a cardiologist.

Both the Quality and Effectiveness and Audit and Risk Committees have taken place and Sheena has recently taken over the chairing of the Fred and Ann Green Advisory Group which she chairs alongside the Charitable Funds Committee. After discussion with the members of Fred and Ann Green it has been agreed to hold the meetings on the same day to make best use of everyone's time who attends both meetings. This should also help to streamline the decision making.

Simon Stevens hosted an event in London which Sheena attended discussing the implementation of the NHS long term plan.

Along with a governor colleague Sheena has recently joined the Ethics Committee to add a lay person's voice to the variety of issues which come before the committee for consideration.

Sheena has met with the transformation team and improvement partner to discuss the Qi approach and how we might utilise it within the Board. This has resulted in an early exploration by the Board of how to employ a Qi approach to their practices.

Sheena attended the CQC lunchtime lecture outlining the CQC inspection framework and joined colleagues at the annual Star Awards celebration.

***Kath Smart***

As part of her buddying arrangements Kath attended two launches of "The Division of Medicine Way" in ED and AMU which aims to support the Trust's vision and values and has been developed by the Medicines Division leadership team.

She also took part in the mock CQC inspection team for Bassetlaw ED in August, which aimed to help departments prepare for the imminent visit from the CQC, and attended one of the CQC preparatory lunchtime lectures the Trust was running.

As part of Kath's Audit Chair role, she has attended the Health & Safety Committee to hear more about the assurances in place to monitor and manage health and safety at the Trust. She also had the opportunity to visit new capital developments on the DRI site including the new CT suite, developments for the old HSDU area' and the Women & Children's Fire safety improvements alongside the Director of Estates and Capital Projects Manager.

Finally, she represented DBTH at Sheffield Teaching Hospitals AGM; attended a 1:1 with Jeannette Reay, and along with other NEDs took part in the NED forward meeting, attended the Finance & Performance Committee and is looking forward to the Trusts Annual Members meeting on 26 September.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

H2

# Chief Executive's Report
11 September 2019

## Care Quality Commission (CQC) inspection

From 3 to 6 September 2019, the CQC visited our Trust to undertake their unannounced inspection.

Services under the scope of the visit were Outpatients, our Emergency Departments, Medical Imaging and Maternity, with the inspection team visiting all four sites. In all, the CQC have conducted a very in-depth and enquiring inspection and I believe colleagues rose to the challenge.

I want to publicly share my thanks and appreciation with the team for their hard work and dedication throughout the process. Visits such as this can often be challenging but I believe colleagues supported this inspection with the upmost professionalism and integrity, and I believe this will be noted in the final report.

Following a 'Use of Resources' inspection which took place on 19 September, The Trust will now undergo a 'Well Led' inspection from 8 to 10 October. Once this complete we will receive our final report, which is likely to be towards the end of the year.

To fulfil our ambition to be CQC Outstanding, prior to the inspection we had enrolled on the "Moving to Good" programme and our place has been confirmed to commence on the 30th of October. Following this inspection we would hope to be rated as Good by the CQC but feel that the learning from the programme will enhance our 'True North' journey to be rated as Outstanding.

## Partnership with Sheffield Children's NHS Foundation Trust

I am pleased to share the news that, together with Sheffield Children's NHS Foundation Trust, we have recently announced plans to work together to explore a more joined up approach to delivering services for children in Doncaster and Bassetlaw.

The partnership will look at how our respective staff can use their strengths and experience to develop better services for children across both organisations. The exploratory work would focus on how working in partnership could strengthen recruitment, better support the workforce and provide new opportunities for professional development for staff. As well as this, it will look into standardising clinical care, improving patient pathways, and giving children equal access to the best paediatric care.

The work will begin from September 2019 and will be overseen by a steering group, with clinical representation from both Trusts. Staff from across paediatrics in both Trusts will be involved in the groups, which will explore the opportunities and design the way forward. Recruitment is also about to begin for a clinical lead (DBTH internal applicants only) from each trust and a network manager, who will work together to shape and lead the work. Both organisations will retain their services and autonomy.

## National Cancer Patient Experience Survey results

This month we received our results for the National Cancer Patient Experience Survey – this showed a substantial improvement for the Trust, moving from a score of 8.6 last year to 8.9 this year.

These results place the Trust as the highest scoring in South Yorkshire, as well as beyond the national average. While we will share a further update on this topic, the Trust scored more than 10% better than the year previous in certain categories and this represents a significant improvement for the Trust and one we are very proud of.

## The Star Awards

On the evening of Thursday 19 September, we hosted our annual Star Awards celebration. Taking place for the first time at the Doncaster Dome, the event was bigger than ever before and a fantastic time was had by all.

I want to congratulate our winners and those shortlisted for their hard work and dedication and eagerly look forward to next year's event.

## Launch of the Doncaster Place Plan

Doncaster's Place Plan sets out the vision to join up a wide range of health and social care services across Doncaster.

Its aim is to improve services for local people and improve the outcomes achieved by them, so that people are more in control of their health and wellbeing. The Integrated Care Partnership is made up of the major NHS, local authority and housing health and social care providers in the Borough, including Doncaster CCG, Doncaster Council, Doncaster and Bassetlaw teaching Hospitals NHSFT, Rotherham, Doncaster and South Humber NHSFT, Primary Care Doncaster, FCMS, St Leger Homes and Doncaster Children's Services Trust.

The event took place on the 16 September 2019, from 4.30pm to 7pm, with colleagues from the Trust in attendance.

## Significantly improved Friends and Family Test (FFT) results

Each quarter, our colleagues are given the opportunity to complete the Staff Friends and Family Test (FFT) which asks a series of questions about working at the Trust. These questionnaires complement our annual Staff Survey, which arrives in October.

For the quarter one Staff FFT, we decided to concentrate our questions on Staff Engagement. In all, over 1,600 members of Team DBTH completed the short survey, with the Trust registering significantly improved results. Most significantly, 78% of all colleagues respondents recommended the Trust as a place to receive care, while we also saw a 12% rise in individuals giving the thumps-up to the organisation as a place to work.

The improvements for each area can seen below:

- **How likely are you to recommend this organisation to friends and family if they needed care or treatment?** Improved by 14.3%
- **How likely are you to recommend this organisation to friends and family as a place to work?** Improved by 11.4%
- **Care of patients /service users is my organisation's top priority:** Improved by 4.9%
- **I am able to make suggestions to improve the work of my team/department:** Improved by 4%
- **There are frequent opportunities for me to show initiative in my role:** Improved by 0.2%+
- **I am able to make improvements happen in my area of work:** Improved by 12.4%+
- **I look forward to going to work:** Improved by 3.2%+
- **I am enthusiastic about my job:** Improved by 1.2%+
- **Time passes quickly when I am working:** Improved 0.6%+

We want to thank everyone who took the time to complete the survey. Please look out for the annual Staff Survey which will land in early October 2019.

## DBTH Digital Transformation: eObservations

In September, our new eObservations system, provided by Nervecentre, will go live at Bassetlaw Hospital.

One of the most important tasks within any hospital, 'clinical observations' is the term we use to describe the multitude of tests and exercises which are used to monitor the health of a patient. From temperature checks to heart rate monitoring, these observations help doctors and nurses understand the condition of their patients, guiding treatment if anything changes.

In short, this new system will replace paperwork for patient observations. Now, our clinicians will be able to record information via the eObservations app, using a mobile device, and the system will calculate whether results are outside the normal range, alerting a senior nurse or medic if urgent attention is required.

The system will go-live initially in the six adult wards of Bassetlaw Hospital, as well as Endoscopy and Day Surgery this month, and If everything goes to plan, a further deployment will commence in Doncaster Royal Infirmary and is scheduled for early November.

## DBTH Digital Transformation: Missed appointments and DrDoctor

I am pleased to note that our patients are now benefiting from a brand new text reminder service, which helps them to monitor and keep their clinical appointments as well as access service specific information.

Known as 'DrDoctor', this new system launched on 1 August within the Trust's Ophthalmology, Gastroenterology and Respiratory services and has so far sent thousands of messages, reminding patients about upcoming hospital dates. The system has been so successful that Doncaster Royal Infirmary's Ophthalmology service has seen missed appointments reduce by more than half, with its average 'did not attend' rate going for 13.5% to just 7% in one month.

Unfortunately, DBTH is within the top 25% of all trusts in the country for patients not attending appointments, recording around 140 missed a day or 50,000 each year. Equating to around £6 million in lost funding annually for the local hospitals, in real-terms this wasted cash is the equivalent of 200 nurses, 747 hip replacements or 22,388 MRI scans – therefore its imperitive that we reduce the number of missed appointments at our Trust.

With early successes and positive engagement from patients, we have rolled-out DrDoctor within ENT, Trauma and Orthopaedics, Gynaecology, Obstetrics and Midwifery.

## Pride in the NHS

Throughout August, as a Trust we have been showing our support for Pride by signing a 'pledge' and proudly wearing a rainbow NHS bade.

Pride (also known as Gay Pride or LGBT Pride) is the positive stance against discrimination towards lesbian, gay, bisexual and transgender (LGBTQ+) people to promote self-affirmation, dignity, equality rights, increase their visibility as a social group, build community and celebrate sexual diversity and gender variance. In all, Pride supports and promotes most LGBT rights movements throughout the world through optimism and inclusivity.

Recognising the difference the health service can make in this area, increasing awareness amongst clinicians of the issues surrounding people of all genders and sexualities when accessing service can make a huge difference in the quality of hospital care and treatment, as well as an individual's experience. As such, we are committed to ensuring our Trust is as inclusive and supportive as possible.

Underlining this ambition we inviting our doctors, nurses and other health professionals to sign a 'Pride Pledge' and receive a rainbow-themed NHS badge.

The voluntary document and colourful pin are designed to help foster an atmosphere where patients and colleagues alike feel comfortable discussing their sexuality and gender identity. This doesn't mean the team have all the answers or are experts in this particular area, but that they are prepared to listen, support and signpost to relevant information.

In a handful of weeks, I am pleased that over 2,000 colleagues are currently signed up and proudly wearing their rainbow badge.

## Award winning teams and individuals

Our Education Team have been nominated for the Nursing Times Workforce Awards for 'Preceptorship of the Year'. Designed to help the transition from pre-registration study at university to working as a staff nurse, midwife or allied health professional, our preceptorship programmes help to develop staff so that they can consolidate their skills and familiarise themselves with their role.

As a Trust we have recently overhauled our approach to preceptorship, in an effort to standardise our offering. Under this new model, candidates are given the same 'core' teaching, which covers general topics like hospital amenities, conflict resolution and resuscitation. In addition to this, they are also invited to informative lectures and classroom sessions which are specifically tailored to their area and speciality.

I believe I speak on behalf of all colleagues when I say that we take the development and training of our staff very seriously. I'm incredibly proud that the team have been shortlisted for this highly prestigious award and wish them the very best of luck.

The Star Awards: Also this month, we will host our annual Star Awards at the Doncaster Dome. With 11 categories it is sure to be a fantastic occasion and I wish our shortlisted colleagues the very best of luck.

## 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

At the Trust, we've made the following appointments in the past month:

- **Emma Challans**, Deputy Chief Operating Officer (DCOO), left the Trust on 1 September 2019 on a secondment to the Yorkshire and Humber Academic Health Science Network.
- **Simon Brown** took up the post of Associate Director of Nursing for Clinical Specialities.
- **Lesley Barnett** moved from the above post to Deputy Director of Quality and Governance.
- **David Purdue**, Deputy Chief Executive, formally took up the post of Director of Nursing, Midwifery and Allied Health Professionals.
- **Andrea Bliss** was named Acting Head of Nursing for Paediatrics, following the Chris Beattie's retirement.
- **Simon Lister** was named Business Manager for Clinical Specialities.
- **Debby Mcknight**, Matron (Maternity) departed the Trust for retirement after 33 years with DBTH on Thursday 29 August. All wished her the very happiest and healthiest of retirements.

## External appointments

- Doncaster Children's Services Chief Executive, Paul Moffat, has stood down to pursue other improvement related opportunities in children's services. He will be replaced by Alan Adams in an interim capacity.

**Minutes of the Meeting of the Management Board**
of
**Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust**
on
**Monday 15 July 2019 at 2:00pm**
**in Boardroom, Doncaster Royal Infirmary**

**Present:**

| | |
|---|---|
| David Purdue (Chair) | Deputy Chief Executive |
| Karen Barnard | Director of People & Organisational Development |
| Jon Sargeant | Director of Finance (part) |
| Sewa Singh | Medical Director |
| Jochen Seidel | Divisional Director – Clinical Specialities |
| Rebecca Joyce | Chief Operating Officer |
| Nick Mallaband | Divisional Director – Medicine |

**In attendance**

| | |
|---|---|
| Gareth Jones | Deputy Head of Corporate Assurance |
| Simon Marsh | Chief Information Officer |
| Marie Purdue | Director of Strategy & Transformation (part) |
| Kirsty Edmondson-Jones | Director of Estates & Facilities |
| Mandy Espey | General Manager Surgery & Cancer Services Division |
| Ken Anderson | Head of IT Programmes and Development |
| Professor Steve Singleton | NHS Improvement (shadowing) |

**Apologies:**

| | |
|---|---|
| Richard Parker OBE | Chief Executive |
| Jeanette Reay | Head of Corporate Assurance / Company Secretary |
| Eki Emovon | Divisional Director - Children and Families |
| Moira Hardy | Director of Nursing, Midwifery and Allied Health Professionals |
| Antonia Durham Hall | Divisional Director – Surgery & Cancer |

**Action**

**Welcome, Introductions and apologies**

**MB/19/7/1** Apologies as recorded above were noted.

**Actions last meeting**

**MB/19/7/2** The action log was discussed and updates acknowledged.

**Corporate Issues**

**Deep Dive – Enabling Strategy for Estates and Facilities**

**MB/19/7/3** Management Board considered an update of the Director of Estates and Facilities that set out the progress of objectives and the key challenges for the Directorate during quarter 1. Several key challenges remained however sufficient estates capacity posed the biggest challenge for the Directorate. The report outlined the key interdependencies, future work programmes and associated key risks.

**MB/19/7/4** Kirsty Edmondson-Jones spoke of the several improvement initiatives that had been put in place and was pleased to report that a 30% increase in the effectiveness of reactive maintenance jobs had been seen throughout the quarter. This had been supported by the implementation of the visual management boards and regular meetings with the team that had seen the achievement of more jobs being completed.

**MB/19/7/5** The Director of Estates and Facilities reported that the capital programme was progressing well and early stages of planning work had begun on the theatre refurbishment. The PAM and ERIC returns had also received sign off by the Trusts Board of Directors within the agreed timescales.

**MB/19/7/6** A new facilities recruitment strategy had been implemented with an aim of increasing conversions rates for those colleagues who had presented with references and CV's as part of the recruitment exercises that had been undertaken.

**MB/19/7/7** Jochen Seidel raised a query around the Centre's request to reduce capital expenditure by up to 25% in 2019/20 and sought assurance on how this would be managed considering the Trusts current financial difficulties and conflicting demands. The Director of Estates and Facilities advised that the capital budget formed two separate budgets of Trust capital and emergency bids. The Trusts capital had already been reduced by £8m and this had been taken into consideration within the Trusts budget for capital spend in year. Emergency capital works on fire and theatres would progress as planned and internal funding from the money received on achievement of the control total would be utilised for this. It was noted that the Integrated Care System as a whole had been asked to reduce its capital expenditure as a single joined up approach totalling £18m.

**MB/19/7/8** In response to a concern raised on the CQC's worries around the organisations awareness of the number of estates jobs required, Kirsty Edmondson-Jones advised that pre CQC inspections were undertaken to assess the work required. Any work required is determined by risk rating with funding being assigned accordingly; £100k had been sourced last year to support the work of CQC and PLACE. A flooring replacement programme had been put in place following some of the concerns raised by CQC.

**MB/19/7/9** Management Board NOTED the update.

**Deep Dive – Enabling Strategy for IM&T**

**MB/19/7/10** Management Board considered an update of the Chief Information Officer and the Head of IT Programmes and Development that set out the progress of objectives and the key challenges for the Directorate during quarter 1. The enabling milestones focused on three key areas; delivery of phase one of EPR, axe the fax and windows 10 rollout. Several key challenges remained however the funding for non-pay between contractual agreements determined against the budgets held posed biggest challenge for the Directorate. The report outlined the key interdependencies, future work programmes and associated key risks.

**MB/19/7/11** Simon Marsh was pleased to report that the rollout of bed management had been completed in Bassetlaw and Mexborough; a few areas required completion in specialist areas which would be completed in October 2019.

**MB/19/7/12** Management Board discussed in detail the rollout of windows 10 and queried what issues had arisen as a result. Simon Marsh advised that a number of issues had been reported in clinical areas and an issues log had been developed and maintained which he would circulate to colleagues. **SM**

**MB/19/7/13** The Chief Information Officer reported that the organisation that ran the bedside entertainment system would go into liquidation in August and the equipment currently installed at Trust sites had been offered to DBTH for a cost of £5k; this would be discussed at Executive Team to agree a way forward.

**MB/19/7/14** Ken Anderson highlighted his personal reflection on one key point that he felt would increase the ability to meet the organisations aim of Safest Trust in England and this was around the increase in staff engagement on IT and Clinical Systems Training. The investment in communication of new software and IT training had been significant which included IT meeting the teams to provide updates rather that asking them to attending training however input had still been minimal. Concerns were highlighted around development of ward leaders and individuals, particularly around newly implement programmes such as e-observations, bed management and hospital at night. Further exploratory work identified that time and capacity remained the biggest issues in lack of engagement and clinician's undertaking training on clinical systems. Management Board felt that this should hold the same level of importance as other strategic pieces of work and further discussions should be held around the underlying issues.

**MB/19/7/15** Management Board NOTED the update.

**ICS Update**

**MB/19/7/16** Management Board received an update from David Purdue on the current work of the South Yorkshire and Bassetlaw Integrated Care System. This included the increased powers available to the ICS, the Senior Leadership Structure and meeting / governance arrangements. Susan Bollam had been appointed to the ICS for two days per week as Head of Clinical Therapies effective from the 1st September 2019; all post that had been vacant within the ICS had now been made permanent.

**MB/19/7/17** The Hospital Services Review vacancies would be recruited to and included five Programme Management posts and Clinical Leads for the 5 networks. The Paediatric Hosted Network would commence at level 1 with an aim to achieve level 3. This would create additional PA sessions and additional part time nursing posts. The Paediatric Hosted Network would be the trailblazer between DTH and Sheffield Children's Hospital.

**MB/19/7/18** It was reported that there was a shortage of capital within the Integrated Care System and budgets did not meet the needs of the service; therefore each ICS had been asked to reduce their capital bill by 25%. The Director of Finance discussed the current position of the Trust and advised that any capital orders must be processed to ensure that funds are committed.

**MB/19/7/19** Nick Mallaband discussed the cardiology proposals of the ICS and asked how the process could be navigated with regards to the centres required across the region. David Purdue advised of a meeting that would take place on 16th September that would review the next stages of the hospital services review. The NHS Long Term Plan specifically mentions cardiovascular diseases and set specific objectives and targets however it was felt that movement would be limited without a regional plan for the delivery of cardiovascular services; current responsibility sat with Sheffield Teaching Hospitals.

**Finance Report as at 31 May 2019**

**MB/19/7/20** Management Board received the report of the Director of Finance which set out the financial position at the end of month 2. He reported the significant risks against the delivery of the Trusts 2019/20 financial control as set out within the appended report. PSF accounted to £2.5m and the managed position was £11k better than plan. He reported the Trust was £400k off plan driven by pay variances and the increases noted within nursing agency spend and drugs spend. The income on emergency had decreased and further work would be required to understand if this is a coding, length of stay or system issue. The overall underlying gap would be £600k and concerns were highlighted around the movement away from plan; escalations meetings would be arranged with Divisions over the coming weeks. The Director of Finance reported a positive cash position with £12m in the bank at the end

of the month. £7m worth of CIP remained to which NHSi would be visiting the Trust on 18th July to review the Trusts progress.

**MB/19/7/21** Management Board NOTED:

- The Trust's deficit (before PSF, FRF and MRET) for month 2 (May 2019) was £1,432k 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 regards to the Cost Improvement Programme.

**Board Assurance Framework & Corporate Risk Register**

**MB/19/7/22** Management Board considered a report of the Deputy Head of Corporate Assurance which set out the latest corporate risk register for consideration. Management Board were asked to consider 4 new risks, escalated via Datix, for escalation to the Corporate Risk Register (CRR). Details were set out in the covering report and were discussed.

**MB/19/7/23** Management Board AGREED the inclusion of risks 2232 and 2246 on the CRR. Management NOTED all risks. **JR**

**Information Items**

**MB/19/7/24** The following items for information were NOTED:

- Business Intelligence Report as at 31 May 2019
- Chief Executives Report
- Minutes of the CIG Meeting held on 29th April 2019
- Children and Families Board Update for May, June & July 2019
- Referral Management and Booking Standard Operating Procedure
- Urgent and Emergency Care Update April & June 2019

Any comments on the Referral Management and Booking Standard Operating Procedure should be shared with Matthew Handley.

**Minutes of the meeting held on 10 June 2019**

**MB/19/7/25** The minutes of the meeting held on 10 June 2019 were agreed as a true record.

**Any Other Business**

**MB/19/7/26** **Capital Investment** – Jochen Seidel discussed feedback from the weekly architect meetings with the planners of the theatre refurbishment and spoke of the confusion around the agreement of the number of theatres. He raised his concerns around the additional two theatres and the associated costs and capacity. Kirsty Edmondson-Jones advised that there would not be an additional two theatres and plans were still in the early stages of discussion of what is required in terms of capacity; the options were still being developed and discussed with no confirmed arrangements made, however funding had been allocated to deal with all ground floor building, capacity of TAU and office space. Further exploratory work would be required to determine what the bid was for and prioritised accordingly.

**Items for escalation to the Board of Directors**

**MB/19/7/27** Nothing to report.

**Items for escalation from Sub-Committees**

**MB/19/7/28** Nothing to report.

**Date and time of next meeting**

**MB/19/7/29** The next meeting of Management Board would take place 12th August 2019 at 2pm in the Boardroom at Doncaster Royal Infirmary.

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

**MANAGEMENT BOARD**

**Minutes of the meeting of the Management Board**
**Held on Monday 12 August 2019 in the Board Room, Doncaster**

| | | |
|---|---|---|
| **Present:** | Richard Parker, Chief Executive (Chair)<br>David Purdue, Deputy Chief Executive<br>Rebecca Joyce, Chief Operating Officer<br>Sewa Singh, Medical Director<br>Marie Purdue, Director of Strategy and Transformation<br>Kirsty Edmondson-Jones, Director of Estates and Facilities<br>Anthony Jones, Deputy Director of People and Organisational Development<br>Claire Jenkinson, Deputy Chief Operating Officer<br>Eki Emovon, Divisional Director - Children & Families<br>Nick Mallaband, Divisional Director - Medicine<br>Antonia Durham- Hall, Divisional Director - Surgery & Cancer | |
| **In attendance:** | Angela O'Mara (Minutes)<br>Petra Bryan, Head of Quality Improvement (Part) | |
| **Apologies:** | Jon Sargeant, Director of Finance<br>Karen Barnard, Director of People and Organisational Development,<br>Ken Anderson, Chief Information Officer<br>Jochen Seidel, Divisional Director – Clinical Specialities<br>Jeannette Reay, Company Secretary/Head of Corporate Assurance | |
| | | **ACTION** |
| **Item** | **Welcome and Apologies for Absence (Verbal)** | |
| **MB19/08/01** | The apologies recorded above were noted. | |
| **Item** | **Action Notes from Previous Meeting (Enclosure A2)** | |
| **MB19/08/02** | ***The Committee:***<br><br>- ***Agreed that actions marked 'close' be considered complete;***<br>- ***Noted the following updates:***<br><br>**MB/18/12/9 & MB/19/1/2** - actions should now be closed.<br><br>**MB/19/1/31** - to carry forward in the absence of Karen Barnard.<br><br>**MB/19/2/28 & MB/19/4/31 -** marked complete, to be removed from the action log. | |

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| | **MB/19/5/2 & MB/19/5/3** - marked complete to be removed from the action log.<br><br>**MB/19/5/2** - to mark as complete. Following the announcement that Trevor Rogers would step down from his role of Director of Research and Development, Richard Parker advised that the Exec Team would consider options going forward.<br><br>**MB/19/5/24 -** Anthony Jones, Deputy Director People & OD advised colleagues that guidance, hints and tips, provided as part of the Leading to Outstanding Programme, would be incorporated within the existing trust policy *CORP/ICT23 - Email and Communications Policy.*<br><br>**MB/19/6/12 -** action outstanding. Richard advised Management Board that a summary of the trust's financial position over time had been prepared by Jon Sargeant. As Jon was not in attendance at the meeting he would share the document post meeting.<br><br>**MB/19/7/3** – the Windows 10 issue log had been circulated with papers. During a 1:1 with the Chief Executive Ken Anderson had agreed to review the content of the log to ascertain true Windows 10 issues i.e. Medisec, as compared to other related PC issues.<br><br>**MB/19/7/23 -** to mark as complete. In the absence of Jeannette Reay, Company Secretary, Richard Parker advised colleagues of the intention to undertake a review of the Corporate Risk Register and Board Assurance Framework to ensure the process of risk management was channelled appropriately from 'Ward to Board'. | **JS**<br><br>**JR** |
| **MB19/08/03** | **<u>Deep Dive – Quality Improvement and Innovation – Petra Byran (Enclosure B1)</u>**<br><br>Management Board received the Head of Qi's presentation which provided an overview of key achievements to date, highlights and benefits, challenges and next steps.<br><br>In excess of 2000 colleagues had now received training in practical Qi skills, the concept was embedded into training and development and had become an integral part of the trust's core objectives and appraisal process.<br><br>Work would continue to develop knowledge and coaching capacity, with a view to achieving a trust wide Qi culture, firmly embedded into everyday practice from ward to Board.<br><br>Feedback received from divisional directors recognised a high level of staff engagement and a marked improvement in staff morale within the respective divisions of Medicine and Children and Families. The need to ensure that good news stories were shared trust-wide was noted and Becky Joyce suggested a way to achieve this would be to identify an area of improvement which had a trust-wide impact, colleagues were invited to consider suitable opportunities.<br><br>Consideration as to how to ensure Qi was embedded within the work of the Board was continuing. As the trust approached the 12 month anniversary directors would reflect on the journey to date, champion the role of Qi coach and ensure that the appointment of a new Head of Qi maintained a clear focus on organisational development. | |
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| **MB19/08/04** | **CQC Update**<br><br>David Purdue provided an update on CQC activities. With the well-led inspection scheduled to take place between 8 - 10 October it was anticipated the unannounced inspection would take place by mid-September. A recent request for statutory and essential training (SET) data for ED, Maternity and Medical Imaging gave an insight into the areas most likely to be inspected.<br><br>Ongoing preparation included CQC Friday lunchtime lectures, a timetable of mock inspections and a bank of CQC related information on the Hive. On the wards, welcome boards and beside information charts had been redesigned and celebration boards to document achievements "to be proud of" were in place.<br><br>On 17 September the first ever World Patient Safety Day would be marked by an event in the Education Centre at DRI. Colleagues would be able to receive a wealth of information on patient safety topics, including falls prevention, skin integrity and the revised fluid balance chart. The afternoon would be devoted to the launch of the department Quality Accreditation Tool (dQAT).<br><br>Finally, as part of the well–led inspection a one day Use of Resources (UoR) assessment would be conducted on 19 September. Led by a team of NHSI/E colleagues the assessment would consider a series of key lines of enquiry (KLOE) to identify how effectively and efficiently resources were utilised. A timetable with suggested representatives would be finalised by the executive team in due course. Ahead of the assessment the trust was required to submit supporting commentary against the KLOEs. | |
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| **MB19/08/05** | **Clinical Services Update**<br><br>This would be included as an agenda item at October's Management Board to ensure momentum was maintained. | **AO'M** |
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| **MB19/08/06** | **ICS Update**<br><br>Richard Parker provided the following ICS updates:<br><br>• National funding of £57.5m had been secured for the primary and community care capital plan.<br>• A SY&B ICS Acute Provider Event would be held on 6 September 2019 to consider the next steps for the Hospital Services Review.<br>• A Hospital Services Review paper would be received at September's Board of Directors.<br>• Kevan Taylor had been appointed on a fixed term basis as the SY&B ICS Workforce Lead, supported by Dean Royles.<br>• Agreement had been reached to determine an operational form for the SY&B Pathology programme, a paper which considered the following options: thick joint venture, thin joint venture, or a host trust model would be prepared.<br>• Board members from SY&B ICS had been invited to feed into the Long Term Plan discussion on 7 October.<br>• Initial discussions to explore the potential for Montagu to be a HASU/stroke rehabilitation centre for the wider ICS. Should matters proceed it was noted this may be subject to consultation. | |

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| **MB19/08/07** | **<u>Finance Report – June 2019 (Enclosure C2)</u>**<br><br>Management Board received the report of the Director of Finance which set out the financial position at the end of month 3, June 2019. The Trust's deficit (before PSF, FRF and MRET) was £2,783k, which was a favourable variance against plan of £189k. The cumulative position to the end of month 3 was a £7,680k deficit before PSF, which is £12k favourable variance to plan (£5,178k deficit including PSF, which was £12k adverse to plan).<br><br>In Jon's absence Richard Parker advised that discussions with Bassetlaw CCG continued with regards to a mis-alignment in referral to treatment funding/plans.<br><br>In light of the current political climate it was agreed that Brexit should be reinstated on all meeting agendas. Should a general election be called Antonia Durham Hall highlighted the potential for disruption with planned activities in Trauma and Orthopaedics. | **AO'M** |
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| **MB19/08/08** | **<u>Information Items to Note:</u>**<br><br>The following reports were noted by Management Board:<br><br>D1 – Business Intelligence Report - June 2019<br><br>D2 – Chief Executive's Report - July 2019<br><br>D3 – Minutes of the CIG Meeting dated 3 June 2019<br><br>D4 – Children and Families Board Update dated 2 August 2019<br>In respect of the basement corridor, it was reported that whilst the robotic cleaner had not yet arrived on site, a deep clean had been undertaken and following the siting of the porthole art work the overall look and feel of this area was much improved. Feedback on the staff Facebook page had been extremely positive. | |
| **MB19/08/09** | **<u>Minutes of the meeting held on 15 July 2019 (Enclosure E1)</u>**<br><br>The minutes of the above meeting were agreed as a true record. | |
| **MB19/08/10** | **<u>AOB</u>**<br><br>***NHS Pension Concerns***<br><br>The impact on senior clinicians and colleagues who exceeded their annual/lifetime pension allowance continued to cause concern. Clinicians were reluctant to take on additional shifts, or continue with current working arrangements where there was the potential for significant tax implications. In response to this reaction, which negatively impacted on patient care and safety, the Department of Health & Social Care had announced their intention to consult on a series of flexible options to negate the financial burden. The impact extended beyond clinicians and this had been fed back for consideration in future plans. Richard Parker reinforced the advice to avoid entering into local solutions and to support the national initiative. Local MPs were also sighted on the issues and were supportive of the need to campaign for change. | |

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| **MB19/08/11** | ***Typing Backlog – Medicine Division***<br><br>Management Board received a paper from Nick Mallaband, Divisional Director of Medicine, which documented the division's current backlog of typing, alongside its current and anticipated vacancy position. The extent of the backlog was a cause for concern and in view of the difficulty to recruit to vacancies a need to consider alternative approaches was identified. One option was to secure additional hours, with the option for colleagues to "home-work" outside of their current contracted hours.<br><br>Divisional directors were asked to provide feedback relating to their areas of work to Becky Joyce, Chief Operating Officer, who would establish the terms of the review. The output would then be considered via the Vacancy Control Panel. Beyond this, changes in activity should be considered as part of the annual business planning process. | **ADH/JS/ EE/NM** |
| **MB19/08/12** | ***Structural Change***<br><br>David Purdue sought approval for the Palliative Care team, currently sitting within the Division of Medicine, to be transferred to the Central Nursing team. No objections were raised. | |
| **MB19/08/13** | ***Corporate Investment Group***<br><br>The Divisional Directors sought clarification on the process to progress outline business cases to the Corporate Investment Group, a request for support and guidance for completion, including appropriate consultation was made.<br><br>Mr Singh recommended the benefits of appropriate early conversations, including the need to consult with both the medical director and director of nursing where the case related to a clinical service.<br><br>Richard Parker agreed to discuss the matter with the Director of Finance, Jon Sargeant, in order that colleagues could be assured of the process. | **RP** |
| **MB19/08/14** | **<u>Items for escalation to the Board of Directors (Verbal)</u>**<br><br>No items were noted for escalation. | |
| **MB19/08/15** | **<u>Items for escalation from sub-committees (Verbal)</u>**<br><br>No items were escalated from the sub–committees of Management Board. | |
| | **<u>Date and time of next meeting</u>** | |
| | Date: Monday 16 September 2019<br>Time: 14:00<br>Venue: Bassetlaw Boardroom | |

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

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**DONCASTER & BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST**

**Minutes of the Quality & Effectiveness Committee held at 2pm on Monday 17 June 2019 in the Boardroom, DRI**

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| PRESENT | : | Pat Drake - Non-Executive Director (Chair) (PD)<br>Sheena McDonnell - Non-executive Director (SM) (by telephone)<br>Karen Barnard - Director of People & OD (KB)<br>David Purdue, Deputy CEO (DP) (part)<br>Mr Ray Cuschieri, Deputy Medical Director (RC) (part)<br>Fiona Dunn – Acting Deputy Director of Quality & Governance (FD) |
| IN ATTENDANCE | : | Rebecca Joyce – Chief Operating Officer (RJ)<br>Mr Eki Emovon – Divisional Director – Children & Families (EE) (part)<br>Lois Mellor – Head of Midwifery (LM) (part)<br>Samantha Fawkes – Matron Paediatrics (SF) (Part)<br>Alison Boldy – Senior Nurse Neo-Natal Services (AB) (part)<br>Dr Tim Noble – Deputy Medical Director (TN) (part)<br>Carolyn Taylor – Executive PA (minutes) (CT) |
| OBSERVORS | | Peter Abell – Public Governor (PA) |
| APOLOGIES: | | Clive Tatley - Governor<br>Moira Hardy – Director of Nursing, Midwifery and AHP's<br>Cindy Storer – Deputy Director of Nursing, Midwifery and AHP's<br>Mr Sewa Singh – Medical Director (RC deputising) |

**Action**

**19/06/1 Agenda Review**

Pat Drake (PD) stated that 'Conflict(s) of Interest' would be added to future agendas. **JR**

**19/06/2 Apologies for absence**

Apologies were noted by the Chair as recorded above. Ray Cushieiri (RC) would be representing Sewa Singh (SS).

Sheena McDonnell (SM) dialled into the meeting and the Chair extended her thanks to Sheena for preparation of the agenda papers.

Rebecca Joyce (RJ) was welcomed to the meeting as newly appointed Chief Operating Officer.

It was noted that this meeting date and time conflicted with the Annual Members Lecture and PD had made a request that consideration be given to this in future.

**19/06/3 Action Log**

The action log was reviewed and updates noted.

**STRATEGY UPDATE PRESENTATIONS**

**19/06/4** Eki Emovon (EE) presented an overview of the presentation My Vision for Quality with support from the Children & Families Divisional team: Lois Mellor (LM), Samantha Fawkes (SF), Alison Boldy (AB) and Tim Noble (TN). The presentation paper had been circulated prior to this meeting and the team then addressed resulting questions arising from the committee members:

SD enquired as to whether the Paediatric team were aware of any of the reasons for the frequent movement of nursing staff to jobs in other Trusts which was resulting in a shortfall of nursing staffing. The team explained that Band 7 nursing roles were, or had been, limited that staff often moved on for personal development reasons or to Trust's near to home. A number of staff have also moved on to roles within DBTH Emergency Department.

Staff Survey Results – EE stated that the key areas for improvement focus were communication, visibility of senior staff and staff feeling involved in decision making. In order to improve communication going forward monthly Senior Sister's meetings would take place in order to ensure that information is shared. There was a concern that one of the results had reported that 70% of staff had witnessed abuse, leading members of the committee to believe that some confusion had arisen regarding the wording of this particular question therefore HR advice would be sought.

Other key challenges were noted around staffing shortfalls (mainly relating to sickness with the highest category being stress, which is often in turn, exacerbated by the staffing shortages). SM challenged the team on what was being done to address this to which EE responded that staffing numbers were being reviewed and recruitment taking place. Staff reporting stress were also signposted to coaching/counselling opportunities and to Occupational Health if required. Discussion surrounding staff sickness also formed part of the standard agenda for Sister's meetings.

Staff suggestion boxes have been introduced in the C & F areas. LM reported that the forthcoming QI Intrapartum Event (26 June 2019) would focus on Band 7 and Band 8a Nurse training. LM assured the committee that additional Band 7 Nurses had been recruited in to areas previously lacking and additional Matrons would be recruited for both Paediatrics and Gynaecology. The Committee acknowledged the recent changes to the Senior Nursing Leadership Teams in the C&F Division and felt assured by the responses and actions from the team.

The next staff survey will be released in October 2019.

PD congratulated the Division on their recent Blue (Outstanding) WQAT results and no SI's reported in the previous 2 years.

Cross cover/site working is in place where possible in order to keep costs to a minimum. PD agreed to share this assurance with the Board.

Midwives – further funding was now in place and vacancies were being prepared for VCF panel with a view that these be advertised externally. **PD**

Update of CQC Action Plan (Paediatrics): weekly meetings with ED were in place and the action plan was progressing.

Hosted Networks Programme: David Purdue (DP) reported that the Hosted Network Programme will now be accelerated in liaison with the Children's Hospital in order to move regional paediatric patients in a timely manner.

Patient Experience (Maternity) PD enquired what action was being taken in order to address the high number of comments received regarding delayed discharges. LM responded that this often related to the Post-natal wards and the requirement for the first day baby check. Not all Midwifes were currently trained in this practice and this was being addressed. Further, plans were progressing for a Discharge Lounge area whilst patients wait for transport and this in turn would help to free up beds. This also meant that patients could be discharged in groups with the discharging Nurse offering advice on infant resuscitation, breast feeding and sleep patterns.

Funding had now been confirmed to appoint further Band 7 Nurses and 14 newly qualified staff had already been offered positions with a view to offering a further 4 across the Trust. It is hoped that a Surgical Nurse (to support with post-operative care in obstetrics) would also be appointed.

LM shared her observations that there did not appear to be an adequate skill mix across the C&F workforce. This would be reviewed.

Governance Related Issues: Paediatrics: TN reported that a new Clinical Governance Lead had now been appointed and would provide much needed consistency across the meetings.

Risk Register: some Paediatric issues remain for review however all are known and are mitigated risks.

Maternity: LM reported that incidents where Duty of Candour (DOC) was required were being worked through and downgraded or closed. Remaining open incidents relate to the use of the Perinatal Mortality Review Tool (PMRT) which meant that the DOC process is often complicated. These incidents were being reviewed individually in order to ensure that any letters sent to patients were appropriate.
Midwifery incidents – the team would work through outstanding incidents over the coming few months, nil harms had been reported.

PD said that she had been visiting the C&F areas and had noted an improvement in the atmosphere amongst staff and added that Royal College of Obstetricians & Gynaecologists (RGOC) requirements were now compliant.

EE added that he now feels that the culture was moving forward now that leaders are making themselves increasingly visible to staff.

EE confirmed that he would be attending the Shadow Board programme alongside C&F General Manager Lauren Ackroyd in order to take up the Trust Management Development opportunities. LM would work with the Band 7/ 8a Nurses in order to support them with training relevant to role. All staff appeared engaged with development and work is ongoing with OD team on bespoke training.

The Committee acknowledged that there have been a lot of positive changes within the Division and this had resulted in an improved culture and environment for both patients and staff. Managers had requested time for these to be embedded and to allow for them to attend leadership events. DP responded that a piece of work will commence shortly to review and prioritise the amount of meetings that managers are expected to attend.

QII engagement at all levels had been excellent and the Division was commended for this.

The Diabetes Transition Business case is now going forward.

Consultation within the community is ongoing to ask the public what they require from their maternity services in order to influence the ongoing changes to the environment for both patients and staff.

Thanks were given to the team for their report and attendance.
Eki Emovon, Lois Mellor, Samantha Fawkes, Alison Boldy and Tim Noble left the meeting.

**LEADERSHIP & IMPROVEMENT**

**19/06/5 Workforce & Education Report (June 2019)**

The committee considered a report from Karen Barnard that set out the Workforce & Education Report for June 2019 and highlighted the key points:

- SET compliance – Data from the report showed that compliance remained at 82% rising to 84% at the date of the meeting. The WERC had reviewed the results of the deep dive exercise in order to understand the reason for the stabilised figures.
- Time taken for face to face learning courses to be minimised - Conflict Resolution can now be accessed via e-learning and will focus on enhanced training.
- Resuscitation Training for Consultants remained a concern for Consultants however an agreement had been made that the training would be revised with an agreed sign off planned for a four year accreditation with annual updates.
- ESR self-service would be re-visited and signatories reviewed to ensure that supervisors are correct.
- Currently one third of all staff sickness reported is stress related and therefore work is being undertaken on reviewing the action plan to

address mental health & wellbeing and to ensure that staff are directed to the appropriate services within the Trust. A drill down report is to be produced in order to ascertain whether these are short term/long term instances and KB agreed to provide this to the committee. **KB**

- Second highest category of sickness related to MSK, particularly back problems, accounting for a further one third of all sickness. Manual Handling training continues to be rolled out in order to address this. Information on what is available to staff is continuously promoted in BUZZ.
- Health & Safety (Violence & Aggression/Security) abuse of staff by members of the public: KB had requested further detail in order to identify any recurrent themes. KB to meet with Kirsty Edmondson Jones in order to review environmental impacts on violence and aggression. There are currently 2 security staff on site however when 24 hour CCTV is in operation it is hoped that this will make staff feel safer on the premises. **KB/KEJ**

SM acknowledged all the positive work that was being undertaken and asked if the Executive team felt assured that these actions were effective. KB responded that the staff survey results were a good indicator of effectiveness however the survey is restricted to 9 questions. In light of this KB acknowledged that there is a need for further additional 'temperature' testing to be done, in particular to be certain how the environment had an impact on these responses.
PD acknowledged progress with SET compliance and expressed the need for increased emphasis on mental health training. PD also stated the need for Divisions to own their own data in terms of compliance and DP confirmed that this would form part of the divisional accountability framework in the future.

<u>Training & Education:</u>
Timeframe for Education Governance Framework – KB reported that a draft had been submitted to the Workforce Education Committee and will review current arrangements and how this is was being utilised.

SM enquired as to what the Executive Team felt set DBTH apart from other Trusts and KB responded that there was an increased focus on local training. Work is ongoing with local colleges and partners with a view to making Doncaster an academic city.

The committee NOTED the update.

**19/06/6 Links Between path to CQC Outstanding & the Staff Survey**
The committee considered a report from Karen Barnard that set out the Trusts vision of CQC outstanding and the results of the staff survey.

It was reported that attendance at recent staff engagement events had been lower than expected and further work would be required to improve attendance. Rebecca Joyce (RJ) added that she would also be visiting divisional areas as part of her induction programme and will talk to managers and share the feedback. DP agreed to share his feedback from the clinical nursing areas

as would the NEDs on the areas that they had visited to enable shared learning.

The CQC had requested a breakdown of Executive visits as part of a well led inspection and this information would be submitted in due course.

The committee considered an update on the Leadership Programmes and heard how the framework was being developed in order to support leaders in delivering service improvement. SM enquired as to how Executives felt assured that the development opportunities were being targeted, and taken up by the relevant staff. KB responded that this formed a key part of the appraisal process and there had been a real increase in opportunities taken up by staff at Band 8a and above. Participation in leadership opportunities will also form part of the revised development framework for Divisional Directors. It was asked that staff engagement would be a standard agenda item. **KB/JR**

PD asked how Equality & Diversity was being addressed within the Trust in terms of cultural diversity in the core planning process. The Committee agreed that diversity issues still required attention and KB is currently considering sourcing external expertise to work with staff across the Trust. PD felt there is still a gap and all staff are required to understand and embrace equality and diversity to recognise the positive effects on the Trust its patients and colleagues. KB confirmed that inclusion of Equality & Diversity principles formed part of SET training and further information is available on the extranet.

The committee NOTED the update.

**QUALITY & CARE**

**19/06/7 Quality Assurance Report**

The committee considered the Quality Assurance Report and NOTED the key points:

The quality dashboards were under review to provide enhanced information and assurance.

The current HSMR position is good with a slight increase noted however this still remained inside the level expected.

Increase in crude mortality in some areas but this was expected.

There had been an increase in the reporting of incidents however a reduction in reporting of incidents relating to surgical sites.

A best practice pathway tariff for fractured Neck of Femur was in place which the Trust aims to achieve but there is still some way to go.

It was reported that there was a lack of administrative support within the divisions for clinical governance related tasks which remains an ongoing issue.

DP clarified that this was not covered as part of the recent admin review. This has been discussed many times at the Clinical Governance Committee who had assigned responsibility for this to the divisions in order to allocate resources from within each specialty. This would include the taking and transcribing of minutes and the following up of CG related actions.

Duty of Candour (DOC) compliance (within 24 hours) is now at 100% (objective set by the CG Committee).

Update on target set by QEC:

No open incidents older than 3 months by June 2019 (detail included in the Risk Management report), the number of open incidents continues to increase.

The Risk Management Report will evolve to ensure that there is meaningful contextual information as to why some areas are scoring red on the risk matrix.

It was agreed a deep dive in Paediatrics staffing would be completed for the next meeting. **DP**

It was reported that the Trust is performing well on reducing agency spending.

HCAs were utilised when there is a nursing staffing shortfall and risk assessments are completed.

Patient Experience: It was acknowledged that there had been a positive improvement in complaint responses.

**Claims**

It was reported that patient claims had reduced by 30% however staff claims had increased by 50%. This was a concern which required further exploratory work and additional detail in order to address the issues raised. FD to provide a report to WERC and present to the next QEC. **FD**

**Patient Story on Learning from Deaths**

An example of a patient story had been shared with members of the committee and PD provided a brief overview that detailed that a patient's family had been asked to return in order to complete formalities on a day when a key member of staff was on holiday. PD enquired as to ether the member of staff involved had received feedback on how this error had affected the patient's family and asked that this be considered in future.

As lessons learned from the patient experience death certificates were now being issued in a timelier manner than of that previously. The key issues as ever was communication and how a revised leaflet for families had been produced.

It is evident from the recent Mortality report that an improvement is needed

for compliance with targets for the Structured Judgement Mortality Reviews. It is acknowledged that this is more achievable within specialities with a lower death rate. The business case for the new Medical Examiner role had been submitted and this would assist and support the review process in order that the six week target can be achieved.

**19/06/8 CQC Update Report dated June 2019**

The committee considered a report that set out the recent work around CQC and the planned mock CQC inspection schedule.

FD provided an update on CQC actions and advised that the main areas of focus were around recent metrics on staff engagement that had now seen an improvement in recent weeks. One pathway suggested at the Clinical Governance Committee is that the quarterly update be moved to a briefer monthly report to include an update and review of outstanding actions or concerns.

Mock inspections had been planned and it was noted that there was a need to ensure balance in areas where the inspection focus will be.

There is also a need to improve updates and communication to staff on the CQC process and provide feedback from the assessors. All notification of reviews or documentation will be shared and collated centrally to ensure action at divisional level. Work is ongoing to submit all information required by the CQC and therefore it was requested that a regular update is reviewed at each QEC meeting.

PD requested that all CQC progress reports are shared with QEC. **FD / JR**

The Committee NOTED the update.

**19/06/9 Annual Review of QPIA Process and Impacts Report dated 17 June 2019**

The committee considered the report that set out the Annual Review of the QPIA process and the impacts of the report dated 17 June 2019. The QPIA's had gone through the corporate process and no schemes had been identified as risk areas.

KB stated that the Senior Responsible Officer will report any risks to SS and MH and any questions to be fed back to them.

**GOVERNANCE & RISK**

**19/06/10 Board Assurance Framework & Corporate Risk Register**

The committee received the Board Assurance Framework and Corporate Risk Register and NOTED the update. The Chair requested that all authors of reports include the BAF risk reference on coversheets for reports going forward. **All Execs**

**19/06/11 Governor queries regarding clarification of the business discussed in items 5 to 9:**

Peter Abell (PA) enquired as to whether the telephone numbers for the Bereavement Service on the internet and in the new booklet are correct and assurance was provided. In addition, there have now been changes to the bereavement team in order to ensure that there is a member of staff responsible for any ward related issues.

PA asked how many cases of sepsis had been in the paediatric area. FD stated there had been no Paediatric SI's.

**ITEMS FOR INFORMATION**

**19/06/12** Minutes of sub-committees:
Clinical Governance Committee meetings held March 2019 and April 2019.

Workforce Education & Research Committee held March 2019.

The above minutes were NOTED.

**19/06/13 Information Reports for Assurance (not for discussion)**
For noting :

1. P & OD Strategy
2. Clinical Site Strategy
3. CGC Risk Management Report on Incidents
4. Q4 Enabling Strategy Exception Report

**19/06/14 Clinical Governance Committee Sub Committee Reports**

- Infection Prevention & Control Report –
- PEEC Report
- NHSR Annual claims Update Report

**19/06/15 National Reports/Areas of National Concern**
SI's, still ongoing.

**19/06/16 New Internal Audit Reports referred by ARC to QEC**
Progress against complaints and any other outstanding actions recommended to QEC.

**19/06/17 Minutes of the Meeting held 24 April 2019**
The minutes of the above meeting were approved.

**19/06/18 Work Plan**
To be updated.

**19/06/19 Any Other Business (agreed prior to the meeting)**
Thanks were extended to Sheen McDonnell for the preparation of the agenda and to Carolyn Taylor for providing secretarial cover for the minutes of the meeting. No further items for discussion.

**19/06/20 Governor Questions regarding the business of the meeting items 11-14:**
Nil.

**19/06/21 Items escalated from sub-Committees:**

Update on Divisional issues relating to Transport & Estates:
Not available at this meeting.

**19/06/22 Items for Escalation to the Board of Directors**

The 50% increase in staff claims posed a concern for the Trust and therefore PD agreed to escalate to the Board of Directors. PD to share the outcome and further information with KB and SM. **PD**

**19/06/23 Identification of New Risks**

None.

**19/06/24 Time and date of next meeting:**

Date: 21 August 2019
Time: 2pm
Venue: Boardroom, DRI

**Signed:…….. ……**

**Pat Drake Chair of QEC Date**

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Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

**FINANCE AND PERFORMANCE COMMITTEE**

**Minutes of the meeting of the Finance and Performance Committee**
**Held on Friday 21 June 2019 in the Board Room, Doncaster Royal Infirmary**

**Present:** Neil Rhodes, Non-Executive Director (Chair)
Karen Barnard, Director of People & Organisational Development (to FP11/19)
Pat Drake, Non-Executive Director
Rebecca (Becky) Joyce, Chief Operating Officer (to FP11/19)
Kath Smart, Non-Executive Director
Jon Sargeant, Director of Finance (to FP11/19)

**In attendance:** Jeannette Reay, Head of Corporate Assurance / Company Secretary (Minutes)Claire Jenkinson, Deputy Chief Operating Officer, Clinical Specialities (for FP09/19)
Paul Mapley, Efficiency Director (for FP06/19)
Lois Mellor, Head of Midwifery (for FP04/19)
Andrew Thomas, Project Director (for FP12/19)

**To Observe:** Bev Marshall, Governor

**Apologies:** David Purdue, Deputy Chief Executive

**ACTION**

**FP01/19** **Welcome and Apologies for Absence (Verbal)**

Neil Rhodes welcomed the Members and attendees, including Becky Joyce and Jeannette Reay, who were attending their first meeting of the Committee.

David Purdue's apologies were noted and it was acknowledged that future attendance would be from Becky Joyce. The Committee's appreciation of David Purdue's input was noted.

**FP02/19** **Action Notes from Previous Meeting (Enclosure A)**

***The Committee:***

- ***Agreed that actions marked 'close' be considered complete;***
- ***Noted the following updates:***

19/5/31 – The Committee requested information on non-urgent patient transport into hospital and outpatients, to understand how the contracts were reviewed with reference to any issues that have been raised by patients and the public.

***Action: Becky Joyce and Jon Sargeant would provide information on patient transport queries to Kirsty for this information to be included on future agendas.*** ***RJ / JS/ KEJ***

19/5/31 – The information required on delayed discharges and delayed transfers of care was that on 21 day targets (which used to be provided).

19/5/43 – A consistent approach was required for deep dive presentations including the mission, issues and targets, and actions for improvement/the future. Coverage of the targets and True North objectives should be included and time limits should be clearly advised to presenters.

***Action: Using examples from PMO and Lois Mellor, Jon Sargeant would provide a template for Board Sub-Committees. This would be agreed by the Executive Team.*** ***JS***

**FP03/19** **Request for Any Other Business (Verbal)**

No other items were requested.

**FP04/19** **CNST Update (Enclosure H)**

This item was taken early on the agenda to allow for Lois Mellor' attendance.

Lois Mellor advised the Committee that the scheme consisted of 10 standards of best practice / quality of care. These were assessed on an annual basis and the value of full compliance was a rebate of £556k – ring fenced for maternity services. Approximately 50% of Trusts achieved the standards each year with DBTH missing the target by a single standard last year (safety action 9 training).

The Committee welcomed the focused work being undertaken, and was assured by the plans in place to achieve full compliance. There was a recognition of the benefits that would come from providing a dedicated resource on this in future years.

***The Committee:***

- ***Supported the approach being taken on compliance with CNST.***

The self-assessment would need to be signed off by the Board of Directors at a meeting prior to submission (15 August 2019).

***Action: Jeannette Reay would add the CNST update to the July 2019 Board agenda.*** ***JR***

***Action: Neil Rhodes would include an update on CNST to the Governors at the July 2019 Council meeting.*** ***NR***

**FP05/19** **Outpatient Department CIP (Enclosure B)**

Becky Joyce presented an approach for the CIP in Outpatients which had a £1m target remaining.

There were two strands to the work:

- Get the basics in place
- Pathway redesign

A project manager had been appointed and the priority was to pin down robust delivery plans. Work was taking place with Divisions to identify opportunities and to put plans in place.

A stocktake of the outpatient provision (environment and activity) – building upon the Draft Outpatient Strategy (circa 2014) - was being undertaken.

***The Committee:***

- ***Supported the approach being taken on the Outpatient CIP.***

***Action:*** ***Becky Joyce would provide an update on progress to a future meeting of the Finance and Performance Committee.*** ***RJ***

***Action:*** ***Neil would include an update on the CIP in Outpatients to the Governors at the July 2019 Council meeting.*** ***NR***

**FP06/19** **Financial Performance – May 2019 (Enclosure C)**

Jon Sargeant provided an update for month two, highlighting:

- An adverse monthly variance of £4k;
- An adverse year to date variance of £194k;
- In month income £1m over budget;
- Pay over budget and creeping agency costs;
- Significant cost pressure in W&C due to sickness, gaps, holidays and a lack of consultants (£100k paid on consultants in the last month) – adverts are out for staff but a short term solution was sought;
- Emergency activity up by 8% in May 2019;
- Adverse variance on outpatient cap.

The Committee noted that grip and control meetings were taking place on the adverse variances. Extra activity meant that the 'winter' beds had not been closed and these required staffing. Divisions were putting together business cases for extra staff.

Jon Sargeant advised of the following current risks:

- Shortage on budgets at Bassetlaw Hospital;
- Coding issues at DRI which could lead to a request (from Doncaster CCG) for a repayment of emergency admissions for ambulatory care;
- £1.5m budget from Bassetlaw CCG for RTT which is not in its plan;
- Waiting lists of £6.3m and £2.2 would need commissioning from DCCG;
- Contract penalties / outpatients cap;
- Lack of activity funding for day cases in outpatients.

***The Committee:***

- ***Noted the Finance Report for May 2019.***

Cost Improvement Plans (CIPs)

NHSI had advised the Trust that representatives would visit during the second week of July, at which time they would expect all schemes to be 'green'.

Paul Mapley advised that, as of month two - £410k savings had been achieved against a plan of £280k.

During the month, under deliveries had been offset by over deliveries.

Paul Mapley advised that the major concerns came from:

- Medical recruitment and agenda spend;
- Outpatient slot utilisation;
- Theatre schemes and ophthalmology;
- Getting it right first time (GIRTH).

The Committee noted that the PLICs meetings were not well attended by divisional directors and it requested further information on the plans and actions against the major concerns.

The Committee acknowledged that the Trust was in a better position this year than last but that focus was required in the next two months if the annual outturn was to be achieved.

The Committee appreciated the level of information in the report which enabled members to ask the right questions.

***The Committee:***

- ***Received the update on CIPs, taking limited assurance on the current position.***

Capital

Jon Sargeant advised that the national position on this had changed as contractual obligations for the year could not be met.

All Trusts had received a letter requesting that capital expenditure be reduced, Jon Sargeant had attended meetings and he had had a call with NHSI – which would also visit the Trust in the coming weeks.

There was a suggestion that the ICS must reduce by 25% but the Trust had provided the majority of the ICS' savings to date (£13.5m of £14m). On this basis Jon Sargeant had refused the request to hold back spending at DBTH as being unsafe.

Jon Sargeant reminded the Committee that the Trust's capital planning had robust processes and that the spending was on a risk basis. He had requested that the ICS provide write to NHSI to determine the basis for the changed position and to ascertain how long the hold on spending was likely to last.

The risk was that the Trust had retained £2.5m worth of contingency and that

this could be lost.

***The Committee:***

- ***Noted the risk to the Trust's capital plan and supported the Finance Director's responses on this matter to date.***

**FP07/19** **Dr Dr / PSL (Verbal)**

Jon Sargeant updated the Committee on the current position with the Dr Dr and PSL contract.

Following negotiation on contract difficulties, the Trust had agreed to continue to contract with PSL on the basis that a joint agreement be signed between PSL and Dr Dr. This was at an additional cost of approximately £700k over the life of the contract. This would be provided for Board approval at the June 2019 meeting.

The difficulties in patient bookings, waiting times, cancellations and DNAs were discussed. Concerns over the numbers were raised but there was also good practice noted (mock CQC visits had noted short waiting times).

The Committee was pleased to note that recruitment to six current vacancies to manage appointments was being progressed.

***The Committee:***

- ***Noted the update on Dr Dr.***

**FP08/19** **Integrated Performance Report (Enclosure D)**

Karen Barnard, Becky Joyce and Jon Sargeant highlighted the key points from the Integrated Performance Report:

- The ED target was at 92.4% (good despite increased activity);
- Plans to deliver ED at 95% by December 2019 were robust;
- RTT performance at 87% was weak and required recovery;
- Diagnostic, 2 week waits and 62 day waits were compliant;
- A 52 week breach had occurred in Trauma and Orthopaedics;
- Appraisal data would be available after 31 July 2019;
- Set training was at 84.3%;
- Sickness absence was at 4.2%.

Becky Joyce advised that the 52 week breach had resulted in no harm and that a piece of work was being undertaken, including a review list for outpatients and staff training. Once the Trust had cleansed the revalidation list, assurance that this would not reoccur would be possible.

Jon advised that the Trust had issued contract figures and divisions were focused on, and monitoring activity tracking. Meetings had been held with divisional leads to agree the aspirations.

***Action:*** ***Jon Sargeant would report divisional performance in the operations report once the Gooroo modelling and outpatient modelling had been completed (end of July) and would include a graph comparing divisional performance year on year in future reports.*** **JS**

Neil Rhodes summarised that the report indicated the Trust was safe.

He welcomed the inclusion of peer and national benchmarking data and requested that this be rag rated. He agreed that the trend graph in the report covered that off.

***Action:*** ***Jon Sargeant would include rag rating in future reports.*** ***JS***

***The Committee:***

- ***Noted the Integrated Performance Report for May 2019.***

**FP09/19** **Outpatients Follow Ups Update (Enclosure E)**

Claire Jenkinson provided an update on the Outpatient follow up work.

The plans on how areas would be followed up had been informed by clinicians and further work would now take place to engage business managers.

A task and finish group had been set up which included looking at IT solutions and communications

***The Committee:***

- ***Supported the approach being taken on the Outpatient CIP.***

**FP10/19** **Workforce Report (Enclosure F)**

Karen Barnard provided the Workforce Report – no queries were raised.

***The Committee:***

- ***Noted the Workforce Report for May 2019.***

**FP11/19** **Workforce Planning Process (Enclosure G)**

Karen presented the Workforce Planning process, advising that this would be provided to the Board of Directors at its meeting on 25 June 2019.

The information highlighted workforce gaps and the options, costs and plans to address them going forward. Some data to complete this was being expedited from Divisions.

***The Committee:***

- ***Noted the Workforce Planning Process.***

Karen Barnard, Becky Joyce and Jon Sargeant left the meeting at 12.10pm.

**FP12/19** **Pharmacy Wholly Owned Subsidiary Update (Enclosure I)**

Andrew Thomas provided an updated business case.

The case had been created at the request of NHSI which had requested a number of non-substantial changes, the main being to the statement of VAT. The Trust had taken advice from Grant Thornton on the changes made.

The revised document would be subjected to a minimum amount of process in early July 2019 (not a full panel) and the case had therefore been delayed by approximately one month. Users of the service should not be affected by the timing.

The transaction would now be classed as 'material' rather than 'significant', meaning that it was now considered less of a risk to the Trust and did not require Trust Board approval.

The Committee recognised that governors would be interested in the transaction and felt that this provided a good news story – with job retention and staff being brought into the DBTH family.

***Action:*** ***Neil would include an update on the Wholly Owned Subsidiary to the Governors at the July 2019 Council meeting.*** ***NR***

The Committee referenced that strong governance would be required for the Subsidiary, and that the conflicts of interests of Non-Executive Directors and staff would need acknowledging and managing. As with any Trust contractor the work of the organisation would have to be open and transparent.

***Action:*** ***Andrew Thomas would include that one of the Non-Executive Directors for the subsidiary should not be a member of the Finance and Performance Committee.*** ***AT***

***The Committee:***

- ***Approved the revised business case for the Pharmacy Wholly Owned Subsidiary – for submission to NHSI.***

**FP13/19** **Corporate Risk Register & BAF Highlights (Enclosure J)**

Neil Rhodes acknowledged that these documents were in the process of handover to Jeannette Reay.

The reports were taken as read with further updates to be provided to the next meeting.

***Action:*** ***Jeannette Reay would lead on a review of the BAF and Risk Registers with a refreshed approach to be determined by September 2019.*** ***JR***

**FP14/19** **Committee Annual Report (Enclosure K)**

Neil Rhodes requested that further detail be provided in the report to better capture how the Committee had discharged its responsibilities throughout the year and to include a forward look at what the Committee would do in the year ahead.

***The Committee:***

- ***Noted the position on the Annual Report.***

***Action:*** ***Jeannette Reay would look at updating the Annual Report of the Finance and Performance Committee, for provision to the meeting in July 2019.*** ***JR***

The membership of the Committee was briefly discussed and Pat Drake advised that a representative from the CCG was included on the Terms of Reference for the Quality and Effectiveness Committee (QEC). This would be looked by a review of the QEC Terms of Reference – there was no such inclusion for the Finance and Performance Committee.

***Action:*** ***Jeannette Reay would circulate the current Terms of Reference for the Finance and Performance Committee to members for information. The Terms of Reference would be added to a future agenda for refresh.*** ***JR***

**FP15/19** **Strategy (Verbal)**

There were no reports on strategy.

**FP16/19** **Items to Note**

***The Committee:***

- ***Noted the following for information:***

• Minutes of the Effectiveness and Efficiency Committee meeting held on 3 June 2019 (Enclosure L).

• Minutes of the Cash Committee meeting held on 15 March 2019 and 10 May 2019 (Enclosure M)

**FP17/19** **Minutes of the meeting held on 20 May 2019 (Enclosure N)**

***The Committee:***

- ***Approved the minutes from the meeting held on 20 May 2019***.

**FP18/19** **Committee Work Plan (Enclosure O)**

***The Committee:***

- ***Noted the work plan.***

**FP19/19** **Items for escalation to the Board of Directors (Verbal)**

No items were highlighted for escalation.

**FP20/19** **Date and time of next meeting**

Date: Tuesday 23 July 2019
Time: 10.00am – 2.00pm
Venue: The Board Room, Bassetlaw Hospital

***Post Meeting Note:***

- ***The meeting arranged for August 2019 was stood down.***

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

**FINANCE AND PERFORMANCE COMMITTEE**

**Minutes of the meeting of the Finance and Performance Committee**
**Held on Tuesday 23 July 2019 in the Board Room, The Hub, Bassetlaw Hospital**

**Present:** Neil Rhodes, Non-Executive Director (Chair)
Karen Barnard, Director of People & Organisational Development
Pat Drake, Non-Executive Director
Kath Smart, Non-Executive Director
Jon Sargeant, Director of Finance
Rebecca Joyce, Chief Operating Officer
Alex Crickmar, Deputy Director of Finance

**In attendance:** Katie Shepherd, Corporate Governance Officer (Minutes) (KAS)
Jeannette Reay, Head of Corporate Assurance/Trust Board Secretary
Ruth Bruce, Strategic Change Manager, Urgent and Emergency Care

**To Observe:** Bev Marshall, Governor

**Apologies:** Kirsty Edmondson-Jones, Director of Estates

**ACTION**

**FP 19/07/01** **Welcome and Apologies for Absence (Verbal)**

Neil Rhodes welcomed the Members and attendees, including Katie Shepherd who was in attendance at her first meeting. The apologies for absence were noted.

Kirsty Edmondson-Jones was absent due to a power outage at DRI. Neil Rhodes asked members if they were happy to note the presentations from Estates and Facilities, and this was agreed.

Kath Smart highlighted that some risks were identified in the enclosures and the meeting agreed that these would be directed to Ruth Bruce who would attend later in the meeting.

Items B1, B2 and B3 were noted.

**FP 19/07/02** **Action Notes from Previous Meeting (Enclosure A2)**

The following updates were provided;

Action 2 – The note should reflect that the deep dive presentation would be provided to the September 2019 meeting;

Action 3 – On the basis that this information was included in the Underlying Deficit

Paper, this action would be closed;

Action 4 – On the basis that this report was included on the agenda, this action would be closed;

Action 5 – On the basis that this was included on the agenda, this action would be closed;

Action 6 – The information on both 21 day targets and delayed discharges would be included in the report of July 2019 data;

Action 8 – No update as yet received from Marie Purdue;

Action 12 – On the basis that the CNST report was included on the Board agenda, this action would be closed;

Action 13 – On the basis that a bullet point was included on the Council presentation and that Karen would provide the information required to Neil Rhodes, this action would be closed;

Action 15 – The target date would be amended to reflect that the update to Governors would follow the deep dive presentation on the Outpatient CIP which would be provided to the Committee in September 2019;

Action 16 – On the basis that concerns on major CIPs were included in each Committee report, this action would be closed;

Action 18 – On the basis that rag ratings to show the direction of travel were included in the July 2019 Committee report, this action would be closed;

Action 19 – On the basis that a bullet point was included on the Council presentation, this action would be closed;

Action 22 – On the basis that the report was included on the agenda, this action would be closed.

Action 23 – On the basis that the Terms of Reference had been circulated, and that a meeting to discuss Committee Terms of Reference was to take place on 23 July 2019, the action would be closed.

***The Committee:***

- ***Noted the updates and agreed, as above, which actions should be closed.***

***Action:*** ***Katie Shepherd would update the Action Log.*** **KAS**

A brief discussion took place on the rag rating colours and, Neil Rhodes requested that these be standardised with the approach taken by Programme Management.

***Action:*** ***Katie Shepherd would amend the Action Log, using standardised rag rating. Jeannette Reay would roll this format out to the Board, and other Committee Action Logs.*** **KAS/JR**

**FP 19/07/03** **Request for Any Other Business (Verbal)**

Jon Sargeant would provide feedback on two points from the meetings he had attended during the previous week with NHSI and NHSE:

- Bassetlaw position on contract difference – high risk centrally;
- CIP Report (Section C).

**FP 19/07/04** **Information Management and Technology Strategy (Enclosure B1)**

***The Committee:***

- ***Noted the Information Management and Technology Strategy presentation.***

**FP 19/07/05** **Estates and Facilities Strategy (Enclosure B2)**

***The Committee:***

- ***Noted the Estates and Facilities Strategy presentation.***

**FP 19/07/06** **Portering (Verbal)**

***The Committee:***

- ***Would raise any questions with Ruth Bruce relating to strategy later in the meeting;***
- ***Noted the presentation on Portering.***

***Action: The Committee requested that an update on the risks identified be added to the future work plan for six months' time.*** **KAS**

**FP 19/07/07** **Financial Performance June 2019 (Enclosure C1)**

Alex Crickmar provided an update on month three, highlighting:

- A favourable monthly variance of £189k;
- A favourable year to date variance of £12k;
- An underperformance in clinical income of £412k;
- The expenditure position was £77k favourable to plan.

The Committee noted that the underperformance in clinical income was partly due to emergency income being below plan, which was being investigated by the Division and correlated with other data sources.

Jon Sargeant suggested this may be a data delay relating to PAS and Rebecca Joyce confirmed that 21-day monitoring should help with this.

The Estates budgets were £136k overspent on non-pay in month which was being reviewed but could be due to an increase in utilities and rates.

Jon Sargeant noted that the Trust was on plan with capital spend, however the request being put to the ICS for savings from the NHSI could adversely this.

Cost Improvement Plans (CIPs)

Alex Crickmar advised that, as of month three, the Trust had delivered £477k of saving versus the plan submitted to NHSI of £311k. NHSI representatives had visited during

the second week of July and had been complimentary about the Trust's processes.

Kath Smart queried whether there was clarity on GIRFT blockages and what the F&P Committee could do to improve this.

***Action: Invite Sewa Singh and Gill Payne to deliver a deep-dive on GIRFT.*** **KAS**

Neil Rhodes noted that it was difficult to understand the Overall Delivery Forecast on page 41 of the F&P Committee papers due to '-' in the variance column. Jon Sargeant confirmed that this was a formatting issue and would ensure that it was clear when the £ was negative.

Neil Rhodes requested that the Progress of CIP planning chart on page 42 of the F&P Committee papers be BRAG rated on future reports, including a clear definition of each.

***Action: Jon Sargeant/Alex Crickmar to include BRAG rating and labels on the Progress of CIP Planning chart on future reports.*** **JS/AC**

Pat Drake asked the Director of Finance if he felt the new process of CIP was bedded in and working well. Jon Sargeant confirmed that the process was working much better as systems were now in place for individuals to be held to account and he hoped that, when the performance meetings commenced in August, there would be a cultural change in which management teams would take ownership. There would be an opportunity to review the process at the end of the year.

Neil Rhodes requested a YTD column on the Division Performance Report on page 36 of the F&P Committee papers.

***Action: Jon Sargeant/Alex Crickmar to add YTD column to the Division Performance Report.*** **JS/AC**

Clarification on debt recovery processes was provided and the Committee noted that all debtors were provided with an automatic reminder when they defaulted against the agreed payment terms. Defaults were discussed at the Cash Committee meetings, including a number of issues relating to NHS Partners which required resolution. There was no set target percentage for debt recovery, rather an aim to get all debtors to pay promptly and receipted accurately on Oracle. The Committee noted that the Director of Finance felt the current rate of 81% was felt to be reasonable.

***Action: Jon Sargeant to inform Operational representations at Cash Committee meeting regarding ensuring Oracle users receipt orders in a timely manner.*** **JS**

Neil Rhodes asked for a deeper explanation of what was meant by the NHSi budget by Division reports which showed an £11.9million ceiling on agency spend for the Trust. Alex Crickmar advised that the report was split by Division for the purposes of internal monitoring; however NHSi monitored the Trust on the bottom line.

Alex Crickmar advised of the following current risks:

- The underlying under performance in clinical income in month was £412k, This was being investigated by Divisions and correlated with other data sources to understand any root causes;
- Whilst the gap to deliver the planned £13.2m CIPs had reduced, there was still a gap of £1.3m which required identification and robust plans for all schemes

were required – This should be clinically led with accountability firmly placed in the Divisions;
- Modelling of required activity to deliver 92% RTT performance had been completed;
- Aligned to capacity plans, robust workforce plans were still outstanding. Control and reduction of agency and additional sessions spend linked to challenging and robust plans and following SOPs needed to be a priority for the Trust. New SOPs were required for the Grip and Control and VCF process (now TRAC had been implemented);
- Resolution of the payback of non-recurrent support received from CCGs (£1.7m) and the ICS (£1.5m) in 18/19;
- The audit of emergency coding was a potential risk to income, however the Trust believed that any such funds needed to be reinvested and should not cause an in year problem.

Jon Sargeant informed the Committee of the need for further analysis of orders and contracts as there was some medical equipment that hadn't been ordered yet.

The Committee noted that the Trust may be losing out financially due to the one-stop-shop clinics.

Jon Sargeant fed back from two meetings:

The first meeting was a follow up from a contract agreement with NHSI/E. Jon Sargeant informed the Committee that there had been a contract alignment to the cost of £1.8million. He confirmed that all data for the PTL (patient tracking list) was put into GooRoo which showed a delivery of 92% RTT performance.

The second meeting, Jon Sargeant advised that Bassetlaw CCG had accepted the numbers before QUIP of £2.4million.

***The Committee:***
- ***Noted the Financial Performance Paper for June 2019.***

**FP 19/07/08** **<u>Reference Cost Report (Enclosure C2)</u>**

Jon Sargeant advised that the costing submissions were due to be submitted week commencing 12 August in line with the national timetable.

***Action: Jon Sargeant to bring the costing submissions to the next F&P Committee.*** **JS**

Kath Smart made reference to the Audit Review 2016/17 and asked what the confidence levels would be if another audit took place. Jon Sargeant confirmed that the Trust was doing well, but that a new manual had been issued with new recommendations and new guidance.

Jon Sargeant confirmed that there had been meaningful feedback from clinicians and, in response to a query from Bev Marshall, he confirmed that the 2016/17 published figures could be used as a benchmark for setting the tariff.

**FP 19/07/09** **Performance Framework (Enclosure C3)**

Jon Sargeant advised the Committee that a bulk of the trajectories across KPI's had been agreed with the Board of Directors and he confirmed that the Performance Framework Meetings would commence in August.

Using RTT as an example of a KPI, Jon Sargeant advised that a monthly review would take place on its achievement with any non-compliance being questioned at the Performance Framework Meetings. Escalation would take place where appropriate and a recovery plan would be requested against any shortfalls. Ultimately reports would be brought to the F&P Committee Meetings. Jon Sargeant advised that the meetings were to ensure accountability for delivery and forward planning.

***The Committee:***

- ***Noted the Performance Framework for June 2019.***

**FP 19/07/10** **Integrated Performance Report (Enclosure D)**

Rebecca Joyce highlighted the key points from the Integrated Performance Report:

- The ED target was at 91.41%;
- RTT performance was 86.6% - significantly lower than the 92% target;
- The six week diagnostic target had been narrowly missed at 98.67%;
- Cancer performance had been strong across all indicators except 62 day wait for first treatment from consultant screening service referral which narrowly missed the target at a performance of 89.3% against 90%;
- Elective activity, both day case and inpatient, was above plan for the year; This reflected previous actions to improve the position for 2019/20;
- Outpatient activity was, overall, above plan for the year, particularly for follow up activity;
- A number of stroke indicators were not reaching the national standards. This would be fully investigated with the team. The Committee had received a full report from the team in recent months, and the Stroke service continued to perform well in terms of SSNAP outcomes.

Rebecca Joyce advised that the RTT was under scrutiny externally and that the ICS was seeking reassurance of the Trust's modelling and processes. .

***Action: Rebecca Joyce to provide a separate report to F&P Committee on RTT.*** **RJ**

In respect of waiting times in ED and CDU, Rebecca Joyce advised that a review of a linked interface to get patients into, and out of Ambulatory Care Unit quicker was currently being undertaken. She also advised that different ways to expand space in majors were being investigated.

Pat Drake highlighted the patient safety link due to the number of falls that have happened in CDU.

Rebecca Joyce discussed the cancer target of 21 days which was a national trial the Trust was taking part in. The results of the trial would be used in national benchmarking. 34 cancer patients that had been cancelled were non-contactable by administrative staff and concerns around the administrative system for contacting

patients within the Urology Department were raised. Karen Barnard highlighted that, whilst the Admin Review had been completed, there were some staff still to commence in post.

Rebecca Joyce informed the Committee that there was a slight increase in patient cancellations due to non-clinical reasons, due to supply.

The Committee agreed that Stroke should be a deep dive topic in at a future F&P meeting.

***Action: Katie Shepherd to invite Stroke – Stacey Nutt to give a deep dive presentation at F&P Committee, including national benchmarking where available.*** **KAS**

The Committee briefly discussed ambulance handovers in relation to times, shorter breaches.

***Action: Rebecca Joyce to get comparative data on ambulance handovers from Information Team.*** **RJ**

There was a discussion around deep dives at the F&P Committee going forward. It was agreed by the Committee that there should be a maximum of two deep dive presentations at each F&P Committee meeting, one of which should be Finance based and one of which should be Performance based.

***Action: It was agreed that the deep dives to take place at the September meeting would be: Workforce and Outpatients.*** **KB/RJ**

It was agreed that the deep dives to take place at the October meeting will be:
Stroke and GIRFT.

***The Committee:***

- ***Noted the Integrated Performance Report for June 2019.***

**FP 19/07/11** **<u>Workforce Report (Enclosure C5)</u>**

Karen Barnard provided the Workforce Report which included updates on:

- Higher number of vacancies in nursing that last year however the vast majority would be full when the newly qualified nurses started during September 2019;
- A high number of vacancies in admin and clerical posts, which were being recruited to;
- The highlighted workforce gaps and the options, costs and plans to address them going forward;
- Difficulties in recruiting experiences medical secretaries.

Karen Barnard provided an update on agency spend:

***Action: Karen Barnard and Jon Sargeant to transmit out the 'other' category on the Agency spend and usage report*** **KB/JS**

Neil Rhodes asked if the report could consider salary planned and actuals against agency spend to add another way of understanding which departments were efficient.

***Action: Jon Sargeant/Alex Crickmar to add planned salary to the Agency Spend Report*** **JS/AC**

Karen Barnard advised that Enhanced Care was a CIP for Workforce Work stream which will included ensuring patients were being classified correctly.

David Purdue had identified that healthcare assistants were being booked in advance as part of Enhanced Care, but then redeployed when not required. This had become normal practice and healthcare assistant spend was up prior to this identification. This issue was to be considered by Nursing Leads with a view to updating the SOP.

Karen Barnard provided an update of sickness absence and advised on work that had been undertaken to support divisions in the timeliness of dealing with sickness absence.

Karen informed that the Sickness Absence Policy was currently being reviewed.

Karen advised that appraisal season was not yet over and that results would be reported into the Quality and Effectiveness Committee.

***The Committee:***

- ***Noted the Workforce Report for June 2019.***

**FP 19/07/12** **Internal Audit Review of Information Department**

Jon Sargeant advised that he hoped to have the finalised report but had not received it back from KPMG as of yet. He provided an overview of the findings.

- It was recommended having a standardised report writing tool;
- It was suggested that all department report into one place so there is one version of activity;
- The report stated that there was not enough resource to support divisions and sub-information teams which results in a delay in reports.

**FP 19/07/13** **Pharmacy Wholly Owned Subsidiary Update**

Jon Sargeant provided an update of the Pharmacy Wholly Owned Subsidiary and confirmed that the action plan was to go live in October.

Jon Sargeant informed the Committee that a name had not been agreed upon as of yet for the wholly owned subsidiary.

**FP19/07/14** **Corporate Risk Register & BAF Highlights (Enclosure D3)**

Jeannette Reay queried whether the Committee was content to remove risk FP23 – inability to test fire dampers (DRI East Ward block), from the risk register, on the basis that the item had been put to the Capital Plan.

Given the current issues with capital funding, Jon Sargeant felt that the risk should remain on the register.

In terms of process, the Committee was clear that this kind of decision should be taken by management, the processes for which required confirming in the forthcoming review of the Risk Management Strategy.

***Action:*** ***Jeannette Reay would remove names from the report, to be replaced with designations.*** **JR**

***Action:*** ***Jeannette Reay would ensure that management processes, including the additional and removal of risks to the Corporate Risk Register, were clearly defined in the Risk Management Strategy.*** **JR**

***The Committee:***

- ***Noted the Board Assurance Framework and Corporate Risk Register.***

**FP 19/07/15** **Committee Annual Report (Enclosure D4)**

Neil Rhodes thanked Jeannette Reay and Katie Shepherd for the additional information that had been added to the Committee Annual Report.

***The Committee:***

- ***Agreed to sign off the Committee Annual Report.***

**FP 19/07/16** **Strategy Planning (Enclosure E1)**

Jon Sargeant provided an update on the Financial Plan and Underlying Financial Position Update which included:

- The underlying financial position has reduced to £30million;
- Non-recurrent money had been made recurrent but improvements were showing.

***The Committee:***

- ***Welcomed the report on the underlying deficit information this early in the financial year.***

Jon Sargeant advised that auditors had mentioned in the annual report that within the next 18-months it would be tasked with a five year plan to bring the deficit to £0.

***The Committee:***

- ***Noted the Financial Plan and Underlying Financial Position Update June 2019.***

**FP 19/07/17** **Enabling Strategies (Enclosure E2)**

Ruth Bruce gave an update on how strategies should be presented and advised of a template that could be used to identify the business benefits as opposed to just the process and stages.

**Bev Marshall left the meeting.**

There was a discussion around the exception reports and how milestones had been brought forward from 2018/19 to 2019/20 if not achieved. It was suggested that these milestones be red flagged to easily identify what was being achieving.

**FP 19/07/18** **Escalation**

***There were no items escalated to/from:***

- F&P Sub-Committees;
- Board Sub-Committees;
- Board of Directors.

**FP 19/07/19** **Sub-Committee Meetings (Enclosure G1):**

***The Committee noted the minutes of the:***

- ***Effectiveness and Efficiency Committee – 24.06.19***
- ***Capital Monitoring Group – 16.05.19***
- ***WERC – 18.03.19***

There were no minutes of the Cash Committee due to absence of the Committee Secretary.

**FP 19/07/20** **Minutes of the meeting held on 21 June 2019 (Enclosure H1)**

***The Committee:***

- ***Approved the minutes from the meeting held on 21 June 2019.***

**FP 19/07/21** **Committee Work Plan (Enclosure H2)**

***The Committee:***

- ***Noted the work plan.***

**FP 19/07/22** **Any Other Business:**

None.

**FP 19/07/23** **Date and time of next meeting**

**Date:** **Friday 20 September 2019**
**Time:** **09:00 – 13:00**
**Venue:** **The Board Room, Doncaster Royal Infirmary**

**Board of Directors – Work-plan**
**(Updated 21/05/19)**

**H6**

| | 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 | *DoF* | | | | | | | | | | | | |
| Procurement Update | *DoF* | | | | | | | | | | | | |
| **Other Annual / Ad Hoc Reports** | | | | | | | | | | | | | |
| EU Exit | | | ✓ | | | | | | | | | | |
| Car Parking and Security Contract (approve) | *DF&E* | | ✓ | | | | | | | | | | |
| Mixed Sex Accommodation | *DNMAHPs* | | | | | | | | | | | | |

| | SRO/Author | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | | | |

**BOARD OF DIRECTORS – PUBLIC MEETING**

**Minutes of the meeting of the Trust's Board of Directors held in Public on Tuesday 30 July 2019 at 9.15am in the Board Room, Doncaster Royal Infirmary**

**Present:**
Suzy Brain England OBE - Chair of the Board
Karen Barnard - Director of People and Organisational Development
Pat Drake - Non-Executive Director
Moira Hardy – Director of Nursing, Midwifery and Allied Health Professionals
Becky Joyce – Chief Operating Officer
Sheena McDonnell – Non-Executive Director
Richard Parker OBE – Chief Executive
Neil Rhodes – Non-Executive Director
Sewa Singh - Medical Director
Kath Smart – Non-Executive Director

**In attendance:**
Suzanne Bolam – Head of Therapies, Clinical Specialist Services (P19/7/3)
Lois Mellor – Head of Midwifery (P19/7/6)
Jeannette Reay – Head of Corporate Governance / Company Secretary
Howard Timms – Deputy Director of Estates and Facilities (P19/7/12)
Emma Shaheen - Head of Communications and Engagement
Georgina Holmes – Staff Side Chair

**Apologies:**
David Purdue – Deputy Chief Executive
Marie Purdue – Director of Strategy and Transformation
Jon Sargeant – Director of Finance

**ACTION**

**P19/7/1** **Declaration of Interests (Verbal)**

No new declarations were noted.

***The Board:***

- ***Noted the Declaration of Interests pursuant to Section 30 of the Standing Orders.***

**P19/7/2** **Actions from Previous Meetings (Enclosure A3)**

The following updates were provided;

Actions 1, 3, 5 and 6 – Updates on these matters had been added to the future work plan – close.

Action 2 – A meeting had been held to assign risk area for capture in the next updates to Terms of Reference – close.

Action 4 – Further discussions on the living wage were to be held with partner Human Resource Directors – the target date would be extended to reflect this work - October 2019.

***The Board:***

- ***Noted the updates and agreed which actions would be closed.***

**P19/7/3** **DBTH Therapy Services Working at System, Place and Neighbourhood (Presentation)**

Suzanne Bolam provided an update on the work of the Trust's five therapy professions:

- Physiotherapy;
- Orthotics;
- Dietetics;
- Speech and language;
- Occupational therapies.

An AHP Council had been established in September 2018 – including representation from ICS partners to raise the profile of the AHP workforce, provide a hub of expertise and to develop a workforce plan. The Council was working on service breakthrough objectives at PLACE and neighbourhood level.

A celebration of the successes and work which professions have undertaken had taken place at the AHPs Working Together Conference, November 2017. The Board received information on the AHPs' progress in South Yorkshire and Bassetlaw Integrated Care System.

Board members commended the integrated work that was taking place and the commitment of the team towards transformation.

The Board thanked Suzanne Bolam for the presentation, her work for the Trust and all wished her well in her retirement and a new part time role within the ICS which she was to commence in the near future.

***The Board:***

- ***Received and noted the presentation on DBTH Therapy Services.***

**P19/7/4** **Committees in Common (Enclosure C1)**

The establishment of a Committee in Common of the ICS Acute Providers had originally been approved at the Board meeting in June 2017.

The updated Terms of Reference – developed from a template provided by Capsticks – were being provided to align Acute Federation Committee's in Common during June and July 2019.

***The Board:***

- ***Noted and approved the Terms of Reference for the Committee's in Common.***

**P19/7/5** **Quality and Performance Report (Enclosure D1)**

The report had been considered in detail at the Finance and Performance Committee meeting held on 23 July 2019. The following points were highlighted to the Board:

*Performance*

- ED performance continues to be challenging and performance was 91.41%;
- Improving the RTT from last years contracted position was proving challenging, compounded by the impact of pension issues, performance was 86.6%;
- Diagnostics had narrowly missed its target at 98.57%;
- Stroke performance remained a challenge - 2 of 5 indicators achieved;
- Cancer performance was good;
- The Trust was to participate in a trial of the new 28 day cancer target.

The Trust had made a commitment to meet the national standard 92% for RTT in Quarter three. Rebecca Joyce confirmed that capacity and demand issues meant that this was now unrealistic and that revised delivery plans were being developed. The Board noted that the Trust was meeting with the ICS to discuss the issues plan for achieving the national target and to ensure that any unintended adverse impacts on RTT performance from the NECs validation and outpatient improvement work would be managed. This issue is also being addressed nationally as given the drive to reduce outpatient work in Acute Trusts.

There was an expectation that the diagnostic target would be achieved in July and a particular focus was to be placed on improving stroke performance prior to the commencement of the Hyper Acute Stroke Unit in October 2019.

In response to a query on the HSDU contract in theatres, Rebecca Joyce advised that the transfer had been well planned and managed which, to date, had resulted in a low level of service disruption.

*Quality and Safety*

- A rise in C.Diff and pressure ulcers in line with early year predictions of the revised classifications but with improvements in line with trajectory;
- Two maternity diverts in June 2019 due to capacity and demand;
- No red flags on quality in the Hard Truths report;
- A refresh of the Friends and Family test in August 2019.
- Appraisals currently at 76%;
- Positive feedback from staff survey feedback.

In response to concerns raised at the previous Board meeting, the Falls Practitioner had focused on issues in the Clinical Decisions Unit.

Members discussed complaints and serious incidents and the recent audit report was referenced which provided detail on themes and issues. The Board requested a more detailed report on children and young people.

HSMR was discussed with members noting a recent rise. Sewa Singh advised that the equation arising from the calculation of comorbidity and diagnosis had been used to rebase the data (to account for the steady improvement across the NHS). The Trust had some areas where the coding of patients on symptoms and signs, rather than diagnosis, was taking place and this was likely to be having an impact on HSMR. Measures were in place to improve this. All were clear that work to improve the quality of care for patients, including learning from deaths, was the focus and that, as a result of this, the HSMR should improve.

***The Board:***

- ***Received and noted the Quality Performance Report.***

**Action: Information, including themes, on complaints and concerns for children and young people would be included in future Quality and Performance reports.** **DP**

**Action: A review of complaints and concerns – including a response to Internal Audit recommendations – would be provided to a future meeting of the Quality and Effectiveness Committee.** **DP**

**P19/7/6** **Maternity Clinical Negligence Scheme for Trusts (CNST) (Enclosure D2)**

The Board was reminded that this was the second year for this quality incentive. The Trust had been compliant in all but one area (multi-disciplinary training compliance) in the prior year.

Focus had been put to the achievement of the standards this year which, if achieved, attracted additional funding of £556k.

Lois Mellor explained the process and current position, advising that since the timing of the Board report, the Trust was now compliant. The evidence for compliance was substantive and the Trust was assessing itself as achieving all ten standards.

The full detail of the work undertaken for the self-assessment had been presented to the Finance and Performance Committee at its meeting on 21 June 2019 which had taken assurance from the process and position. An internal audit of the process had been undertaken from which significant assurance had been provided.

The Trust would upload its information on compliance from 1 August 2019.

The Board recognised and congratulated the efforts put to this process and confirmed that it would welcome a case to invest in a member of staff to support the process going forward - on the basis of quality improvements which could be funded out of the additional income received from compliance.

***The Board:***

- ***Noted the update on compliance with the Maternity CNST Standards.***

**P19/7/7** **<u>The NHS Patient Safety Strategy (Enclosure D3)</u>**

The Board received the Trust's response to the recently published national strategy which drew a number of pre-existing initiatives together.

The response included an action plan, capturing existing work and some issue for progression. This would be monitored by the Trust's Quality and Effectiveness Committee. It was noted that the current recruitment to the Medical Examiner post would have a positive impact, and that the Trust's pre-existing Patient Safety Strategy would be aligned to the National Strategy.

An event had been planned for the 1st National Patient Safety day on 17 September 2019.

***The Board:***

- ***Noted the Trust's response to the NHS Patient Safety Strategy.***

**P19/7/8** **<u>Board Assurance Framework and Corporate Risk Register Quarterly Update – Q1 (Enclosure D4)</u>**

The Board Assurance Framework and Corporate Risk Register for quarter one were received.

The documents had been provided to the Trust's Board Committees during June and July and the Corporate Risk Register had been approved by Management Board at its meeting on 15 July 2019.

The Board noted that improvement work was being undertaken on risk management processes throughout the Trust and that this included the escalation of risks to the Corporate Risk Register. Jeannette Reay was to lead on a refresh of the format of the Board Assurance Framework and Corporate Risk Register in the coming months, with a view to enabling those with accountability to manage their own areas and to ensure that the documents aligned to the Trust's objectives and correctly reflected strategic risks.

***The Board:***

- ***Noted the Board Assurance Framework and Corporate Risk Register for Quarter one.***

**P19/7/9** **Workforce/Recruitment Plan (Enclosure E1)**

Karen Barnard introduced the paper, highlighting the strategic context of recruitment, retention, skills mix and training.

The plan would be monitored via KPIs which would be reported to the Finance and Performance and Quality Effectiveness Committees and the overall delivery would be tracked by the Board of Directors.

There was a lot of work going on with initiatives to attract employees and retain employees in the long term – including working with universities for placements. The 'progress' programme had been developed to help junior members of staff to develop.

Neil Rhodes advised that the Shadow Board had worked through the report in detail at its meeting on 29 July 2019 and he reported that strong views had been expressed for the Board's attention:

- Real challenge with Senior Nurse Practitioners as higher rates of pay were believed to be available elsewhere in the ICS.

Karen Barnard reported that work was in place with the ICS to ensure that consistency in terms and conditions offered to employees was in place. Whilst this was a system wide issue, there was some intelligence to suggest that nationally Trusts were finding local solutions for nursing retention.

- A morale issue amongst administrative staff, exacerbated by a lack of capacity and a number of vacancies.

The Board confirmed that it was aware of the issue with the recruitment of administrative staff, and the effect that this had on current employees, were acknowledged. Work to ensure that staff, including recent recruits, were sufficiently trained and working to standard operating procedures was in place and it was important that the value of the Trust's clerical staff be recognised.

***The Board:***

- ***Received and noted the update on the Workforce/Recruitment Plan.***

**P19/7/10** **Workforce Race Equality Standards and Workforce Disability Equality Standards Reports (Enclosure E2)**

The Board received the first year report for Working Race Equality Standards (WRES) and the annual report for Workforce Disability Equality Standards (WDES).

The Trust remained focused on identifying and recording underlying disabilities and leadership development was focused on ensuring a compassionate and caring approach. Initiatives such as work placement programmes for individuals with disabilities were being progressed. News of the recent appointment of a substantive Freedom to Speak Up Guardian was

being promoted throughout the Trust, and this would further enable staff to highlight issues of concern, including any relating to WRES and WDES.

Differences in the data between clinical and non-clinical staff were noted and it was acknowledged that a lot of work was required on WRES and WDES. A network approach to develop and address key action points was suggested – where individuals from a diverse range of backgrounds, with an interest in the area, could be part of the solution. Members were keen to ensure that all characteristics were covered, including groups with qualifications from abroad.

Board members recognised that the reports did not capture all of the proactive work that had been, and was being undertaken – with reference to the Trust's involvement in the forthcoming Doncaster Pride event being made.

***The Board:***

- ***Received the WRES and WDES reports and approved the publication of the data contained within.***

**<u>Action:</u> A workshop to develop the Trust's approach to meeting and improving WRES and WDES would be undertaken.** **KB**

**P19/7/11** **<u>Learning Lessons to Improve our People Practices (Enclosure E3)</u>**

The Board received the Trust's local solution to the national initiative.

It was noted that at present a significant proportion of Trust disciplinary cases resulted in no action being taken. Recognising the Trust's quality improvement approach, the question as to how much good practice could influence the outcomes of staff disputes was raised.

Karen Barnard confirmed that the Trust could not enforce advocacy on staff who wished to represent themselves, even where mental health issues were present.

Sheena asked that a further discussion be held at QEC.

***The Board:***

- ***Noted the Trust's approach to Improving People Practices.***

**<u>Action:</u> A progress update would be provided to a future meeting of the Quality Effectiveness Committee.** **KB**

**P19/7/12** **<u>Estates and Facilities Report – Q1 (Enclosure E3)</u>**

Howard Timms - Deputy Director of Estates and Facilities – summarised the key points in the report, highlighting:

- Improvements in appraisals, SET completion, completion of category one response jobs (100%), and hospital cleanliness, and an increase

in planned maintenance;
- The achievement of Sodexo KPIs for patient satisfaction and a reduction on the reporting of catering issues on Datix;
- That a review of the Estates workforce and skills mix was being undertaken.

In response to a previous Board request for assurance on portering jobs completed within 30 minutes, a report had been provided to the July 2019 Finance and Performance Committee meeting. Board also requested information relating to requests for wheelchairs.

It was noted that the results of the staff survey (environmental factors) would be provided to a future Board of Directors (scheduled for October 2019).

***The Board:***

- ***Noted the Estates and Facilities Report.***

**Action: Information on the response times for requests for wheelchairs would be provided to a future meeting of the Quality Effectiveness Committee.** **KEJ**

**P19/7/13** **Finance Report – 30 June 2019 (Enclosure F1)**

The report had been considered in detail at the Finance and Performance Committee meeting held on 23 July 2019. The following points were highlighted to the Board:

- A favourable monthly variance of £189k;
- A favourable year to date variance of £12k;
- An underperformance in clinical income of £412k (being investigated for any root causes, and winter plan being produced);
- An expenditure position of £77k favourable to plan;
- Capital expenditure on plan (although the national demand exceeded the current national limit).

The position was improved from 2018/19 but finances continued to be a challenge.

*Cost Improvement Programme*

The profiling of the cost improvement plans to obtain the most savings in later quarters held inherent risks. As of the start of month three the Trust had delivered £477k of saving versus the plan submitted to NHSI of £311k. NHSI representatives had visited during the second week of July and had been complimentary about the Trust's processes.

Whilst the gap to deliver the planned £13.2m CIPs had reduced, there was still a gap of £1.3m which required identification and robust plans for all schemes required. This would be clinically led with accountability firmly placed in the Divisions.

***The Board:***

- ***Received and noted the Finance Report and Cost Improvement position for June 2019.***

**P19/7/14** **Use of Trust Seal (Enclosure F2)**

The Trust seal had been applied twice on 24 July 2019:

- For the lease of 15 Shaw Lane, Industrial Estate, Ogden Road;
- For the licence to underlet unit 15 Shaw Lane, Industrial Estate, Ogden Road.

***The Board:***

- ***Approved uses of the Trust seal – 111 and 112.***

**P19/7/15** **Chairs Assurance Logs for Board Committees (Enclosure F3)**

P19/7/15(i) Audit and Risk Committee – 18 July 2019

Kath Smart advised that a presentation on the Trust's positive approach to Cyber Security had been well received at the meeting. A dashboard to identify any gaps against the National Cyber Essential Standards, and the plan to redress them, would be provided to the Audit and Risk Committee meeting in November 2019.

The internal audit report on progress against the CQC's Emergency Department Action plan had been provided to the meeting. Five of the 15 internal audit recommendations made had been classified as high risk. David Purdue had provided a verbal assurance update to the Audit and Risk Committee meeting on actions already taken. The internal audit report, and a further update would also be provided to the Quality Effectiveness Committee meeting on 21 August 2019.

***The Board:***

- ***Noted the update from the Audit and Risk Committee meeting held on 18 July 2019.***

P19/7/15(ii) Finance and Performance Committee – 23 July 2019

Neil Rhodes confirmed that detailed reviews of the Quality and Performance Report (P19/7/5) and Finance Report (P19/7/13) had been undertaken at the meeting.

The following points were highlighted:

- A focus on RTT would be provided to the next Finance and Performance Committee meeting in September 2019;
- Action to recruit to known vacancies and to reduce agency spending had been discussed.

- Key questions on budgets and CIPs had been raised, with members confirming that they were looking for a good level of achievement;
- £1m worth of CIPs required identification;
- The detailed plans for identified schemes which had not yet progressed were required.

The Finance and Performance Committee members had concluded that issues of focus were correctly identified and that the Committee had been assured on action plans in place for redress.

***The Board:***

- ***Noted the update from the Finance and Performance Committee meeting held on 23 July 2019.***

**P19/7/16** **Information Items (Enclosures G1 – G6)**

***The Board:***

- ***Noted the Chair and NED's Report;***
- ***Noted the Chief Executive's Report;***
- ***Noted the Minutes of the Management Board, 13 May 2019;***
- ***Noted the Minutes of the Quality Effectiveness Committee, 24 April 2019;***
- ***Noted the Minutes of the Finance and Performance Committee, 20 May 2019;***
- ***Noted the Board Work Plan.***

**P19/7/17** **Minutes of the Meeting held on 25 June 2019 (Enclosure H1)**

***The Board:***

- ***Received and Approved the Minutes of the Public Meeting held on 25 June 2019.***

**P19/7/18** **Any Other Business (Verbal)**

No other items of business were raised.

**P19/7/19** **Governor Questions Regarding the Business of the Meeting (Verbal)**

Geoffrey Johnson queried what data and policies that the Trust held for working carers. The meeting noted that this was not a standard question asked of Trust employees but that the Trust's general flexible working policies were available to all.

Doug Wright queried why the meetings of the Committees in Common (P19/7/4) were held in private. The meeting noted that the items considered were system wide and may contain commercial and/or in confidence issues. Suzy Brain England advised that, following meetings of Committees in Common, relevant issues were shared with DBTH's Board and, where possible, this was done in Public session.

Hazel Brand provided positive soft intelligence obtained from a 29 July 2019 Governors' Open Surgery held at Bassetlaw Hospital. Six Governors had surveyed a total number of 289 patients, visitors, carers, and members of staff with just 15 (5%) of those responding 'no' to the question 'Has your visit today met your expectations?'

To increase the ability of Governors and members of the public to attend the Trust's Public Board of Directors meetings, improvements to the communications between sites would be examined.

***The Board:***

- ***Noted the queries raised, and information provided by Trust Governors.***

**Action: The potential to improve the Trust's systems for streaming and conference calling meetings between the Trust's three sites would be examined.** **KA**

**P19/7/20** **Date and Time of Next meeting (Verbal)**

***The Board:***

- ***Noted the date and time of the next meeting:***

  *Tuesday 24 September 2019*
  *9:15am*
  *The Fred and Ann Green Board Room, Montagu Hospital*

**P19/7/21** **Close of meeting (Verbal)**

The meeting closed at 12.45pm.