Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting Held in Public
To be held on Tuesday 20th April 2021 at 09:30
Via StarLeaf Videoconferencing

Enc		Purpose	Page	Time
A	**MEETING BUSINESS**			**09:30**
A1	Welcome, apologies for absence and declarations of interest *Suzy Brain England OBE, Chair* *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*		-	15
A2	Actions from previous meeting *Suzy Brain England OBE, Chair*	*Review*	5	
B	**PRESENTATION**			**09:45**
B1	Quality Framework Strategy *David Purdue, Chief Nurse, Dr T J Noble, Medical Director*	*Approve*	8	15
C	**True North SA1 - QUALITY AND EFFECTIVENESS**			**10:00**
C1	Board Assurance Framework *David Purdue, Chief Nurse / Dr T J Noble, Medical Director*	*Assurance*	15	5
C2	Chief Nurse Update *David Purdue, Chief Nurse*	*Assurance*	18	10
C3	Medical Director Update *Dr T J Noble, Medical Director*	*Assurance*	35	10
C4	Ockenden Report *David Purdue, Chief Nurse*	*Assurance*	42	10
	BREAK 10:35 – 10:45			
D	**True North SA2 & 3- PEOPLE AND ORGANISATIONAL DEVELOPMENT**			**10:45**
D1	Board Assurance Framework *Karen Barnard, Director of People and Organisational Development*	*Assurance*	45	10
D2	Our People Update *Karen Barnard, Director of People and Organisational Development*	*Assurance*	47	10
D3	Staff Survey Action Plan / People Plan Priorities *Karen Barnard, Director of People and Organisational Development*	*Assurance*	57	10

D4	RACE Equality Code Action Plan *Karen Barnard, Director of People and Organisational Development*	*Assurance*	69	10
E	**True North SA4 - FINANCE AND PERFORMANCE**			**11:25**
E1	Board Assurance Framework *Jon Sargeant, Director of Finance & Rebecca Joyce, Chief Operating Officer*	*Assurance*	107	10
E2	COVID-19 Update / Recovery of Elective Work – Looking Forward *Rebecca Joyce, Chief Operating Officer*	*Note*	-	10
E3	Performance Update *Rebecca Joyce, Chief Operating Officer*	*Assurance*	-	10
E4	Finance Update *Jon Sargeant, Director of Finance*	*Assurance*	108	10
E5	Going Concern *Jon Sargeant, Director of Finance*	*Approve*	115	5
E6	Capital Plan 2021/22 *Jon Sargeant, Director of Finance*	*Approve*	120	10
BREAK 12:20 – 12:30				
F	**STRATEGY**			**12:30**
F1	Annual Objectives *Richard Parker, Chief Executive*	*Approve*	128	10
G	**GOVERNANCE AND ASSURANCE**			**12:40**
G1	Corporate Risk Register *Fiona Dunn, Deputy Director Corporate Governance/Company Secretary*	*Review*	137	15
G2	Terms of Reference of the Audit and Risk Committee *Kath Smart, Non-Executive Director and Chair of the Audit and Risk Committee*	*Assurance*	141	
G3	COVID19 Business Continuity Terms of Reference – Trust SO's *Fiona Dunn, Deputy Director Corporate Governance/Company Secretary*	*Approve*	148	
G4	Finance and Performance Committee Annual Report *Neil Rhodes, Non-Executive Director and Chair of the Finance and Performance Committee*	*Assurance*	190	
H	**INFORMATION ITEMS (To be taken as read)**			**12:55**
H1	Chair and NEDs Report *Suzy Brain England OBE, Chair*	*Information*	196	5

H2	Chief Executives Report *Richard Parker OBE, Chief Executive*	*Information*	202	5
H3	ICS Update *Richard Parker OBE, Chief Executive*	*Information*	205	
H4	Minutes of the Audit and Risk Committee – 29 January 2021 *Kath Smart, Non-Executive Director*	*Information*	210	
H5	Minutes of the Finance and Performance Committee – 26 January 2021 *Neil Rhodes, Non-Executive Director*	*Information*	224	
H6	Minutes of the Management Board Meeting – 8 March 2021 *Richard Parker OBE, Chief Executive*	*Information*	239	
H7	Minutes of the Quality and Effectiveness Committee – 2 February 2021 *Pat Drake, Non-Executive Director*	*Information*	248	
H8	Infection Prevention and Control Board Assurance Framework *David Purdue, Chief Nurse*	*Assurance*	264	
H9	Minutes of the Acute Federation Chairs and Chief Executives 1 February 2021 and 1 March 2021	*Assurance*	266	
I	**OTHER ITEMS**			**13:05**
I1	Minutes of the meeting held on 16th March 2021 *Suzy Brain England OBE, Chair*	*Approval*	272	
I2	Any other business (to be agreed with the Chair prior to the meeting) *Suzy Brain England OBE, Chair*	*Discussion*	-	
I3	Governor questions regarding the business of the meeting (10 minutes)* *Suzy Brain England OBE, Chair*	*Discussion*	-	10
I4	**Date and time of next meeting:** **Date:** Tuesday 18th May 2021 **Time:** 09:30 **Venue:** StarLeaf Videoconferencing	*Information*	-	
I5	**Withdrawal of Press and Public** Board to resolve: That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. *Suzy Brain England OBE, Chair*	*Note*	-	
J	**MEETING CLOSE**			**13:15**

***Governor Questions**

The Board of Directors meetings are held in public but they are not 'public meetings' and, as such the

meetings, will be conducted strictly in line with the above agenda.

For Governors in attendance, the agenda provides the opportunity for questions to be received at an appointed time. Due to the anticipated number of governors attending the virtual meeting, Hazel Brand, as Lead Governor will be able to make a point or ask a question on governors' behalf. If any governor wants Hazel to raise a matter at the Board meeting relating to the papers being presented on the day, they should contact Hazel directly prior to the meeting to express this. All other queries from governors arising from the papers or other matters should be emailed to Fiona Dunn for a written response.

In respect of this agenda item, the following guidance is provided:

- Questions at the meeting must relate to papers being presented on the day.
- Questions must be submitted in advance to Hazel Brand, Lead Governor.
- Questions will be asked by Hazel Brand, Lead Governor at the meeting.
- If questions are not answered at the meeting Fiona Dunn will coordinate a response to all Governors.
- Members of the public and Governors are welcome to raise questions at any other time, on any other matter, either verbally or in writing through the Trust Board Office, or through any other Trust contact point.

Suzy Brain England, OBE, Chair of the Board

Action notes prepared by: Katie Shepherd
Updated: 15th April 2021

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Action Log

Meeting:	Public Board of Directors
Date of latest meeting:	16 March 2021

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

No.	Minute No.	Action	Lead	Target Date	Update
1.	**P21/01/F1**	**Corporate Risk Register** Risk owners required to update their risk where there were older review dates.	**ALL**	**March 2021**	**Update 11/03/2021:** Progress made (see Corporate Risk Register). Some reviews still for logging on DATIX. **Update 15/04/2021** – Progress made and would now be monitored at the Executive Team meeting.
2.	**P21/02/C2**	**People Plan Priorities 2021/22** The People Plan priorities for 2021/22 would be presented at the Board in March 2021.	**KB**	**March 2021**	**Update 11/03/2021** – This would be presented to the Board in April 2021.
3.	**P21/02/H3**	**Governor Briefing – Outcome of White Paper ICS Consultation** Governors would receive an update on the outcome of the white paper following NHSE/I ICS Consultation.	**FD**	**April 2021**	**Closed.** Added to future programme of governor updates once timeline established.
4.	**P21/03/C1i**	**Board Assurance Framework – SA 1 – Quality and Effectiveness** The two internal audit reports undertaken in-year on financial governance and remote working arrangements would be added under the 'assurance' section of the COVID-19 major incident board assurance framework.	**DP**	**April 2021**	**Closed.** The COVID-19 major incident board assurance framework had been updated.

Action notes prepared by: Katie Shepherd
Updated: 15th April 2021

No.	Minute No.	Action	Lead	Target Date	Update
5.	P21/03/C1ii	**Board Assurance Framework – SA 1 – Quality and Effectiveness** A date would be added to the 'assurances' within the board assurance framework inform of when assurance was provided to the Board committees.	FD	April 2021	**Closed.** Included in the BAF review process.
6.	P21/03/C2i	**Board Papers** The use of 'this year' within reports to Board would be changed to reflect the financial year being discussed (e.g. 2020/21).	All	April 2021	**Closed.**
7.	P21/03/C2ii	**ReSPECT Forms** Feedback would be provided on the ReSPECT form which had replaced the DNACPR form, following a suggestion that the use of 'DNACPR' meant that progress hadn't been made. This would be presented to the Quality and Effectiveness Committee.	DP	June 2021	**Closed** – This item would be discussed at the Quality and Effectiveness Committee in June 2021.
8.	P21/03/C3	**Committee Structures** Following the discussion of the Clinical Governance meeting structure. It was agreed that work would be undertaken with the Communications and Engagement Team to devise a clear and understandable outline of the committee structure and each committees purpose.	TN / ES	May 2021	
9.	P21/03/D2	**COVID-19 Positive Staff by Ethnicity** The total number of Positive Staff by Ethnicity would be reported to the People Committee.	KB	April 2021	**Close.** Added to the People Committee work plan.
10.	P21/03/D3	**General Themes of the 'free-text' Staff Survey Results** An analysis would be undertaken on the 'free-text' comments received within the staff survey results. The general themes would be reported back to the Board in May 2021. This would be reported to the People Committee.	KB	April 2021	**Close.** Added to the People Committee work plan.

Action notes prepared by: Katie Shepherd
Updated: 15th April 2021

No.	Minute No.	Action	Lead	Target Date	Update
11.	**P21/03/E2**	**Service Changes** A report would be provided on the service changes made during the COVID-19 pandemic, and any fundamental changes that would form how services would be delivered in the future.	**RJ**	**April 2021**	
12.	**P21/03/E3**	**Deep Dive – Cancer Services** The Finance and Performance Committee would receive a deep dive into cancer services.	**RJ**	**April 2021**	**Close –** The deep dive had been planned in for May 2021 at the Finance and Performance Committee.
13.	**P21/03/G1**	**Committee Effectiveness Review Framework** The Committee Effectiveness Review Framework would be updated to include feedback from members and attendees of Committees.	**FD**	**April 2021**	**Close** – The Committee Effectiveness Review Framework had been updated as required.

Quality Framework Leading to Outstanding

Planning for the Future

Marie Purdue, Director of Strategy & Transformation

David Purdue, Chief Nurse

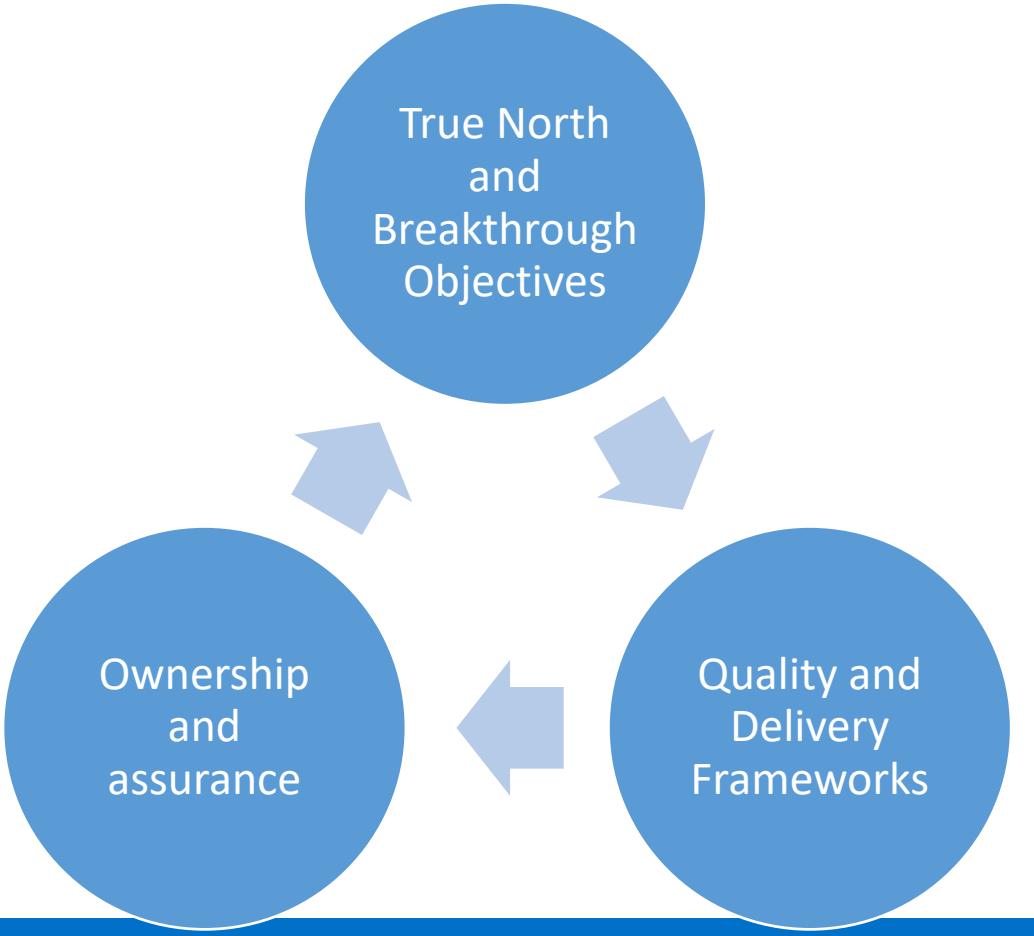
Quality Management Framework

- The Health Foundation identifies that most of the NHS trusts in England that have an outstanding CQC rating have implemented an **organisational approach** to improvement*
- This identifies initial thinking but development process will need to include stakeholders in line with QI principles
- Need to consider overlap with other committees for supporting elements – leadership, culture, performance
- Long term process to continually improve underpinning quality management systems

*Jones, B., Horton T. & Warburton, W. (2019) *The improvement journey: Why organisation-wide improvement in health care matters, and how to get started,* The Health Foundation Learning Report available at https://www.health.org.uk [accessed on 10/5/19]

Developing the Quality Framework

Elevator Pitch



Proposed Quality Framework

	Safe and Outstanding						
	True North 1		True North 2	True North 3	True North 4		
	Definition	**PATIENT FOCUSSED IN ALL WE DO**	**Development of People**	**Processes**	**Leadership Culture**	**Co-production**	**Displays "We Care" values**
Quality Planning	*Set vision and objectives* *Develop high level strategic plans* *Partnership*		Set OD strategy and workforce strategy Identification of required resource Patient and Public involvement strategy	Breakthrough objectives Annual planning Business processes	Self-development Role model Coach Working in partnership – system not organisation	Engagement with all stakeholders in planning Open to feedback Patient and public involvement as default	
Quality Control	*Really good operational management*		Training needs analysis and development plan (based on standard work) Competency Coaching training	Huddles Regular report outs* Standard work - Evidence based practice Visual management Use data to inform and improve	Interprets and owns objectives **Visible** – report out* Kind and calm Coach Unleashes creativity	Patient and public involvement as default	
Quality Improvement	*Specific projects with Executive oversight and allocated resource AND Everyday improvement* *Coaching*		QI training – various levels is mandated	Compliance with the QI practice Research	Ownership Permission to try new ways of working Share learning	Patient and public involvement as default	
Quality Assurance	*Meeting standards and trajectories – internal and external*		Clear lines of accountability and escalations	Assurance processes built in e.g. audit, self-assessment, peer review Internal External	"No surprises" Positive view of assurance Openness and transparency	Representation on assurance bodies	

Proposed Quality Framework

	Safe and Outstanding					
	True North 1		True North 2	True North 3	True North 4	
	Definition		**Development of People**	**Processes**	**Leadership Culture**	**Co-production**
Quality Planning	*Set vision and objectives* *Develop high level strategic plans* *Partnership*	**PATIENT FOCUSSED IN ALL WE DO**	Reviews the operational management resource within the divisional Sets appraisal dates for staff	Jointly develops the breakthrough objectives. Contributes to strategic vision for services and relevant partnerships Develop the business plan for the division Sets trajectories for performance delivery and financial controls	Understands their role in the leadership of the organisation. Aligns divisional objectives and plans with Trust vision and communicates this regularly Individual development plan in place.	Engagement with all stakeholders in planning Open to feedback Patient and public involvement as default
Quality Control	*Really good operational management*		Understands own role in terms of sphere of influence and accountability. Ensures succession planning by developing BMs/SMs Professionalization of admin. TNA undertaken to ensure skills are in place Coach training	Follows standard work Uses information effectively to manage performance and financial control – Reports regularly on trajectories to line manager with early escalation of concerns and ideas for improvement Seeks regular feedback from direct reports – using coaching Follows SFIs Manages performance of individuals	**Visible** – Kind and calm Develops teams and allows for individuality and creativity Takes ownership of their divisions performance and financial targets Supports the corporate view of the organisation Is curious about problems and potential solutions	Patient and public involvement as default Reviews pathways and processes using feedback from staff and patients to improve effectiveness and efficiency.

Proposed Quality Framework

Quality Improvement	*Specific projects with Executive oversight and allocated resource AND Everyday improvement Coaching*		Mandated QI coaching and practitioner	Utilises QI techniques to improve efficiency. e.g. booking process Unblocks problems in QI processes and coaches	Works across the organisation to share successes. Role models use of the QI process Supports others to use QI	Uses feedback from the public, patients and staff to develop new processes.
Quality Assurance	*Meeting standards and trajectories – internal and external*		Understands their levels of responsibility and accountability and ensures their teams understand their levels of accountability and the need to escalate	Provide reports to key assurance groups, PTL, accountability meetings Develops action plans to address with non-performance against agreed trajectories	Ensures issues are raised so "No surprises" Ownership of trajectories and a positive view of assurance	Representation on assurance bodies

Appendix Level1

Board Assurance Framework – Risks to achievement of Strategic Aims

OUR VISION : To be the safest trust in England, outstanding in all that we do

True North Strategic Aim 1	True North Strategic Aim 2	True North Strategic Aim 3	True North Strategic Aim 4
To provide outstanding care and improve patient experience	**Everybody knows their role in achieving the vision**	**Feedback from staff and learners in top 10% in UK**	**In recurrent surplus to invest in improving patient care.**
Breakthrough Objective: Achieve measurable improvements in our quality standards & patient experience	**Breakthrough Objective:** Achieve a 5% improvement in our staff having a meaningful appraisal linked to our vision	**Breakthrough Objective:** The Trust is within the top 25% for staff & learner feedback	**Breakthrough Objective:** Every team achieves their financial plan for the year

Current Risk Level Summary

The entire current BAF was last reviewed in April 2021 reviewed alongside the corporate risk register.

The entire BAF and CRR were reviewed at Board Sub Committee meetings during March 2021 and by the Strategic aim sponsors in April 2021. The individual BAF sheets indicate the assurance detail.

COVID -19 BAF - The integrated pandemic governance process has been embedded and the trust is proactively managing the new and emerging risks identified as part of the restoration and recovery phase. Additional assurance continues to be sought internally and the evidence of this is referenced in the respective director reports to the March Sub Committee and Trust Board.

The key risks to outstanding patient experience remains workforce, the key risk to financial sustainability is underperformance against income plan, cost improvement plan and the underlying financial sustainability and the key risk to operational excellence remains RTT 18 and the 52 week breach position. Additional assurance continues to be sought internally and the evidence of this is referenced in the respective director reports to the February Trust Board .

There has been no change in the BAF risk level during quarter 4 2020/2021.

Heat Map of individual SA risks (identified 2019 -2020 BAF)

	No Harm 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Rare 1					
Unlikely 2		2 Q&E8, Q&E3	1 Q&E4	2 A&R1, F&P10	2 F&P18, Q&E10
Possible 3		1 Q&E7	3 Q&E5, Q&E2, F&P14	4 Q&E11, F&P5, F&P9, Q&E6	2 **F&P11**, F&P19
Likely 4			2 F&P12, F&P15	7 Q&E9, **F&P1**, F&P3, F&P6, F&P13, F&P8, Q&E1,	4 F&P4, F&P20 Q&E12, F&P12,
Certain 5				NEW DCC ID 2664	COVID 2472

Overall change per Strategic Aim (SA)

	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	No of risks/SA	Change
SA1	new	⟺	⟺	⟺		⟺
SA2	new	⟺	⟺	⟺		⟺
SA3	new	⟺	⟺	⟺		⟺
SA4	new	⟺	⟺	⟺		⟺
COVID	⟺	⟺	⟺	⟺	several	⟺

COVID19 Major incident

Risk Owner: Trust Board **Committee: Q&E, F&P,**	**COVID19 - Addition to SA1**	**Date last reviewed : APR 2021**	
Strategic Objective To deliver safe & effective service to patients and staff during a World-wide pandemic of Coronavirus which will infect the population of Doncaster and Bassetlaw (including staff) resulting in reduced staffing, increased workload due to COVID-19 and shortage of beds, ventilators.	**Risk Appetite:** The Trust has a **high appetite** for risks that impact on patients and staff during a worldwide pandemic.	**Initial Risk Rating** **Current Risk Rating** **Target Risk Rating**	5(C) x 5(L) = 25 extr 5(C) x 4(L) = 20 extr 3(C) x 3(L) = 9 low
Risks: • Impact on safety of patients • Impact on patient experience • Potential delays to treatment • Impact on patient harm • Impact on reputation • Adverse impact on Trust's financial position • Impact on staff & Inability to provide viable service	**Rationale for risk current score:** • Previous unknown pandemic: ○ Patients, staffing, resources etc • Data modelling predictions based on "best" guess principles from previous flu epidemics • Unknown timescale of outbreak	**Future risks:** • Impact of COVID on elective restoration **Opportunities:** • Change in practices, new ways of working by	

Controls / assurance (mitigation & evidence of making impact):
• Pandemic incident management plan implemented.
• Governance & Performance Management and Accountability Framework
• ~~Gold & Silver Command pandemic management structure (Strategic & Tactical) in place 24/7~~
• Individual work streams identified to deliver a critical pathway analysis
• Regular data modeling and analysis of trends and action to address shortfalls.
• Continued liaison with leads of operational work streams to identify risks to delivery.
• National reporting & monitoring eg PHE, NHSI/E, WHO etc
• Summary of Post Implementation Review undertaken
• Includes stabilization & recovery plans
• response to COVID wave3 plans
	Comments:
	• Temporary Site Reconfiguration
	• Reduction in Planned Care – Outpatients & Surgery
	• Vulnerable Patients
	• Emergency Pathways (Adult)
	• Increasing Critical Care Capacity
	• Consolidation of maternity and Delivery of Children's Services
	• Trauma Consolidation
	• Diagnostics and Pharmacy
	• Care of Deceased Patient
	• People Planning, Education and Research
	• Ethical Decision Making
	• Infection Control and Prevention Support
	• IT and Digital, Estates, Finance & Procurement
	• Partnerships, Communication and Engagement
	• Recovery Phase
		Assurance (evidence of making an impact):
		• See evidence of plans in link (Overall Plan)
		• Risk log (see link)
		• High Level COVID Narrative
		• Post implementation review
		• Internal Audit reviews on quality outcomes:
		  ○ Covid-19: Business Continuity, Pandemic Response Plan and Remote Working - October 2020 - Significant assurance with minor improvement opportunities
		  ○ COVID-19 Financial Governance and Controls - October 2020 - Significant assurance with minor improvement opportunities
		•	

		Gaps in controls / assurance (actions to achieve target risk score): • Overall delivery of work streams pandemic plans – link CRR Risk ID2472 on DATIX	

Appendix Level1

OUR VISION : To be the safest trust in England, outstanding in all that we do			
True North Strategic Aim 1 – To provide outstanding care & improve patient experience.			
Risk Owner: Trust Board **Committee: QEC**	**People, Partners, Performance, Patients, Prevention**	**Date last reviewed : APR 2021**	
Strategic Objective To provide outstanding care and improve patient experience **Breakthrough Objective** Achieve measurable improvements in our quality standards & patient experience	**Risk Appetite:** The Trust has a **low appetite** for risks **Measures:** • Ward/department quality assessment scores, recommencement of the IQAT and DQAT • Evidence of "closing the loop", through sharing of learning from incidents and follow up from QI processes • Focus on key safety risks – IPC Outbreaks, Patient experience - waits, falls, milestones set through business planning for each division aligned to the divisions breakthrough objectives • Clinical effectiveness, processes to include the following of NICE guidance • IQPR measures • Co-production of changes with patients	**Initial Risk Rating** **Current Risk Rating** **Target Risk Rating**	4(C) x 5(L) = 16 extr 4(C) x 4(L) = 16 extr 3(C) x 3(L) = 9 low
Risks: • Risk of patient harm if we do not listen to feedback and fail to learn • Risk of not using available quality assurance data to best effect in order to identify areas to improve or manage patient care. • Risk to safety and poor patient experience as a result of failure to improve the estate and infrastructure. • Risk of non-delivery of national performance standards that support timely, high quality care	**Rationale for risk current score:** Impact: • Impact on performance • Impact on Trust reputation • Impact on safety of patients • Impact on patient experience • Potential delays to treatment • Possible Regulatory action	**Future risks:** • Impact of COVID on elective restoration • Staff engagement post covid • Patient expectations following Covid **Risk references:** Q&E9, F&P 6 and F&P 8. **Opportunities:** • Change in practices, new ways of working • Advent of more digital care • Greater opportunity for collaboration at place / system level • Implementation of National Safety Strategy • Restructure to focus on patient experience • Quality improvement processes focused on Falls in the 10 high risk areas • Workforce development plan	
Controls / assurance (mitigation & evidence of making impact): • BIR Data targets & exceptions • Clinical effectiveness measures • Quality framework outcomes ○ Quality control to Quality Assurance • Quality Improvement outcomes • Clinical Governance Review • Integrated Quality Performance Report • Accountability Framework • Annual planning process • External compliance review action plans	**Comments:** • Need to ensure Trust Values are effective • Need to develop quality/patient safety strategy • Need to sustain improvements in QI initiatives • Need to widen the focus on patient and user feedback	**Assurance (evidence of making an impact):** Output from Board sub committees Internal Audit reviews on quality outcomes, falls documentation compliance 20/21, DToC 2019/20, Complaint process 2020/21 Positive feedback from people on the services BAF completion on specific areas, evaluated by CQC, IPC BAF reviewed at Board of Directors December 2020. Trust plan against the Ockenden Report, plan reviewed at Board February 2021 and QEC April 2020 **Gaps in controls / assurance (actions to achieve target risk score):** Uncertainty re COVID recovery outcomes Uncertainty re SYB ICS changes	

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	**20th April 2021**	**Agenda Reference:**	**C2**
Report Title:	**Chief Nurse Report**		
Sponsor:	**Mr David Purdue, Deputy Chief Executive and Chief Nurse**		
Author:	**David Purdue, Chief Nurse** **Cindy Storer, Deputy Director Nursing, Patient Safety, Patient Safety Specialist** **Stacey Nutt, Deputy Director of Nursing, Patient Experience** **Abigail Trainer, Deputy Chief Nurse**		
Appendices:	N/A		

Executive Summary	
Purpose of report:	**To assure the Board of the actions being taken to address concerns raised in respect of patient safety.** **To ensure the Board are sighted on the perinatal Dashboard and the actions in progress to support the delivery of the National agenda.** **To assure the Board of the safe nursing/midwifery staffing of wards and departments** **To highlight the new appointments are part of the leadership in Nursing**
Summary of key issues:	• The paper identifies the key quality metrics and the plans to ensure learning from incidents set out in the format of the National Safety Strategy of Insight, Involvement and Improvement. • Incidents identified in Maternity Services and the actions being undertaken to address and learn. • Identify the key areas from patient feedback and plans to improve • To identify the mitigations to ensure safe staffing in wards and departments.
Recommendation:	The board is asked to take assurance of the quality metrics and safe staffing and to note the changes to frameworks and reporting systems in patient's safety planned for 2021.

Action Require:	~~Approval~~	Information	~~Discussion~~	Assurance ✓	~~Review~~

Link to True North Objectives:	**TN SA1:** ✓	**TN SA2:**	**TN SA3:**	**TN SA4:**
	To provide outstanding care for our patients	*Everybody knows their role in achieving the vision*	*Feedback from staff and learners is in the top 10% in the UK*	*The Trust is in recurrent surplus to invest in improving patient care*

Implications	
Board assurance framework:	
Corporate risk register:	Q&E9, F&P6

Regulation:			Supports CQC compliance in Safe, Caring and Effective
Legal:			
Resources:			
Assurance Route			
Previously considered by:			
Date:		**Decision:**	
Next Steps:			Build timelines for changes in the National Patient Safety Strategy in the new Trust Quality Strategy Undertake Quality Improvement work on the 10 key falls areas
Previously circulated reports to supplement this paper:			

Safer Culture, Safer Systems

The National Safety Strategy translates the high level objectives for the safety culture and safety system strands into more tangible deliverables. Safety culture indicators should not be used to assess performance or for regulatory purposes, but more to support and enable Trusts to improve safety culture through embedding a continuous cycle of understanding the issue – developing a plan – delivering the plan – evaluating the outcome.

The Safety Culture Index (SCI), a psychometrically-sound measure designed to assess the extent of shared attitudes, values and beliefs that support safety at work and is made available to health organisations on a commercial basis. The first two test areas have begun their surveys (NNU and Main Theatres) to analyse how far cultural values influence safety at work. Results will be monitored through the Clinical Governance Committee and included in the Quality and Effectiveness Committee quarterly learning from patient safety report.

Magnet4Europe Study

DBTH are now part of the exciting Magnet4Europe (M4E) study. As one of only 14 NHS Trusts in England, joining 5 other European counties, the specific aim of the M4E study is to improve the mental health and wellbeing of nurses and doctors in European hospitals.

The study will twin DBTH with Hospitals with 'magnet status' in the US, which report a positive effect on healthcare professional's mental health and on patient treatments. M4E is about testing these principles in European Hospitals, including ours, with the hope of achieving the same positive effects.

The initial surveys are on line for all nurses and doctors to complete with the aim of having 30% of questionnaires completed by the 30th of April.

INSIGHT

There were seven Serious Incidents (SI) reported in March. Two of these were cases are retrospective incidents, reported at the time to NRLS and investigated by HSIB. Following confirmation that all HSIB investigations should be reported to Strategic Executive Information System (StEIS), these two incidents have been included in the number of SIs this year. There has been a further SI in maternity, an inpatient fall resulting in severe harm, a delayed diagnosis, suboptimal care of a deteriorating patient and a never event for a wrong site injection.

This takes the total number of Serious Incidents this year to 39. This includes 23 SI for care issues, four Never Events, 6 falls with severe harm and 1 Category 4 pressure ulcer (one SI was de-logged as the ulcer was present on admission). All Trust SIs are reported on the date the incident is reported on StEIS.

Falls

There were 118 patient falls reported in March. Of these falls, 1 resulted in moderate harm to the patient (FAU).

In 2020/21, 1386 patients have fallen, of which 33 falls resulted in moderate and severe harm. Of these incidents, seven have been escalated as serious incidents.

In 2019/20 there were 1162 falls, of which 46 falls resulted in moderate and severe harm. Of these, four were escalated as Serious Incidents.

This means we have seen a 19.3% increase in all falls but a 28.2% reduction in falls with moderate and severe harm.

The now established 'Learning from Falls' panel is extracting learning from these cases, which is sent out to all ward managers, matrons and divisional directors of nursing as soon after the falls as possible. A year end collation of themes will be also shared across the Trust so the falls accreditation can be based around local learning.

The new Holistic Care Team has now launched, with the support if the Qi team. This will include the falls prevention practitioner, lead dementia nurse along with a MDT. The initial focus will be on the top 10 wards, with wards 16 and 17 the first 2 wards started the work.

Hospital Acquired Pressure Ulcers (HAPU)

There were 64 HAPU (category 2 and above) reported in March. Of these, four were category 3 HAPU (C2/CCU, G5, DCC and Rehab 1) and there was one Category 4 HAPU (Ward 24).

This takes the total numbers of HAPU (category two and above) for 2020/21 to 835. Of these, 56 were Category 3 HAPU and 2 were Category 4.

In 2019/20 there were 771 Category 2 and above HAPU. Of these, 57 were Category 3 HAPU. This means the numbers of moderate harms from HAPU has remained the same, but there has been an increase in the number of Category 2, UN/DTI ulcers and Category 4 by 9.1%

The now established 'Learning from HAPU' panel is extracting learning from these cases, which is sent out to all ward managers, matrons and divisional directors of nursing as live as possible. A year end collation of themes will be also shared across the Trust so the Skin Integrity accreditation can be based around local learning.

Infection Prevention and Control

Hospital onset COVID-19 cases

Recent guidance has been released how to report hospital onset probable or definite healthcare associated COVID-19.

While all hospital onset COVID-19 infections have been reported to the daily and weekly Hospital Onset Covid Infection (HOCI) SitRep. The Covid Patient Notification System (CPNS) has been used to report hospital acquired Covid deaths.

Trusts are now being advised, for cases of definite and probably hospital onset Covid, these should be collated, to establish if they resulted in death, moderate or severe harm and to follow the definition of a patient safety incident. This work has now commenced to establish how many patients this has affected, linked to ward outbreaks and whether the next of kin has received information, an apology and relevant support.

Clostridium difficile
There were three cases of Clostridium difficile in March. All cases were hospital associated, hospital acquired (HOHA). This takes the total number of cases, year to date to 56, split as 39 cases of HOHA and 17 cases of COHA.

No lapses in care have been identified as yet, with patients appropriately being prescribed antibiotics.

MRSA bacteraemia
There were no MRSA bacteraemia reported in March. The total number in the year were the two cases reported in February 2021.

INVOLVEMENT

The completed framework for the Patient Safety Partners (PSP) is expected by Q3 2021/22 after an additional series of focus groups. The PSP will sit on safety-related clinical governance committees and elsewhere as appropriate. The Trust action plan for delivery of the patient safety strategy will aim to have the PSP in post by the end of Q4 2021/22.

The National Patient Safety Syllabus will be launched and available to all staff by Q2 2021/22. An identified accreditation model will accompany the syllabus by Q1 2021/22. This will enable benchmarking against other Trusts on the adoption and implementation of the syllabus.

A number of clinicians in the Trust have been able to contribute towards the early proposed content of the first two Patient Safety Syllabus Modules in March 2021, with positive feedback on the content.

One Patient Safety Specialist (PSS) has been identified for the Trust to date, with learning sets for the role expected by Q4 of 2021/22. Virtual technology is giving access to a network of PSS across the country with a local network already in place. Regular webinars with the national team are also enabling updates in real time.

IMPROVEMENT

<u>Managing Deterioration</u>

The ongoing work to implement eObservations, fluid balance and sepsis, via nerve centre has continued at pace. This work is essential for improvements on deterioration management tools such as NEWS2.

In the last week of March, the Orthopaedic wards at Doncaster introduced eObservations, fluid balance and handover, which means the eObservations rollout will be coming to completion at DRI.

Nursing assessments are currently being developed, along with preparations for the Nervecentre system upgrade that will bring additional functionality, fixes and ground work for future developments in the system.

The introduction of the assessment tool will allow newly admitted patients who require a nursing assessment to be documented digitally. This will mean that work can start towards implementing the Care Plan project.

The Digital Technology Assessment Criteria (DTAC) were launched in February to provide new national standard for digital health tools. If you're trialling, procuring or promoting a new digital health technology (including apps) in your organisation, you will first need to make sure it meets these criteria.

NHSX has launched the DTAC to help give staff, patients and citizens confidence that the digital health tools they use meet its clinical safety, data protection, cyber security, interoperability and accessibility requirements.

Adaptation and spread improvement programmes

The adaptation and spread safety improvement programs are launched and registered with clinical audit and will be monitored through divisional clinical governance and in the annual audit and effectiveness report.

Infection Prevention and Control

Compliance with infection prevention and control (IPC) measures will be critical in healthcare settings as restrictions ease and more people become vaccinated. To support trusts, NHSE/I has led a project focussed on understanding the complex drivers of behaviours that influence how people act and what support can be offered to improve compliance.

The 'Every action counts' products suite was developed to address the key themes of the research. The suite includes an implementation toolkit supported by communication and operational resources to strengthen IPC leadership and culture, staff and patient engagement, training, and operational management.

The Medication Safety Improvement Programme (MedSIP)

MedSIP is led by the Medication Safety Officer for the Trust to help reduce avoidable medication-related harm in the Trust.

There is a planned launch date for the upgrade of the current Electronic Prescribing and Medicines Administration (EPMA) in the early hours of 17 May 2021. Although all the functionality of the current system for prescribing and medicines administration will still be available on the new version, it is being created as a web based system it will look very different.

Medical and Nursing staff who use the current system will need to complete an online training package available via ESR. This will also enable symphony to work with the system to improve prescribing in the Emergency Department.

The Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)

All maternity units have now submitted the assurance assessment for the seven immediate actions required from the first Ockendon report. Regional and national overarching reports are currently being compiled, that will identify the level of compliance across England, the gaps that remain, and the common areas of challenge in achieving full implementation. All trusts will be asked to submit supporting evidence of their self-assessment to a central portal in April/May.

The Maternity and Neonatal Safety Improvement Programme Team (MatNeoSIP) has been working with colleagues across the NHS to address the variation and care issues highlighted by the Ockenden report.

At the NHS England and NHS Improvement Board meeting on the 25th March (agenda-item-9.1.1-national-response-first-ockenden-report.pdf (england.nhs.uk)), an additional investment of £95m was announced to support work in the following areas of maternity services:

- workforce numbers
- training and development programmes to support culture and leaders
- strengthening board assurance and surveillance to identify issues earlier thereby enabling rapid intervention.

The MatNeoSIP team will continue to support this important work, focussing on the area of leadership and culture with the creation of a patient safety culture development programme for leaders across maternity services.

Work is continuing with the Local Maternity System (LMS) in conjunction with other recent safety improvement work at the Trust, which includes;

- Implementation of all five key elements of saving babies lives (version 2 – NHS I project)
- CNST MSDS scorecard for MIS compliance
- Second lowest birth rate in Yorkshire and Humber LMS
- Establishment of new preterm prevention clinic and service
- Development of fetal medicine service

Perinatal maternity Dashboard

Findings of review of all perinatal deaths using the real time data monitoring tool
3 Babies meet the criteria

Gestation /age	Initial review findings care until the birth of the baby	Initial review findings of care of the baby	PMRT and investigation /review outcome
22+4	G1 P0, MLC, BMI 30, Spontaneous labour. 999 transfer to Triage. FD on arrival. SROM, Cord Prolapse	Cause of death agreed – extreme prematurity and cord prolapse	C,C,A Met relevant CNST
37+4	G5 P2 x C/S, CLC, Low papa 0.36 Known hypoplastic left heart, planned compassionate care, GDM, BMI 40	Known hypoplastic left heart. Apgar 2,4. No resus as previous planned. Compassionate care provided on CDS as declined bluebell	PMRT in progress and for discussion at next meeting
29+5	G2 P1, CLC, Smoker, increased alcohol intake when found out pregnant, low risk AN screening	Apgar 2, 6. Multiple unsuccessful to intubate. Transferred to NNU. ? Dysmorphic features commented. RIP on NNU	PMRT in progress and for discussion at next meeting

Findings of review all cases eligible for referral to HSIB.

Reports Received
2010- 2579 – Neonatal Death
Recommendation – The Trust to ensure that all staff are supported to undertake a holistic risk assessment, including a CTG for high risk mothers.
Current Actions:

- Discussed at clinical governance meetings
- Assessment process reviewed to ensure that a CTG is performed and not just auscultation with a

handheld Doppler
- Band 7 midwifery leader being recruited substantively to ensure clear leadership, and audit of standards in Triage

Reports in progress
2007-2270 – Neonatal death
2012-2795 – HIE (at parents request)
MI-003301 – Neonatal death

Serious Incidents
2021/27 – Never Event
Immediate actions put in place (removal of tampons from the packs) and relaunching the LOCCSIPs standard operating procedure.
Report in final draft, has been shared with the family who have further queries. Extension requested to ensure that the report answers the families' questions.

Training compliance
For all staff groups in maternity related to the core competency framework and wider job essential training
Latest CNST requirements under review by the education team.

Midwifery Workforce
The midwifery staffing workforce model meets Birthrate+ requirements. There have been a number of resignations within the service, with a predicted vacancy of 14 WTE by May 2021. An urgent review of the way services are delivered is being undertaken by the senior midwifery team.

Mitigation currently in place to manage the vacancies
- Proactively managing the workforce and workload daily
- Offering all vacant shifts on NHSP with a 20% uplift
- Specialist midwives to contribute to the clinical requirement
- Deputy HOM, and Matron work clinically in time of escalation
- Reviewing the way care is delivered to improve midwifery staffing cover
- Instigating the Escalation policy when services are assessed as unsafe

In the longer term the service is:

Continuing to recruit and advertise vacancies

- Looking at overseas recruitment
- Looking at Return to practice courses
- Expanding the number of students working in the service from Sheffield Hallam University, Sheffield University (New MSc Course expected to start in Sept 2021) and Lincoln University.

Service User Voice feedback

The maternity service Facebook page receives lots of positive feedback.

There are discussion with the newly formed MVP's on both sites and there has been feedback and work ongoing on the following:

Doncaster MVP
Chair has stepped down and interim plan in place, no meeting since last report

Bassetlaw MVP

No meeting since last report Partner attendance a common concern on the Facebook pages. Attendance at 12 & 20 week scans now in place. Plans to accommodate partners at all ante-natal appointments progressing to be in place by the 12th April 2021 as set out in the latest guidance
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust None
Coroner Reg 28 made directly to Trust None
Progress in achievement of CNST 10 Currently the service is working on compliance, areas of concern are: Safety Action 7 – Maternity Voices partnership meetings (clarification from NHSR needed) Safety Action 8 – Attendance at MDT training, plans in place to achieve 90 % by July 2021 and update to training levels is expected shortly.

BIR March 2021

Insight

There are many sources of patient insight:

Complaints

There was an overall reduction in complaints in March with 31 (40/90 WD), bringing the total number of complaints year to date to 359.

March feedback has seen a change in the top 3 main subjects; Staff Attitude and Behaviour (14); Communication (11) and Treatment (11) However, one complaint can have multiple subjects and on review of the number of complaints per each subject, Staff attitude and Behaviour has the highest number of complaints.

There are currently 153 feedback cases open of which 73 (87 in February) feedback cases are overdue with having breached their original timescale with the complainant; 43 are complaints and 30 ACQ's.

FFT

The FFT provides a simple, headline metric and therefore when interpreting FFT data it is important to triangulate it with other sources of insight about patient experience so that the bigger picture can be built. FFT data collection recommenced in December 2020 and from 2021 there will no longer be a calculation or publication of response rates. However, the number of responses and number of eligible patients will be published – the data collected in December will be published in April. Local data intelligence for March demonstrates a response rate of 3.5% for inpatient areas which is a big reduction from February at 17.98%. Issues identified contributing to reduced submissions are wrong cards or no cards being available and confusion over the collection. This will hopefully be resolved for April.

KPMG

The complaints handling audit was presented to Audit and Risk Committee on the 25th March demonstrating significant assurance with minor improvement opportunities. The purpose of the audit was to test the design and operating effectiveness of the new complaints procedure (July 2020).

KPMG selected a sample of 25 complaints received between 6 July 2020 and 31 December 2020. It is worth noting that this time period was during the COVID 9 pandemic and whilst other organisations opted to cease all complaints activity, DBTH continued. In total there were 8 recommendations and 7 instances of good practices.

The action plan will be put into action and progress fed back to QEC.

Key Focus 'Staff Attitude and Behaviour'	
Staff Attitude and Behaviour has again been identified as the top subject for complaints with 14 being recorded. This amounted to 11 complaints.	6 complaints were attributed to ED, 1 Paediatrics, 1 Rehab 1, 1 General Surgery, 1 Cardiology and 1 for Minor Injuries Unit. There are no common themes associated with staff groups.
On Datix there are 39 Subjects to choose from with approx. 330 sub-subjects	T&F group for DATIX arranged - streamline to <6 'core subjects' and reduce number of sub-subjects to make themes more purposeful
At present 3 of the 11 complaints are closed and all have not been upheld	Subjects to be selected once the complaint has been investigated.

Overview of Key Achievements Made This Month	
Patient Experience	**Patient/People Involvement**
23 % Reduction in Complaints & ACQs 30% Reduction in Overdue Complaints & ACQs KPMG Audit results demonstrating significant assurance with minor improvement opportunities Excellent engagement with divisions Compliments recording simplified on Datix showing 59 recorded as opposed to usually <10	Regular meetings arranged with CCG and HW AI: progression with full engagement from IT Partnership working: People Focus Group, Carers strategic oversight group, Health Ambassadors Health Inequalities - working collaboratively with Director of Strategy

Voluntary services - welcome back events and roles being identified	

Key Challenges and Risks			
Description	**Owner**	**Coments/Actions**	**Rating**
Coding of subjects	SN/TEP	T&F group arranged to review datix - coding of subjects at present is subjective and subsequently causing concern	
Vacancy within PALS	SN	VCFs approved, out to recruitment	
Complaints given inappropriate timescales and not allocated against correct Risk process	SN	New RAG rating to be agreed	
Lack of progress of complaints, complaints not being highlighted to Risk and Legal team	SN/DP	Complaints panel to be implemented and chaired by Chief Nurse	
Visiting restrictions due to COVID 19	ET	Themes to complaints include lack of information, not knowing that patients are deteriorating. Visiting recommenced 29th March which hopefully will see a reduction in complaints	

Nursing and Midwifery Staffing

All NHS Trust providers are required to publish Nursing and Midwifery staffing data on a monthly basis. The data describes planned hours for staffing based against the actual hours worked. In addition to this the care hours per day (CHPPD) are reported as a monthly metric. In the last 12 months the on-going Covid 19 pandemic has created additional workforce challenges across the breath of the organisation, with particular pressure in areas such as respiratory and critical care. This has been reflected in our safe staffing data with a number of areas 10% under their planned versus actual.

March 2021 data

In March 40 inpatient wards were open.

- *20 (50%) were on green for planned v actual staffing*
- *12 (30%) were on amber for being 5% under planned v actual staffing (B5, Ward 1/3, Ward S11, C1, AMU, FAU, CCU DRI, Ward 24, DCC, G5, CDS and Gresley). 1*
- *(2.5%) ward was amber for being 5% over planned v actual staffing (SAW).*
- *5 (12.5%) wards were red for being 10% under planned v actual staffing (M2, Ward 32, Respiratory, ATC and S10).*
- *2 (5%) ward was red due to being 10% over planned v actual staffing (Rehab 2, Ward 25).*

Despite a number of areas reporting 10% reduction against planned versus actual there has been a continual decline since the beginning of the year in this number. All areas are risk assessed using professional judgement, staff redeployment or utilisation of other key roles such as therapy staff to ensure patient safety isn't compromised. Also to note that three of these areas had a reduction of over 40% of patients occupying beds at midnight. Therefore although nurse staffing levels were below their planned trajectory the number of patients in their care was also significantly reduced. All known gaps were reviewed and all shifts were sent to bank and agency. Due to on-going pressures from the pandemic fill rates for bank and agency shifts

continue to be compromised due to availability of workforce. This is closely monitored with NHSP colleagues and the senior nursing team.

As the pandemic has continued the surgical elective programme has been reinstated to ensure patients receive the care they require. Essential training has also been reinstated to support staff development. Staff sickness remains static and there continues to be areas of sickness related to covid or staff requiring to isolate. New guidance on shielding staff is expected at the end of March with a plan for this staff group to return to return to work from 1st April 2021. Comprehensive risk assessments will need to be undertaken as not all shielded staff will be able to return to front line duties.

Mitigation

The on-going risk around nurse and midwifery staffing remains a constant challenge for the nursing leadership teams however mitigation has been put in place to support clinical areas and the risk is reviewed as part of the x4 daily operational site meetings that take place. Nurse staffing is also reported monthly via our mandated safe staffing return and at the Trust QEC committee.

Future Developments

DBTH remains committed to providing outstanding care and it is recognised that having the correct workforce in place is key to this.

As part of the future developments for 2021/22 the senior nursing leadership team are looking to utilise the Allocate SafeCare model to support how nurse staffing is managed.

SafeCare is x3 times a day staffing software that matches staffing levels to patient acuity, providing control and assurance from bedside to board. It allows comparison of staff numbers and skill mix alongside actual patient demand in real time, allowing you to make informed decisions and create acuity driven staffing. This option is currently being scoped by the Deputy Chief Nurse and E roster team. This workstream will be a key objective of the newly appointed workforce matron in June 2021.

The Deputy Chief Nurse is leading a workstream around enhanced care and bed watch allocation. The aim is to ensure patient assessments are robust, requests for enhanced care and bed watches are scrutinised by a senior nurse before being approved and that patient safety is maintained. There is an expected financial return from this work as the current model isn't always cost effective.

Workforce Appointments

The leadership structure in nursing has been reviewed and an internal process has been undertaken to enhance development and improve patient care in the Trust. The new divisional structure now includes a head of nursing for the divisions and a more aligned matron structure, including the introduction of a matron for workforce.

The 4 Heads of Nursing will support emergency, elective, outpatient and discharge pathways across the divisions as well as supporting the management structures in the divisions.

Professor of Nursing/ Joint Chair of the University of Sheffield

As a Trust, we have appointed our first ever Professor of Nursing, in partnership with the University of Sheffield and Sheffield Teaching Hospitals (STH).

Dr Parveen Ali has been appointed to the role, and will work with our Trust, as well as the South Yorkshire Integrated Care System (ICS) to develop and enhance nursing research within the region.

A hugely distinguished figure in nursing, Dr Ali was one of six recipients of the annual Mary Seacole awards from the Royal College of Nursing to fund her work to reduce inequality for black and minority ethnic communities and in 2017 received an Emerging Nurse Researcher award from the European region of Sigma Theta Tau International. Dr Ali is also a Senior Fellow of the Higher Education Academy and a Fellow of the Royal Society of Arts and leads MMedSci Advanced Nursing Studies and Chair the School of Nursing and Midwifery's Research Ethics Committee at the University of Sheffield.

Working closely with our Director and Deputy Director of Education and Research, as well as nursing leadership teams, Parveen will help us to develop our nursing research portfolio, supporting our strategic direction as a teaching hospital and enhancing the opportunities available for our clinicians and learners both locally and regionally.

With a wealth of experience, this appointment underlines our ambition to improve our research portfolio within South Yorkshire, and in the near future we will look to add a further four research fellows per each of our clinical divisions.

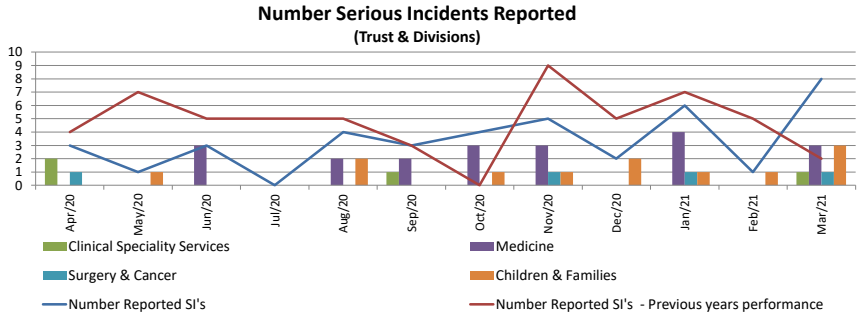
These additions will help us in our ambition to be the safest Trust in England, outstanding in all that we do, in addition to providing the very best learning environment for our students, as well as our colleagues' continuing professional development as clinicians.

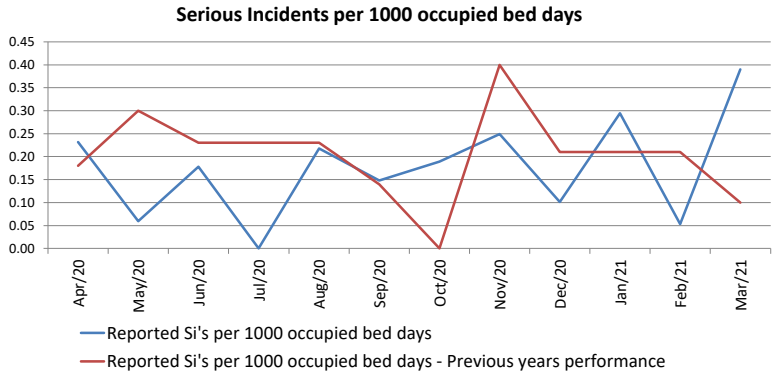
Serious Incidents - March 2021 (Month 12)

(Data accurate as at 07/04/2021)

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





Current YTD reported SI's (April-Feb 21)	41	Number reported SI's (Apr-Feb 20)	57
Current YTD delogged SI's (April-Feb 21)	1	Number delogged SI's (Apr-Feb 20)	6

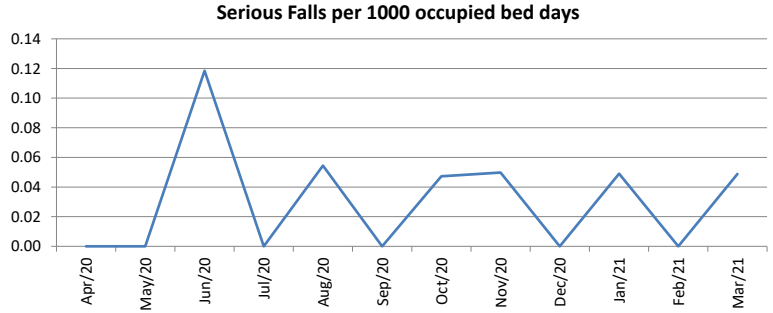
Maternity Serious Incidents

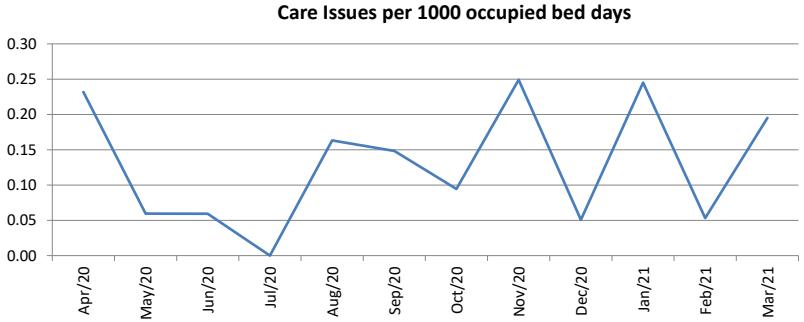
There have been six Serious Incidents relating to maternity care year to date and these are included in the list below;

- May 2020 - Incident around informed consent (Trust investigation)
- July 2020 Maternal and neonatal death (HSIB)
- July 2020 Neonatal death (HSIB)
- August 2020 - Incident around lack of robust record keeping during investigation (Trust investigation)
- October 2020 – Stillbirth (HSIB)
- December 2020 – Cooled baby (HSIB)
- January 2021 – Retained swab after delivery (Never Event – Trust investigation).
- February 2021 – Stillbirth
- March 2021 – Neonatal death (HSIB)

Four of these investigations are being carried out by HSIB although two cases* were not reported to StEIS as they didn't meet the SI framework criteria. Clarification has now been received that all HSIB investigations should be reported to StEIS, which will be actioned and included in next month's report.

Serious Incident Themes

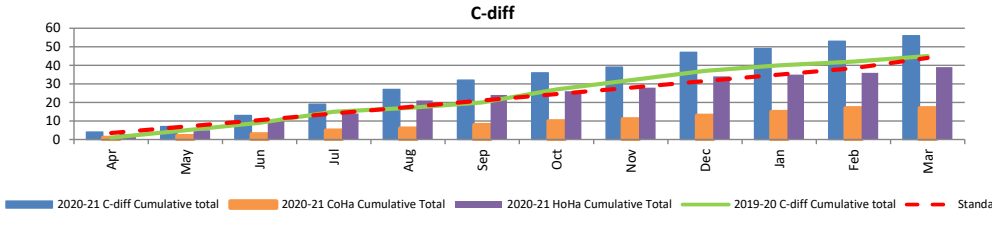


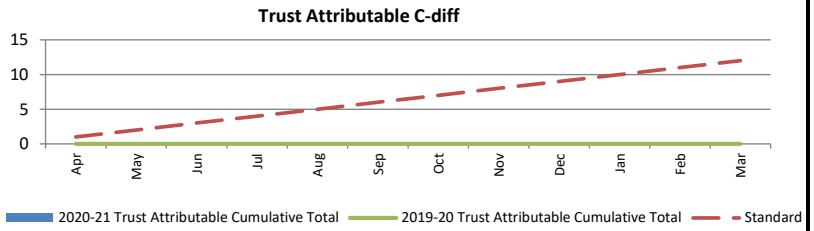


Infection Control C.Diff - March 2021 (Month 12)
(Data accurate as at 07/04/2021)

	Standard	Qtr 1	Qtr 2	Qtr 3	Jan	Feb	Mar	YTD
2020-21 Infection Control - C-diff	44 Full Year	13	19	15	2	4	3	56
2019-20 Infection Control - C-diff	39 Full Year	9	11	17	3	2	3	45
2020-21 Trust Attributable	12	0	0	0	0	0	0	0
2019-20 Trust Attributable	12	0	0	0	0	0	0	0

	Qtr 1	Qtr 2	Qtr 3	Jan	Feb	Mar	YTD
HOHA	10	14	10	0	2	3	39
COHA	3	5	5	2	2	0	17

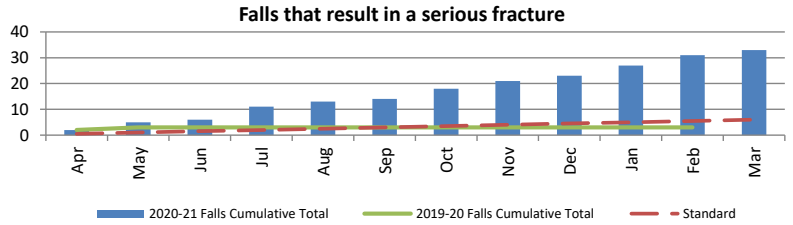




Pressure Ulcers & Falls that result in a serious fracture - March 2021 (Month 12)
(Data accurate as at 07/04/2021)

	Standard	Qtr 1	Qtr2	Qtr3	Jan	Feb	Mar	YTD
2020-21 Serious Falls (moderate/severe harm)	6 Full Year	6	8	10	4	4	1	33
2019-20 Serious Falls	10 Full Year	3	0	0	0	0	1	4

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



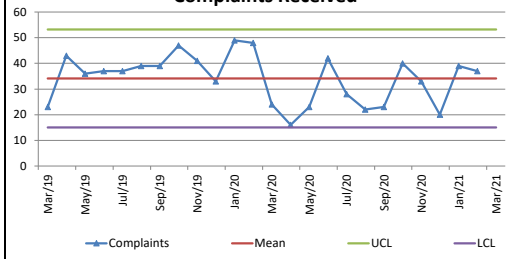
	Standard	Qtr 1	Qtr 2	Qtr 3	Jan	Feb	Mar	YTD
2020-21 Pressure Ulcers	56 Full Year	192	174	246	73	86	64	835
2020-21 Pressure Ulcers (Cat 4)		0	1	0	1	0	1	3
2020-21 Pressure Ulcers (Cat 3)		17	10	19	3	3	4	56
2020-21 Pressure Ulcers (UNS/DTI Low Harm/Cat 2)		175	163	227	69	83	59	776

Complaints & Claims - March 2021 (Month 12)

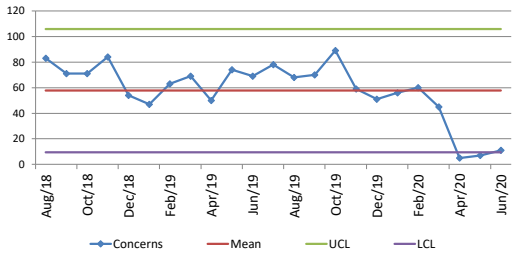
Data accurate as at 07/04/2021

Complaints

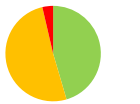
Complaints Received



Concerns Received



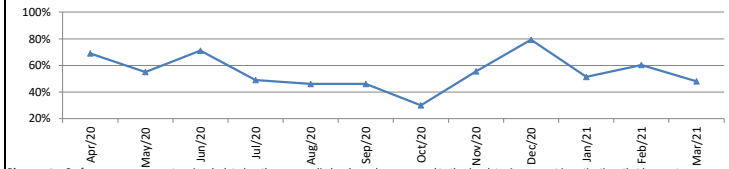
March 2021 Complaints Received Risk Breakdown



Year to Date Complaints Received Risk Breakdown

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

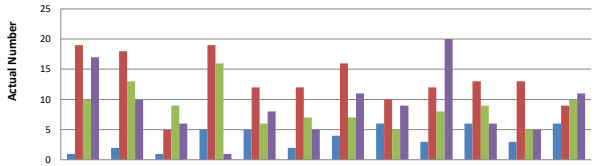
Complaints Resolution Performance



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



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Complaints Upheld	1	2	1	5	5	2	4	6	3	6	3	6
Complaints Partially upheld	19	18	5	19	12	12	16	10	12	13	13	9
Complaints not upheld	10	13	9	16	6	7	7	5	8	9	5	10
Outcome not reported	17	10	6	1	8	5	11	9	20	6	5	11

Parliamentary Health Service Ombusdman (PHSO)

Month	Number of cases referred for investigation	Number Currently Outstanding
Mar-21	0	4

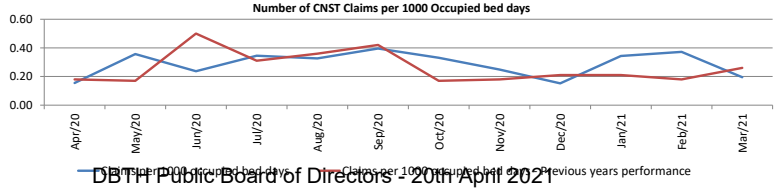
	Number referred for investigation YTD	Outcomes YTD	
2017/18	7	Fully / Partially Upheld	3
		Not Upheld	1
		No further Investigation	0
		Case Withdrawn	0
		Not Investigated	3
		Outstanding	0
2018/19	9	Fully / Partially Upheld	4
		Not Upheld	3
		No further Investigation	0
		Not Investigated	0
		Case Withdrawn	0
		Outstanding	1
2019/20	4	Fully / Partially Upheld	1
		Not Upheld	2
		Outstanding	1
2020/21	1	Outstanding	2

Claims

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Clinical Negligence Scheme for Trusts (CNST) Not including Disclosures	2020/21	2	6	4	6	6	8	7	5	3	7	7	4	65
	2019/20	4	4	11	7	8	9	4	4	5	5	4	5	70
Liabilities to Third Parties Scheme (LTPS)	2020/21	2	1	2	2	1	0	1	2	2	1	0	1	15
	2019/20	5	3	1	4	0	1	4	3	1	1	0	0	23

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



Report Cover Page					
Meeting Title:	Board of Directors				
Meeting Date:	20 April 2021	**Agenda Reference:**	**C3**		
Report Title:	Medical Director Update				
Sponsor:	Dr Tim Noble, Medical Director & Responsible Officer				
Author:	Dr Tim Noble				
Appendices:	n/a				
Report Summary					
Purpose of report:	To update the Board on work led by the Medical Director's Office				
Summary of key issues/positive highlights:	▪ 95% of patients on the admitted RTT active waiting list (excluding planned waiters & diagnostics) have been stratified using the guidance issued by the Royal College of Surgeons, using categories 1a – 4. ▪ The Medical Advisory Committee has been established and a number of key issues are evolving to steer the agenda. ▪ Average uptake for Medical appraisals during 2020/21 was 64.94% ▪ Compliance for response to Declarations of Interest for medical staff increased to 99%				
Recommendation:	The Board is asked to note the update.				
Action Require:	~~Approval~~	Information √	Discussion	Assurance √	~~Review~~
Link to True North Objectives:	**TN SA1:** *To provide outstanding care for our patients*	**TN SA2:** *Everybody knows their role in achieving the vision*	**TN SA3:** *Feedback from staff and learners is in the top 10% in the UK*	**TN SA4:** *The Trust is in recurrent surplus to invest in improving patient care*	

Implications	
Board assurance framework:	No change
Corporate risk register:	No risk identified.
Regulation:	
Legal:	n/a
Resources:	n/a

Assurance Route	
Previously considered by:	▪ HSMR and Medical Examiner process report to the Mortality Governance Group and Clinical Governance Committee. ▪ RSAB reports directly to the Clinical Governance Committee

Date:		**Decision:**	
Next Steps:			
Previously circulated reports to supplement this paper:			

EXECUTIVE SUMMARY

The Board is asked to note the update on work led by the Medical Director's office.

Risk Assurance Body (RSAB)

Risk Stratification

As of 8th April 2021, 95% of patients on the admitted RTT active waiting list (excluding planned waiters & diagnostics) have been stratified using the guidance issued by the Royal College of Surgeons, using categories 1a – 4.

National Clinical Prioritisation Programme

The fourth national upload of data was submitted on 12th March 2021. This took into account those patients who have been risk stratified (as above) and those patients on an admitted pathway (elective or day case) allocated the new status codes of P5 (delay due to covid reasons) and P6 (delay due to non-covid reasons).

The final submission for this programme is due on Friday 9th April 2021.

Guidance is expected during quarter 4 2020/21 for the risk stratification process for diagnostics, with guidance for out-patients due in quarter 1 2021/22.

Priority 2 Patients Outstanding

As of 4th April 2021, 626 priority 2 patients are waiting for surgery. These include those patients who have been re-reviewed and been upgraded from a category 3 or 4 to a category 2. The majority of the Trauma & Orthopaedic priority 2 waiters have been upgraded.

For context, the Trust is undertaking approximately 230 category 2 procedures per week.

Patient Letters / Communication Plan

Following agreement from all stakeholders, the patient communication plan commenced on Monday 8th March 2021,with letters being sent to the agreed cohorts of patients:-

- Acknowledging the delay, but provide assurance the patient has not been forgotten and will be sent an appointment / date for treatment in due course
- Providing an opportunity for the patient to contact the hospital if they have decided they no longer require hospital input.

Management of Diagnostic Patients

Further to the process below being discussed and agreed internally, this has not yet been agreed by Primary Care / CCGs in terms of discharging GP referrals back to primary care should a patient wish to wait until 'after covid' for their diagnostic test / procedure.

The Trust has received draft national guidance for the prioritisation and management of long waiting patients for diagnostics and the team are now working to amalgamate the previously agreed process with some of the National requirements to ensure any agreed process will capture the necessary data sets to allow accurate submissions to be made without any further changes.

The revised process will be taken through the appropriate governance structure for sign off.

HSMR

	**Hospital Standardised Mortality Ratio (HSMR) 12 month rolling**	
	October	**123.29**
	November	**135.6**
	December	**144.18**

Medical Examiner Process

Deaths in Quarter 3 (Adult inpatients)	
Doncaster	**707**
Bassetlaw	**165**
	872
Total Inpatient deaths	
Deaths in Quarter 3 (A&E)	
Doncaster	**55**
Bassetlaw	**18**
Total A&E deaths	**73**
Deaths Screened by MEO	
Doncaster	**404**
Bassetlaw	**23**
Total MEO scrutiny (49%)	**427**
Deaths scrutinised by ME	
Doncaster	**519**
Bassetlaw	**139**
Total ME team Scrutiny (75%)	**658**
Total deaths screened/scrutinised by ME team	**87.7%**
Structured Judgement Reviews (SJR)	
Number requested	**54**
Number returned (as of 9/3/21)	**17**

Themes of learning identified

- Patients ID bracelet being in place on the admission assessment is completed and signed accurately.
- Consideration must be given on an individual basis regarding visiting.
- Challenges: families are reporting difficulties in phoning the wards during the COVID-19 Pandemic.

Top 5 cause of death recorded on MCCD this quarter

1. Covid 19 (281)
2. Pneumonia (137)
3. Sepsis (30)
4. Metastatic cancer (28)
5. Multi Organ Failure (28)

Top 5 "main condition treated" as coded from the notes:

1. Covid 19 (218)
2. Pneumonia (108)

3. Sepsis (44) 4. Acute Kidney Injury (31) 5. Heart Failure (26)	
Percentage of deaths registered within 5 days of death	**790 (90%)**

Medical Advisory Committee

The Medical Advisory Committee has been established with the Medical Director as chair. A role description for the Co-Chair has been developed and will be interviewed after inviting expressions of interest. Two meetings have been held with good involvement.

In listening to consultant and SAS doctors a number of key topics are emerging which will form a comprehensive work plan moving forward, the content of which should encourage medical engagement

Proposed work plan:

- IT
- Education, research and Training
- Patient Safety
- Quality Improvement
- Trust Strategy
- ICS impact of changes
- Divisions strategy status
- Finance & Procurement
- Leadership
- Civility
- Payroll
- New Consultants
- Wellbeing

Medical Appraisals

Completion 2020/2021			
	At 8/2/21	At 8/3/21	At 8/4/21
Q1	51.69%	62.35%	96.67%
Q2	43.48%	56.10%	66.25%
Q3	32.95%	48.78%	56.41%
Q4	9.8%	16%	40.43%
Average uptake for 2020/21			**64.94%**

Although the uptake for medical appraisals during 2020/21 has been commendable and far more than expected nationally, it is apparent that a number of our doctors have been unable to complete their appraisals for this period as a consequence of the pandemic. This can be for a number of reasons ie pressures of work,

inability to complete MAG forms in view of the change in work practices, lack of evidence in terms of Continuing Professional Development.

As directed nationally, for those doctors unable to undertake their appraisals for 2020/21, records will be individually reviewed and appraisals will be triggered afresh for 2021/22.

With the Revalidation Team being up to full establishment as of January 2021, it is expected that support for appraisals in 2021/22 will be greatly improved.

Standards of Business Conduct and Employees Declarations of Interest Policy

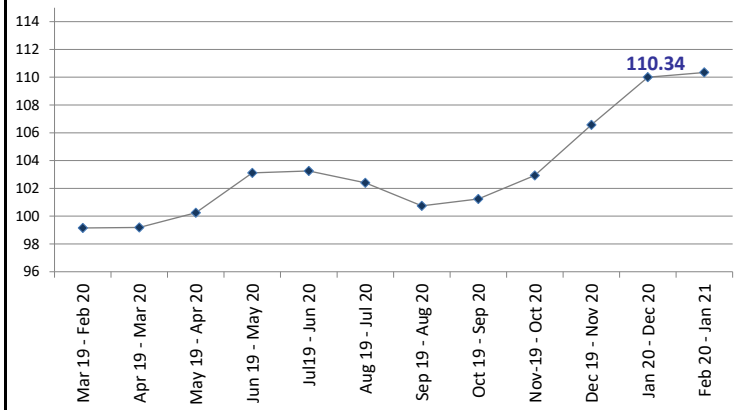
Medical staff compliance with the above policy has increased to **99%**.

Clinical Governance Review

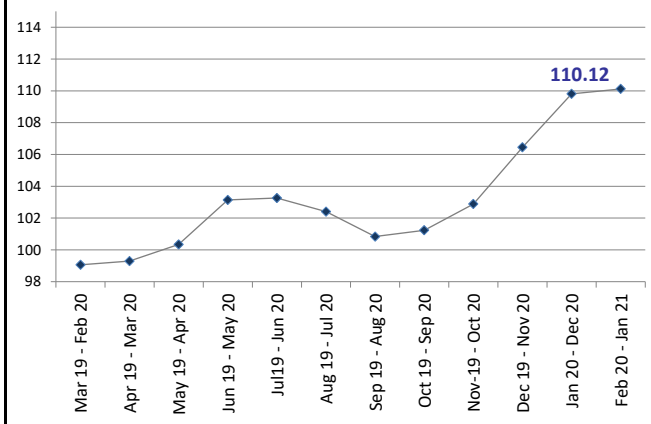
Final discussions are required to complete the clinical governance structure with a review of the terms of reference for each of the key committees to be undertaken within the next few weeks.

Hospital Standardised Mortality Ratio (HSMR) - January 2021 (Month 10)

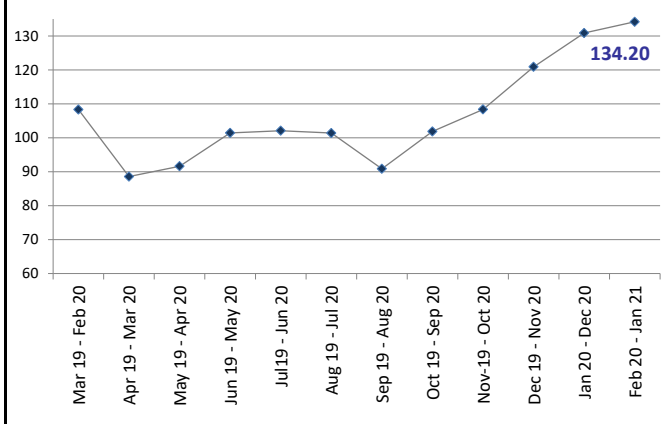
Overall HSMR (Rolling 12 months)



HSMR - Non-elective Admission (Rolling 12 months)



HSMR - Elective Admission (Rolling 12 months)

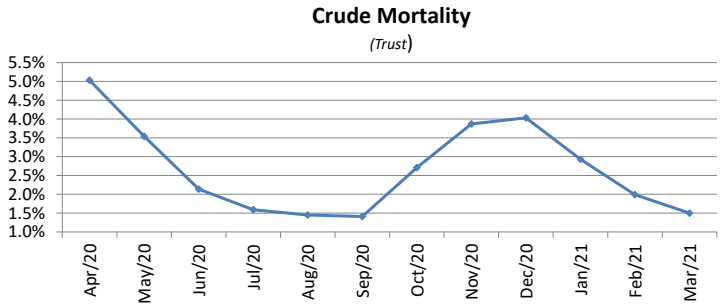


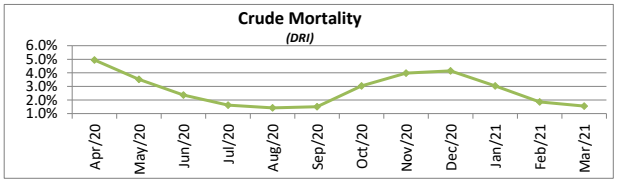
HSMR Trend (monthly)

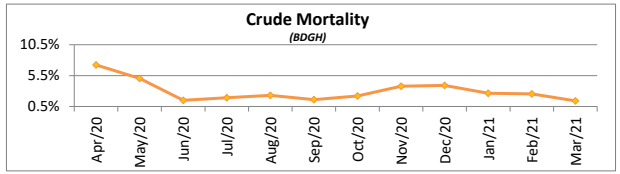
	2017	2018	2019	2020	2021
January	99.21	94.86	105.78	110.26	114.23
February	97.73	105.44	98.13	92.56	
March	97.37	88.42	101.87	102.51	
April	88.50	98.37	100.70	118.94	
May	96.60	91.20	91.36	133.60	
June	93.67	89.98	98.32	95.60	
July	97.73	107.07	104.77	92.56	
August	87.52	94.65	112.17	89.85	
September	95.34	90.09	83.64	88.56	
October	88.66	96.74	100.24	119.41	
November	82.30	99.04	88.64	132.21	
December	93.52	80.45	103.24	140.71	

Crude Mortality (monthly) - March 2021 (Month 12)

(number of deaths/number of patient discharged)







	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Trust	**5.03%**	**3.54%**	**2.14%**	**1.59%**	**1.46%**	**1.41%**	**2.71%**	**3.87%**	**4.03%**	2.93%	1.99%	1.50%
DRI	4.95%	3.52%	2.37%	1.62%	1.42%	1.51%	3.04%	3.98%	4.15%	3.04%	1.86%	1.55%
BDGH	7.23%	5.05%	1.51%	1.92%	2.30%	1.61%	2.21%	3.79%	3.91%	2.65%	2.53%	1.41%

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	*Board of Directors*		
Meeting Date:	*April 2021*	**Agenda Reference:**	**C4**
Report Title:	*DBTH Response to Ockenden*		
Sponsor:	*David Purdue – Chief Nurse and Deputy Chief Executive*		
Author:	Lois Mellor, Director of Midwifery David Purdue, Chief Nurse and Deputy Chief Executive		
Appendices:	*0*		

Report Summary					
Purpose of report:	*Update on the Trust response to the Ockenden Report*				
Summary of key issues/positive highlights:	• Good progress is being made in relation to objectives. • Outstanding elements waiting for the National Pathways • Ockenden report put into context with previous Maternity reports				
Recommendation:	None				
Action Require:	~~Approval~~	Information	~~Discussion~~	~~Assurance~~	~~Review~~
Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**	
	To provide outstanding care for our patients	*Everybody knows their role in achieving the vision*	*Feedback from staff and learners is in the top 10% in the UK*	*The Trust is in recurrent surplus to invest in improving patient care*	

Implications	
Board assurance framework:	*None*
Corporate risk register:	*None*
Regulation:	*CQC – Safe Care and Treatment and Patient Centred Care. Achievement of Outstanding.*
Legal:	*Trusts licence to operate*
Resources:	*Nil*

Assurance Route			
Previously considered by:	*Quality and Effectiveness Committee*		
Date:	*April 2021*	**Decision:**	*Regular updates required to QEC*
Next Steps:	*Update progress to QEC*		
Previously circulated reports to supplement this paper:	None		

Ockenden Actions Outstanding

Immediate and Essential Action 1: Enhanced Safety	Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.	Reporting system to the LMS needs to be agreed and implemented		Lois Mellor / Manju Singh	TBC	Waiting for the LMS to agree
		External review for all SI's within the the LMS		Lois Mellor / Manju Singh	TBC	
Immediate and essential action 2: Listening to Women and Families	Maternity services must ensure that women and their families are listened to with their voices heard.	Senior advocate role to developed (waiting for the national job description)			TBC	waiting for JD from the national team
		Continue developing the MVP's and their links with the women and DBTH		Lois Mellor	Ongoing	Need to identify other contact medical / neonatal etc
		Monthly meetings with the Non Exec Director and MVP chairs		Lois Mellor / Pat Drake	Sep-21	Contact started
Immediate and essential action 3: Staff Training and Working Together	Staff who work together must train together	Consultant Ward rounds twice daily to be completed and audited		Manju Singh / Mr Emovon	Mar-21	SOP being completed and going for ratification
		External funding to be ringfenced for training		David Purdue		
Immediate and essential action 4: Managing	There must be robust pathways in place for managing women with complex pregnancies	Development of a maternal medicine unit in the ICS		Manju Singh	TBC	Discussions in progress

Complex Pregnancy		Robust pathways for women with complex pregnancies until the maternal medicine centres created		Manju Singh / Emma Merkuschev	Jun-21	Currently under review
Immediate and essential action 5: Risk Assessment Throughout Pregnancy	Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.	Consistent use of risk assessments and management plans in the K2 system and audit of compliance		Jacqui yeates	Sep-21	Working ongoing
Immediate and essential action 6: Monitoring Fetal Wellbeing	All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.			Sharon Rainsforth / Amy Wood / Aous Du Jaily	Apr-21	2 x 0.4 WTE CTG midwives and medical staff identifed. Obstetric case review meetings on both sites weekly.
Immediate and essential action 7: Informed Consent	All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.	Significant development of the DBTH maternity website required		Becky Wakeman	TBC	Midwife identified but needs support from the IT / Comms team

Appendix Level1

OUR VISION : To be the safest trust in England, outstanding in all that we do		
True North Strategic Aim 3 – Feedback from staff and learners in top 10% in UK		
Risk Owner: Trust Board **Committee: People**	**People, Partners, Performance, Patients**	**Date last reviewed : MAR 2021**
Strategic Objective Feedback from staff and learners in top 10% in UK **Breakthrough Objective** The Trust is within the top 25% for staff & learner feedback	**Risk Appetite:** The Trust has a **low appetite** for risks TBC **Measures:** • Learner feedback • Staff survey results on development and engagement – recommending the Trust as a place to work • Clear organisational strategy co-developed with our people	**Initial Risk Rating** 4(C) x 4(L) = 16 extr **Current Risk Rating** 4(C) x 4(L) = 16 extr **Target Risk Rating** 3(C) x 3(L) = 9 low
Risks: • Failure to provide appropriate learner environment that meets the needs of staff and patients • Failure to enable staff in self actualization • Failure to deliver an organizational development strategy that allows implementation of trust values	**Rationale for risk current score:** Impact: • Impact on Trust reputation • Impact on safety of patients & experience • Possible Regulatory action • Recruitment and retention issues • Increased staff sickness levels • Deterioration in management-staff relationships • Financial impact for the Trust	**Future risks:** • Morale and resilience of colleagues as we move into recovery phase **Risk references:** PEO1 & PEO2 **Opportunities:** • Change in practices, new ways of working • Future new build • Focus on wellbeing and EDI across the Trust
Controls / assurance (mitigation & evidence of making impact): • Introduction of People committee and sub committees • Work programme to implement the People Plan • Staff survey results and action plan • PPQA feedback • GMC trainee survey	**Comments:** • Requires good OD plan “fit for purpose” • Staff survey impact • Need good data • Recruitment & retention	**Assurance (evidence of making an impact):** Feedback from staff and learner networks Junior doctor forum **Gaps in controls / assurance (actions to achieve target risk score):** COVID response impacted on development work

OUR VISION : To be the safest trust in England, outstanding in all that we do		
True North Strategic Aim 2 – Everybody knows their role in achieving the vision		
Risk Owner: Trust Board **Committee: People**	**People, Partners, Performance, Patients**	**Date last reviewed : MAR 2021**
Strategic Objective Everybody knows their role in achieving the vision **Breakthrough Objective** Achieve a 5% improvement in our staff having a meaningful appraisal linked to our vision	**Risk Appetite:** The Trust has a **low appetite** for risks TBC **Measures:** • Staff survey results – appraisals and ability to improve • Examples of changes from local QI/innovation	**Initial Risk Rating** 4(C) x 4(L) = 16 extr **Current Risk Rating** 4(C) x 4(L) = 16 extr **Target Risk Rating** 3(C) x 3(L) = 9 low
Risks: • Risk of disconnect between ward and Board leading to negative impact on staff morale and patient care • Failure of people across the Trust to meet the need for rapid innovation and change • Impact of Covid	**Rationale for risk current score:** Impact: • Impact on performance • Impact on Trust reputation • Impact on safety of patients & experience • Possible Regulatory action • Recruitment and retention issues • Increased staff sickness levels • Deterioration in management-staff relationships	**Future risks:** • Morale and resilience of colleagues as we move into recovery phase **Risk references:** PEO1 & PEO2 **Opportunities:** • Change in practices, new ways of working • Increase skill set learning
Controls / assurance (mitigation & evidence of making impact): • Monitoring uptake of appraisal through accountability meetings • Staff survey action plans to ensure appraisal conversations are meaningful as defined by the staff survey • Listening events held on regular basis • Use of team brief • Extended management board sessions • Introduction of wellbeing appraisals	**Comments:** Considerations – capacity & capability of workforce including our leaders	**Assurance (evidence of making an impact):** Feedback from the appraisal season and staff survey results **Gaps in controls / assurance (actions to achieve target risk score):** • Regular feedback on appraisal discussions through Staff FFT • Impact on COVID of appraisals not taking place during the year

Report Cover Page			
Meeting Title:	Board of Directors		
Meeting Date:	April 2021	**Agenda Reference:**	D2
Report Title:	Our People update		
Sponsor:	Karen Barnard, Director of People & OD		
Author:	Karen Barnard, Director of People & OD		
Appendices:	None		

Executive Summary	
Purpose of report:	As a Teaching Hospital we are committed to continuously developing the skills, innovation and leadership of our staff to provide high quality, efficient and effective care – this paper provides an update on covid related activities
Summary of key issues:	The report this month continues to provide an update related to absence and swabbing data, including lateral flow testing together with an update in relation to the covid vaccination programme. Covid related absences saw a reduction in February but a small increase in March with a further reduction in staff requiring a swab and subsequently testing positive. Colleagues who were shielding have in the main returned to work. With regard to lateral flow testing – circa 0.31% of staff testing are reporting a positive result. As members will be aware we have completed the first phase of the covid vaccination programme with second doses well underway. We will complete our campaign at the end of April. In excess of 6000 colleagues working on our sites have been vaccinated with circa 88% of our colleagues being vaccinated. We are working with our Place partners to continue to offer the first dose to those who now want/are able to have the vaccine. We have launched the 2021 appraisal season with refreshed paperwork combining the wellbeing conversation with the standard appraisal documentation. Recognising the importance of the wellbeing conversation we have taken the decision to continue with a 4 month appraisal season (April to July) to ensure those conversations take place. We have also continued with the approach of either maintenance or developmental appraisals.
Recommendation:	Members are asked to receive this report.

Action Require:	Approval	**Information**	Discussion	**Assurance**	Review
	TN SA1:	**TN SA2:**	**TN SA3:**	**TN SA4:**

Report Title: Our People Update **Author:** Karen Barnard **Report Date:** April 2021

Link to True North Objectives:	*To provide outstanding care for our patients*	***Everybody knows their role in achieving the vision***	***Feedback from staff and learners is in the top 10% in the UK***	*The Trust is in recurrent surplus to invest in improving patient care*

Implications	
Board assurance framework:	SA2 & 3 – future risks in relation to morale and resilience of colleagues as we move into the recovery phase
Corporate risk register:	PEO1 Failure to engage and communicate with staff and representatives in relation to immediate challenges and strategic development PEO2 Inability to recruit right staff and have staff with right skills leading to: (i) Increase in temporary expenditure (ii) Inability to meet and Trust strategy (iii) Inability to provide viable services
Regulation:	
Legal:	
Resources:	

Assurance Route			
Previously considered by:		People Committee	
Date:	2nd March 2021	**Decision:**	
Next Steps:		Ongoing discussions at People Committee	
Previously circulated reports to supplement this paper:		None	

COVID UPDATE

1. Staff Absence

2. Staff Testing

3. Lateral Flow testing

4**.** Covid vaccination

GENERAL UPDATE

5. Appraisal season

List of figures included with this report:

Figure 1 – Absence Graph, March 2020 – March 2021
Figure 2 – Covid Related Absence
Figure 3 – Swabbing data March 2020 to February 2021
Figure 4 – Positive Lateral Flow Test

List of tables included in this report:

Table 1 – Daily Absence
Table 1 – COVID Related Absence and Return to Work Figures
Table 2 – Staff Testing Figures
Table 3 – Total Number of Staff Testing Positive by Month & Area of Work
Table 4 – Positive Staff by Ethnicity

COVID UPDATE

1. STAFF ABSENCE

As can be seen Covid related absence did reduce after April but has risen since August, specifically staff who are self isolating either due to having symptoms themselves or members of their household having symptoms, particularly children – with a reduction showing in December. However in January we saw a small rise, followed by a dip in February and small rise in March. It should be noted that non covid related sickness absence continues at a similar rate to previous years, with usual seasonal rise. The Trust has seen a reduction more recently in the numbers of staff being confirmed as covid positive

Figure 1 – Absence Graph, March 2020 – March 2021

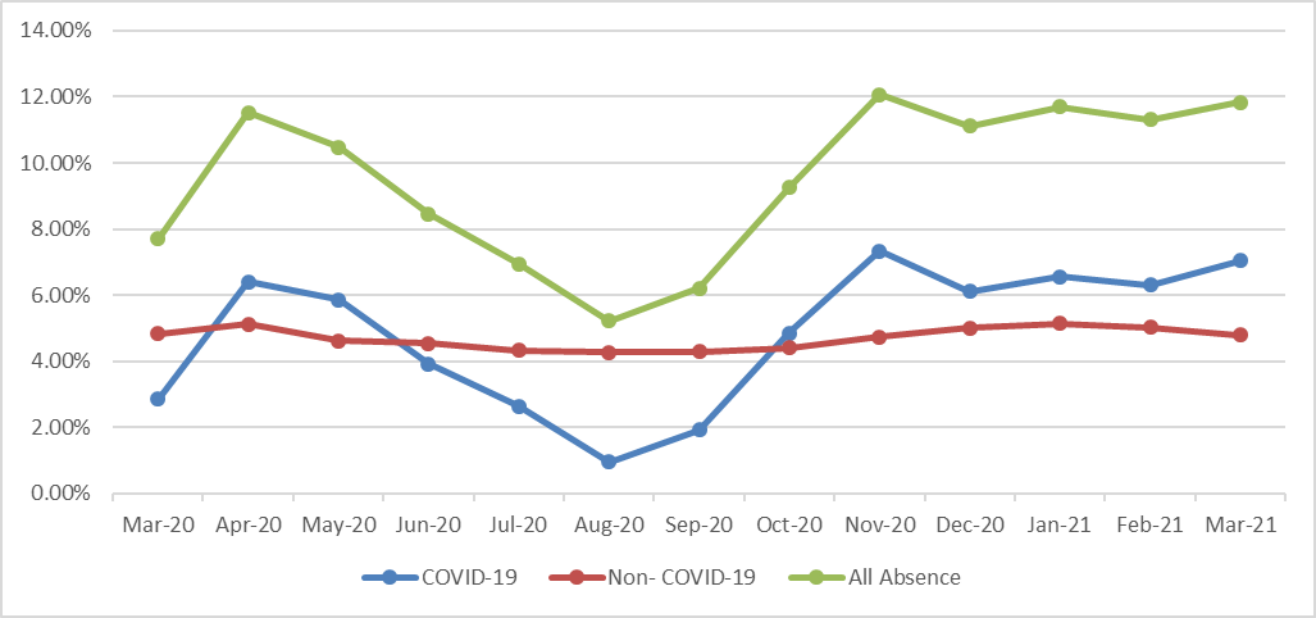


Table 1 – Daily Absence

Daily Absence				Daily Absence			
Reason	Volume	% of total	Heads	Reason	Volume	% of total	Heads
COVID confirmed	44		0.64	COVID confirmed	37		0.54
Medical exclusion with symptoms	5		0.07	Medical exclusion with symptoms	6		0.09
Medical exclusion without symptoms	17		0.25	Medical exclusion without symptoms	5		0.07
Test and Trace	3		0.04	Test and Trace	4		0.06
LFT	2		0.03	LFT	1		0.01
Shielding	174		2.54	Shielding	2		0.03
Non COVID sickness	322		4.70	Non COVID sickness	320		4.67
Total sick absence	366		5.34	Total sick absence	357		5.21
Total isolating	201		2.94	Total isolating	18		0.26

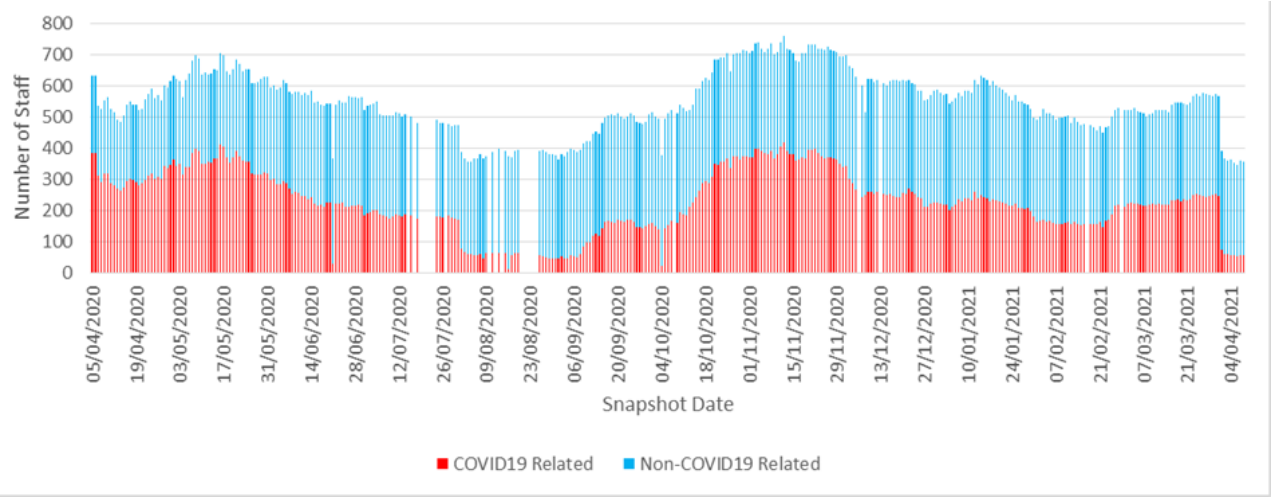
These tables demonstrate the change following the end of shielding on 1 April and the more recent continued reduction in covid related absences.

Table 2 – COVID Related Absence and Return to Work Figures

Absence Reason	Total Absences	Have Not Returned	Have Returned	% Returned
COVID-19 Symptoms	587		587	100%
Medical exclusion LFT - Negative PCR	4		4	100%
Medical Exclusion Post D&V	2		2	100%
Medical exclusion with Covid 19 confirmed	200		200	100%
Medical exclusion Track & Trace W/O COVID symptoms	579	1	578	100%
Medical exclusion with Covid 19 symptoms	2617	6	2611	100%
Medical exclusion without Covid 19 symptoms	2205	9	2196	100%
Medical exclusion LFT	204	1	203	100%
Medical Exclusion – COVID Shielding	572	4	568	99%
Medical Exclusion - Side effects from Vaccine	45	1	44	98%
COVID-19 Confirmed	1334	50	1284	96%
Grand Total	**8349**	**72**	**8277**	**99%**

The above table details the numbers of staff who have been absent and the proportion who have returned to work – not surprisingly the lower proportions of returning staff are those confirmed as being Covid positive and those who have been shielding.

Figure 2 – Covid Related Absence



This graph shows the absolute number of absences across the Trust on a Day by Day basis. Reasons for absence such as Pregnancy, training, annual leave are not included within these figures. The recent cessation of shielding can be seen in the step reduction in April with regard to covid related absences.

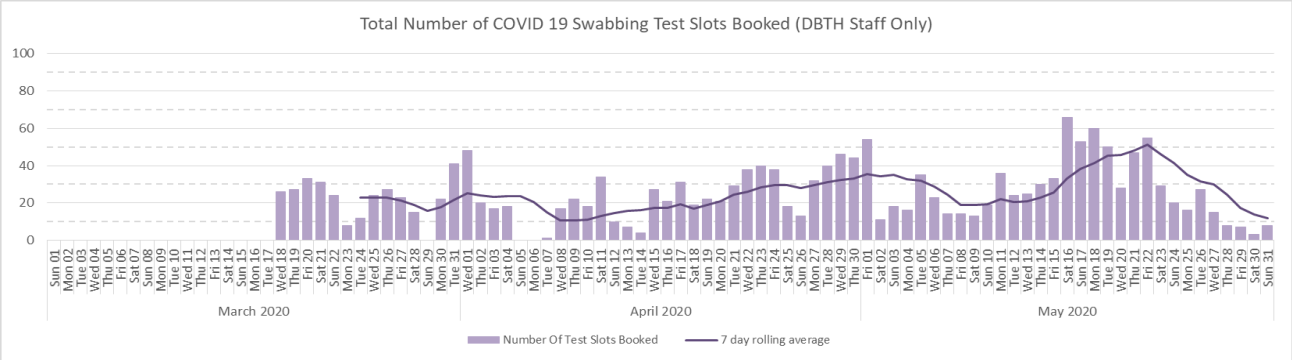
2. STAFF TESTING

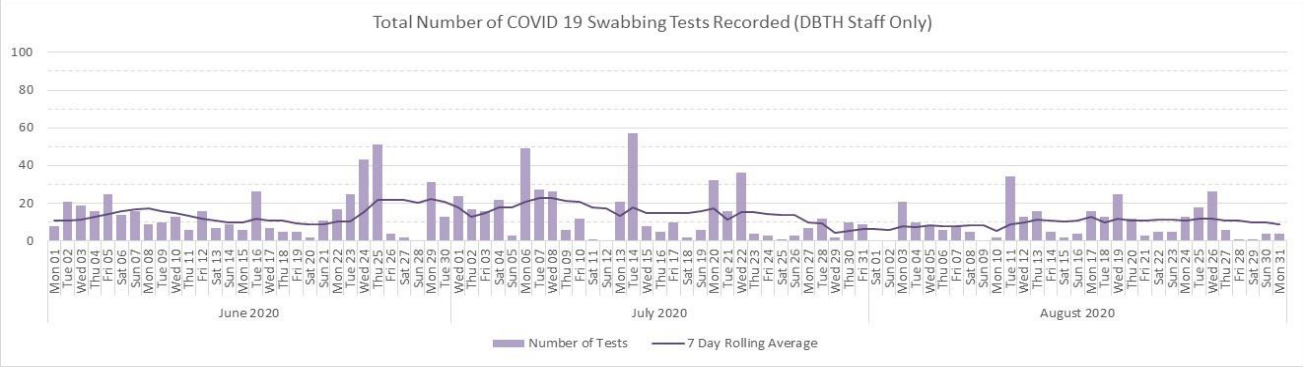
Table 3 – Staff Testing Figures

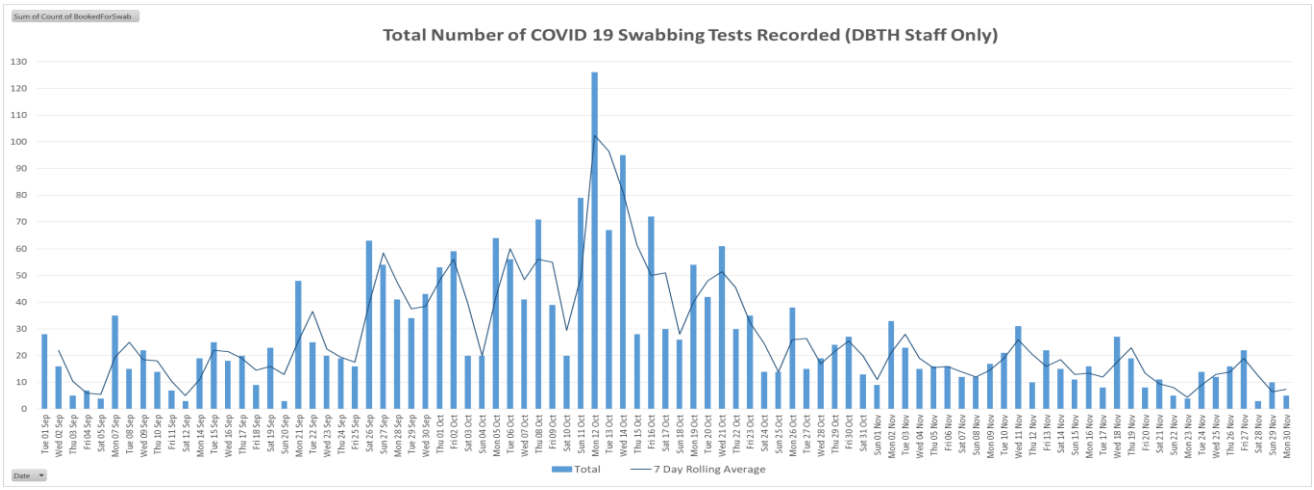
Date	March	April	May	June	July	August	September
Total	363	805	869	437	447	286	593
Date	**October**	**November**	**December**	**January**	**February**	**March**	**April**
Total	1352	443	225	183	400	405	33
Date	**May**	**June**	**July**	**August**	**September**	**October**	**November**
Total							

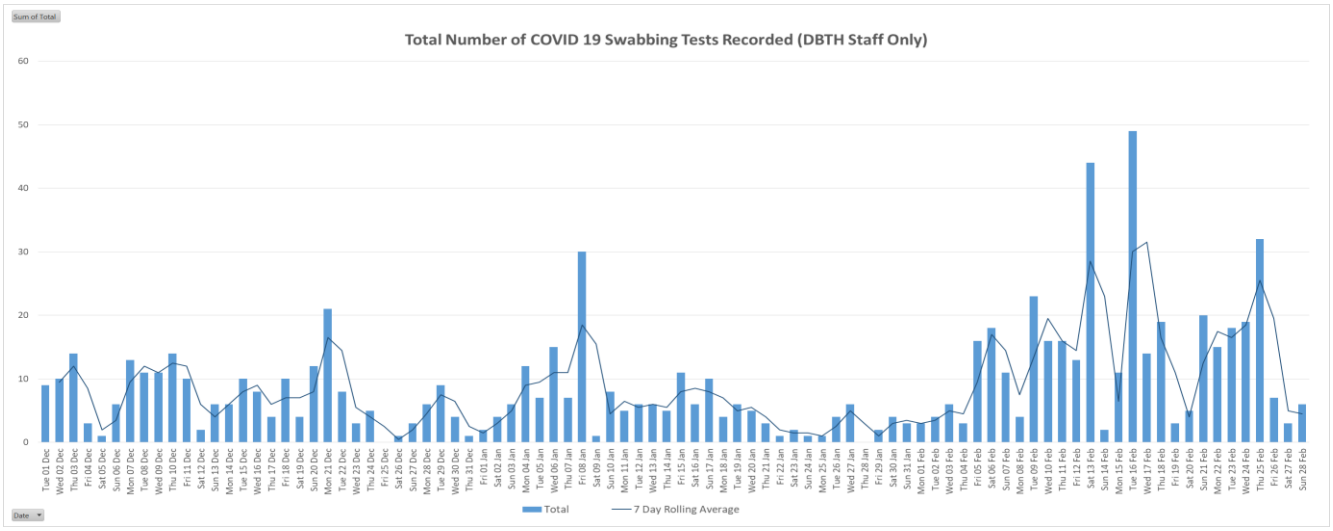
This details the numbers of staff who have been swabbed whilst the tables further in the report details the levels of positive results. There was quite a fluctuation in the numbers requiring swabs with a rise in February and March linked to schools returning but generally with very few results being positive.

Figure 3 – Swabbing data March 2020 to February 2021






Sum of Count of BookedForSwab
Total Number of COVID 19 Swabbing Tests Recorded (DBTH Staff Only)
Total
7 Day Rolling Average
Date


Sum of Total
Total Number of COVID 19 Swabbing Tests Recorded (DBTH Staff Only)
Total
7 Day Rolling Average
Date

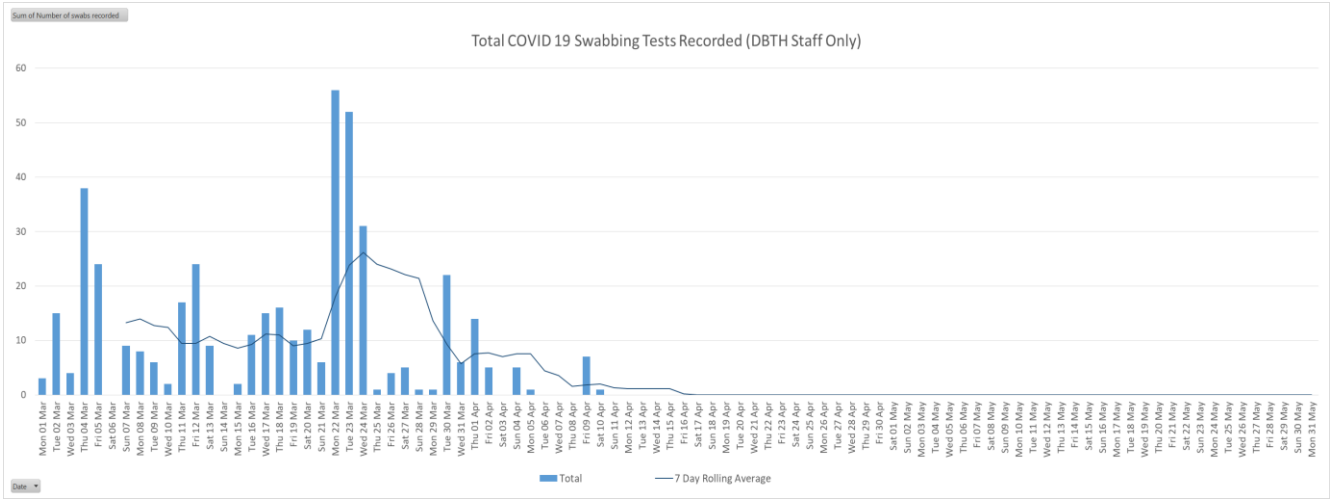

Sum of Number of swabs recorded
Total COVID 19 Swabbing Tests Recorded (DBTH Staff Only)
Total
7 Day Rolling Average
Date

Table 4 – Total Number of Staff Testing Positive by Month & Area of Work

Count of PKAbsenceID	Column Labels														
Row Labels	2020/03	2020/04	2020/05	2020/06	2020/07	2020/08	2020/09	2020/10	2020/11	2020/12	2021/01	2021/02	2021/03	No Date	Grand Total
	7	17	7					11	12	11	3	3	4		75
272 Children & Families Division	2	7	4	1				7	6	10	8	5	12	1	63
272 Clinical Specialties Division	13	16	32	2			6	27	22	19	22	10			169
272 COVID-19			1	1				4	6	2	1				15
272 Directorate Of Strategy & Improvement								1							1
272 Education and Research Directorate	2	2													4
272 Estates & Facilities	3	9	14	5			1	21	9	18	15	2			97
272 Executive Team Board	3	2	1					1		2			1		10
272 Finance & Healthcare Contracting Directorat	1	1			1			1	4	1		1			10
272 IT Information & Telecoms Directorate		1							1		1				3
272 Medicine Division	16	90	44	21	3	1	4	102	77	73	20	11	1		463
272 Nursing Services Directorate			2					1	3	4		1			11
272 People & Organisational Directorate								1		1			1		3
272 Performance Directorate		1	5					3	6	4	3	2	1		25
272 Surgery and Cancer Division	15	32	63	16	3		2	40	38	33	14	7			263
Grand Total	**62**	**178**	**173**	**46**	**7**	**1**	**13**	**220**	**184**	**178**	**87**	**42**	**20**	**1**	**1212**

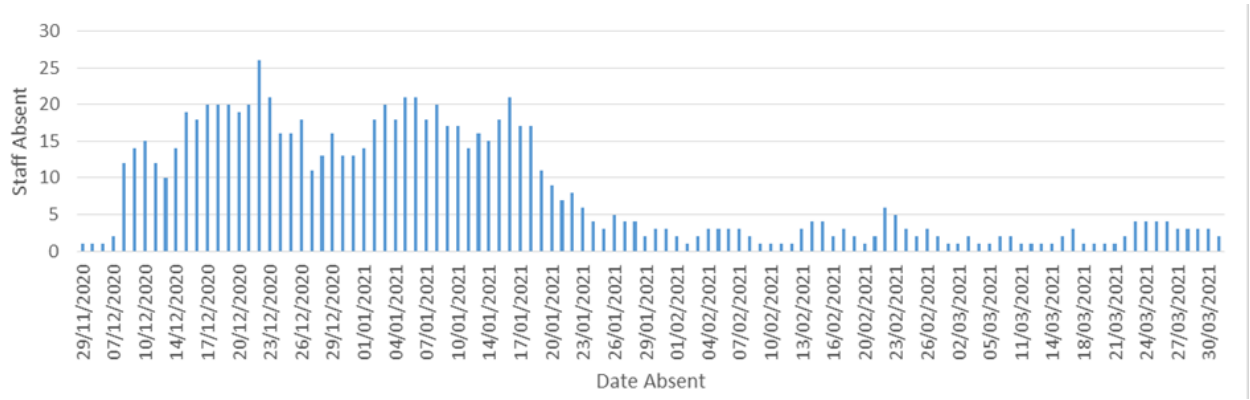
Table 5 – Positive Staff by Ethnicity

Count of PKAbsenceID	Column Labels														
Row Labels	2020/03	2020/04	2020/05	2020/06	2020/07	2020/08	2020/09	2020/10	2020/11	2020/12	2021/01	2021/02	2021/03	No Date	Grand Total
	7	18	9	1				14	13	12	3	3	5		85
A White - British	37	132	141	40	7	1	10	182	156	135	76	36	15		968
B White - Irish		1						1	1	2					5
C White - Any other White background	2	2	2	1				4		2	1				14
C3 White Unspecified		1													1
CP White Polish			1							2					3
CX White Mixed										1					1
CY White Other European							1				1				2
D Mixed - White & Black Caribbean	1		1	1											3
E Mixed - White & Black African		2	1												3
F Mixed - White & Asian	1		1												2
G Mixed - Any other mixed background			1							1					2
GC Mixed - Black & White										1					1
GF Mixed - Other/Unspecified									1						1
H Asian or Asian British - Indian	5	5	6					4	1	10	1	1		1	34
J Asian or Asian British - Pakistani	1	1					1	1		1					5
K Asian or Asian British - Bangladeshi			1					1							2
L Asian or Asian British - Any other Asian background		2	3				1	4			1	1			12
LA Asian Mixed			1												1
LF Asian Tamil	1														1
LH Asian British										1					1
LK Asian Unspecified	1	2	1						1						5
M Black or Black British - Caribbean		1													1
N Black or Black British - African	1	1	1	1				1	3	2	2				12
P Black or Black British - Any other Black background		1						1	1						3
PC Black Nigerian	1	1								1					3
R Chinese								2							2
S Any Other Ethnic Group	1	1								2					4
SC Filipino		6	2	1					1						10
SD Malaysian											1				1
SE Other Specified	1														1
Unspecified	1								1						2
Z Not Stated	1	1	1	1				5	5	5	1	1			21
Grand Total	**62**	**178**	**173**	**46**	**7**	**1**	**13**	**220**	**184**	**178**	**87**	**42**	**20**	**1**	**1212**

3. LATERAL FLOW TESTING

This graph shows the number of staff absent on a single day due to returning a positive lateral flow test. It is pleasing to note the continued reduced number of positive tests.

Figure 4 – Positive Lateral Flow Test



Over 5,500 staff are reporting their test results with 0.31% of tests currently returning a positive result. We have now got sufficient supply of testing kits to facilitate all staff working on site to have access to the tests.

4. COVID VACCINATION

Through working with primary care colleagues we were able to offer the Covid vaccine to Trust colleagues from the 21 December 2020. We were then allocated vaccine in our own right as a wave 4 hub commencing 4 January 2021. Through a combined effort we have been able to vaccinate in excess of 6,000 colleagues working on our sites. In addition the Trust has been supporting the vaccination of other NHS and social care colleagues in conjunction with RDaSH.

All DBTH staff have now had the opportunity to have their vaccination on site with circa 88% of all staff having received a first vaccine. As we are no longer vaccinating on site staff who do now wish to receive the vaccine are being directed to the national booking service and locally through the PCNs.

We are now a significant way through our second dose programme with only 2 weeks left for the programme. We are being provided with the same number of batches as we received first doses. Where colleagues will not be able to have the vaccine before the end of our programme they will be directed towards their GP practice.

GENERAL UPDATE

5. APPRAISAL SEASON

As we move into 2021/22 we have commenced the appraisal season – in recognition of the importance of all colleagues being able to have a wellbeing conversation as we move forward we are combining this with the appraisal process. As such we have launched the appraisal season for the period April to July 2021. Refreshed paperwork and soundbites have been made available together with a video detailing the importance or appraisals. Completion rates will be included in reports to the People Committee.

Report Cover Page			
Meeting Title:	Board of Directors		
Meeting Date:	April 2021	**Agenda Reference:**	D3
Report Title:	Staff Survey action plan/People Plan priorities		
Sponsor:	Karen Barnard, Director of People & OD		
Author:	Karen Barnard, Director of People & OD		
Appendices:	People Plan workshop output		

Executive Summary	
Purpose of report:	As a Teaching Hospital we are committed to continuously developing the skills, innovation and leadership of our staff to provide high quality, efficient and effective care – this paper provides an update on the Board's decision to become an early adopter of the Race Equality Code
Summary of key issues:	 Our commitment to improving the experience of Team DBTH will be captured within the True North and Breakthrough objectives. Key areas of focus are: • the improvement of people practices • the health and wellbeing of our people • EDI and inclusive leadership • Caring and compassionate leadership • Organisational development • Opportunity for our people to contribute to improvements in their area
Recommendation:	Members are asked to receive this report.

Action Require:	Approval	**Information**	Discussion	**Assurance**	Review

Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**
	To provide outstanding care for our patients	*Everybody knows their role in*	***Feedback from staff and***	*The Trust is in recurrent surplus*

		achieving the vision	***learners is in the top 10% in the UK***	*to invest in improving patient care*

Implications	
Board assurance framework:	SA2 & 3 – future risks in relation to morale and resilience of colleagues as we move into the recovery phase
Corporate risk register:	PEO1 Failure to engage and communicate with staff and representatives in relation to immediate challenges and strategic development PEO2 Inability to recruit right staff and have staff with right skills leading to: (i) Increase in temporary expenditure (ii) Inability to meet and Trust strategy (iii) Inability to provide viable services
Regulation:	
Legal:	
Resources:	

Assurance Route			
Previously considered by:		People Committee	
Date:	March 2021	**Decision:**	Detailed action plan to the next People committee in May 2021
Next Steps:		Ongoing discussions at People Committee	
Previously circulated reports to supplement this paper:		Staff survey results	

Report Title: Staff Survey Action Plan/People Plan priorities Author: **Karen Barnard** Report Date: **April 2021**

STAFF SURVEY/PEOPLE PLAN PRIORITIES

Members will recall that the four sections of the NHS People Plan are:

- Looking after our people including the NHS People Promise
- Belonging in the NHS
- New ways for working and delivering care
- Growing for the future

As indicated previously the staff survey moving forward will be constructed to reflect the NHS People Promise. In the meantime feedback is provided on the basis of 10 themes as below.

Theme	2019 score	2019 respondents	2020 score	2020 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.3**	3603	**9.3**	3064	Not significant
Health & wellbeing	**5.8**	3621	**5.9**	3077	↑
Immediate managers †	**6.8**	3617	**6.7**	3082	Not significant
Morale	**6.3**	3559	**6.2**	3028	Not significant
Quality of care	**7.5**	3282	**7.4**	2753	↓
Safe environment - Bullying & harassment	**8.3**	3581	**8.3**	2961	Not significant
Safe environment - Violence	**9.5**	3582	**9.5**	3066	Not significant
Safety culture	**6.7**	3586	**6.8**	3054	Not significant
Staff engagement	**7.0**	3647	**6.9**	3111	Not significant
Team working	**6.4**	3608	**6.1**	3084	↓

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

† The calculation for the immediate managers theme has changed this year due to the omission of one of the questions which previously contributed to the theme. This change has been applied retrospectively so data for 2016-2020 shown in this table are comparable. However, these figures are not directly comparable to the results reported in previous years. For more details please see the technical document.

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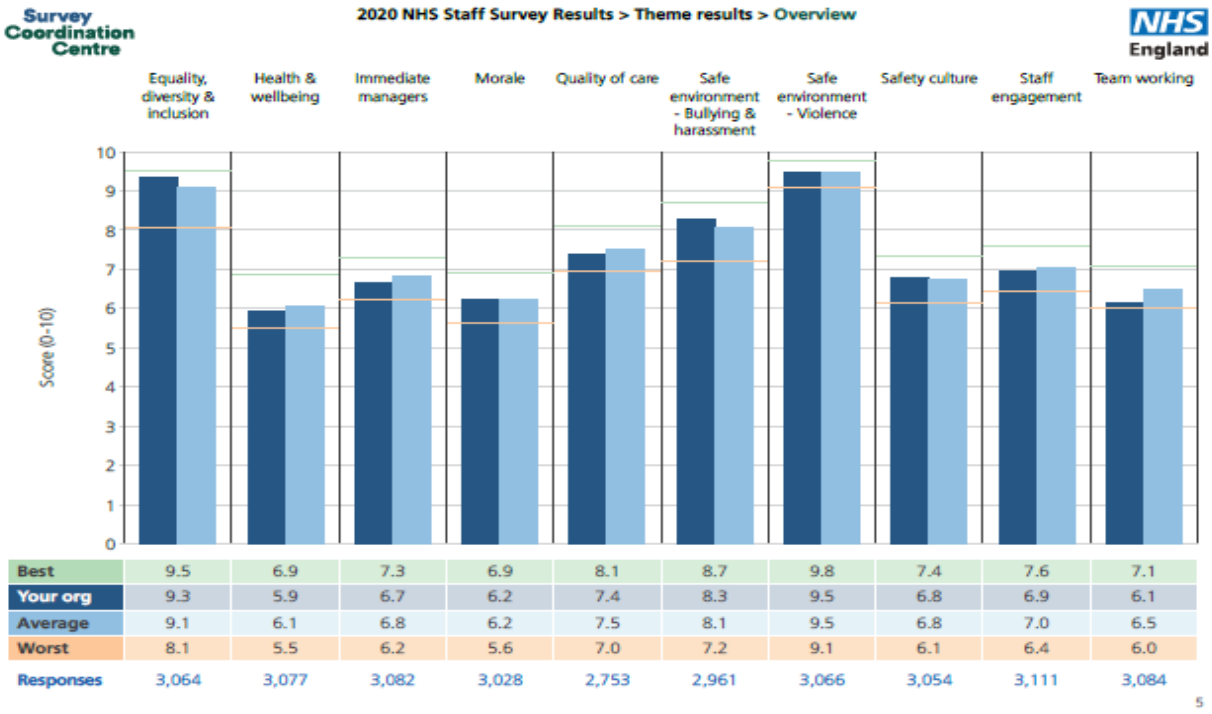
The table below provides us with benchmarking data as compared with other Acute and Acute/Community Trusts, from which we can identify our priority areas. Members will also be receiving a report on the key actions associated with our Trust North and Breakthrough objectives for 2021/22.



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.9	7.3	6.9	8.1	8.7	9.8	7.4	7.6	7.1
Your org	9.3	5.9	6.7	6.2	7.4	8.3	9.5	6.8	6.9	6.1
Average	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5
Worst	8.1	5.5	6.2	5.6	7.0	7.2	9.1	6.1	6.4	6.0
Responses	3,064	3,077	3,082	3,028	2,753	2,961	3,066	3,054	3,111	3,084

5

As previously reported a workshop was held with extended attendance from the People Committee, Executive Team, board and Divisional Directors to discuss our key priorities for 2021/22 *(Appendix 1 – People Promise)*. The discussion centred on what could be quick wins and what major projects was felt should be embarked upon. The output of discussions at the workshop are appended.

The key priorities for the Trust in relation to our people is ensuring that our HR processes are robust, that we have a strong leadership development/talent management and organisational development offer to our teams and leaders at all levels (linked to our approach to quality improvement) and also that we strengthen our wellbeing offer to our people and leaders building on the initiatives we have brought in during the pandemic. The impact of these offers will be assessed as part of appraisals being conducted to include wellbeing conversations. As a reflection of the specific post pandemic challenges which are likely to be experienced by our people, health and well-being and training and development will be a significant feature of recovery. Specific quality improvement and leadership programmes will be delivered with the aim of ensuring that the initial work is targeted towards the Senior Divisional and Directorate Leadership Teams, leading to an improvement in colleagues reporting they are able to make suggestions to improve the work of their team/department and that they have the opportunity to show initiative in their area and make improvements in their area of work.

Leadership Development – we will continue to offer the Develop, Belong, Thrive Here programmes but we will be explicit as to which roles must undertake this development opportunity. To complement this we are introducing a workshop for all our people with regard to respect and civility (Everyone Counts) – the People committee will receive a more detailed report at its May meeting. A leadership development programme for senior leaders (Leading to Outstanding) is being constructed to include both leadership skills and technical skills – this is being aimed at Divisional and Directorate leadership teams. It is planned that this programme will commence in September 2021.

Organisational Development – we will work with particular teams, for example the Emergency Department to support the improvement in team effectiveness and team working. Additionally we will introduce a programme of work around a just and learning culture (this will bring together various streams of work already in place for that single goal – the regional social partnership forum comprising HR Directors and full time regional trade union office have recently signed up to a set of guiding principles) and also move forward with our approach to agile working building on the changes we've adopted during the pandemic. We recognise that this is so much more than the introduction of working from home but also a cultural change programme.

Other areas of focus from the staff survey are health and wellbeing – the health and wellbeing committee are undertaking a review of the NHSI/E toolkit to ensure we are focused on the right areas – we are currently submitting our portfolio for the Health at Work award (gold level); whilst we benchmark well in relation to EDI we have committed to adopting the RACE equality code and enacting the agreed action plan – see a separate report – this will complement the action plans in relation to the WRES and WDES specifically.

We have recently been advised that a new quarterly staff survey will be introduced focusing on the 9 engagement questions around motivation, involvement and advocacy. This will enable us to track our progress against our breakthrough objectives. More detailed reports detailing each of these areas will be received by the People committee.


We are compassionate and inclusive
We are recognised and rewarded
We each have a voice that counts
We are safe and healthy
We are always learning
We work flexibly
We are a team
OUR NHS PEOPLE PROMISE

People Committee

** Meets Bi-monthly*

People Promise and DBTH Break Through Objectives

People Promise work streams

Workstreams

- **Compassion & Inclusion**
- **Recognition & Reward**
- **Voice that Counts**
- Safe and Healthy
- **Always Learning**
- Work Flexibly

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Our vision
The ambition of the Trust

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

True north
How we arrive at our vision

- **Objective one:** To provide outstanding care and improve patient experience.
- **Objective two:** Everybody knows their role in achieving the vision.
- **Objective three:** Feedback from staff and learners in top 10% in UK.
- **Objective four:** In recurrent surplus to invest in improving patient care.

Breakthrough
How we will move to deliver our True North in **2020/21**.

- **Objective one:** Achieve measurable improvements in our quality standards and patient experience.
- **Objective two:** Achieve a 5% improvement in our staff having a meaningful appraisal linked to our vision.
- **Objective three:** The Trust is within the top 25% for staff and learner feedback.
- **Objective four:** Every team achieves their financial plan for the year.

Our Foundations

We care

Priority Matrix – Quick Wins

- Appraisals – improved staff feedback
- Leaders Visibility (going to the gemba)
- Wider Mentorship – cross functional
- Flexible working opportunities
- Active travel plans/step campaigns
- Schwartz rounds/Psychological support
- Values refresh - conversation
- Symbols of gratitude and communication
- Thank you's. Star awards
- Story telling
- Walking in others shoes – understand their experience
- Problem finding and fixing
- Civility saves lives
- Zero vacancies
- Skills development matrix
- Promote role of H and W Guardian

Priority Matrix Quick Wins

- Feeling safe – PPE and psychological safety
- Agile working
- Co-production
- Listening and giving a voice
- Recruitment – new in post support
- Staff voice
- Skills development matrix
- Apprentice recruitment
- Environment focus – better reporting campaign
- Annual leave – ensuring everyone takes their leave
- Career trajectories
- New ways of working
- Psychological support
- Work life balance
- Task and finish groups
- Development academy

Major Projects

System leadership
Senior clinician involvement
Succession planning and talent management – all professions
Evaluate the impact of what we do – leverage of benefits from training programmes eg Shadow board
Core skills – technical and leadership
Living the we care values and feeling included
Overseas staff and their first impressions of DBTH – Welcome
Recognition programme – ask staff
Environmental issues
Compassionate conversations
Distributed leadership – ward to board
What do we mean by inclusivity
Recruitment process, model employer – agility to grasp opportunities

Major Projects

Empower leaders and staff
Distributed leadership (allow mistakes to be made)
Giving permission to do things differently
Whats bothering staff, how to respond quickly, troubleshoot minor niggles
Workforce plans (incl system wide)
System wide working
Support functions like IT
Involvement
Approaches to communications and engagement with differing staff groups
We Care message to be embedded – how translate into action
Involvement of wider families in celebratory events
Civility programme aligned to our values
Co-production/shared governance – how to get the voice

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	Board of Directors		
Meeting Date:	April 2021	**Agenda Reference:**	D4
Report Title:	RACE Equality Code and action plan		
Sponsor:	Karen Barnard, Director of People & OD		
Author:	Karen Barnard, Director of People & OD		
Appendices:	RACE Equality Code Assessment Report and action plan		

Executive Summary	
Purpose of report:	As a Teaching Hospital we are committed to continuously developing the skills, innovation and leadership of our staff to provide high quality, efficient and effective care – this paper provides an update on the Board's decision to become an early adopter of the Race Equality Code
Summary of key issues:	***Race Equality Code*** The report provides a summary of the process by which the Trust has been assessed against the Race Equality Code launched by Karl George of the Governance forum. The paper details the outcome of the assessment and the detailed action plan which we have agreed to commit to. The assessment report confirms that Doncaster and Bassetlaw completed all the required stages of the assessment and demonstrated a **good** level of compliance. Completion of Stage 2 and 3 of the assessment processes provides confidence that based on the discussions that took place, and the evidence provided at Stage 1, Doncaster and Bassetlaw are applying the principles of the RACE Equality Code. The RECA has highlighted seventy-one (71) actions in total that Doncaster and Bassetlaw need to complete. • Thirteen (13) actions identified in Stage 1 (DDR - 5 and Survey - 8) • Twenty-seven (27) actions identified in Stage 2 • Thirty-one (31) actions identified in Stage 3 This action plan will be monitored through regular reports to the People Committee.
Recommendation:	Members are asked to receive this report.

Action Require:	Approval	**Information**	Discussion	**Assurance**	Review

Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**
	To provide outstanding care for our patients	*Everybody knows their role in*	***Feedback from staff and***	*The Trust is in recurrent surplus*

		achieving the vision	***learners is in the top 10% in the UK***	*to invest in improving patient care*

Implications	
Board assurance framework:	SA2 & 3 – future risks in relation to morale and resilience of colleagues as we move into the recovery phase
Corporate risk register:	PEO1 Failure to engage and communicate with staff and representatives in relation to immediate challenges and strategic development PEO2 Inability to recruit right staff and have staff with right skills leading to: (i) Increase in temporary expenditure (ii) Inability to meet and Trust strategy (iii) Inability to provide viable services
Regulation:	
Legal:	
Resources:	

Assurance Route			
Previously considered by:	People Committee		
Date:		**Decision:**	
Next Steps:	Future discussion at People Committee in May followed by regular monitoring of action plan		
Previously circulated reports to supplement this paper:			

RACE EQUALITY CODE

1. RACE EQUALITY CODE ASSESSMENT

Members will recall that at a previous Board meeting we received a presentation from Karl George of The Governance Forum introducing the newly developed Race Equality Code. At that meeting we discussed whether we should become an early adopter of that code and agreed that undertaking the diagnostic associated with the early adopter process would provide us with a robust assessment against the code and provide us with an action plan to drive forward our equality, diversity and inclusion priorities.

The RACE Equality Code (REC) provides best practice guidance that helps organisations to understand, not only what is required of them by their sector, regulator and/or their stakeholders but also how to apply what is required. Stakeholders will gain assurance where an organisation is able to demonstrate compliance with the RACE Equality Code 2020. Boards, as part of their annual cycle of work, should include the RECA processes as part of their overall Equality, Diversity and Inclusion strategy. By being an early adopter we have been able to provide feedback on the code and assessment process.

There are three stages to the assessment process which are detailed below:

Stage 1 - Pre-Assessment Process

Diagnostic Document Review and Survey

Whilst the Diagnostic Document Review (DDR) is not a formal document review against any legal or regulatory requirements, the process of reviewing Doncaster and Bassetlaw's documents, was to purely focus on where or how race was embedded into its strategic documentation, and review Equality, Diversity and Inclusion documentation and practice.

Alongside this process, a survey was undertaken to start to get an understanding of the culture and leadership empathy, around race equity and representation of Black, and other ethnic groups on Doncaster and Bassetlaw's board and in the senior leadership team.

Stage 2 – tgf Governance Assessment

The 12 Principles of Governance

Level 1 of the assessment process was carried out to receive evidence and assurance of the systems employed in governing the organisation, and the impact on diversity and inclusion.

a) **Resources** - The documents that describe the governance framework.

b) **Competency** - The composition and capacity of the leadership

c) **Execution** - The work carried out in ensuring accountability of the senior leadership.

An initial assessment was then carried out as the high-level compliance to the four principles identified in the RACE Equality Code i.e. Reporting, Action, Composition and Education.

Stage 3 – Self- Assessment

RACE Code Diagnostic

Level 2 of the assessment process considers the 41 provisions of the Code and Doncaster and Bassetlaw's compliance with each of the provisions. The provisions are divided into three distinct categories. The first category relates to the **Must** provisions and there are 10 provisions with which an

organisation must comply. Where there is partial or non-compliance at the time of the assessment, an explanation and date for compliance must be given. The **Should** and **Could** sections, which make up a further 31 provisions, are examined on a comply or explain basis. Actions from each of the above stages are provided throughout a report and combined into fully referenced actions in a RACE Action Plan (RAP).

The assessment was undertaken on 12 and 30 November 2020 with feedback on that assessment being provided on 3 February 2021. The assessment involved Suzy Brain England, Richard Parker, Karen Barnard and Fiona Dunn together with Karl and his colleagues. Kirby Hussain, the Trust's newly appointed EDI lead joined us at the feedback session. At that feedback session we received a draft report and action plan.

ACTION PLAN

The assessment report can be found at Appendix 1. It confirms that The REC has been adopted by Doncaster and Bassetlaw. The organisation demonstrates compliance with the Code by; (a) outlining how it will apply the main principles, (b) complying with the provisions on a comply or explain basis and (c) providing explanations of how they will achieve any of the Must provisions that were assessed as partial compliance.

It confirms that Doncaster and Bassetlaw completed all the required stages of the assessment and demonstrated a **good** level of compliance. Completion of Stage 2 and 3 of the assessment processes provides confidence that based on the discussions that took place, and the evidence provided at Stage 1, Doncaster and Bassetlaw are applying the principles of the RACE Equality Code.

The RECA has highlighted seventy-one (71) actions in total that Doncaster and Bassetlaw need to complete.

- Thirteen (13) actions identified in Stage 1 (DDR - 5 and Survey - 8)
- Twenty-seven (27) actions identified in Stage 2
- Thirty-one (31) actions identified in Stage 3

The combined action plan can be found at Appendix 2. This action plan will form part of the work of the EDI forum supported by the BAME staff network and progress will be monitored through regular reports to the People Committee. We will be required to undergo an interim assessment in 18 months' time which demonstrates how we have progressed with the **must** actions, evidence of Board and committee meeting reports where this code has been monitored and other examples of good practice.

RACE Equality Code Assessment Report

Doncaster and Bassetlaw NHS Foundation Trust

Organisation	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
Date of RACE Equality Code Assessment Meetings	12 and 30th November 2020
Organisation's Representatives	Suzy Brain-England, Chair
	Richard Parker, CEO
	Karen Barnard, Director of People and OD
	Fiona Dunn Deputy Director of Quality and Governance
RACE Consultants	Dr Karl George MBE Rob Neil
Report Date	1st February 2021 (Version 1)
Reassessment Required	September 2022
RACE Report Authentication Code	01/11-20/DBFT057/C/KG/RN

Contents Page

1. INTRODUCTION

1.1 Following the RACE Equality Code Assessment (RECA), completed by **the governance forum (tgf)** on 12th and 30th November 2020 this report has been prepared to provide guidance and recommendations for Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (hereinafter "Doncaster and Bassetlaw").

1.2 Doncaster and Bassetlaw will be guided on how it might address culture, policy or practice that contributes to underrepresentation of Black and other ethnic groups, on its board and in the senior leadership team.

1.3 The RECA has tested the governance at Doncaster and Bassetlaw in the following ways, to demonstrate its compliance in relation to Race Equality and how this, and other protected characteristics, are addressed in the overall Equality, Diversity and Inclusion Strategies:

(a) Stage 1 - Pre-Assessment Process

Diagnostic Document Review and Survey

Whilst the Diagnostic Document Review (DDR) was not a formal document review against any legal or regulatory requirements, the process of reviewing Doncaster and Bassetlaw's documents, was to purely focus on where or how race was embedded into its strategic documentation, and review Equality, Diversity and Inclusion documentation and practice.

Alongside this process, the purpose of the survey was to start to get an understanding of the culture and leadership empathy, around race equity and representation of Black, and other ethnic groups on Doncaster and Bassetlaw's board and in the senior leadership team. The key findings from the pre-assessment process are provided in Section 3 (DDR) and Section 4 (Survey) with copies of the full reports at Appendix B (DDR) and the attachment (Survey) with a description of the philosophy and thinking around the approach to race equity in the form of the DRIVERS (Appendix C).

(b) Stage 2 – tgf Governance Assessment

The 12 Principles of Governance

Level 1 of the assessment process was carried out to receive evidence and assurance of the systems employed in governing the organisation, and the impact on diversity and inclusion.

(a) **Resources** - The documents that describe the governance framework.
(b) **Competency** - The composition and capacity of the leadership
(c) **Execution** - The work carried out in ensuring accountability of the senior leadership.

An initial assessment was then carried out as the high-level compliance to the four principles identified in the RACE Equality Code i.e. Reporting, Action, Composition and Education.

(c) Stage 3 – Self- Assessment

RACE Code Diagnostic

Level 2 of the assessment process considers the 41 provisions of the Code and Doncaster and Bassetlaw's compliance with each of the provisions.

The provisions are divided into three distinct categories. The first category relates to the **Must** provisions and there are 10 provisions within which an organisation must comply. Where there is partial or non-compliance at the time of the assessment, an explanation and date for compliance must be given. The **Should** and **Could** sections, which make up a further 31 provisions, are examined on a comply or explain basis.

1.4 Actions from each of the above stages are provided throughout the report and combined into 26 fully referenced actions in RACE Action Plan (RAP) in Section 6.

2. EXECUTIVE SUMMARY

2.1 The RACE Equality Code (REC) provides best practice guidance that helps organisations to understand, not only what is required of them by their sector, regulator and/or their stakeholders but also how to apply what is required. Stakeholders will gain assurance where an organisation is able to demonstrate compliance with the RACE Equality Code 2020. Boards, as part of their annual cycle of work, should include the RECA processes as part of their overall Equality, Diversity and Inclusion strategy.

2.2 The REC has been adopted by Doncaster and Bassetlaw. The organisation demonstrates compliance with the Code by; (a) outlining how it will apply the main principles, (b) complying with the provisions on a comply or explain basis and (c) providing explanations of how they will achieve any of the Must provisions that were assessed as partial compliance.

2.3 Doncaster and Bassetlaw completed all the required stages of the assessment and demonstrated a **good** level of compliance. Completion of Stage 2 and 3 of the assessment processes provides confidence that based on the discussions that took place, and the evidence provided at Stage 1, Doncaster and Bassetlaw are applying the principles of the RACE Equality Code.

The RECA has highlighted seventy-one (71) actions in total that Doncaster and Bassetlaw need to complete.

- Thirteen (13) actions identified in Stage 1 (DDR - 5 and Survey - 8)
- Twenty-seven (27) actions identified in Stage 2
- Thirty-one (31) actions identified in Stage 3

2.4 **Key Actions** - The actions below are some of those identified from each of the 3 Stages of the assessment process. Reflected in the table below, they show the Stage that the action was identified, and each action has also been RAG rated to demonstrate the priority with which it should be addressed. Red actions require **immediate action** (0/3 months), amber actions should be completed **within 3/6**

months and green actions should be completed **within 6/12 months**. Actions are presented in the order of the Stages from which they arose. As part of the work to implement the action plan, Doncaster and Bassetlaw should assign a priority rating to all of the actions included in the full RACE Action Plan in Section 6 of this report.

Stage	Action Required	Action No.	RAG
1	Explore how to ensure the Black Workers Support Group can be empowered, strategic and part of the governance framework whilst ensuring that it is truly representative.	17	Red
1	Review the vision and values and induction resources where Race is expected to be reflected.	22	Amber
2	Review the Competency and Skills Framework.	26	Amber
2	Board performance should be measured in three ways; • Long-term - vision and culture going in the right direction • Medium–term - processes are being developed • Short–term - do people say the organisation is making a difference day to day. How can the organisation find tools to measure this?	32	Green
3	Undertake further work in developing the psychological safety in the organisation and review the Speaking Up Policy.	42	Amber
3	Document and report at board level, the strategy for dealing with Race inequity and the resources, financial and otherwise, that the organisation will commit to ensuring transformational change.	46	Green

2.5 **Benchmarking** - During Stage 3 of the assessment, Doncaster and Bassetlaw was asked to score its current performance on a scale of 1–5 against; 10 **Must** benchmark questions. These questions are included in full in Section 7. The scale of 1–5 was interpreted as 1 (not satisfactory) and 5 (no development required). There were zero instances where Doncaster and Bassetlaw scored themselves below 3 (not satisfactory). They scored themselves as a 4 in 4 of the questions and as a 5 (no development required) in 5 of the questions.

Areas where Doncaster and Bassetlaw identified that they had development needs (where a score of 1 or 2 was given) and where strengths were highlighted, included:

Development Needs (Scores of 1 or 2)	Key Strengths (Scores of 4 or 5)
N/A	**Code A2** – Organisations **must** identify a board-level sponsor for race or include the remit for race within an appropriate broader responsibility of a board member for example if there is a director whose responsibility is employee matters this may be considered to be a useful fit). This individual will provide visible leadership on race for the organisation. **Code C1** - Organisations **must** collate the following information and set stretching targets: • Board race diversity; • Senior Leadership Team race diversity; • Board and Senior Leadership Team race diversity targets (including an explanation where targets have not been met by a relevant date). Breakdown of employees by race and pay band. • Steps being taken to improve race diversity within the organisation. • Description of the Board's and Organisation's policy on race diversity **Code E1** - Organisations **must** explain to all employees how supplying diversity data around race will assist the organisation in improving racial diversity overall. Organisations **must** demonstrate how they have used the diversity data already collected to positive effect.

2.6 **Statement of Compliance -** Having completed the RECA, Doncaster and Bassetlaw have demonstrated that they have worked through a robust, facilitated self- assessment. The assessment reviewed the **tgf** Governance Code, the RACE Equality Code 2020 and has created an action plan that they have agreed to be accountable for.

3. DIAGNOSTIC DOCUMENT REVIEW (DDR)
Summary and Actions

3.1 As part of the RECA process, a DDR was undertaken. This was to verify that Doncaster and Bassetlaw have in place all of the essential governance documentation to be able to demonstrate they have the right resources in place with regard to Race. The DDR found that, Doncaster and Bassetlaw most of the required documents in place.

3.2 **tgf** specifically assess whether there are governing documents in place for the Board and Committees and the organisation overall in line with best practice to demonstrate accountability at the highest level in the organisation.

3.3 Having undertaken the DDR, **tgf** can confirm that Doncaster and Bassetlaw have substantially all lines of accountability and responsibility evidenced in:

- Terms of Reference for the Board and Committees
- Role Descriptions for senior officers
- Robust Policies that include race in Equality, Diversity and Inclusion

3.4 Furthermore, the information outlined below provides an example of what key documents are in place and where there are any that require updating or creation.

Documents in place	Documents requiring update/creation
• Code of Conduct • Recruitment pack • Stakeholder Engagement Report/Plan	• Induction Pack • Equality and Diversity Policy • Staff Engagement Report/Plan

3.5 It should be noted that the DDR is undertaken in the form of a desktop review and does not constitute an in-depth document review in relation to regulatory requirements.

4. SURVEY
Summary and Actions

4.1 The rating outlined in this Section is based an assessment made by the RACE Consultant in relation to the number of respondents who had 'not agreed/ disagreed' and the number of disagreements to positive statements. Green means a high percentage of respondents agreed with the statements, with little or no disagreement.

4.2 The purpose of the survey was to start the process of beginning to understand the culture and leadership empathy, around race equity and representation of Black and other ethnic groups on the board of Doncaster and Bassetlaw and within the senior leadership team.

4.3 The Survey was disseminated to 22 individuals connected to the organisation either at Board level or at senior management level. In total, the Survey was completed by 16 people which consisted of nine board members and seven members of the senior leadership team. A summary of the overall findings is shown below:

			RAG	Action No
D	Diversity	The organisation takes equality seriously and is comfortable with focusing on race.	Amber	
R	Responsibility	Vast majority say the organisation does not tolerate racism however only 5 agree that the organisation does enough to tackle racism with 5 disagreeing. **Actions:** • The organisation should do more to tackle racism and create clear actions and accountability for the board and senior leadership team. • The organisation should clearly communicate that Racism will not be tolerated there were 3 people from the sample which didn't agree that this was being done	RED	6 7
I	Integrity	The representation of black people on the board and senior leadership team was deemed not acceptable by the majority of participants to the survey 11 for the board representation and 8 for the senior leadership team. **Action:** The organisation should treat representation as a priority in the overall D&I plans.	Red	8
V	Values	13 people say the organisation is anti-racist however 1 person disagreed and 2 neither agreed nor disagreed. Only 7 people say the organisation's EDI policies do enough to tackle racism. Only 3 people from the survey could sat the organisation's EDI policies were working adequately. **Actions:** • EDI strategy, planning and integration across the organisation to be discussed and results documented. • Any plans developed should address the negative experiences some have had with harassment, bullying, discrimination or micro-aggressions.	Amber	9 10
E	Equity	9 or 10 people of the 16 agreed that there were no barriers to black or other minority ethnic groups getting on the board or senior leadership team **Action**: The organisation should examine what it can do to stop counter any barriers that exist to limit the attraction, recruitment and retention of black people into the board and SLT.	Amber	11
R	Reality	10 people said it was difficult to find targets and 8 disagreed that targets that were found were adequate. **Action**: Develop and communicate effective targets	Red	12
S	Society	The majority of responses said the culture was motivating, inclusive and embracing and all participants were comfortable speaking about race. There were 9 unsure whether black colleagues felt the environment was inclusive and belonging.	Green	13

Action: Work on developing a more inclusive background for all employees but addressing this apparent gap when dealing with Black employees.	

5. RACE EQUALITY CODE

5.1 Level 1 - tgf Code Principles of Governance (Apply and Explain Compliance with Principles)

No.	tgf Governance Code Principle	Action/Review Required	Action No.	Priority
1.	**The board should have a clear purpose, appropriate structures and an effective governance framework.** As the custodian of corporate governance, it must be effective in strategically leading the organisation and have an appropriate constitutional framework with the essential functions recorded in its terms of reference and other relevant documentation. The core documents should show that Equality and Diversity is a board responsibility and an overarching principle with a focus on Race.	The Race Equality Plan is to be presented to the People Committee in order to get assurance about the activities and positioning of the activity around ensuring it's not about re-assurance.	14	
		The EDI group to ensure there are clear actions and buy-in from the Organisation by ensuring the group is truly representative.	15	
		Monitor regularly and robustly the mood of the organisation with appropriate tools and mechanisms to ensure that work in this area of Race Equality is moving in the right direction and across all divisions.	16	
		Explore how to ensure the Black Workers Support Group can be empowered, strategic and part of the governance framework whilst ensuring that it is truly representative.	17	
2.	**The board should have access to the right reports and information and should present a fair and balanced assessment.** This information should be appropriate and relevant and provided in an accurate and timely manner.	Continue to gather the data around Race Pay and consider the actions that can be taken and those that are outside of the rights as an employer.	18	
		The board reporting to include more specific and transparent mechanisms for reporting against actions in race equity.	19	
		Define in a more meaningful way what success looks like and what the organisation will do with the information that is being collected. This will be in line with the meaningful measures in the true north and breakthrough model.	20	
3.	**The board should have the right documentation in place including forms, policies and registers.** These documents should be in line with legal, statutory and best practice requirements.	Use the opportunity to look at the training programme in the Statutory and Essential Training programme to include training around race.	21	
		Review the vision and values and induction resources where Race is expected to be reflected.	22	
		BAME FTSU champion to be discussed and the concept to be developed.	23	
		Develop a house style to reporting with a particular focus on developing the equality impact assessment and ensuring that there is a race perspective.	24	
4.	**The board's roles and responsibilities around accountability for Race, including the division of responsibilities should be clearly defined.** The organisation should have a profile of each board member and senior leadership team.	The Chair Role Description to be reviewed to ensure that the responsibility for Race is included.	25	
5.	**The board should be diverse, balanced and suited to the needs of the organisation in its composition.** Board and committee membership should be balanced taking into account knowledge, skills, experience, diversity, size and independence.	Review the Competency and Skills Framework.	26	

6.	**The board should conduct themselves appropriately, avoiding conflicts of interest and adhering to an anti-racist behaviour.** They should uphold ethically high standards of integrity and probity at all times, always acting in the best interests of the organisation.	Review the Fair Treatment Policy.	27	
		Review the behaviours that align with the organisation's values.	28	
		The principle of not accepting the unacceptable to be continually spread and endorsed with a Zero Tolerance Policy	29	
7.	**The board should have clear processes for appointment, induction and training in place for board members to attract and retain black board members and employees.** These processes should be robust, formal, rigorous and transparent and take succession planning into account. Board members should be appointed objectively on merit.	Encourage more Board Observations	30	
8.	**The board should have effective processes for evaluation of itself as a whole, individual board member and its committees.** The board should implement and oversee robust processes for the evaluation of its own effectiveness and performance and that of each board member. Evaluation should take place at regular intervals, including periodic external support.	When carrying out the Board Effectiveness Review a number of these race equality areas are to be adopted.	31	
		Board performance should be measured in three ways; • Long-term - vision and culture going in the right direction • Medium–term - processes are being developed • Short–term - do people say the organisation is making a difference day to day. How can the organisation find tools to measure this?	32	
10.	**The board should be able to evidence challenge, debate, accountability and transparency.** The work of the board should be open, and they should be able to demonstrate sufficient scrutiny.	Hold the non-executives responsible for staff well-being.	33	
		Define how governors will hold non-executives to account for the Race Equality Code and broader EDI.	34	
		Provide support and plan composition of committees so that the committees can ask the right questions	35	
12.	**The board should be able to demonstrate active and effective engagement with stakeholders.** Board members should act as ambassadors for the organisation and always seek to encourage meaningful and effective participation from all stakeholder groups targeting Black communities. They should be responsive to the needs of all stakeholders.	The work on EDI and the Race Code to be included in Stakeholder Engagement Surveys.	36	

5.2 Level 1 - Apply and Explain RACE Assessment

An initial self-assessment demonstrated that Doncaster and Bassetlaw are applying the 4 Principles but have some strategic actions to complete in order to demonstrate full compliance. The actions that will aid in achieving full compliance are identified in the following action plan.

Area	Statement	Overall Score		
		We are not able to demonstrate with any evidence that we are fulfilling the requirements of this Principle. NON-COMPLIANT (Score 0-1)	We satisfy and can demonstrate that we fulfil the requirements of this Principle but have a number of actions that we need to still take. PARTIALLY COMPLIANT (Score 2-4)	We have a great deal of evidence and fulfil all or substantially all of these requirements and if there are any actions, they are minor. COMPLIANT (Scored 5)
Reporting	A clear commitment to be transparent to all stakeholders through the disclosure of required, concise and current information on the progress and impact of RACE initiatives across the organisation. Openness and transparency will be actively pursued and valued in order to create the right environment for change.		ü	
Action	A list of the measurable actions and outcomes that contribute to and enable a shift in the organisation's approach to be delivering positive and sustainable change in race equity and equality. Without a set of targets and detailed plans for their achievement, real change will not happen, and organisations will not be accountable.	ü		
Composition	A set of key indicators that create tangible differences in race diversity across all levels of the organisation. The narrative around what is acceptable will need to change through dialogue and data, and this will lead to challenging conversations leading to necessary decisions which the organisation is committed to making.		ü	
Education	A robust organisational framework that develops the ethical, moral, social and business reasoning for race diversity at all levels of the organisation. This will be underpinned by inclusive and embedded programmes of continuous professional development (using the Principles) through which perspectives and prejudices will need to be challenged, and systemic and institutional practices acknowledged.		ü	

Summary comments:

Reporting – Do more work on the meaningful framework so that the organisation can understand if it is moving forward. **Action No. 37**
Action – Create the baseline to report on. **Action No. 38**
Composition – Continue to collect the data that the organisation is required to collect whilst starting to look at the data that is needed. **Action No. 39**
Education – Change in education to create the cultural change needed. **Action No. 40**

5.3 Level 2 - Comply and Explain (Must)

No.	RACE Code	Actions	Action No.	Priority
R1	Organisations **must** publish the following information in their Annual Report and in an easily accessible place, i.e. publicly on organisation's website and on any internal forums used by employees: • Board race diversity • Senior Leadership Team race diversity • Board and Senior Leadership Team measurable race diversity targets (including an explanation where targets have not been met by a relevant date). • Steps being taken to improve race diversity within the organisation and the results of any initiatives taken. • Breakdown of employees by race and pay band • Description of the Board's and Organisation's policy on race diversity The information must disclose the number of individuals in role, by ethnicity, including Black colleagues. References to targets include a long-term (5-year) target with annual milestones to track progress against those targets. Companies that do not meet Board composition recommendations by the relevant date should disclose in their annual report why they have not been able to achieve compliance and the steps being taken to achieve compliance.	Develop measures that help to usefully translate all the core requirements into useful indicators and find the best way to report them.	41	
A1	Organisations **must** take positive action to improve reporting rates amongst its workforce demonstrating how supplying data will assist the organisation in increasing diversity overall, with a focus on Black people.	Consider how the organisation can demonstrate how it has communicated across the organisation the importance of gathering this data and in particular to diverse groups, how it will benefit the organisation.	42	
A4	Organisations **must** include diversity in every board evaluation as a measure directly linked to performance, including what it has done in reviewing the RACE Code, its strategy around improving Race Diversity as a part of the overall Diversity and Inclusion Strategy, and progress against its formal Race objectives	Ensure that a review is carried out of the Board evaluation resource to ensure diversity objectives and indicators are covered.	43	

E1	Organisations **must** explain to all employees how supplying diversity data around race will assist the organisation in improving racial diversity overall. Organisations **must** demonstrate how they have used the diversity data already collected to positive effect.	Carry out further work in demonstrating how the data on diversity can have a positive impact.	44	
E2	Organisations **must** build psychological safety in boards and throughout the organisation to create a culture where racial issues and experiences are discussed and shared to encourage empathy	Undertake further work in developing the psychological safety in the organisation and review the Speaking Up Policy.	45	

5.4 Level 2 - Comply or Explain (Should/Could)

No.	RACE Code Action/Review Required	Partial/None	Action No.	Priority
R2	Document and report at board level, the strategy for dealing with Race inequity and the resources, financial and otherwise, that the organisation will commit to ensuring transformational change.	☐ Non-Compliant	46	
R3	Create a publicly available Anti-Racism Statement. This should make clear and promote that: ☐ The organisation has zero tolerance of racism ☐ The organisation has zero tolerance of harassment and bullying	☐ Partially Compliant	47	
R4	Report in the annual report and/or other employee publications on how the organisation have included its commitment to ensure there is a golden thread between achieving race equity, within its broader values and how this is aligned with its purpose and strategy.	☐ Partially Compliant	48	
A6	Improve diversity in the talent pipeline including: ☐ Embedding mentoring and sponsorship schemes in the organisation. ☐ New entrants to the organisation to receive a proper induction, including basic and clear information on how the organisation's career progression works, it's pay and reward guidelines and how promotions are awarded - ensuring transparency on career pathways. ☐ A robust Talent Management Strategy to fill current senior vacancies and future leadership pipelines. ☐ Increase participation levels from Black students in key programmes	☐ Partially Compliant	49	
A7	Measure the effectiveness of mechanisms to identify, develop and promote Black employees within the organisation in order to ensure over time, that there is a pipeline of board capable candidates and the senior leadership ranks appropriately reflect the importance of diversity to the organisation.	☐ Partially Compliant	50	
A8	Review the governing documents to ensure race is fundamentally and consistently embedded ie ☐ Ensure roles and responsibilities of the board and senior management relating to race accountability is documented. ☐ Ensure that accountability is upheld and that the discourse on race informs board and committee discussions and decisions.	☐ Partially Compliant	51	
A9	Create a clear accountability framework to address the performance criteria and targets that have been set around race equality. This should include how decisions and how often monitoring reports are made to the board, ensuring that responsible board members and the senior leadership team are accountable for racial diversity. Actions as a result of such monitoring should be reported.	☐ Non-Compliant	52	

A10	Make it clear that supporting equality in the workplace is the responsibility of all leaders and managers. Include a clear race diversity objective in all leaders' annual appraisal, (covering their responsibility to support fairness for all staff), with race diversity as a key performance indicator, to ensure that they take positive action seriously. Employee's performance reviews and remuneration to tie in with contributions to development in this area.	☐ Partially Compliant	53	
A11	Ensure formal interview processes are held for all roles and that diversity quotas around race are set and met during recruitment (panels) and interview/short-listing and any recruitment agencies used. Ensure proportional representation on long and short recruitment selection lists and reject lists that do not reflect the local and/or stakeholder working age population.	☐ Partially Compliant	54	
A13*	The Nomination Committee to require the human resources teams or search firms (as applicable), to identify and present qualified Black people and other ethnic groups to be considered for board appointment when vacancies occur.	☐ Partially Compliant	55	
A14*	Ensure that any executive search firm used follows the Standard Voluntary Code of Conduct for Executive Search Firms that the relevant principles of that code be extended on a similar basis to the recruitment of Black and other ethnic candidates.	☐ Partially Compliant	56	
A15	Led by board chairs, existing board directors to mentor and/or sponsor Black employees within the organisation where possible, to ensure their readiness to assume senior leadership positions internally, or non-executive board positions externally.	☐ Partially Compliant	57	
A16*	Executive Recruiters to be demonstrably proactive in identifying and marketing talented Black candidates and be provided with specific targets.	☐ Partially Compliant	58	
A17	Convene conversations involving Black people throughout the decision-making process in the workplace for active listening, and then make plans on agreed actions together with Black employees.	☐ Partially Compliant	59	
A18	Identify and develop a pool of high potential Black leaders and senior managers as part of a cross-sector sponsorship/mentoring programme.	☐ Partially Compliant	60	
A19	Encourage and support candidates drawn from diverse backgrounds, including Black people, to take on Board roles internally (e.g. subsidiaries) where appropriate, as well as board and trustee roles with external organisations, to develop individuals' oversight, leadership and stewardship skills.	☐ Non-Compliant	61	
A22*	Ensure that the selection and interview process is undertaken by more than one person and should ideally include individuals from Black backgrounds to help eliminate bias (ensuring a diverse interview panel).	☐ Partially Compliant	62	
A23*	Critically examine entry requirements into their business, focusing on potential achievement and not simply which university or school the individual went to (challenging school and university selection bias).	☐ Partially Compliant	63	

C7	Measure opportunities to provide work experience to Black people.	☐ Partially Compliant	64	
E3	Ensure that all employees undertake Race Awareness Training.	☐ Partially Compliant	65	
E5	Make clear arrangements to educate senior leaders to actively sponsor Black talent in the workplaces.	☐ Partially Compliant	66	
E7	Senior management teams, executive boards and those with a role in the recruitment process, to go further than taking mandatory training and undertake more comprehensive workshops that tackle bias.	☐ Non-Compliant	67	
E8	All induction programmes to include modules to show how the career ladder works in the organisation (noting for Black employees that the stats may show a lack of career progression and may be structurally racist).	☐ Non-Compliant	68	
E9	Establish formal race diversity networks and encourage individuals to participate and use the networks to provide education opportunities. Consult with the networks (as appropriate) and allow the networks to contribute to decisions that have the potential to impact Black employees.	☐ Partially Compliant	69	
E12	As part of the education of Black employees, employers to explain how success has been achieved. Senior managers to publish their job history internally (in a brief, LinkedIn style profile) so that junior members of the workforce can see what a successful career path looks like.	☐ Partially Compliant	70	
E13	The organisation to source or work with employee representatives, trade unions and third sector organisations to develop a simple guide on how to discuss race in the workplace.	☐ Partially Compliant	71	

6. RACE Action Plan (RAP)

Combined Action Points of All Sections

RECRUITMENT AND INDUCTION – Business and process for inclusive recruitment and panels					
No.	**Actions Required**	**Completed**	**Responsibility**	**Priority** (in months)	**RECA Linked Actions**
1.	Review the vision and values and induction resources where Race is expected to be reflected. The organisation should examine what it can do to stop/counter any barriers that exist to limit the attraction, recruitment and retention of black people into the board and SLT. Senior management teams, executive boards and those with a role in the recruitment process, to go further than taking mandatory training and undertake more comprehensive workshops that tackle bias.	Yes/In Progress/No			11, 22, 67
2.	Ensure formal interview processes are held for all roles and that diversity quotas around race are set and met during recruitment (panels) and interview/short-listing and any recruitment agencies used. Ensure proportional representation on long and short recruitment selection lists and reject lists that do not reflect the local and/or stakeholder working age population. Ensure that the selection and interview process is undertaken by more than one person and should ideally include individuals from Black backgrounds to help eliminate bias (ensuring a diverse interview panel).	Yes/In Progress/No			54, 62
3.	The Nomination Committee to require the human resources teams or search firms (as applicable), to identify and present qualified Black people and other ethnic groups to be considered for board appointment when vacancies occur. Ensure that any executive search firm used follows the Standard Voluntary Code of Conduct for Executive Search Firms that the relevant principles of that code be extended on a similar basis to the recruitment of Black and other ethnic candidates. Executive Recruiters to be demonstrably proactive in identifying and marketing talented Black candidates and be provided with specific targets	Yes/In Progress/No			55, 56, 58
4.	Critically examine entry requirements into their business, focusing on potential achievement and not simply which university or school the individual went to (challenging school and university selection bias).	Yes/In Progress/No			63

EQUALITY, DIVERSITY AND INCLUSION – Educating yourself about being anti-racist. Compassion, empathy, culture and drivers					
No.	**Actions Required**	**Completed**	**Responsibility**	**Priority**	**RECA Linked Actions**
5.	Ensure there are clear actions and buy-in from the organisation by ensuring the EDI group is truly representative. The organisation should clearly communicate that racism will not be tolerated not least as there were 3 people from the sample which did not agree that this was being done. EDI strategy, planning and integration across the organisation to be discussed and results documented.	Yes/In Progress/No			7, 9, 15
6.	The principle of not accepting the unacceptable to be continually spread and endorsed with a Zero Tolerance Policy. Monitor regularly and robustly the mood of the organisation with appropriate tools and mechanisms to ensure that work in this area of Race Equality is moving in the right direction and across all divisions. The organisation should treat representation as a priority in the overall D&I plans and create the baseline to report on.	Yes/In Progress/No			8, 16, 29, 38
7.	Establish formal race diversity networks and encourage individuals to participate and use the networks to provide education opportunities. Consult with the networks (as appropriate) and allow the networks to contribute to decisions that have the potential to impact Black employees	Yes/In Progress/No			69

POLICY, POLITICS AND PARLIAMENT – Law, documents, responsibility, barriers and structural barriers					
No.	**Actions Required**	**Completed**	**Responsibility**	**Priority**	**RECA Linked Actions**
8.	The Race Equality Plan is to be presented to the People Committee in order to get assurance about the activities and positioning of the activity around ensuring it's not about re-assurance.	Yes/In Progress/No			14
9.	Explore how to ensure the Black Workers Support Group can be empowered, strategic and part of the governance framework whilst ensuring that it is truly representative. BAME FTSU champion to be discussed and the concept to be developed.	Yes/In Progress/No			17, 23
10.	The Chair Role Description to be reviewed to ensure that the responsibility for Race is included. Encourage more Board Observations, provide support and plan composition of committees so that the committees can ask the right questions and hold the non-executives responsible for staff well-being.	Yes/In Progress/No			25, 30, 33, 35
11	The organisation should do more to tackle racism and create clear actions and accountability for the board and senior leadership team which includes a review the Fair Treatment Policy. Review the governing documents to ensure race is fundamentally and consistently embedded ie (a) Ensure roles and responsibilities of the board and senior management relating to race accountability is documented and (b) Ensure that accountability is upheld and that the discourse on race informs board and committee discussions and decisions.	Yes/In Progress/No			6, 27, 51
12.	Create a clear accountability and meaningful framework to address the performance criteria and targets that have been set around race equality ensuring it is moving forward. This should include how decisions and how often monitoring reports are made to the board, ensuring that responsible board members and the senior leadership team are accountable for racial diversity. Actions as a result of such monitoring should be reported.	Yes/In Progress/No			37, 52

AWARENESS AND EDUCATION – Creating a workplace culture which is inclusive. Understanding underlying conditions, personal actions to be taken					
No.	**Actions Required**	**Completed**	**Responsibility**	**Priority**	**RECA Linked Actions**
13.	Review the behaviours that align with the organisation's values and use the opportunity to look at the training programme in the Statutory and Essential Training programme to include training around race. Ensure that all employees undertake Race Awareness Training. Undertake further work in developing the psychological safety in the organisation and review the Speaking Up Policy. Any plans developed should address the negative experiences some have had with harassment, bullying, discrimination or micro-aggressions.	Yes/In Progress/No			10, 21, 28, 45, 65
14.	Carry out further work in demonstrating how the data on diversity can have a positive impact create the cultural change needed. The work on EDI and the Race Code to be included in Stakeholder Engagement Surveys. Work on developing a more inclusive background for all employees but addressing this apparent gap when dealing with Black employees.	Yes/In Progress/No			13, 36, 40, 44
15.	Convene conversations involving Black people throughout the decision-making process in the workplace for active listening, and then make plans on agreed actions together with Black employees.	Yes/In Progress/No			59
16.	As part of the education of Black employees, employers to explain how success has been achieved. Senior managers to publish their job history internally (in a brief, LinkedIn style profile) so that junior members of the workforce can see what a successful career path looks like. The organisation to source or work with employee representatives, trade unions and third sector organisations to develop a simple guide on how to discuss race in the workplace.	Yes/In Progress/No			70

INFORMATION AND DATA GATHERING – Why and how to set targets					
No.	**Actions Required**	**Completed**	**Responsibility**	**Priority**	**RECA Linked Actions**
17.	The board reporting to include more specific and transparent mechanisms for reporting against actions in race equity including the strategy for dealing with Race inequity and the resources, financial and otherwise, that the organisation will commit to ensuring transformational change. Define in a more meaningful way what success looks like and what the organisation will do with the information that is being collected. Develop a house style to reporting with a particular focus on developing the equality impact assessment and ensuring that there is a race perspective. This will be in line with the meaningful measures in the true north and breakthrough model.	Yes/In Progress/No			19, 20, 24, 46
18.	Develop measures and effective targets and data that helps to usefully translate all the core requirements into useful indicators and find the best way to report/communicate them. Consider how the organisation can demonstrate how it has communicated across the organisation the importance of gathering this data and in particular to diverse groups, how it will benefit the organisation.	Yes/In Progress/No			12, 39, 41, 42
19.	Create a publicly available Anti-Racism Statement. This should make clear and promote that: (a) The organisation has zero tolerance of racism and(b) the organisation has zero tolerance of harassment and bullying. Report in the annual report and/or other employee publications on how the organisation have included its commitment to ensure there is a golden thread between achieving race equity, within its broader values and how this is aligned with its purpose and strategy.	Yes/In Progress/No			47, 48
20.	Measure the effectiveness of mechanisms to identify, develop and promote Black employees within the organisation in order to ensure over time, that there is a pipeline of board capable candidates and the senior leadership ranks appropriately reflect the importance of diversity to the organisation.	Yes/In Progress/No			50

REWARDS AND RECOGNITION – How to ensure fair treatment and consistency					
No.	**Actions Required**	**Completed**	**Responsibility**	**Priority**	**RECA Linked Actions**
21.	Review the Competency and Skills Framework and continue to gather the data around Race Pay and consider the actions that can be taken and those that are outside of the rights as an employer.	Yes/In Progress/No			18, 26
22.	Define how governors will hold non-executives to account for the Race Equality Code and broader EDI and when carrying out the Board Effectiveness Review a number of these race equality areas are to be adopted. Board performance should be measured in three ways; (a) Long-term - vision and culture going in the right direction, (b) Medium–term - processes are being developed and (c) Short–term - do people say the organisation is making a difference day to day. How can the organisation find tools to measure this?	Yes/In Progress/No			31, 32, 34
23.	Ensure that a review is carried out of the Board evaluation resource to ensure diversity objectives and indicators are covered. Make it clear that supporting equality in the workplace is the responsibility of all leaders and managers. Include a clear race diversity objective in all leaders' annual appraisal, (covering their responsibility to support fairness for all staff), with race diversity as a key performance indicator, to ensure that they take positive action seriously. Employee's performance reviews and remuneration to tie in with contributions to development in this area.	Yes/In Progress/No			43, 53

SPONSORING AND SUPPORT – Governance and top-down influences					
No.	**Actions Required**	**Completed**	**Responsibility**	**Priority**	**RECA Linked Actions**
24.	Led by board chairs, existing board directors to mentor and/or sponsor Black employees within the organisation where possible, to ensure their readiness to assume senior leadership positions internally, or non-executive board positions externally. Improve diversity in the talent pipeline including: - Embedding mentoring and sponsorship schemes in the organisation. - New entrants to the organisation to receive a proper induction, including basic and clear information on how the organisation's career progression works, it's pay and reward guidelines and how promotions are awarded - ensuring transparency on career pathways. - A robust Talent Management Strategy to fill current senior vacancies and future leadership pipelines. Increase participation levels from Black students in key programmes	Yes/In Progress/No			49, 57
25.	Identify and develop a pool of high potential Black leaders and senior managers as part of a cross-sector sponsorship/mentoring programme. Measure opportunities to provide work experience to Black people. Make clear arrangements to educate senior leaders to actively sponsor Black talent in the workplaces. All induction programmes to include modules to show how the career ladder works in the organisation (noting for Black employees that the stats may show a lack of career progression and may be structurally racist).	Yes/In Progress/No			60, 64, 66, 68
26.	Encourage and support candidates drawn from diverse backgrounds, including Black people, to take on Board roles internally (e.g. subsidiaries) where appropriate, as well as board and trustee roles with external organisations, to develop individuals' oversight, leadership and stewardship skills.	Yes/In Progress/No			61

7. APPENDICES

Appendix A
tgf Governance Code – 12 Principles
Resources (TIDY)

PRINCIPLE 1
The board should have a clear purpose, appropriate structures and an effective governance framework. As the custodian of corporate governance, it must be effective in strategically leading the organisation and have an appropriate constitutional framework with the essential functions recorded in its terms of reference and other relevant documentation. The core documents should show that Equality and Diversity is a board responsibility and an overarching principle with a focus on Race.

Our essential functions are recorded in our terms of reference and we are able to demonstrate our commitment to equality and diversity making specific reference to Race. There are clear aims for the work of our organisation that are supported by aims and objectives, amongst the overall strategy there is an alignment with the commitment to equality. There is a clear governance structure in place which describes how the organisation is accountable at the highest level for Race equity and is supported by an effective governance framework.

PRINCIPLE 2
The board should have access to the right reports and information and should present a fair and balanced assessment. This information should be appropriate and relevant and provided in an accurate and timely manner.

Information provided to the board is relevant, accurate and timely. This information presents a clear and balanced assessment of the organisation's position around Race and prospects. The information is such that is can be sufficiently scrutinised and monitored against our strategic plan. Good quality reports and data help to inform the work we do.

PRINCIPLE 3
The board should have the right documentation in place including forms, policies and registers. These documents should be in line with legal, statutory and best practice requirements.

We have a full suite of strategic policies with a policy review schedule that is actively monitored and all the necessary policies dealing with racial equality. To complement this, there are registers and forms in place that facilitate reporting and compliance with these policies which promote ethical practices. The relevant governance documentation is in place and is periodically reviewed.

PRINCIPLE 4
The board's roles and responsibilities around accountability for Race, including the division of responsibilities should be clearly defined. The organisation should have a profile of each board member and senior leadership team.

There is a clear division of responsibilities at board and executive level for who is accountable for Race. Roles are clearly defined in written documents that are up to date and reflect the current work of the organisation. These responsibilities are defined are also defined in delegated authorities or equivalent. Profiles of each board member and members of the executive team are readily available. A code of conduct has been adopted and the skills of the board are recently and accurately recorded and used to inform recruitment and succession planning.

Competency (BITE)

PRINCIPLE 5
The board should be diverse, balanced and suited to the needs of the organisation in its composition. Board and committee membership should be balanced taking into account knowledge, skills, experience, diversity, size and independence.

The board is balanced in relation to the proportion of executives and non-executives and overall diversity. Board members are competent, the board is the right size, and we have the right skills represented. The board and senior leadership ethnically diverse/The board and senior leadership team are working towards becoming more ethnically diverse. There is a positive culture that is in line with the organisation's values.

PRINCIPLE 6
The board should conduct themselves appropriately, avoiding conflicts of interest and adhering to an anti-racist behaviour. They should uphold ethically high standards of integrity and probity at all times, always acting in the best interests of the organisation.

The board lead by example and consider and undertake its corporate social responsibilities and demonstrate zero-tolerance to racism evidenced by the culture and values. Board members act with humility, good judgement, resilience and determination whilst safeguarding the ethos, vision and values of the organisation. Our board members seek to avoid conflicts of interest and declare them where this is not possible.

PRINCIPLE 7
The board should have clear processes for appointment, induction and training in place for board members to attract and retain black board members and employees. These processes should be robust, formal, rigorous and transparent and take succession planning into account. Board members should be appointed objectively on merit.

We have robust, formal, open, rigorous and transparent processes for appointment, induction and training of board members. Appointments to the board are made on merit. Board members devote sufficient time to their role. We have a nomination committee (or equivalent) to oversee these processes. Board members actively participate in training around Race and training needs identified at induction, during skills audits and appraisals are integrated into the annual calendar.

PRINCIPLE 8
The board should have effective processes for evaluation of itself as a whole, individual board member and its committees. The board should implement and oversee robust processes for the evaluation of its own effectiveness and performance and that of each board member. Evaluation should take place at regular intervals, including periodic external support.

We have effective processes in place to evaluate the performance of the board with EDI objectives / targets that include race for them as a board and for the organization. This evaluation takes place at regular intervals and is independently and externally facilitated every 3 years. The outcomes of these evaluations are actively monitored, and recommendations are implemented.

Execution (DOVE)

PRINCIPLE 9
The board should make informed decisions that take risk into account in ways that safeguard and promote the future success of the organisation. A sound decision–making framework that identifies and oversees its internal controls, risk appetite and mitigation should be established and monitored.

We have a sound decision-making framework in place that helps us to make informed decisions that take into account the risks faced by our organisation and how decisions around equality are made. Our decision-making framework identifies our internal controls, risk appetite, mitigation and the agreed processes for remuneration of our board members (where applicable) and senior executives with gender and race considerations. We ensure that getting race equality wrong is considered for the risk register reputationally and financially.

PRINCIPLE 10
The board should be able to evidence challenge, debate, accountability and transparency. The work of the board should be open, and they should be able to demonstrate sufficient scrutiny.

Our board scrutinises the work of the organisation and what it is doing about Race Equity. The work of the board is open, the executive is accountable to the board. There is evidence of debate and our work is open and transparent with healthy dialogue, trust and candour between stakeholders. The remuneration committee (or equivalent) exercises independent judgement when supervising and authorising remuneration.

PRINCIPLE 11
The board should be stewards of the vision, values and culture of the organisation and are responsible for setting and monitoring strategy. This should include monitoring the performance of the organisation in line with the vision and strategic objectives, there should be a golden thread that has equality at its core.

As a board, we actively monitor the organisation's strategy and act as stewards of the vision, values and culture ensuring equality and inclusion is at the core whilst reviewing ethnicity. We periodically review the strategic objectives and take into account the long-term success of the company.

PRINCIPLE 12
The board should be able to demonstrate active and effective engagement with stakeholders. Board members should act as ambassadors for the organisation and always seek to encourage meaningful and effective participation from all stakeholder groups targeting Black communities. They should be responsive to the needs of all stakeholders.

We actively engage with our stakeholders and take their views into account when making decisions. We ensure that we are responsive to the needs to all stakeholder groups and encourage their active participation making specific engagement with Black and other non-white groups. The board, including the chair, act as ambassadors for the organisation reaching into local communities.

Appendix B

Diagnostic Document Review (DDR)

A desktop review of the following documentation was undertaken as part of the DDR.

Section 1 - General

No.	Document	Evidence/Comments to include document dates and review timescales where applicable.	Yes	Partial	No	N/A
1.1	Performance Management Framework (NB: What are the targets and the appraisal process?)		☐	☐		☐
1.2	Corporate Plan (including Vision, Mission, Objectives) (NB: Is race in the strategic objectives?)	Your vision and corporate documents clear		☐	☐	☐
1.3	Documentation describing Values and Company Ethos (NB: Where is the organisation in relation to equity, fairness and inclusion and how does this feature in the values and other strategic statements?)	V. good. Bursting with diversity images and references You state and define – e.g. people focussed leading people performance and change		☐	☐	☐
1.4	Diversity and Inclusion Statement (NB: Looking for the organisation's stance/position?)			☐	☐	☐
1.5	Anti-Racism Statement (NB: Is this integrated or just a statement?)	does not have an Anti-Racism Statement	☐	☐		☐
1.6	Brochures and/or Marketing Material (NB: Looking for the organisation's promotion/support of race in its literature and any obvious social media?)	Broad approach to EDI	☐		☐	☐
1.7	Newsletters (Internal and/or External)	Images of diversity as appropriate		☐	☐	☐

Section 2 – Terms of Reference

No.	Document	Evidence/Comments to include document dates and review timescales where applicable.	Yes	Partial	No	N/A
2.1	Board	Documentation to include specific references to accountability to the various committees and working groups.	☐		☐	☐
2.2	Any relevant Committees which address Diversity and Inclusion (NB: If this committee is present, what level of authority is there in relation to race initiative?)		☐		☐	☐
2.3	Schedule of Matters Reserved for the Board			☐	☐	☐
2.4	Committees (all) (NB: What level of executive leadership or support is there? Is the committee a network or staff group with a voice to inform strategic direction? What does the Nominations or Remuneration Committee say about race?)			☐	☐	☐
2.5	Calendar of Meetings			☐	☐	☐

Actions

1. Clear EDI objectives to be identified
2. Develop the workings of the EDI group
3. People Committee to include Race Objectives in the TOR and work programme

Section 3 – Roles and Responsibilities

No.	Document	Evidence/Comments to include document dates and review timescales where applicable.	Yes	Partial	No	N/A
3.1	Role Descriptions and Person Specifications for the following (NB: Check for who is responsible and get a flavour of their understanding?)					
	(a) Board Members	Standard		☐	☐	☐
	(b) Chair	Standard		☐	☐	☐
	(c) Company Secretary	Standard		☐	☐	☐
	(d) Committee Chairs	Not presented as part of DDR	☐	☐	☐	
	(e) Deputy/Vice-Chair	Not presented as part of DDR	☐	☐	☐	
	(f) Senior Independent Director	Standard		☐	☐	☐
	(g) Chief Executive	Standard		☐	☐	☐
3.2	Board Member Profiles	Standard		☐	☐	☐
3.3	Senior Leadership Team Profiles	Standard		☐	☐	☐

Section 4 – Conduct

No.	Document	Evidence/Comments to include document dates and review timescales where applicable.	Yes	Partial	No	N/A
4.1	Code of Conduct Policy (or equivalent) (NB: What about psychological safety and how people are treated. Are there microaggressions provides as examples?)	C of C is to standard, however would benefit from being specific about psychological safety; defining what constitutes BHD; and signposting to grievance policy in the event someone feels they are not being treated fairly.		☐	☐	☐
4.2	Code of Ethics (if separate from code of conduct document) (NB: Is there a specific area that covers EDI or one specifically on race?)		☐	☐	☐	

Section 5 – Board Member Resources

No.	Document	Evidence/Comments to include document dates and review timescales where applicable.	Yes	Partial	No	N/A
5.1	Skills Matrix and/or Skills Report (NB: Is there a focus on race and skills/ experience?)		☐	☐		☐
5.2	Succession Plan (NB: Is there a talent pipeline and what specifically in being done to bring people through from other less represented areas but particularly race?)		☐	☐		☐
5.3	Induction Pack (and checklist)		☐	☐		☐
5.4	Recruitment Pack			☐	☐	☐
5.5	Board Evaluation		☐		☐	☐

Section 6 – Staff and Stakeholder

No.	Document	Evidence/Comments to include document dates and review timescales where applicable.	Yes	Partial	No	N/A
6.1	Stakeholder Engagement Analysis Report/Plan			☐	☐	☐
6.2	Staff Engagement Analysis Report/Plan		☐		☐	☐
6.3	Performance Management Criteria	Not presented as part of DDR	☐	☐	☐	

Section 7 – Board Administration

No.	Document	Evidence/Comments to include document dates and review timescales where applicable.	Yes	Partial	No	N/A
7.1	Last 2 Board Meeting Minutes			☐	☐	☐
7.2	Last 2 Board Packs/Reports			☐	☐	☐

Section 8 – Policies

No.	Document	Evidence/Comments to include document dates and review timescales where applicable.	Yes	Partial	No	N/A
8.1	List of Strategic Board Policies and Review Schedule	Not presented as part of DDR	☐	☐	☐	
8.2	Board Recruitment Policy (NB: Are agencies briefed and what does the recruitment panel look like in terms of race?)	Not presented as part of DDR	☐	☐	☐	
8.3	Board Induction Policy (NB: Is there a focus on race as part of the induction?)	Not presented as part of DDR	☐	☐	☐	
8.4	Board Renewal and Review Policy or Succession Policy	Not presented as part of DDR	☐	☐	☐	
8.5	Board Training & Development Policy (NB: Is there anti-racism training specifically?)	Not presented as part of DDR	☐	☐	☐	
8.6	Bullying and Harassment Policy		☐		☐	☐
8.7	Complaints Policy			☐	☐	☐
8.8	Equality & Diversity Policy (or equivalent) (NB: Start with this policy and see how others are linked to it?)		☐		☐	☐
8.9	Staff Training & Development Policy			☐	☐	☐
8.10	Whistleblowing Policy			☐	☐	☐

Action

4. Fair Treatment Policy to refer to safe place, micro aggressions etc
5. Statutory and Essential Training Policy to include Race training

Review/Discuss at the Meeting (Assessor: You may enquire about the documentation below during the assessment, but you do not need to see these)

Section 9 – Board Member Resources

No.	Document	Evidence/Comments to include document dates and review timescales where applicable.	Yes	Partial	No	N/A
9.1	Governing Document – i.e. Constitution, Articles of Association, Model Rules			☐	☐	☐
9.2	Declaration of Interests Register	Standard		☐	☐	☐
9.3	Gifts and Hospitality Register	Standard		☐	☐	☐
9.4	Declaration of Directorship Form	Standard		☐	☐	☐
9.5	Risk Plan/Register	Not presented as part of DDR	☐	☐	☐	

Review Prior to the Meeting (Assessor: You will need to explore the following areas prior to the consultation to possibly incorporate into the discussion as well as the report)

Section 10 – Digital Presence/Social Media Platforms

No.	Document	Evidence/Comments to include document dates and review timescales where applicable.	Yes	Partial	No	N/A
10.1	Website	Diversity images and refs as appropriate		☐	☐	☐
10.2	Facebook Page/Posts	Diversity images and refs as appropriate		☐	☐	☐
10.3	Instagram Page/Posts		☐	☐	☐	
10.4	LinkedIn Page/Posts/Articles	Standard		☐	☐	☐
10.5	Twitter Page/Feed	Standard		☐	☐	☐
10.6	YouTube Channel		☐	☐	☐	☐
10.7	Accessibility and Links	Standard		☐	☐	☐
10.8	Customer Experience/ User Friendly			☐	☐	☐

Appendix C
Drivers

D Diversity	Representation of diverse talent is an essential element of inclusion. We must include RACE and it's time to address the inequalities Black people face. It has long been accepted that boards need to be sufficiently skilled to be able to engage in effective decision making, but how is ethnic diversity considered when looking at the composition of the boardroom and senior leadership team?
R Responsibility	Accountability for and capability to impact race inequity in the leadership and wider Equality, Diversity and Inclusion will have the desired impact when the core leadership team are at the centre. The responsibility to tackle inequality does not sit with one individual or department but is organisation wide. The tone is set top-down rather than bottom-up, and it is the board which should promote and demonstrate that there is a 'no-excuses' attitude towards discrimination and racial injustice.
I Integrity	Organisations need to be clear about their own data in regard to ethnic representation and create meaningful solutions demonstrating what actions they will be accountable for, in addition to the bold statements. Integrity of an organisation is elevated by transparency in processes and reporting, and ensuring that its objectives are reviewed, monitored and re-evaluated over time.
V Values	Black leaders are not a novelty; increasing the proportion of Black representation is not tokenism. Recruiting in a diverse manner does not require the organisation to lower its standards. On the contrary, recognition of ethnicity as a key diversity component will have a positive and sustainable impact for every organisation. Adopters of the Code must value different lived experience and look to integrate and provide space for perspectives, thoughts and practises that may be different, but should never be underestimated. Fairness and Transparency underpin a zero-tolerance policy towards racism.
E Equity	Introducing policy around race inequality is more than just a moral imperative - doing what is right. It is about working towards creation of a level playing field where, in the context of merit, Black people are not only fairly recruited but thrive. Opportunity is enabled by creating opportunity through fairness and transparency.
R Reality	It's time for change, this is the tipping point and Race needs to be talked about and addressed in the fight for equality. The regularity of the reporting will be crucial to transparency, ensuring that a balance is met between maintaining the impetus for change and allowing for a proper period of assessment, with meaningful reporting on the results. Transparency requires both an acknowledgement of successes and constructive criticism of shortcomings.
S Society	Each organisation has a part to play in society and it starts with fostering an inclusive and belonging culture, engaging with the wider community appropriately. Educating themselves and creating psychologically safe working environments is an integral part of their social contract. At a time when there are so many questions regarding the exercise of power, it is for boards to ensure that they are exercising their duties in a socially responsible way that does not shy away from the key issue of equality and diversity and seeks to redress the balance with fairness and transparency.

This Governance Action Plan Report has been prepared by **the governance forum** using the results of a comprehensive governance diagnostic review carried out with this Organisation and forms part of the Organisation's Board Effectiveness Review and self-assessment framework.

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RACE Action Plan (RAP)
Combined Action Points of All Sections

RECRUITMENT AND INDUCTION – Business and process for inclusive recruitment and panels						
No.	**Actions Required**	**Organisation Response**	**Responsibility**	**Success Measure**	**Priority** (months)	**RECA Linked Actions**
1.	Review the vision and values and induction resources where Race is expected to be reflected. The organisation should examine what it can do to stop/counter any barriers that exist to limit the attraction, recruitment and retention of black people into the board and SLT. Senior management teams, executive boards and those with a role in the recruitment process, to go further than taking mandatory training and undertake more comprehensive workshops that tackle bias.	Incorporation into refreshed True North and Breakthrough objectives. Refresh of corporate and local induction processes Review of SET training and enhanced leadership programmes	Executive Team		June 2021	11, 22, 67
2.	Ensure formal interview processes are held for all roles and that diversity quotas around race are set and met during recruitment (panels) and interview/short-listing and any recruitment agencies used. Ensure proportional representation on long and short recruitment selection lists and reject lists that do not reflect the local and/or stakeholder working age population. Ensure that the selection and interview process is undertaken by more than one person and should ideally include individuals from Black backgrounds to help eliminate bias (ensuring a diverse interview panel).	Review of recruitment and selection policy with regard to interview panels.	DP&OD		October 2021	54, 62
3.	The Nomination Committee to require the human resources teams or search firms (as applicable), to identify and present qualified Black people and other ethnic groups to be considered for board appointment when vacancies occur. Ensure that any executive search firm used follows the Standard Voluntary Code of Conduct for Executive Search Firms that the relevant principles of that code be extended on a similar basis to the recruitment of Black and other ethnic candidates. Executive Recruiters to be demonstrably proactive in identifying and marketing talented Black candidates and be provided with specific targets	As required	DP&OD		Ongoing	55, 56, 58
4.	Critically examine entry requirements into their business, focusing on potential achievement and not simply which university or school the individual went to (challenging school and university selection bias).	Ensure included explicitly within Recruitment and selection policy	DDP&OD		October 2021	63

EQUALITY, DIVERSITY AND INCLUSION – Educating yourself about being anti-racist. Compassion, empathy, culture and drivers						
No.	**Actions Required**	**Organisation Response**	**Responsibility**	**Success Measure**	**Priority** (months)	**RECA Linked Actions**
5.	Ensure there are clear actions and buy-in from the organisation by ensuring the EDI group is truly representative. The organisation should clearly communicate that racism will not be tolerated not least as there were 3 people from the sample which did not agree that this was being done. EDI strategy, planning and integration across the organisation to be discussed and results documented.	Ensure that the EDI forum has representation from across the Trust. Refresh of EDI policy statement and Fair Treatment for All policy			May 2021	7, 9, 15
6.	The principle of not accepting the unacceptable to be continually spread and endorsed with a Zero Tolerance Policy. Monitor regularly and robustly the mood of the organisation with appropriate tools and mechanisms to ensure that work in this area of Race Equality is moving in the right direction and across all divisions. The organisation should treat representation as a priority in the overall D&I plans and create the baseline to report on.	Regular surveys to be conducted	Head of Leadership & OD; Head of Communications & Engagement		ongoing	8, 16, 29, 38

7.	Establish formal race diversity networks and encourage individuals to participate and use the networks to provide education opportunities. Consult with the networks (as appropriate) and allow the networks to contribute to decisions that have the potential to impact Black employees	Support the ongoing development of the BAME staff network	EDI lead		ongoing	69

POLICY, POLITICS AND PARLIAMENT – Law, documents, responsibility, barriers and structural barriers

No.	Actions Required	Organisation Response	Responsibility	Success Measure	Priority (months)	RECA Linked Actions
8.	The Race Equality Plan is to be presented to the People Committee in order to get assurance about the activities and positioning of the activity around ensuring it's not about re-assurance.	Scheduled for May 2021. Regular reports thereafter	DP&OD		May 2021	14
9.	Explore how to ensure the Black Workers Support Group can be empowered, strategic and part of the governance framework whilst ensuring that it is truly representative. BAME FTSU champion to be discussed and the concept to be developed.	Support the ongoing development of the BAME staff network. FTSU forum to include the BAME staff network chair as a minimum. Recruitment of BAME FTSU champions	EDI lead FTSU Guardian		June 2021	17, 23
10.	The Chair Role Description to be reviewed to ensure that the responsibility for Race is included. Encourage more Board Observations, provide support and plan composition of committees so that the committees can ask the right questions and hold the non-executives responsible for staff well-being.	Refresh of Board agenda and development sessions. Board evaluation process to continue.	Company Secretary			25, 30, 33, 35
11	The organisation should do more to tackle racism and create clear actions and accountability for the board and senior leadership team which includes a review the Fair Treatment Policy. Review the governing documents to ensure race is fundamentally and consistently embedded ie (a) Ensure roles and responsibilities of the board and senior management relating to race accountability is documented and (b) Ensure that accountability is upheld and that the discourse on race informs board and committee discussions and decisions.	Review of Fair Treatment for All Policy. Refresh of Director role descriptors. Regular discussion in relation to race at Board and committee meetings	DP&OD Chief Executive			6, 27, 51
12.	Create a clear accountability and meaningful framework to address the performance criteria and targets that have been set around race equality ensuring it is moving forward. This should include how decisions and how often monitoring reports are made to the board, ensuring that responsible board members and the senior leadership team are accountable for racial diversity. Actions as a result of such monitoring should be reported.	Regular reports on WRES to the Board of Directors and People Committee	EDI lead		Ongoing	37, 52

AWARENESS AND EDUCATION – Creating a workplace culture which is inclusive. Understanding underlying conditions, personal actions to be taken

No.	Actions Required	Organisation Response	Responsibility	Success Measure	Priority (months)	RECA Linked Actions
13.	Review the behaviours that align with the organisation's values and use the opportunity to look at the training programme in the Statutory and Essential Training programme to include training around race. Ensure that all employees undertake Race Awareness Training. Undertake further work in developing the psychological safety in the organisation and review the Speaking Up Policy. Any plans developed should address the negative experiences some have had with harassment, bullying, discrimination or micro-aggressions.	Develop behaviours to complement the Trust values. Review the training available for race equality to include within SET. Refresh of Speaking Up policy. Just and learning culture.	DP&OD EDI lead FTSU Guardian			10, 21, 28, 45, 65
14.	Carry out further work in demonstrating how the data on diversity can have a positive impact create the cultural change needed. The work on EDI and the Race Code to be included in Stakeholder Engagement Surveys. Work on developing a more inclusive background for all employees but addressing this apparent gap when dealing with Black employees.	Inclusive and compassionate leadership as part of the leadership development programme	Head of Leadership & OD		In place	13, 36, 40, 44
15.	Convene conversations involving Black people throughout the decision-making process in the workplace for active listening, and then make plans on agreed actions together with Black employees.	Engage with the BAME staff network to develop approach to be adopted. Reciprocal mentoring programme	EDI lead		Ongoing	59

16.	As part of the education of Black employees, employers to explain how success has been achieved. Senior managers to publish their job history internally (in a brief, LinkedIn style profile) so that junior members of the workforce can see what a successful career path looks like. The organisation to source or work with employee representatives, trade unions and third sector organisations to develop a simple guide on how to discuss race in the workplace.	Reciprocal mentoring programme	EDI lead		In place	70

INFORMATION AND DATA GATHERING – Why and how to set targets

No.	Actions Required	Organisation Response	Responsibility	Success Measure	Priority (months)	RECA Linked Actions
17.	The board reporting to include more specific and transparent mechanisms for reporting against actions in race equity including the strategy for dealing with Race inequity and the resources, financial and otherwise, that the organisation will commit to ensuring transformational change. Define in a more meaningful way what success looks like and what the organisation will do with the information that is being collected. Develop a house style to reporting with a particular focus on developing the equality impact assessment and ensuring that there is a race perspective. This will be in line with the meaningful measures in the true north and breakthrough model.	Source best practice examples	EDI lead			19, 20, 24, 46
18.	Develop measures and effective targets and data that helps to usefully translate all the core requirements into useful indicators and find the best way to report/communicate them. Consider how the organisation can demonstrate how it has communicated across the organisation the importance of gathering this data and in particular to diverse groups, how it will benefit the organisation.	Incorporation of WRES data into dashboard reporting. Communication strategy to encourage colleagues to provide data.	EDI lead			12, 39, 41, 42
19.	Create a publicly available Anti-Racism Statement. This should make clear and promote that: (a) The organisation has zero tolerance of racism and(b) the organisation has zero tolerance of harassment and bullying. Report in the annual report and/or other employee publications on how the organisation have included its commitment to ensure there is a golden thread between achieving race equity, within its broader values and how this is aligned with its purpose and strategy.	Inclusion with Annual report. Develop anti-racism statement	EDI lead Head of Communications and Engagement			47, 48
20.	Measure the effectiveness of mechanisms to identify, develop and promote Black employees within the organisation in order to ensure over time, that there is a pipeline of board capable candidates and the senior leadership ranks appropriately reflect the importance of diversity to the organisation.	Develop approach to talent management. Use of WRES data to identify trend of BAME senior leadership	Head of Leadership &OD EDI lead			50

REWARDS AND RECOGNITION – How to ensure fair treatment and consistency

No.	Actions Required	Organisation Response	Responsibility	Success Measure	Priority (months)	RECA Linked Actions
21.	Review the Competency and Skills Framework and continue to gather the data around Race Pay and consider the actions that can be taken and those that are outside of the rights as an employer.	Undertake a Race Pay gap analysis to assess implications and determine action plan	EDI lead			18, 26
22.	Define how governors will hold non-executives to account for the Race Equality Code and broader EDI and when carrying out the Board Effectiveness Review a number of these race equality areas are to be adopted. Board performance should be measured in three ways; (a) Long-term - vision and culture going in the right direction, (b) Medium–term - processes are being developed and (c) Short–term - do people say the organisation is making a difference day to day. How can the organisation find tools to measure this?	Company secretary to consider how to achieve this action	Company Secretary			31, 32, 34

23.	Ensure that a review is carried out of the Board evaluation resource to ensure diversity objectives and indicators are covered. Make it clear that supporting equality in the workplace is the responsibility of all leaders and managers. Include a clear race diversity objective in all leaders' annual appraisal, (covering their responsibility to support fairness for all staff), with race diversity as a key performance indicator, to ensure that they take positive action seriously. Employee's performance reviews and remuneration to tie in with contributions to development in this area.	Inclusion of race equality in all board members objectives. Consider approach to the 2021/22 Board evaluation review	Chair and Chief Executive			43, 53

SPONSORING AND SUPPORT – Governance and top-down influences

No.	Actions Required	Organisation Response	Responsibility	Success Measure	Priority (months)	RECA Linked Actions
24.	Led by board chairs, existing board directors to mentor and/or sponsor Black employees within the organisation where possible, to ensure their readiness to assume senior leadership positions internally, or non-executive board positions externally. Improve diversity in the talent pipeline including: ❒ Embedding mentoring and sponsorship schemes in the organisation. ❒ New entrants to the organisation to receive a proper induction, including basic and clear information on how the organisation's career progression works, it's pay and reward guidelines and how promotions are awarded - ensuring transparency on career pathways. ❒ A robust Talent Management Strategy to fill current senior vacancies and future leadership pipelines. Increase participation levels from Black students in key programmes	Introduction of reciprocal mentoring programme Refresh of induction programme Development of Talent Management strategy	EDI lead Head of Leadership & OD			49, 57
25.	Identify and develop a pool of high potential Black leaders and senior managers as part of a cross-sector sponsorship/mentoring programme. Measure opportunities to provide work experience to Black people. Make clear arrangements to educate senior leaders to actively sponsor Black talent in the workplaces. All induction programmes to include modules to show how the career ladder works in the organisation (noting for Black employees that the stats may show a lack of career progression and may be structurally racist).	Reciprocal mentoring programme commencing April 2021, aspiring leaders identified.	EDI lead			60, 64, 66, 68
26.	Encourage and support candidates drawn from diverse backgrounds, including Black people, to take on Board roles internally (e.g. subsidiaries) where appropriate, as well as board and trustee roles with external organisations, to develop individuals' oversight, leadership and stewardship skills.	Associate NED programme Extension of Shadow Board programme Leading to Outstanding programme for senior leaders	DP&OD			61

Appendix Level1

OUR VISION : To be the safest trust in England, outstanding in all that we do

True North Strategic Aim 4 – In recurrent surplus to invest in improving patient care

Risk Owner: Trust Board **Committee: F&P**	**People, Partners, Performance, Patients**	**Date last reviewed : April 2021**	
Strategic Objective In recurrent surplus to invest in improving patient care **Breakthrough Objective** Every team achieves their financial plan for the year	**Risk Appetite:** The Trust has a **low appetite** for risks **Measures:** • Delivery of in year financial plan/budgets • Underlying/recurrent financial position of the Trust • Trust Cash Balances	**Initial Risk Rating** **Current Risk Rating** **Target Risk Rating**	5(C) x 5(L) = 25 extr 5(C) x 4(L) = 20 extr 3(C) x 3(L) = 9 low
Risks: • Lack of clarity regarding the future NHS financial regime: ➢ Trust's underlying deficit financial position ➢ Limited capital funding • Uncertainty with regards to the future of Commissioning arrangements • Culture Risk – Impact of COVID on re-engaging Divisions with financial processes and controls • Robust plans required for the delivery of operational activity requirements in H1 of 21/22 to meet 85% required standards for H1 of 21/22 within baseline resource and funding. • Delivery of ERF - Guidance (including those requirements that are not activity related) is not currently clear in terms how this will be measured or achieved. - ERF will be casemix adjusted based on work done, not volumes early trust plans look at increasing lower value work - ICS hold/manage all funding and are developing a financial framework for ERF which will likely lead to orgs who under-deliver against targets losing funding. • Lack of clarity in terms of the Trust's bed plan and therefore costs of workforce plans. • H2 – currently there is no guidance for the second half of the year with the potential that system top up funding is removed causing a potential significant deficit in the second half of the year for the Trust of c.£14m.	**Rationale for risk current score:** • Currently the Trust is in a significant underlying deficit position with significant uncertainty regarding the future financial regime and availability of capital. This impacts on: • Trust's ability to invest in its services and infrastructure. • Delivery of safe and sustainable services for patients including any backlogs in activity due to COVID. • Ensuring the sustainability and safety of the Doncaster site. • Impacts on Trust reputation with potential regulatory action • Impacts on level of input and influence with regards to local commissioning.	**Future risks:** NHS Sector financial landscape Regulatory Intervention • National guidance is awaited regarding understand how the financial regime will impact the Trust this year and into future years. **Risk references:** • **F&P1, 2 and 3** • **F&P2** • **F&P3** **Opportunities:** • Change in practices, new ways of working	
Controls / assurance (mitigation & evidence of making impact): • Budget setting and business planning • Key Financial Control Processes: Vacancy Control Panel, CIG, Grip and Control, Capital Monitoring Committee, Cash Committee. • External and Internal Audit • Reporting to Board, F&P and Audit Committee, ICS and NHSE/I • ICS DoFs and Contract Board with Commissioners • Working with the ICS through CEO's and DoFs regarding the rules on ERF and funding arrangements. Reporting back through F&P and Board. • Work with DoN to support on bed plan, with bed plan presented back to F&P.	**Comments:** • The indications nationally are that previous years spend levels will be used as the basis of reviewing and setting financial positions. Since the Trust had not implemented a number of now agreed business cases/commitments (e.g. ED etc.) or recruited to establishment levels (e.g. nursing), these along with any other increase in the expenditure run rate above previous years levels will be challenged and likely not funded. • Currently there is no clear route to funding for significant builds. Limited capital will impact on the Trust's ability to invest in the Trust's infrastructure, especially with regards to ensuring the sustainability and safety of the Doncaster site.	**Assurance (evidence of making an impact):** • Delivery of financial position • Improvement in underlying financial position • Improvement in site infrastructure • Internal and External Audit • Feedback from NHSI/E **Gaps in controls / assurance (actions to achieve target risk score):** • Uncertainty regarding future financial regime	

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Trust Board**		
Meeting Date:	**20/4/21**	**Agenda Reference:**	**E4**
Report Title:	**Financial Performance – Month 12 March 2021**		
Sponsor:	**Jon Sargeant - Director of Finance**		
Author:	**Alex Crickmar – Deputy Director of Finance** **Jon Sargeant - Director of Finance**		
Appendices:			

Executive Summary	
Purpose of report:	To report the draft month 12 financial position to the Trust Board.
Summary of key issues:	The Trust's surplus for month 12 (March 2020) was £4.3m (excluding donated assets), which is c. £5.2m favourable to plan. The Trust's YTD position is a £4.1m surplus excluding donated assets (£5.5m including donated assets). Therefore, the Trust achieved its forecast required financial performance for the year which was a break-even position. The favourable variance against the breakeven forecast, is driven in by the Trust receiving c£4m of additional funding from NHSE/I relating to the additional costs of increased annual leave (due to increase in carried forward leave due to COVID). Please note the annual leave accrual funding (notified in month 12) and 'lost' NHS income (received in month 11) is subject to change post submission of the Trust's key data return on the 19th April. Therefore, this position is draft and is subject to change. The other key area under review is a potential staff pay issue that we have been made aware of and is being assessed by P&OD. Capital expenditure in month 12 is £11.0m, with annual capital expenditure being £36.3m, including COVID-19 capital spend of £1.5m and donated asset spend of £1.9m. This is £1.0m behind the £37.4m original plan but is £0.1m ahead of the forecast (excluding donated assets). Thereby the Trust achieved its revised capital plan. The cash balance at the end of March was £51.7m (February: £77.1m). Cash has fallen as a result of the Trust not receiving Block income in the month, reversing that the Trust received two months' worth of the block income in April 2020 as a cash advance (which was the same for all Trust's nationally). The Trust also received £10.1m of PDC Dividend for capital schemes in month, and there are capital creditors of £11.6m at March 2021.
Recommendation:	The Board is asked to note: • The Trust's surplus for month 12 (March 2020) was £4.3m. • The Trust's draft year end financial position is a £4.1m surplus.

Action Require:	Approval	Information	Discussion	Assurance	Review
		X			

	TN SA1:	**TN SA2:**	**TN SA3:**	**TN SA4:**

Link to True North Objectives:	*To provide outstanding care for our patients*	*Everybody knows their role in achieving the vision*	*Feedback from staff and learners is in the top 10% in the UK*	***The Trust is in recurrent surplus to invest in improving patient care***

Implications	
Board assurance framework:	This report relates to strategic aims 2 and 4 and the revised BAF risk F&P1.
Corporate risk register:	See above
Regulation:	No issues
Legal:	No issues
Resources:	No issues

Assurance Route			
Previously considered by:	N/A		
Date:		**Decision:**	
Next Steps:			
Previously circulated reports to supplement this paper:			

FINANCIAL PERFORMANCE

Month 12 – March 2021

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

P12 March 2020

1. Income and Expenditure vs. Plan

Performance Indicator	Monthly Performance		YTD Performance		
	Actual £'000	Variance to budget £'000	Actual £'000	Variance to budget £'000	Plan £'000
I&E Perf Exc Impairments & top up	(5,941)	(6,862) F	(5,496)	(14,052) F	921
Income	(63,106)	(25,653) F	(467,492)	(29,858) F	(37,453)
Operating Expenditure	56,317	19,420 A	447,278	17,629 A	36,897
Pay	37,740	12,171 A	302,483	7,340 A	25,570
Non Pay & Reserves	18,577	7,250 A	144,795	10,290 A	11,327
Financing costs	2,489	1,011 A	16,159	(382) F	1,478
I&E Performance excluding Donated Asset adjustment	**(5,941)**	**(6,862) F**	**(5,496)**	**(14,052) F**	**921**
Donated Asset adjustment	1,641	1,641 A	1,441	1,441 A	0
I&E Performance including Donated Asset Adjustment	**(4,300)**	**(5,221) F**	**(4,055)**	**(12,611) F**	**0**

F = Favourable A = Adverse

Financial Sustainability Risk Rating	Plan	Actual
Risk Rating	3	3

2. CIPs

Performance Indicator	Monthly Performance		YTD Performance		Annual
	Actual £'000	Variance to budget £'000	Actual £'000	Variance to budget £'000	Plan £'000
Local	25	810 A	632	606 A	1,238
Nursing and AHP workforce	1	2 A	7	35 A	42
Medical Workforce	47	99 A	167	483 A	650
Outstanding Outpatients	0	1 A	0	3 A	3
Procurement	17	10 A	160	0 A	160
Total	**91**	**922 A**	966	**1,128 A**	**2,094**

3. Statement of Financial Position

All figures £m	Opening Balance	Closing balance	Movement in year
Non Current Assets	**213,162**	**237,055**	**23,893**
Current Assets	63,216	77,100	**13,884**
Current Liabilities	-130,077	-69,545	**60,532**
Non Current liabilities	-16,657	-14,788	**1,869**
Total Assets Employed	**129,644**	**229,822**	**100,178**
Total Tax Payers Equity	**-129,644**	**-229,822**	**-100,178**

4. Other

Performance Indicator	Monthly Performance		YTD Performance		Annual
	Plan £'000	Actual £'000	Plan £'000	Actual £'000	Plan £'000
Cash Balance		50,948		50,948	28,011
Capital Expenditure	6,999	11,042	37,374	36,345	34,370

5. Workforce

	Funded WTE	Actual WTE	Bank WTE	Agency WTE	Total in Post WTE
Current Month	6,241	5,707	258	300	6,265
Previous Month	6,240	5,766	160	106	6,032
Movement	-1	59	-98	-194	-233

Key

Income		Expenditure	
Over-achieved	F	Overspent	A
Under-achievement	A	Underspent	F

1. Month 12 Financial Position Highlights

Summary Income and Expenditure – Month 12

	Mth 12			YTD	
	Plan	Actual	Variance	Actual	Variance
	£000	£000	£000	£000	£000
Income	**-37,453**	**-63,106**	**-25,653**	**-467,492**	**-29,858**
Pay					
Substantive Pay	24,061	34,871	10,810	277,111	2,486
Bank	243	1,173	929	9,295	4,263
Agency	682	1,124	443	8,874	445
Recharges	583	572	-11	7,204	146
Total pay	**25,570**	**37,740**	**12,171**	**302,483**	**7,340**
Non-Pay					
Drugs	871	883	12	8,353	-296
Non-PbR Drugs	1,511	1,755	244	18,107	247
Clinical Supplies & Services	2,522	7,180	4,657	31,524	4,417
Other Costs (including reserves)	5,275	7,696	2,421	72,223	5,180
Recharges	1,148	1,064	-84	14,587	742
Total Non-pay	**11,327**	**18,577**	**7,250**	**144,794**	**10,290**
Financing costs & donated assets	**1,478**	**2,489**	1,011	**16,159**	**-382**
(Surplus) / Deficit Position as at month 12	**921**	**-4,300**	**-5,221**	**-4,056**	**-12,611**

(Note: Within other costs/reserves is the increase in annual leave accrual, this will be allocated to pay in the accounts)

The Trust's surplus for month 12 (March 2020) was £4.3m (excluding donated assets), which is c. £5.2m favourable to plan. The Trust's YTD position is a £4.1m surplus excluding donated assets (£5.5m including donated assets). Therefore, the Trust achieved its forecast required financial performance for the year which was a break-even position. The favourable variance against the breakeven forecast, is driven in by the Trust receiving c£4m of additional funding from NHSE/I in month 12 relating to the additional costs of increased annual leave (due to increase in carried forward leave due to COVID).

Please note the annual leave accrual funding (notified in month 12) and 'lost' NHS income (received in month 11) is subject to change post submission of the Trust's key data return on the 19th April. Therefore, this position is draft and is subject to change. The other key area under review is a potential staff pay issue that we have been made aware of and is being assessed by P&OD.

The underlying favourable variance against plan was driven in year by activity being lower than Divisional plans to reinstate activity, continued unfilled vacancies, underspend against the winter plan, lower PDC (due to the cash advance) and non-clinical income being above plan.

In month 12 several key transactions have been included within the position to bring to the Board's attention, including:

- Annual Leave Income from NHSE/I of - £4m
- Flowers (National claim against pay rates for holidays) - £1.1m (income and expenditure)
- Pension top up - £11.1m (income and expenditure)
- Donated Assets for NHS E Loan Scheme (these are assets provided by the NHS free of charge to Trusts during the wave 1 of covid to support patient care) - £1.6m (income and capital)
- CCG restoration income (additional funding to treat patients above covid funding) and costs c.£1m (mainly Medinet and Pain outsourcing)
- Impact of stock movements c£0.9m (£0.6m at M11).

- Education income and expenditure c. £0.9m
- Centrally Procured Stock (PPE for Covid) of c. £4.4m
- Outsourcing clawback risk which had been accrued to month 11 as previously reported has not been included at month 12 (c. £2m)

The clinical income position reported is aligned to the revised national block arrangements and central top ups. In month 12, significant additional income has been received for a number of areas as outlined above (clinical and non-clinical income).

Activity levels across most points of delivery (POD) continue to be lower than the normal Trust averages (19/20) and below Divisional plans as shown in the table below. However, there was an increase in activity in month compared to February, including:

- Overall outpatient attendances increased in March in both physical and non-physical attendances especially for follow ups.
- A&E saw a significant increase of in month activity, in which there were high number of activities relating to 'no investigation with no significant treatments'.
- Increase in Day Case activity during March particularly in General Medicine, Ophthalmology, T&O and General Surgery.

Point of Delivery	Mar-21	Feb-21	Jan-21	Dec-20	Nov-20	Oct-20	Sep-20	Aug-20	Jul-20	Jun-20	May-20	Apr-20
Daycase	-42.92%	-42.83%	-44.55%	-46.37%	-50.12%	-53.21%	-59.12%	-69.01%	-72.40%	-77.19%	-81.63%	-84.05%
Elective	-49.24%	-48.05%	-50.39%	-50.97%	-51.31%	-50.98%	-56.15%	-64.22%	-67.00%	-68.75%	-67.80%	-76.99%
Non-Elective	-18.79%	-18.71%	-18.57%	-18.77%	-19.23%	-19.36%	-20.22%	-27.51%	-30.52%	-34.44%	-38.09%	-42.36%
OP First	-57.35%	-57.26%	-59.01%	-60.46%	-62.13%	-64.15%	-67.15%	-74.02%	-76.90%	-79.65%	-81.79%	-81.43%
OP Follow Up	-62.82%	-62.63%	-64.00%	-64.91%	-65.79%	-67.61%	-70.90%	-77.61%	-79.25%	-81.14%	-82.09%	-79.31%
OP Procedure	-53.45%	-53.86%	-56.21%	-58.84%	-62.21%	-65.61%	-69.44%	-76.42%	-78.58%	-82.40%	-85.19%	-87.14%

N.B. The outpatient activity above currently excludes any virtual attendances.

The underlying pay expenditure (excluding non-recurrent items as highlighted above) in month 12 increased over month 11 spend by c.£0.9m partly due to an increase in agency spend (c. £0.2m) and bank nurse spend (c. £0.3) in the Medicine Division. The underlying non-pay increased over month 11 spend by £1m, the main drivers of this were a reduction in costs due to stock movements on drugs (c£0.3m) and clinical supplies (c. 0.7m), offset by increased non-pay costs for outsourced activity (c. £1m) and education costs (c £0.8m). The Trust's month 12 financial position includes revenue costs of c. £655k relating to COVID (£13m YTD).

In March 2021, CIP savings of £91k are reported, against a plan of £1m, an under achievement of £922k in month. Year to date the Trust has delivered savings of £966k versus a plan of £2,094k an under-delivery of £1,128k.

Capital expenditure in month 12 is £11.0m, with annual capital expenditure being £36.3m, including COVID-19 capital spend of £1.5m and donated asset spend of £1.9m. This is £1.0m behind the £37.4m original plan but is £0.1m ahead of the forecast (excluding donated assets). Thereby the Trust achieved its revised capital plan.

The cash balance at the end of March was £51.7m (February: £77.1m). Cash has fallen as a result of the Trust not receiving Block income in the month, reversing that the Trust received two months' worth of the block income in April 2020 as a cash advance (which was the same for all Trust's nationally). The Trust also received £10.1m of PDC Dividend for capital schemes in month, and there are capital creditors of £11.6m at March 2021.

2. Recommendations

The Board is asked to note:

- The Trust's surplus for month 12 (March 2020) was £4.3m.
- The Trust's draft year end financial position is a £4.1m surplus.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	Trust Board				
Meeting Date:	20/4/21	**Agenda Reference:**	**E5**		
Report Title:	Going Concern				
Sponsor:	Jon Sargeant - Director of Finance				
Author:	Alex Crickmar – Deputy Director of Finance Jon Sargeant - Director of Finance				
Appendices:					
Report Summary					
Purpose of report:	The purpose of this paper is to set out the Trust's assessment of Going Concern.				
Summary of key issues/positive highlights:	International Accounting Standard (IAS) 1 requires the management of all entities to assess, as part of the accounts preparation process, the bodies' ability to continue as a going concern. This is further enforced by Department of Health requirements to review the trust's going concern basis on an annual basis. The going concern principle being the assumption that an entity will remain in business for the foreseeable future. This is to facilitate the accounting basis to be used in the preparation of the Trust's annual accounts. The paper sets out the reasons why the Trust should be considered a going concern the next 12 months.				
Recommendation:	The Board are asked to agree and approve the following: • The Trust should be considered a going concern for accounts preparation purposes. • The Trust should prepare its annual accounts for the year 2020/21 and balance sheet as at 31st March 2021 on that basis. • The annual report should clearly state this assessment whilst also outlining the risks facing the trust.				
Action Require:	Approval	~~Information~~	~~Discussion~~	~~Assurance~~	~~Review~~

Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**
	To provide outstanding care for our patients	*Everybody knows their role in achieving the vision*	*Feedback from staff and learners is in the top 10% in the UK*	***The Trust is in recurrent surplus to invest in improving patient care***

Implications	
Board assurance framework:	No changes to BAF.
Corporate risk register:	No changes to risks.
Regulation:	N/A
Legal:	N/A

Resources:			N/A
Assurance Route			
Previously considered by:			
Date:		**Decision:**	
Next Steps:			
Previously circulated reports to supplement this paper:			

Going Concern

1. Introduction

International Accounting Standard (IAS) 1 requires the management of all entities to assess, as part of the accounts preparation process, the bodies' ability to continue as a going concern. This is further enforced by Department of Health requirements to review the trust's going concern basis on an annual basis. The going concern principle being the assumption that an entity will remain in business for the foreseeable future.

This is to facilitate the accounting basis to be used in the preparation of the Trust's annual accounts. Should an assessment be made that an entity is not a going concern then the year end balance sheet should be prepared on a 'disposals' basis i.e. items valued at their likely sale value. In many cases this would propose significantly lower values than the usual valuations based on ongoing trading (e.g. stocks) and require the inclusion of other 'winding up costs' (e.g. redundancies).

2. Guidance

The 'Group Accounting Manual 2020-21' published by the Department of Health contains the following guidance:

4.13 For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity. A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up.

4.14 Sponsored entities whose statements of financial position show total net liabilities must prepare their financial statements on the going concern basis unless, after discussion with their sponsor division or relevant national body, the going concern basis is deemed inappropriate.

4.15 Where an entity ceases to exist, it must consider whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern in its final set of financial statements.

4.16 Where a DHSC group body is aware of material uncertainties in respect of events or conditions that cast significant doubt upon the going concern ability of the entity, these uncertainties must be disclosed. This may include, for example, where continuing operational stability depends on finance or income that has not yet been approved.

4.17 Should a DHSC group body have concerns about its "going concern" status (and this will only be the case if there is a prospect of services ceasing altogether) it must raise the issue with its sponsor division or relevant national body as soon as possible.

For year end NHSI/E have also released some guidance with regards to going concern including:

The Public Audit Forum issues guidance to auditors on how auditing standards should be applied in the public sector. Its publication 'Practice Note 10'1 was revised in late 2020. This updated guidance to auditors, approved by the Financial Reporting Council, explains that ***where the applicable financial reporting framework provides that the anticipated continued provision of services is a sufficient basis for going concern, then this should determine the extent of the auditor's procedures on going concern.***

This is the case in the NHS, with the DHSC Group Accounting Manual (GAM) and NHS foundation trust annual reporting manual (FT ARM) both based on the HM Treasury Financial Reporting Manual (FReM) where this definition applies. ***This means that, for the 2020/21 year end onwards, while management in NHS bodies will still need to document their basis for adopting the going concern basis, this assessment should solely be based on the anticipated future provision of services in the pubic sector. This means that it is highly unlikely that NHS organisations would have any material uncertainties over going concern to disclose.***

Therefore, given support from local commissioners and NHSE&I for the continuing operations of the trust, the national guidance strongly indicates that the trust should assess itself as a going concern.

Going Concern Assessment

Despite the strong guidance identified above the Board of Directors should still satisfy themselves that the trust remains a going concern. There are 2 scenarios that need to be considered:

A Covid-19 scenario where the "emergency" regime that took place in 2020/21, carries on for the whole of 2021/22. In this scenario, the mechanism of block contracts will remain, and cashflows will be maintained so providers can focus on delivery of patient care. The funding arrangements have been confirmed for H1 of 21/22 as a rollover of H2 20/21 with block contracts etc and therefore this risk is partially mitigated however the position for the second half of the year is less clear with funding arrangements yet to be decided.

A return to "business as usual" in the latter part of 2021/22, which would mean that traditional contracts are reinstated between commissioners and providers. Work has taken place to understand the underlying position of the Trust, under this scenario, and through discussions with local CCG's, no major changes to the underlying service provision or demand for the Trust has been indicated.

Other factors as part of going concern assessment

1) During 2020/21, the business rules issued for the financial year 20/21 meant that the DoH converted revenue loans to PDC Dividend (equity funding). This is significant as previously, the uncertainty of whether the Trusts revenue loans of £71m would be repayable by the Trust, caused. Therefore, this risk has now substantially reduced.

2) The going concern status of the Trust is also supported by the healthy cash position that the Trust has, going into 2021/22. The Trust has a c. £51m cash position at year end. Whilst capital creditors are £12m at year end, this still means that the underlying cash position is £39m, which is an extremely healthy position to be in. It is important to note that if the Trust failed to receive any income in 2021/22, cash would run out in mid-May 2021. However, given the consistent nature of the income

streams, and financial stability of the Trust's customers (CCG's backed by Central Government through NHS England/DHSC), this is deemed to be an extremely unlikely situation.

3) In addition to the above, the following supports the assessment of the Trust being treated as a going concern for the next 12 months:
   - Continuing support from local commissioners.
   - The Trust has delivered break even financial positions or better for the last 3 years.
   - There are no licence conditions in place on the Trust from its regulatory body.
   - The Trust has received a Good rating from the CQC for use of resources during 2019/20.

Therefore, it is considered appropriate based on the reasons set out above, that the trust should continue to prepare its financial statements on a going concern basis and to make the necessary declarations as part of its annual report and annual accounts. However, the continued risks, particularly around the financial regime in H2 of 2021/22 will also be clearly stated in the 2020/21 annual report. This, however, may evolve between now and the date upon which the accounts are signed off.

Recommendations

The Board are asked to agree and approve the following:

- The Trust should be considered a going concern for accounts preparation purposes.
- The Trust should prepare its annual accounts for the year 2020/21 and balance sheet as at 31st March 2021 on that basis.
- The annual report should clearly state this assessment whilst also outlining the risks facing the trust.

Report Cover Page					
Meeting Title:	**Trust Board**				
Meeting Date:		**Agenda Reference:**	**E6**		
Report Title:	**Capital Plan – 2021/22**				
Sponsor:	**Jon Sargeant - Director of Finance**				
Author:	**Alex Crickmar – Deputy Director of Finance** **Jon Sargeant - Director of Finance**				
Appendices:	Appendix 1 - Capital Plan 2021/22 – Detailed Schemes				
Executive Summary					
Purpose of report:	To present the capital plan for 21/22, noting the sources of funding and the detailed schemes for approval by the Board.				
Summary of key issues:	The Trusts capital delegated expenditure limit (CDEL) for 21/22 is £18.9m which will be self-funded by the Trust through depreciation £11.3m, and cash reserve of £7.6m (which is net of repayment of the capital loan in year £2.0m). The capital sub-committees (Estates, Medical Equipment, and IT) along with engagement from the Divisions/Corporate Directorates have collated the capital priorities for the Trust over the next 12 months. On this basis the groups have recommended the capital programme as detailed in the below paper which is in line with the initial allocation splits agreed by the Executive Team which is affordable within the Trusts allocated CDEL for 21/22. The Executive team have also reviewed the priorities and agreed the capital plan for 21/22. The recommended capital programme delivers the key priorities over the next 12 months including: • Continuation with eradicating the high Critical Infrastructure Risk • Continuation of the Fire Safety works, and Electrical Enhancement programmes • Replacement of high risk Medical Equipment • Replacement and Upgrade of high risk IT equipment and systems				
Recommendation:	The Board is asked to approve: • The Trust's capital plan for 21/22				
Action Require:	Approval X	Information	Discussion	Assurance	Review

Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**
	To provide outstanding care for our patients	*Everybody knows their role in achieving the vision*	*Feedback from staff and learners is in the top 10% in the UK*	*The Trust is in recurrent surplus to invest in improving patient care*

Implications	
Board assurance framework:	

Corporate risk register:	
Regulation:	
Legal:	
Resources:	

Assurance Route			
Previously considered by:			
Date:		**Decision:**	
Next Steps:			
Previously circulated reports to supplement this paper:			

Capital Plan 2021/22

In 2021/22 unlike previous years the capital allocation has been set at an ICS/system level with South Yorkshire & Bassetlaw ICS being allocated circa £105m (£79m operational capital, and £26m badged as emergency capital). It is to be noted that outline capital plans submitted by organisations within SYB ICS back in December 2020 totalled £181m of which DBTH submission totalled circa £34m. SYB ICS in discussions with leads from each organisation has agreed the organisational level split in which DBTH will receive £18.9m as the capital allocation.

DBTH has receive a capital delegated expenditure limit (CDEL) for 21/22 of £18.9m which will be self-funded by the Trust through depreciation £11.3m, and cash reserve of £7.6m (which is net of repayment of the capital loan in year £2.0m). This can be seen in the table below.

Source of Funds	**21/22**
	£'000
Depreciation	11,357
Loan Repayment	(2,056)
Disposals	0
Cash Reserve	9,599
Internal Capital Resource	**18,900**
External Funding Sources	**0**
Total Capital Resource	**18,900**

Proposed Schemes 21/22

The Trust has been progressing in line with the annual planning timetable the capital priorities arising for 21/22. Engagement has been sought with all divisional/corporate directorate leads in order to collate the full schedule of priorities including scheme description, risk rating, and priority ranking. Note the total requests that were received totalled circa £36m. These requests have been collated and reviewed by each of the capital sub-committees (Estates, Medical Equipment, and IT) focusing on risk, and priority. These groups have put together a proposed plan in line with the initial allocation splits agreed by the Executive team which is affordable within the Trusts allocated CDEL for 21/22. The Executive team have also reviewed the priorities and agreed the capital plan for 21/22.

The below table shows a summary of the recommended schemes to be funded in 21/22, a more detailed breakdown of the schemes are included within Appendix 1 to this paper.

Applications	
	£'000
Cross Year Commitments	900
Emergency Fire Works	3,000
Essential Electrical Upgrades	1,770
ED BDGH Front Door	200
Essential Estates Upgrades - Backlog	5,530
Essential Medical Equipment Replacement (Incl. Medical Imaging)	5,000
Essential IT Upgrades - High Priorities	2,500
Contingency	0
Internal Capital Resource	**18,900**
External Funding Sources	**0**
Total Capital Expenditure	**18,900**

Points to note

- Cross year commitments relate to schemes that have been committed in 20/21 or were part of the 20/21 plan that have not been fully expended before the end of the financial year and therefore become first call on 21/22 capital.
- The proposed plan doesn't allow for any contingency. If slippage against the funded schemes occurs this will provide a contingency and will need to be re-prioritised.
- All sources of funding are generated from internal funds, no external sources of funding have yet been identified.

Submission Requirements

Submission of the capital plan has been requested by NHSI this year separate to the fully completed Trust operation plan submission. Below are the key dates for submission in line with local and National guidance.

- Submission to SYB ICS - 21/22 capital plan – Thursday 8th April 2021 (by noon)
- Submission to NHSi – 21/22 capital plan - Monday 12th April 2021 (by noon)

Recommendation

The recommended capital programme delivers the key priorities over the next 12 months including:

- Continuation with eradicating the high Critical Infrastructure Risk
- Continuation of the Fire Safety works, and Electrical Enhancement programmes
- Replacement of high risk Medical Equipment
- Replacement and Upgrade of high risk IT equipment and systems

Therefore, the Board is asked to approve the capital plan for the financial year 2021/22.

Appendix A – Capital Plan 2021/22 – Detailed Schemes

Scheme Description	Spend type (Estates, Medical Equipment or IT)	£
Cross Year Commitments	Estates	**900,000**
Electrical Infrastructure - Phase 3b - Substation 2	Estates	**1,770,000**
Pathology standby generator	Estates	**Incl. Above**
Fire Enforcement Works	Estates	**3,000,000**
SYF Enforcement Notice	Estates	**Incl. Above**
SYF Enforcement Notice	Estates	**Incl. Above**
BDGH - Emergency Lighting	Estates	**Incl. Above**
BDGH - Emergency Lighting	Estates	**Incl. Above**
BDGH - Emergency Lighting	Estates	**Incl. Above**
BDGH - Emergency Lighting	Estates	**Incl. Above**
BDGH - Emergency Lighting	Estates	**Incl. Above**
BDGH L1 Fire Alarm	Estates	**100,000**
BDGH Fire Compartmentation - Trust wide	Estates	**100,000**
MMH TDM Panel replacement & Rehab	Estates	**80,000**
Surveys to inform risk register and related works	Estates	**100,000**
Lift Refurbishment	Estates	**300,000**
EWB Theatre bed, Service & Pharmacy lifts	Estates	**Incl. Above**
DRI	Estates	**Incl. Above**
Ventilation (Trust Wide upgrade for Critical Plan)	Estates	**500,000**
Vent Plant inspection	Estates	**Incl. Above**
Obstetrics Theatres	Estates	**Incl. Above**
DRI - Orthopaedics 1,2 & 3	Estates	**Incl. Above**
DRI - Main Theatres 1& 3	Estates	**Incl. Above**
BDGH - Maternity (Entanox)	Estates	**Incl. Above**
BDGH - Theatres	Estates	**Incl. Above**
Water Safety/Control of Legionellae	Estates	**250,000**
Control of Legionellae	Estates	**Incl. Above**
Replacement of CWST	Estates	**Incl. Above**
Hose Reel removal	Estates	**Incl. Above**
Local C/W storage tank replacement	Estates	**Incl. Above**
EWB Tank and associated services	Estates	**Incl. Above**
Asbestos - Trust Wide abatement works	Estates	**50,000**
Medical Gas - BDGH O2 Manifolds	Estates	**35,000**
Ward Refurbishment Programme - DRI - W&C/CDS	Estates	**1,000,000**

Scheme Description	Spend type (Estates, Medical Equipment or IT)	£
Nurse Call - Ongoing programme to upgrade obsolete systems	Estates	**30,000**
CQC Compliance/EQAT - Ongoing programme to respond to CQC audits	Estates	**100,000**
Window Replacement - Programme of replacement following quality and safety audits	Estates	**800,000**
Roofing - On-going upgrades - OPD, W&CH, ED Majors	Estates	**100,000**
Refrigeration - BDGH - York Chiller	Estates	**65,000**
Roadways, Car Parks and Footpaths - Re-surfacing and repairs including Park & Ride	Estates	**140,000**
Security - Park & Ride - CCTV & Lighting	Estates	**20,000**
Concrete Repairs - Repairs following 20/21 Survey	Estates	**50,000**
Minor Works - Minor to improve internal environment (showers, changing and accommodation)	Estates	**125,000**
Vehicle replacement (Cadavers & Laundry)	Estates	**75,000**
HPV De-contamination Equipment x 3	Estates	**42,000**
Cleaning Equipment	Estates	**25,000**
Site Rationalisation - Lister Court -demolition (Phase 1)	Estates	**240,000**
Site Rationalisation - BDGH South Site - rationalisation and demolition	Estates	**75,000**
COVID - Make permanent - Post Covid (doors/ventilation) & additional wipe up	Estates	**250,000**
Site Appraisal (Estatecode) - DRI/BDGH/MMH - 20% Six Facet	Estates	**21,000**
Sustainability - Carbon reduction schemes identified by Green Plan/Sustainability Group	Estates	**50,000**
Med - ED BDGH Front Door	Estates	**200,000**
W&C - Gynae OP Recovery	Estates	**30,000**
CSS - Orthopaedic Theatres storage re-configuration	Estates	**50,000**
TED - Academic Hub pre-commitment - backlog maintenance	Estates	**167,000**
MED - BDGH: C1 bathroom changes (upgrades and reconfiguration)	Estates	**150,000**
Further Divisional Priorities following further prioritisation and feasibility	Estates	**300,000**
Survey	Estates	**60,000**
Initial allocation	Estates	**50,000**
Additional Office Desktop licenses (or 365 - ref. Off 2010 EOL)	IT	**225,000**
Windows Server 2016+ licensing	IT	**170,000**
System Upgrades in relation to Windows 10 (multiple systems)	IT	**300,000**
Upgrade of Xcelera System - hardware & software (Win10)	IT	**80,000**
TeraRecon Replacement	IT	**150,000**
Automated documentation solution	IT	**30,000**
Division System Upgrades	IT	**495,000**
Brocade replacement	IT	**450,000**
Critical Care Information System	IT	**600,000**
3 x Mini C arm	Medical Equipment	**187,600**
Central monitoring and 14 monitors	Medical Equipment	**243,600**

Scheme Description	Spend type (Estates, Medical Equipment or IT)	£
X-ray static machine x 2 and ultrasounds x 2	Medical Equipment	**450,000**
Intensive ventilators x 20	Medical Equipment	**240,000**
Central monitoring and 12 monitors	Medical Equipment	**219,600**
Foetal heart monitors x 13	Medical Equipment	**67,200**
Birthing beds x 14	Medical Equipment	**24,000**
Children's cots x 25	Medical Equipment	**118,770**
Neonate incubators x 10	Medical Equipment	**25,200**
Haemodialysis machines x 12	Medical Equipment	**60,000**
Anaesthetic monitoring	Medical Equipment	**72,000**
Anaesthetic machines x 26 (Hawks)	Medical Equipment	**57,600**
Anaesthetic machines	Medical Equipment	**72,000**
Operating tables x 3	Medical Equipment	**180,000**
15 x Diathermy equipment	Medical Equipment	**96,000**
Defibrillators x 19	Medical Equipment	**62,568**
Patient trolleys x 60 (Inc. Theatre request)	Medical Equipment	**126,000**
Patient hoists x 47	Medical Equipment	**58,723**
Arjo Maximove hoists x 36	Medical Equipment	**43,200**
Dynamic mattress systems	Medical Equipment	**27,000**
Graesby 3000 series infusion pumps x 36	Medical Equipment	**32,400**
Anaesthetic monitoring	Medical Equipment	**172,800**
Mindray anaesthetic monitors with 2 BIS for BH	Medical Equipment	**192,000**
Mindray anaesthetic monitors with 1 BIS for Women's and Children's DRI	Medical Equipment	**186,000**
Anaesthetic TCI or TIVA infusion pumps Fresenius Kabi	Medical Equipment	**36,000**
MRI compatible infusion pumps	Medical Equipment	**108,000**
MRI compatible anaesthetic machine & monitoring	Medical Equipment	**96,000**
Manikins - Clinical Skills	Medical Equipment	**108,000**
Manikins - Resus	Medical Equipment	**108,000**
Kitting out additional Training Room in C Block	Medical Equipment	**108,000**
Olympus CY-F5A cystoscope x 3	Medical Equipment	**126,000**
X-ray room 3 refurbishment (equipment only)	Medical Equipment	**240,000**
X-ray room 5 refurbishment (equipment only)	Medical Equipment	**71,739**
Ultrasound Room 2 DRI (equipment only)	Medical Equipment	**90,000**
Ultrasound Room 5 DRI (equipment only)	Medical Equipment	**90,000**
Ultrasound Room 2 BH (equipment only)	Medical Equipment	**90,000**
Ultrasound Room 1 MMH (equipment only)	Medical Equipment	**90,000**
3 x Foetal telemetry units	Medical Equipment	**36,000**

Scheme Description	Spend type (Estates, Medical Equipment or IT)	£
Foetal telemetry units x 3	Medical Equipment	**36,000**
1 x ultrasound machine	Medical Equipment	**30,000**
4 x Airvo humidifiers	Medical Equipment	**12,000**
Monitors AMU	Medical Equipment	**36,000**
Replacement ECG Machines x 4	Medical Equipment	**54,000**
Replacement echo machines x 2	Medical Equipment	**240,000**
Stainer	Medical Equipment	**60,000**
Upgrade to mortuary fridges	Medical Equipment	**60,000**
Evara operating table	Medical Equipment	**60,000**
Total		**18,900,000**

Report Cover Page					
Meeting Title:	**BOARD OF DIRECTORS**				
Meeting Date:	20 April 2021	**Agenda Reference:**	**F1**		
Report Title:	True North, Breakthrough and Corporate Objectives 2021/2022				
Sponsor:	Chief Executive Officer				
Author:	Chief Executive Officer				
Appendices:	Appendix 1				
Report Summary					
Purpose of report:	This report identifies minor changes to the True North and Breakthrough objectives to reflect the impact of, and lessons learnt from, the Covid 19 pandemic identifying the approach to be taken, and the Corporate objectives for 2021/ 2022.				
Summary of key issues/positive highlights:	• The paper reinforces the commitment to the Trust Values, Strategic Objectives and True North • The paper identifies the 2021/2022 Breakthrough Objectives which will support the delivery of the Trusts Vision • The paper identifies the specific work which will be undertaken to ensure delivery of the Breakthrough objectives				
Recommendation:	The Board of Directors is asked to note the contents of this paper, advise on any required changes and amendments to the suggested objectives to ensure that actions through 2021/2022 continue progress towards True North and mitigate risks to delivery of the Strategic Vision.				
Action Required:	Approval **X**	Information	Discussion **X**	Assurance **X**	Review

Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**
	To provide outstanding care for our patients	Everybody knows their role in achieving the vision	Feedback from staff and learners is in the top 10% in the UK	The Trust is in recurrent surplus to invest in improving patient care

Implications	
Board assurance framework:	The Corporate objectives reflect the work needed to deliver the Board of Directors strategic direction and mitigate known and reasonably foreseeable risks.
Corporate risk register:	Delivery of the Corporate Objectives for 2021/2022 will support the reduction in known and reasonably foreseeable risks.
Regulation:	The Corporate Objectives for 2021/2022 identify actions which will be taken to improve the Trusts CQC Good rating at the next assessment by

	demonstrating compliance with the standards expected to be achieved for a Good rating in the Safe Domain and an Outstanding rating in the Caring Domain.		
Legal:	The Corporate Objectives for 2021/2022 aim to maintain the Trusts progress.		
Resources:	The resources required to deliver the Corporate Objectives for 2021/2022 are identified as part of the planning processes for 2021/2022.		
Assurance Route			
Previously considered by:	Executive Team		
Date:	14 April 2021	**Decision:**	To be presented to the Board of Directors on 20 April 2021
Next Steps:	Specific Objectives will be reviewed at Board Sub Committees with overall progress reported to the Board of Directors in: • July 2021 • October 2021 • January 2022 • April 2022		
Previously circulated reports to supplement this paper:	2019/2020 Corporate Objectives, True North and Breakthrough Objectives, Board of Directors Papers and Performance Reports.		

1. INTRODUCTION

This paper updates the Board of Directors (BoD) on the work which has been undertaken by the Executive Team to consider the overall impact of the Covid pandemic on the Trusts patients and staff and the impact that this has, and could have, on the Trusts performance, and on the Trusts ability to deliver the Strategic aims and objectives and the True North vision.

Measures and actions to mitigate the risks and restore the Trust progress towards the 'True North' are then set out through the 'Breakthrough Objectives' for 2021/ 2022 and the specific work which will be undertaken to support their delivery.

2. BACKGROUND

Prior to the Covid pandemic the Trust had established a framework by which the Strategic Aims and Objectives were reflected from Ward to Board so that every member of staff could visualise and describe how they could contribute to the delivery of the Trusts Vision; The True North. The True North being the 'Golden Thread,' with progress towards the vision supported, and measured through the delivery of the Breakthrough, Corporate, Divisional, Directorate, Team and Individual Objectives.

However, 2020/2021 brought the specific, and unforeseen challenges of the Covid pandemic, and required the NHS nationally, regionally and locally to respond to the level 4 National Incident through a Command and Control Infrastructure. In responding to the challenges, the Executive Team sought to maintain the frameworks, tools and techniques which had been embedded through the previous turnaround and 'Vital Signs' quality improvement programmes. However, the impact upon progress is such that the post pandemic challenges will require a revitalised, supportive and transformation approach if the Trust is to regain and maintain progress.

The proposed Breakthrough and Corporate Objectives for 2021/2022 set out to recognise the need to better support staff to recover and restore services, learning the lessons from the innovation and transformation which has occurred through the pandemic.

3. VALUES, STRATEGIC OBJECTIVES AND TRUE NORTH

3.1 Values

Following review, the Directors feel that post pandemic the Trusts Values continue to be reflective of the services we want to provide, and the needs of our staff:

- We always put the patient first
- Everyone counts – we treat each other with courtesy, honest, respect and dignity
- Committed to quality and continuously improving patient experience
- Always caring and compassionate
- Responsible and accountable for our actions – taking pride in our work
- Encouraging and valuing our diverse staff and rewarding ability and innovation

3.2 Strategic Objectives

During 2021/2022 the Trusts strategic direction will be subject to review in the work being led by the Director of Strategy and Improvement, and new, or revised objectives may be a consequence of this work. As we move through the new financial year our focus will remain on the 5 P's;

- Patients – Work with patients to continue to develop, accessible, high quality and responsive services.
- People – As a Teaching Hospital we are committed to continuously developing the skills, innovation and leadership of our staff to provide high quality, efficient and effective care.
- Performance – We will ensure our services are high performing, developing and enhancing elective care facilities at Bassetlaw and Montagu Hospitals and ensuring the appropriate capacity for increasing specialist care at Doncaster Royal Infirmary
- Partners – We will increase partnership working to benefit people and communities.
- Prevention – Support the development of enhanced community-based services, prevention and self-care.

Underpinned by an overall ethos of Quality Improvement to benefit people and communities.

However, in some areas additional work is required as a result of the impact of the pandemic on our patients, specifically to tackle inequality and waiting times but also to reduce and mitigate the significant impact the pandemic has had on staff.

Work will also be required within our Places and the wider ICS to reflect and enhance the process of change which is underway through the White Paper – *Integration and innovation; working together to improve health and social care for all.*

3.3 True North

Following review, the Directors feel that post pandemic the Trusts True North, 'To be the safest Trust in England, outstanding in all that we do', continues to set an appropriate level of ambition and the four supporting objectives remain relevant through 2021/2022:

- To provide outstanding care and patient experience
- Everybody knows their role in achieving our vision
- Team DBTH feel valued
- In recurrent surplus to invest in improving patient care

Additional focus will be needed on performance and the way staff feel valued and, on their ability, to contribute to delivering the vision.

4. BREAKTHROUGH OBJECTIVES

Each year the Trust has concentrated on making consistent progress towards the True North. In 2021/2022 the Breakthrough Objectives will maintain the drive to improve the quality, safety and sustainability of our services, reduce inequality in service delivery but also to reflect the need to strengthen staff and patient experience, involvement and satisfaction.

Through 2021/2022 the proposed Breakthrough objectives will be:

4.1 Achieve measurable improvement in our quality standards and patient experience

The elements of this objective will be:

Demonstrate Improvements in governance, management information, systems and processes to improve performance against the CQC Acute Insight Standards.

Demonstrate delivery of the standards required to achieve Outstanding in the CQC domain.

Demonstrate delivery of the standards required to achieve Good in the CQC domain – are services safe? Specifically;

- Develop and implement a Quality Framework which shapes the delivery of improvements in patient safety and experience.
- A 20% reduction in falls causing medium – severe harm.
- Achieve compliance with the National Perinatal Framework and Ockenden recommendations.
- Deliver national access standards for cancer diagnosis and treatment.
- Deliver national access standards for elective and diagnostic care
- Deliver urgent and emergency care access standards.
- Ensure that the patient and carer voice is listened to by delivering co-produced outcomes.
- Celebrate, share and promote good practice.

4.2 At least 90% of colleagues have an appraisal linked to the Trusts Values and feel able to contribute to the delivery of the Trust vision.

The elements of this objective will be:

At least 90% of colleagues have an appraisal linked to the Trust's objectives and values – standard KPI so perhaps not needed to be here?

5% improvement in colleagues reporting they are able to make suggestions to improve the work of their team/department.

Delivery of a 5% improvement in the number of colleagues who have the opportunity to show initiative in their area and make improvements in their area of work.

As a reflection of the specific post pandemic challenges which are likely to be experienced by staff training and development will be a significant feature of recovery. Specific quality improvement and leadership programmes will be delivered with the aim of ensuring that the initial work is targeted towards the Senior Divisional and Directorate Leadership Teams:

90% of the Divisional and Directorate leaders will have undertaken QI training as part of leadership development programme.

Specific well- being work will be undertaken and the impact assessed as part of staff appraisals.

4.3 Team DBTH feel valued and feedback from staff and learners in top 10% in

The elements of this objective will be:

Delivery of a 5% improvement in colleagues and learners recommending the Trust as a place to work and learn in the 2021/2022 staff survey results.

Delivery of a 5% improvement in how valued colleagues feel by managers and the Trust in the 2021/ 2022 staff survey results

Delivery of 5% improvement in health and wellbeing feedback in the 2021/2022 staff survey results

Delivery of 5% improvement in WRES and WDES feedback in the 2021/2022 staff survey results

4.4 The Trust is in recurrent surplus to invest in improving patient care

The elements of this objective will be:

The delivery of the agreed Corporate, Divisional and Directorate Budgets and activity levels.

Specified improvements in efficiency and effectiveness to return the Trust, as much as is possible to at least pre pandemic levels.

Demonstrate Improvements in governance through improved management information, systems and processes.

5. CORPORATE OBJECTIVES

The contributions each Director will make towards delivery of the Breakthrough Objectives in 2021/ 2022 are identified in appendix 1, which also sets out the Board sub-committees which will be responsible for assurance. It is intended that all objectives will be specific, measurable, attainable, relevant and time-based (SMART). In this context it is appropriate for the relevant committees to agree the information which will be required to provide assurance but it is expected that the majority of this information will be contained in the existing committee and BOD of Director performance reports, or in the new 2021/2022 Assurance Framework which is nearing completion.

The information to support assurance will be presented, amended and updated as needed by committees, with the overall progress presented to the Board of Directors each quarter.

6. RECOMMENDATIONS

The BoD is asked to discuss the contents of this paper, advise upon any necessary amendments and approve the True North and Breakthrough objectives for 2021/ 2022.

True North Objective	Senior Responsible Officer	Strategic Objectives for 2021 / 2022	Oversight and Assurance	Expected Outcome	Q1 UPDATE - July 2021	Q2 UPDATE - September 2021	Q3 UPDATE - January 2022	Q4 UPDATE - April 2022
To be the Safest Trust in England Outstanding in all that we do.	**Chief Executive Officer (CEO) Director of Strategy and Improvement**	Accelerate progress towards the delivery of the Trusts Strategic aims and objectives Re invigorate the Trust Quality Improvement Programme to drive innovation, efficiency, transformation and service delivery Complete the review of the Trust Clinical and Service Strategies Work with partners at a local, ICS and national level to identify opportunities and maximise the benefits and impact of enhanced health and social care collaboration and partnership in our communities and workforce.	Board of Directors (BOD) Audit and Risk Committee (ARC)	Quantitative and Qualitative Evidence will be available to assure the BOD that the Trust has delivered improvements across the full range of strategic aims and objectives				
BREAKTHROUGH OBJECTIVE								
Achieve measurable improvement in our quality standards and patient experience	**Chief Nurse/ Deputy CEO Executive Medical Director Chief Operating Officer**	Develop and Implement a DBTH Quality Framework which describes how 'Outstanding' is defined and achieved.	BOD	A DBTH Quality Framework will be in place by 30/6/2021				
		Demonstrate evidence which supports the delivery of the standards which would allow The CQC to rate all Divisions as Good for Services Safe	QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet or exceed the CQC standards				
		Demonstrate evidence which supports the delivery of the standards which would allow the CQC to rate the Trust as Outstanding for Caring	QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet or exceed the CQC standards				
		Achieve National, agreed ICS, and local access and performance standards	QEC	The 2021/ 2022 Assurance Framework will confirm that the Trusts plans are being delivered.				
		Ensure that the Patient and Carer voice is listened to by delivering co-produced outcomes	QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet or exceed the CQC standards				
		Celebrate, share and promote good practice and successes	BOD	Quantitative and Qualitative Evidence will be available to confirm that services meet or exceed the CQC standards				
At least 90% of colleagues have an appraisal linked to the Trusts Values and feel able to contribute to the delivery of the Trust vision.	**Director of People and Organisational Development**	At least 90% of colleagues have an appraisal linked to the Trust's objectives and values	People Committee (PC)	The 2021/ 2022 Assurance Framework will confirm that the Trusts plans are being delivered.				
		5% improvement in colleagues reporting they are able to make suggestions to improve the work of their team/department	PC	Local monitoring and the 2021/ 2022 Staff Survey will confirm the improvement				
		Delivery of a 5% improvement in the number of colleagues who have the opportunity to show initiative in their area and make improvements in their area of work.	PC	Local monitoring and the 2021/ 2022 Staff Survey will confirm the improvement				
		90% of the Divisional and Directorate leaders will have undertaken Q1 training as part of leadership development programme	PC	Quantitative and Qualitative Evidence will be available to confirm that services meet or exceed the CQC standards				
The Trust is within the top 25% for people and learner feedback	**Director of People and Organisational Development Chief Nurse/ Deputy CEO Executive Medical Director**	Delivery of a 5% improvement in colleagues and learners recommending the Trust as a place to work and learn in the 2021/ 2022 staff survey results	PC	Local monitoring and the 2021/ 2022 Staff Survey will confirm the improvement				
		Delivery of a 5% improvement in how valued colleagues feel by managers and the Trust in the 2021/ 2022 staff survey results	PC	Local monitoring and the 2021/ 2022 Staff Survey will confirm the improvement				
		Delivery of 5% improvement in health and wellbeing feedback in the 2021/ 2022 staff survey results	PC	Local monitoring and the 2021/ 2022 Staff Survey will confirm the improvement				
		Delivery of 5% improvement in WRES and WDES feedback in the 2021/ 2022 staff survey results	PC	Local monitoring and the 2021/ 2022 Staff Survey will confirm the improvement				
The Trust is in recurrent surplus to invest in improving patient care	**Director of Finance Chief Operating Officer**	Delivery of the agreed Corporate, Divisional and Directorate Budgets and activity levels.	Finance and Performance Committee (FPC)	The 2021/ 2022 Assurance Framework will confirm that the Trusts plans are being delivered.				
		Deliver specified improvements in efficiency and effectiveness to return the Trust, as much as is possible to at least pre pandemic levels	FPC	The 2021/ 2022 Assurance Framework will confirm that the Trusts plans are being delivered.				
		Demonstrate Improvements in Governance through improved management information, systems and processes.	FPC ARC	The 2021/ 2022 Assurance Framework will be in place with high quality information on performance and delivery which reflects the Trusts aims and objectives and allows				

DIRECTOR	OBJECTVIES IN SUPPORT OF THE DELIVERY OF THE TRUSTS TRUE NORTH AND BREAKTHORUGH OBJECTIVES	EXPECTED COMPLETION DATES AND BOD UPDATES	EXPECTED OUTCOMES
Chief Executive Officer	To be Agreed with Chair following BOD on the 20 April 2021		The Trust will make significant progress towards achieving the True North Vision
Chief Nurse/ Deputy Chief Executive	Working with the Executive Medical Director and Director of Strategy and Improvement develop a 'Quality Framework' define the characteristics and evidence that will define and support the Trust to be 'Outstanding in all that we do.'	Quarter 3	A quality Framework will be presented to the BOD for use across the Trust
	Demonstrate evidence of compliance with the standards expected to achieve Outstanding in the CQC Caring domain	Quarter 4	Compliance will be assessed by our internal CQC assessment
	With the Executive Medical Director ensure that the Trust is able to demonstrate evidence of compliance with the standards expected to achieve Good in the Safe CQC Safe domain	Quarter 4	Compliance will be assessed by our internal CQC assessment and evidenced in CQC Acute Insights
	Deliver a reduction of 20% in falls causing medium-severe harm by a quality improvement framework, in the 10 high falls risk areas.	Quarter 4	The reduction in falls is demonstrated in the performance and assurance reports
	Reduce perinatal mortality rate through compliance with the National Perinatal Framework and Ockenden recommendations	Quarter 4	Delivery is evidenced in the Maternity Safety reports
	Ensure the patient/carer voice is listened to by delivering increasing evidence of co-produced outcomes	Quarter 2, 3 and 4	Confirmed by evidence of delivery and direct feedback from patients
	Ensure safe and benchmarked staffing levels through the Trust	Quarter 2 and 4	Evidenced in the safe staffing and Human resource reports
	Continue to develop and implement the Research and Education Strategy as a vehicle for improvements in care, recruitment and retention and achieving a surplus for additional investments in patient care.	Quarter 4	Evidenced in the Research and Education updates
	Celebrate, share and promote good practice	Quarter 4	Evidenced through local, regional and national recognition for the Trust, Teams and Individual members of staff.
Director of Finance	Implement the 2021/ 2022 Performance and Assurance Framework	Quarter1	The 2021/ 2022 Performance and Assurance Framework is in place and informing successful delivery of objectives and identifying risks to delivery
	Work with the Corporate and Divisional Directors to ensure the delivery of the Trusts Revenue Plan	Quarter 4	Activity is delivered with the agreed budgets
	Work with the Corporate and Divisional Directors to ensure the delivery of the Trusts Capital Plan	Quarter 4	The capital programme is delivered on time and within the allocated budgets
	Complete the work on the New Hospital Strategic Outline Business Case	Quarter 2	The options for the future of the DRI site are set out within a strategic Outline Business Case
	Ensure the delivery of the Digital Information Strategy	Quarter 1	The Digital Information Strategy is approved by the Board of Directors
	Complete implementation of Divisional Information Officers	Quarter 1	Divisional Information Officers are in place in each Division and a process from assuring the quality of information is established.
	Maximise the benefits and opportunities of the WOS	Quarter 4	The WOS is making an increasing contribution to the Trust's plans
	Agree and ensure the delivery of local efficiency and effectiveness targets	Quarter 1	The Trusts 2021/2022 Efficiency and Effectiveness programme is achieved
Executive Medical Director	Complete the recruitment and selection process for the Executive Medical Directors Team to support the delivery of the Trust objectives, performance and transformation	Quarter 1	Recruitment to the Executive Medical Directors structure will be completed in Quarter 1
	With the Chief Nurse ensure that the Trust is able to demonstrate evidence of compliance with the standards expected to achieve Good in the Safe CQC Safe domain	Quarter 2	Compliance will be assessed by our internal CQC assessment and evidenced in CQC Acute Insights
	Ensure robust arrangements are in place within the Medical Examiner Teams to maintain, and improve HSMR/ SHMI	Quarter 2	Learning from Death Reviews and lessons learnt will be used to maintain and improve outcomes and reduce HSMR and SHMI
	Demonstrate improvements in the efficiency and effectiveness of clinical services	Quarter 4	Evidence of Improvement will be demonstrated in internal and external reports; GIRFT, Model Hospital, National Benchmarking
	Ensure safe and appropriate medical staffing and job plans are in place in all areas	Quarter 4	Actions from the Internal Audit Review of Job Planning are completed.
	Review the Corporate, Divisional and Directorate Governance arrangements to inform the future structure and arrangements for the Trust Governance Team	Quarter 3	The current Governance Arrangements will be reviewed to ensure lessons learnt from the pandemic are incorporated into systems and process to strengthen the delivery of safe and sustainable care
	Complete the implementation of the Medical Advisory Committee as the first step in improving communication and engagement with senior medical staff	Quarter 1	Direct and Indirect information, including the staff survey results are demonstrating appropriate progress
	Ensure that training and development programmes are in place in each Division and Directorate to support current medical leaders and encourage and prepare future leaders	Quarter 3	Direct and Indirect information, including the staff survey results are demonstrating appropriate progress
Director of People and Organisational Development	Improve performance across the full range of Human Resource services	Quarter 4	The 2021/ 2022 Performance and Assurance Framework is demonstrating improving performance
	Ensure the delivery of a refreshed recruitment and retention strategy to drive towards zero vacancies in all areas.	Quarter 2	The 2021/ 2022 Performance and Assurance Framework is demonstrating improving performance
	Ensure the successful transfer of Payroll and Pension Service	Quarter 3	Direct and Indirect information and feedback is demonstrating successful delivery and staff satisfaction
	Undertake a skills gap analysis to inform the development and implementation of an enhanced training and development programme to support current and future leaders	Quarter 2	Direct and Indirect information and feedback is demonstrating successful delivery and staff satisfaction
	Maximise the opportunities for learning from 'Speaking Up'	Quarter 2	Direct and Indirect information and feedback is demonstrating successful delivery and staff satisfaction
	Completion of RACE action plan and objectives for 2021/ 2022	Quarter 1 and Quarter 4	Action plan is presented to People Committee and the BOD and objectives are delivered
	Develop and provide an enhanced wellbeing offer to Team DBTH	Quarter 2	Direct and Indirect information and feedback is demonstrating successful delivery and staff satisfaction
Chief Operating Officer	Ensure that the recruitment to posts within the COO structure is completed and that staff within the Directorate have the skills and experience to be successful	Quarter 1	Recruitment to the vacant posts will be completed in Quarter 1
	Ensure the delivery of the National, ICS and Local standards for Urgent and Emergency Care, Elective Care and cancer care, and diagnostics	Quarter 1, 2, 3 and 4	The 2021/ 2022 Performance and Assurance Framework is demonstrating delivery
	Ensure wherever possible that recovery and restoration plans reduce inequality	Quarter 1, 2, 3 and 4	The 2021/ 2022 Performance and Assurance Framework is demonstrating delivery
	Ensure arrangement are in place to maintain and improve patient flow to maximise efficiency and effectiveness	Quarter 1, 2, 3 and 4	The 2021/ 2022 Performance and Assurance Framework is demonstrating delivery
	Ensure that services deliver the required levels of transformation to allow access to enhanced funding	Quarter 2	The 2021/ 2022 Performance and Assurance Framework is demonstrating delivery
	Develop, agree and implement robust plans to manage winter pressures and enhanced IPC measures	Quarter 2 and 3	The 2021/ 2022 Performance and Assurance Framework is demonstrating delivery

Director of Strategy and Improvement	Complete the review of the Trusts clinical and organisational strategy	Quarter 3	The strategies are presented and adopted by the BOD
	Drive transformation and improvement opportunities to make services more effective and efficient and where possible reducing the impact of inequality	Quarter 4	Evidence of improvement will be demonstrated in internal and external reports; GIRFT, Model Hospital, National Benchmarking
	Complete the Service Line reporting work	Quarter 1, 2, 3 and 4	Progress will be presented to the BOD and the actions included in the clinical strategy
	Support the delivery of a robust learning and development programme to maximise the capacity and capability for improvement	Quarter 3	Direct and Indirect information and feedback is demonstrating successful delivery and staff satisfaction
	Support the Board of Directors to champion Quality Improvement as the vehicle for transformation	Quarter 1, 2, 3, and 4	Direct and Indirect information and feedback is demonstrating successful delivery and staff satisfaction
	Once funding has been approved ensure the deliver of the BDGH Emergency Village scheme	TBC	The Emergency Village Scheme is delivered to plan
	Engage at Place and ICS to identify transformation and development opportunities which enhance the services for our communities and staff	Quarter 1, 2, 3 and 4	Opportunities are evidenced in the clinical and organisational strategy

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	20 April 2021	**Agenda Reference:**	**G1**
Report Title:	**Corporate Risk Register**		
Sponsor:	David Purdue, Chief Nurse / Deputy Chief Executive		
Author:	Fiona Dunn, Deputy Director Corporate Governance/Company Secretary		
Appendices:	CRR APR 2021		

Executive Summary	
Purpose of report:	For assurance that the Trust risk management process is being followed; new risks identified and current risks reviewed and updated in a timely way.
Summary of key issues:	Key changes to the CRR this period: • No new corporate risks added or escalated from Management Board • Currently there are 109 risk logged rated 15+ across the Trust . • 14 of these risks are currently monitored via Corporate Risk register (CRR) ○ 1 RISK 1412 (F&P12) Risk of fire to Estate- 20 (Extreme) decreased to 15 (Extreme). SYFR wrote to CEO on 1st April to rescind both notices for East Ward Block and Women's & Children's and replaced with action plans to be complied with. Internal Audit Assurance • KPMG is currently undertaking check on previous recommendations and to sample several risk rated 15+ from the risk log for compliance with the risk management policy. Action required • Continuous review of existing risks and identification of new or altering risks through improving processes. • Ensure embedding of risk management process through refreshed training and education to ensure consistency of process. • Link to key strategic objectives indicated within the Board Assurance Framework. • Further internal audit to check on previous recommendations and to sample several risk rated 15+ from the DATIX risk log for compliance with the risk management policy.
Recommendation:	The Board is asked to note the Corporate Risk Register information and the progress from the previous report.

Action Require:	~~Approval~~	Information	~~Discussion~~	Assurance	~~Review~~

Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**
	To provide outstanding care for our patients	*Everybody knows their role in*	*Feedback from staff and learners*	*The Trust is in recurrent surplus*

		achieving the vision	*is in the top 10% in the UK*	*to invest in improving patient care*

Implications	
Board assurance framework:	The entire BAF has been reviewed alongside the CRR. The corresponding TN SA's have been linked to the corporate risks.
Corporate risk register:	This document
Regulation:	All NHSF trust are required to have a corporate risk register and systems in place to identify & manage risk effectively.
Legal:	Compliance with regulated activities and requirements in Health and Social Care Act 2008.
Resources:	Actions required are currently being delivered within existing trust Resources highlighted in individual risks

Assurance Route			
Previously considered by:		Board, F&P Executive Team – (15+ risks)	
Date:	April 2021	**Decision:**	Reviewed and updated
Next Steps:		Continuous review of individual risk by owners on DATIX risk management system	
Previously circulated reports to supplement this paper:		None	

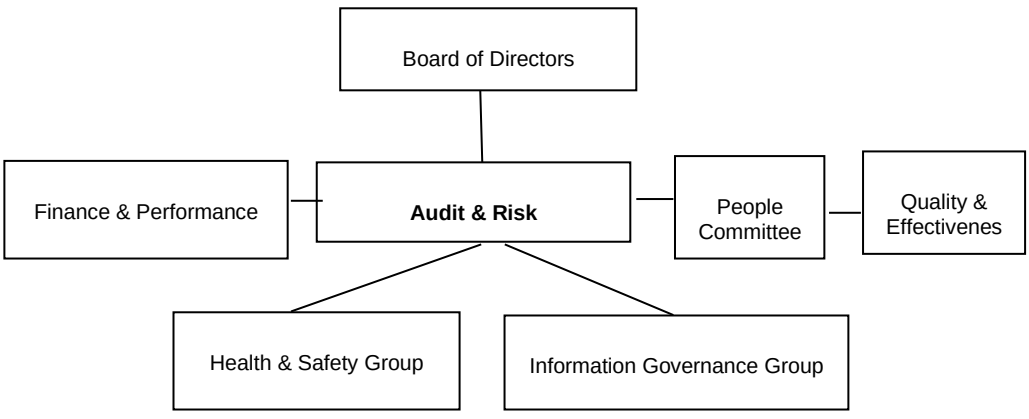
Corporate Risk Register Summary April 2021

ID	Ref	Review date	Division / Corporate(s)	Speciality(ies)	Title	Description	Risk Owner	Exisiting Controls	Risk level (current)	Rating (current)	Risk level (Target)	Last Reviewed	Movement since last review
1517	Q&E9	31/05/2021	Clinical Specialist Services	Pharmacy (Outpatient), Pharmacy (inpatient)	**Availability and Supplies of Medicines**	There are extraordinary stresses on the medicine supply chain which are leading to unavailability of medicines in the hospital. This could have an impact on patient care, potentially delaying the delivery of treatment, non-optimisation of treatment and decrease in patient satisfaction. It could also increase the chance of error and harm occurring The issues is causing significant disruption and increased workload of the pharmacy procurement and logistics team which compounds the problem. Disruption of work by other professionals involved in supply and administration of medicines is possible as well. There a number of issues causing it: - Manufacturing Issues - Central rationing of supplies by CMU - Wholesaler and supply chain issues - Unpaid invoices - Knock on disruption of procurement and logistics teams sometimes delaying response Updated: 18/12/2020 The reason there has been no local action on review id that we have been explicitly instructed by NHS E & DoH not to take nay local action. There is an national mechanism for managing medicines shortages which has been used during the COVID-19 pandemic and will be used if required to manage any issues as a result of EUexit. Working with national and regional colleagues Esoop's team take any local actions required by the national scheme on a medicine by medicine basis - this general Datix is not the appropriate place to record these specific individual case actions	Barker, Andrew	There is an national mechanism for managing medicines shortages which has been used during the COVID-19 pandemic and will be used if required to manage any issues as a result of EUexit.	Extreme Risk	15	High Risk	Mar-20	⟺
2664	PEO3	01/05/2021	Clinical Specialist Services	Critical Care	**Staff shortage - Consultant Intensive Care**	Severe shortage of consultants in intensive care medicine (especially DRI site), caused by inability to recruit for past 6 years and two recent resignations from existing staff. Now high risk of burnout of remaining consultant staff with subsequent sick leave and possible further resignations. Negative impact on quality of patient care, team work on DCC and training of other staff, especially doctors.	Noble, Timothy / Jochen Seidel	Some support from general anaesthetists and external locums. This is inadequate as a medium or long term solution.	Extreme Risk	20	High Risk	Mar-21	⟺
2472	COVID1	30/04/2021	Directorate of Nursing, Midwifery and Allied Health Professionals	Not Applicable (Non-clinical Directorate)	**COVID-19**	World-wide pandemic of Coronavirus, which will infect the population of Doncaster and Bassetlaw (including staff) resulting in reduced staffing, increased workload due to COVID-19 and shortage of beds, ventilators. Now includes stabilisation and recovery plans etc	Purdue, David	[09/02/2021 Covid planning robust, staffing reallocated due to reduction in elective care. Command Structure in place working through current issues	Extreme Risk	25	High Risk	Feb-21	⟺
11	F&P1	01/08/2020	Directorate of Finance, Information and Procurement	Not Applicable (Non-clinical Directorate)	**Failure to achieve compliance with financial performance and achieve financial plan**	Failure to achieve compliance with financial performance and achieve financial plan leading to : (i) Adverse impact on Trust's financial position (ii) Adverse impact on operational performance (iii) Impact on reputation (iv) Regulatory action	Sargeant, Jonathan	New and Developing Controls i) Additional grip and control mechanisms. (ii) Performance Assurance Framework. (iii) Deep Dives undertaken at F&P	Extreme Risk	16	High Risk	Jun-20	⟺
7	F&P6	12/04/2021	Chief Operating Officer	Not Applicable (Non-clinical Directorate)	**Failure to achieve compliance with performance and delivery aspects of the SOF, CQC and other regulatory stanadrds**	Failure to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards leading to: (i) Regulatory action (ii) Impact on reputation	Joyce, Rebecca	[10/03/2021] IQPR, Performance assurance framework goes to Sub committees, At divisional level = activity & performance meetings & wider governance framework. Accountability framework also in place at Organisational level. CQC regular engagement meetings & CQC action plan complete (Feb 21& agreed by CQC.) Performance also reported and discussed at ICS level and to NHSE/I etc via cancer alliance, weekly delivery meetings and performance delivery group.	Extreme Risk	16	High Risk	Mar-21	⟺
1244	F&P3	30/11/2020	Directorate of Finance, Information and Procurement	Not Applicable (Non-clinical Directorate)	**Failure to deliver Cost Improvement Plans in this financial year**	Failure to deliver Cost Improvement Plans in this financial year leading to : (i) Negative impact on Turnaround (ii) Negative impact on Trust's financial positon (iii) Loss of STF funding	Sargeant, Jonathan	New and Developing Controls i) Additional grip and control mechanisms. (ii) Performance Assurance Framework. (iii) Deep Dives undertaken at F&P	Extreme Risk	16	Moderate Risk	Sep-20	⟺
19	PEO1 (Q&E1)	31/03/2021	Directorate of People and Organisational Development	Not Applicable (Non-clinical Directorate)	**Failure to engage and communicate with staff and representatives in relation to immediate challenges and strategic development**	Failure to engage and communicate with staff and representatives in relation to immediate challenges and strategic development	Barnard, Karen	[12/02/2021] New people committee set up. People plan priorities being finalised for 2021/22. Improving staff survey performance focus on this via breakthrough objectives.	Extreme Risk	16	High Risk	Sep-20	⟺

Corporate Risk Register Summary April 2021

ID	Ref	Review date	Division / Corporate(s)	Speciality(ies)	Title	Description	Risk Owner	Exisiting Controls	Risk level (current)	Rating (current)	Risk level (Target)	Last Reviewed	Movement since last review
12	F&P4	29/10/2021	Estates and Facilities	Not Applicable (Non-clinical Directorate)	**Failure to ensure that estates infrastructure is adequately maintained and upgraded in line with current legislation**	Failure to ensure that estates infrastructure is adequately maintained and upgraded in line with current legislation, standards and guidance. Note: A number of different distinct risks are contained within this overarching entry. For further details please consult the E&F risk register. leading to (i) Breaches of regulatory compliance and enforcement (ii) Claims brought against the Trust (iii) Inability to provide safe services (iv) Negative impact on reputation (v) Reduced levels of business resilience (vi) Inefficient energy use (increased cost) (vii) Increased breakdowns leading to operational disruption (viii) Restriction to site development	Edmondson-Jones, Kirsty	[16/11/2020 16:51:07 Sean Alistair Tyler] - DBTH not included on list of 40 new hospitals, Board decision required on continuing developing case in preparation for bid for further 8 new hospitals mid decade.	Extreme Risk	20	High Risk	Nov-20	⟺
1410	F&P11	03/01/2021	Information Technology	Not Applicable (Non-clinical Directorate)	**Failure to protect against cyber attack**	Failure to protect against cyber attack - leading to: (i) Trust becoming non-operational (ii) Inability to provide clinical services (ii) Negative impact on reputation The top 3 DSP risk areas have been recognised as: (1) Insider threat (accidental or deliberate) (2) New / zero day vulnerability exploits (3) Failure to wholly implement patch management	Anderson, Ken	[23/11/2020 Server patching and ATP: Implementation on-going - expected completion date end Dec 2020 (then ongoing maintenance). Backup software and hardware upgrades: Procurement completed - expected implementation end Dec 2020.	Extreme Risk	15	Moderate Risk	Nov-20	⟺
16	PEO2 (F&P8)	31/03/2021	Directorate of People and Organisational Development	Not Applicable (Non-clinical Directorate)	**Inability to recruit right staff and ensure staff have the right skills to meet operational needs**	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	Barnard, Karen	[12/02/2021] People Committee now in place to review vacancy data and obtain assurance re recruitment report and expenditure vs agency etc. International recruitment uptake where appropriate. Apprenticeship schemes in place. People committee reporting structures reviewed to ensure good governance,	Extreme Risk	16	High Risk	May-20	⟺
2426	F&P	29/12/2020	Information Technology	Not Applicable (Non-clinical Directorate)	**Multiple software systems end-of-support**	Installed software versions have gone past the date of supplier support and there has been insufficient internal resources to upgrade and dependencies with multiple software systems being incompatible with the supported software, have prevented these upgrades. This leads to vulnerabilities within our infrastructure. For example, unpatched systems are significantly more vulnerable to cyber attacks. A single compromised device threatens all devices. There is a further vulnerability the Trust faces where we cannot draw on the expertise of the supplier to fix faulty software in a timely manner or at all.	Linacre, David	Where possible support has been extended with supplier. Firewalls and antivirus software are in place.	Extreme Risk	15	High Risk	Sep-20	⟺
2147	F&P21	07/07/2021	Estates and Facilities	Not Applicable (Non-clinical Directorate)	**REF 29 - Edge Protection DRI**	Due to the lack of edge protection on flat roofs across the site at DRI there is an increased risk of falls from height, which could result in death or serious injury	Edmondson-Jones, Kirsty		Extreme Risk	15	Moderate Risk	Apr-21	⟺
1807	F&P20 / Q&E12	08/07/2021	Estates and Facilities	Not Applicable (Non-clinical Directorate)	**Risk of critical lift failure**	Risk of critical lift failure leading to: (a) Reduction in vertical transportation capacity in the affected area (b) Impact on clinical care delivery (c) General access and egress in the affected area	Edmondson-Jones, Kirsty	[08/04/2021] - Site wide Lift survey undertaken by independent lift consultant, lifts 3 and 7 in the EWB identified for upgrade and included within the FY21/22 Capital Plan.	Extreme Risk	20	High Risk	Apr-21	⟺
1412	F&P12	29/10/2021	Estates and Facilities	Not Applicable (Non-clinical Directorate)	**Risk of fire**	Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the Regulatory Reform (Fire Safety) Order 2005 and other current legislation standards and guidance. Note: a number of different distinct risks are conatained within this overarching entry. For further details please consult the EF risk register. leading to : (i) Breaches of regulatory compliance could result in Enforcement or Prohibition notices issued by the Fire and Rescue Services (ii) Claims brought against the Trust (iii) Inability to provide safe services (iv) Negative impact on reputation No change to risk - work ongoing	Edmondson-Jones, Kirsty	07/04/2021] SYFR wrote to CEO on 1st April to rescind both notices for EWB and W&C and replace with action plans to be complied with	Extreme Risk	15	High Risk	Apr-21	⬇

Audit and Risk Committee (ARC)
Terms of Reference

Name	Audit and Risk Committee ("the Committee").
Purpose	To provide the Board of Directors ("the Board") with a means of independent and objective review of internal controls and risk management arrangements relating to: • Financial systems; • The financial information used by the Trust; • Controls and assurance systems; • Risk management; • Health and Safety, Fire and Security; • EPRR; • Compliance with law, guidance and codes of conduct; and • Counter fraud activity.
Responsible to	The Committee reports to the Board. The Chair of the Committee is responsible for reporting assurance to the Board on those assurance matters covered by these Terms of Reference through review and update of the Board Assurance framework. The minutes of the Committee shall be submitted to the Board of Directors. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the Council of Governors, or require executive action. The Committee will present a written annual report to the Board summarising the work carried out during the financial year and outlining its work plan for the future year.
Delegated authority	The Committee is a Non-Executive Committee and holds no executive powers other than those specifically delegated in these Terms of Reference.
	

	The Committee is authorised to investigate any activity within its Terms of Reference. It is further authorised to seek any information it requires from any employee of the Trust and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to secure legal or independent professional advice, or to request the attendance of external advisers with relevant experience and expertise if it considers this necessary.
Duties and work programme	1 <u>Integrated Governance, Risk Management and Control</u> 1.1 The Committee shall review the effectiveness of the system of integrated governance, risk management and internal controls, to satisfy the Board that its approach to integrated governance remains effective. 1.2 Determine the actions, controls and audits/reviews required to provide Non-Executives and the Board with robust assurance regarding the reported financial position going forward; and to maintain the confidence of governors, regulators and the public. Undertake ongoing review of the implementation and effectiveness of these. 1.3 The Committee will review the adequacy of: i. all risk and control related disclosure statements (in particular the Annual Governance Statement and Declarations of Compliance made to NHSI) together with any accompanying Head of Internal Audit statement, external audit opinions or other appropriate independent assurance, prior to endorsement by the Board; ii. the underlying assurance processes that include the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of related disclosure statements; iii. the policies and procedures for ensuring compliance with relevant regulatory, legal and code of conduct requirements; and iv. the arrangements, policies and procedures for all work related to fraud and corruption (but shall not be responsible for the conduct of individual investigations); and v. The operating of, and proposed changes to, the Board ~~of Directors~~ standing orders, standing financial instructions, the constitution, codes of conduct, scheme of delegation and standards of business conduct. 1.4 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurance from executive directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

2 Internal Audit

2.1 The Committee shall monitor the effectiveness of the internal audit function established by management that meets mandatory *Public Sector Internal Audit Standards* and provides appropriate independent assurance to the Committee, Chief Executive and Board. This will be achieved by:

i. consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;
ii. review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;
iii. consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources;
iv. oversee the effective implementation of internal and external audit recommendations;
v. ensuring that the Internal Audit function is adequately resourced and have appropriate standing within the organisation; and
vi. annual review of the effectiveness of Internal Audit.

3 External Audit

3.1 The Committee shall review the work and findings of the External Auditor whom are appointed by the Council of Governors and consider the implications of and management's responses to their work. This will be achieved by:

i. consideration of the appointment and performance of the External Auditor in accordance with the Trust specification for an External Audit Service, informed by NHSI's Audit Code for NHS Foundation Trusts;
ii. discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan ensuring co-ordination, as appropriate, with other External Auditors in the local health economy;
iii. discussion with the External Auditors of their local evaluation of audit risk and assessment of the Trust and associated impact on the audit fee;
iv. review of all External Audit reports, including agreement of the annual audit letter, before submission to the Board and review of any work carried outside the annual audit plan, together with the appropriateness of management responses; and
v. review of the annual audit letter and the audit representation letter before consideration by the Board.

4 Other Assurance Functions

4.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider their implications to the governance of the organisation. These may include, but will not be limited to: any reviews by Department of Health Arms' Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Resolution, Health and Safety, Shared Business Services etc.); professional bodies with responsibility for the performance of staff; or functions (e.g. accreditation bodies, etc.) relevant to the Terms of Reference of this Committee.

4.2 In addition, the Committee will review the work of the other Committees within the organisation whose work can provide relevant assurance to the Committee's own scope of work.

5 Management

5.1 The Committee shall request and review reports and assurance from directors and managers on the overall arrangements for governance, risk management and internal control.

5.2 They may also request reports from individual functions from within the organisation as appropriate.

6 Financial Reporting

6.1 The Committee shall review the Annual Report and Financial Statements before recommendation to the Board, focusing particularly on:

i. the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
ii. compliance with accounting policies and practices;
iii. unadjusted mis-statements in the financial statements;
iv. major judgemental areas;
v. significant adjustments resulting from the audit;
vi. the clarity of disclosures; and
vii. the going concern assumption.

6.2 The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

7 Counter Fraud Arrangements

7.1 The Committee shall ensure that there is an effective counter fraud function established by management that meets the NHS Counter Fraud standards and provides independent assurance to the Committee, Chief Executive and Board. This will be achieved by:

i. review the adequacy of the policies, procedures and plans for all work related to fraud, bribery and corruption;
ii. ensuring effective co-operation with the Counter Fraud function and that it has appropriate standing within the Trust;
iii. receipt of quarterly reports and an annual report from the Local Counter Fraud Specialist (LCFS) on counter fraud activity and investigations;
iv. ensuring compliance with Section 24 of the NHS National Contract regarding fraud and NHS Standards for Providers as required by the NHS Counter Fraud Authority.

8 Other areas of work

8.1 Information Governance:- The Committee shall receive reports and review assurance from directors and managers on the overall arrangement for compliance with Information Governance Standards.

8.2 Health and Safety, Fire and Security:- The Committee shall receive reports from relevant directors and officers, including the Local Security Management Specialist, on the arrangements for compliance with relevant health and safety, fire and security standards.

8.3 EPRR:- The Committee shall receive reports from the Trust's Emergency Planning Officer on Emergency Preparedness, Resilience and Response, including the proposed statement of compliance arising from the annual self-assessment against NHS England's Core Standards return.

9 Special Assignments

9.3 The Committee shall commission and review the findings of any special assignments required by the Board.

10 Performance

10.3 The Committee shall request and review reports and assurance from directors and managers on the overall arrangements for reporting compliance with:

i. the Trust's corporate objectives;
ii. NHSI's governance standards and declarations, including the review of areas of non-compliance in the context of NHSI's "comply or explain" philosophy; and

	iii. key performance objectives as appropriate but not to duplicate the work of QEC or F&P 11 Risk Management 11.3 The Committee will provide assurance to the Board that the Risk Management Strategy is being complied with, including, but not limited to, reviewing Risk Registers. The Committee shall request and review reports and assurance from directors and managers on effects of arrangements to identify and monitor risk. The Board will retain the responsibility for routinely reviewing specific risks. 12 Workplan 12.3 The Committee's annual work plan is an appendix to these Terms of Reference and is subject to annual review by the Committee.
Policy approval	The Committee has responsibility for approving the following policies: • Fraud, Bribery & Corruption Policy and Response Plan; • Standards of Business Conduct and Employees Declarations of Interest Policy.
Chair	A Non-Executive Director, appointed by the Board of Directors, will chair the Committee.
Membership	Four Non-Executive Directors. Time served needs to be removed agreed by the committee and needs to be 2 out of the 4 NEDs for quoracy. • One of the Non-Executives shall have recent and relevant financial experience. • Each Non-Executive shall normally not serve more than three years as a Committee member, unless the requirement for one of the members to have recent and relevant financial experience is compromised. • The Trust Chair of the Trust shall not be a member of the Committee.
In attendance	• Director of Finance • Deputy Director of Finance • Company Secretary/Deputy Director Corporate Governance • Local Counter Fraud Specialist • Appropriate internal and external audit representatives • Security Management Specialist • Corporate Governance Officer (Minutes) • Other trust staff as appropriate / requested The Chief Executive, executive directors or other officers will be required to attend at the request of the Committee, for issues relevant to their areas of responsibilities.

	Two public governors, nominated by the Council of Governors, will be invited to attend the Committee, as observers. The Chair and Chief Executive of DBTH will be invited to attend at least annually.
Secretary	Corporate Governance Officer
Voting	Matters will generally be decided by way of consensus. Where it is necessary to decide matters by a vote then each member will have one vote. The Chair will have a casting vote.
Quorum	Two members.
Attendance requirements	Committee members must attend at least 50% of meetings.
Frequency of meetings	No less than quarterly and more frequently as required. At least once per year, the Committee should meet with the external and internal auditors, without management being present, to discuss matters relating to its responsibilities and issues arising from the audit. The External Auditor and Head of Internal Audit may request a private meeting if they consider that one is necessary. They will also have direct access to the Chair of the Committee.
Papers	Papers will be distributed a minimum of five clear working days in advance of the meeting.
Permanency	The Committee is a permanent Committee.
Reporting Committees	Health and Safety Committee Information Governance Steering Group
Circulation of minutes and other reporting requirements	The Governor observers shall report to the Council of Governors on a quarterly basis regarding the work of the Committee, any matters needing action or improvement and the corrective actions to be taken. Following the Council of Governors appointment of the External Auditors, the Committee shall report to the Council of Governors regarding the reappointment, termination of appointment and fees of the External Auditors.
Date approved by the Committee:	25/3/2021
Date approved by the Board of Directors:	
Review date:	

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	**Tuesday 20th April 2021**	**Agenda Reference:**	**G3**
Report Title:	**COVID19 Business Continuity Terms of Reference - Trust Board and Sub Committees**		
Sponsor:	David Purdue, Chief Nurse / Deputy Chief Executive		
Author:	Fiona Dunn, Deputy Director Corporate Governance/Company Secretary		
Appendices:	Trust Standing Orders with COVID addendum CORP/FIN 1 (A) v10		

Report Summary	
Purpose of report:	**To propose an extension to the COVID19 Business Continuity Terms of Reference - Trust Board and Sub Committees**
Summary of key issues/positive highlights:	• There is still a clear organisational need to continue to respond to the COVID-19 pandemic with all available efforts, whilst continuing to have an overview on the safety of all DBTH patients and the wellbeing of staff, during the pandemic. • It was agreed at the Board on 21st March 2020 to suspend certain elements of the Trust current standing orders (SO's) relating to Board and its sub-committee meetings normal terms of reference. It was agreed to invoke section 6.2 of the SO's Emergency powers. This was reflected in the **COVID19 Business Continuity Terms of Reference** (See attached) • The Trust still continues to adapt to meet organisational need during this time with processes, meetings and other business matters of the Trust. • The Trust has taken account of emerging regional and national guidance in the preparation of these terms of reference, and continues to consult with governance colleagues from across the health sector in its response to the COVID Pandemic and proposes an extension to the **COVID19 Business Continuity Terms of Reference** until such time restoration plans have become sustainable.
Recommendation:	• **APPROVE** the extension to the **COVID19 Business Continuity Terms of Reference** for further 12 months, unless reviewed earlier.

Action Required:	Approval	~~Information~~	Discussion	~~Assurance~~	~~Review~~
	TN SA1:	**TN SA2:**	**TN SA3:**	**TN SA4:**	

Link to True North Objectives:	*To provide outstanding care for our patients*	*Everybody knows their role in achieving the vision*	*Feedback from staff and learners is in the top 10% in the UK*	*The Trust is in recurrent surplus to invest in improving patient care*

Implications	
Board assurance framework:	No changes to BAF as impacts on all domains – also COVID19 BAF addendum
Corporate risk register:	The CRR includes risk for overall COVID19 management (RISK ID 2472). This has been reflected in an addendum to the current BAF .
Regulation:	This proposal/process impacts as part of Well-led framework for governance reviews for NHS Foundation Trusts.
Legal:	Compliance with regulated activities and requirements in Health and Social Care Act 2008.
Resources:	None identified

Assurance Route			
Previously considered by:		Agreed at Board of Directors 21 April 2020	
Date:	21/4/2020	**Decision:**	Agreed to addendum to Trust Standing Orders.
Next Steps:		Review in one year	
Previously circulated reports to supplement this paper:		Trust Standing Orders with COVID addendum CORP/FIN 1 (A) v10	

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Standing Orders
Board of Directors
July 2020

NHS Foundation Trusts must agree Standing Orders (SOs) for the regulation of their proceedings and business. The Board of Directors are also required to adopt schedules of reservation of powers and delegation of powers. These documents, together with Standing Financial Instructions, provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

The Standing Orders, Scheme of Delegation and Standing Financial Instructions provide a comprehensive business framework. All executive and non-executive directors, and all members of staff, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

Provisions within the Standing Orders which are not subject to suspension under SO 5.40 are indicated in italics.

Did you print this document yourself?
The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.**

Name and title of author/reviewer:	Jon Sargeant and Matthew Bancroft
Date written/revised:	July 2020
Approved by (Committee/Group):	Board of Directors
Date of approval:	21/7/2020
Date issued:	27/7/2020
Next review date:	July 2021
Target audience:	Trust-wide

Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 10	July 2020	• Update of legislation references to include any subsequent updates relating to the UK's exit from EU. • Removal of all references and detail pertaining to the use of 'Approved Lists' in relation to Works tenders. • Removed references to Prudential Borrowing Limits. • Updated limits with relation to Charitable Funds expenditure. • Includes Appendix 1. Temporary COVID19 Business Continuity Terms of Reference Trust Board, Board Committee and Governor Meetings – Emergency powers section 6.2	Matthew Bancroft

CONTENTS

1 INTRODUCTION

1.1 Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust is a Public Benefit Corporation that was established by the granting of Authorisation by Monitor (now NHS Improvement).

1.2 The principal purpose of the Trust is set out in the 2012 Act, and the Trust Constitution.

1.3 The Trust is required to adopt Standing Orders (SOs) for the regulation of its proceedings and business.

1.4 The powers of the Trust are set out in section 4 of the Constitution.

1.5 The Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to NHS Improvement. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

1.6 Failure to comply with SFIs and SOs is a disciplinary matter which could result in dismissal.

1.7 **Delegation of Powers**
The Trust has resolved that certain powers and decisions may only be exercised or made by the Board of Directors in formal session. These powers and decisions are set out in the Scheme of Delegation.

1.8 Under the Standing Orders relating to the Arrangements for the Exercise of Functions (SO 6) the Board of Directors may exercise its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee appointed by virtue of SO 7 or by an executive director, in each case subject to such restrictions and conditions as the Board of Directors thinks fit or as NHS Improvement may direct.

1.9 Delegated Powers are covered in the Scheme of Delegation, which has effect as if incorporated into the Standing Orders.

2 INTERPRETATION AND DEFINITIONS

2.1 Save as permitted by law, at any meeting the Chair of the Trust, advised by the Chief Executive, shall be the final authority on the interpretation of Standing Orders.

2.2 These Standing Orders shall only be applied in accordance with the Constitution. Where any provision in these Standing Orders contradicts any provision in the Constitution, the Constitution shall be paramount.

2.3 In these Standing Orders:

"the 2006 Act"	means the National Health Service Act 2006 as amended from time to time;
"the 2012 Act"	means the Health and Social Care Act 2012 as amended from time to time;
"Accounting Officer"	means the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act;
"Board of Directors"	means the board of directors as constituted in accordance with the Trust Constitution;
"Chair"	means the Chair of the Trust appointed in accordance with the Trust Constitution;
"Chief Executive"	means the Chief Executive Officer of the Trust appointed in accordance with the terms of the Trust Constitution;
"Committee"	means a committee appointed by the Board of Directors;
"Committee members"	means those persons formally appointed by the Board of Directors to sit on or to chair specific committees;
"Constitution"	means the Trust Constitution and all annexes to it;
"Corporate Director"	A non-voting director with executive responsibilities, appointed by the Board of Directors;
"Director"	means a director on the Board of Directors;
"Director of Finance"	means the Chief Finance Officer of the Trust;
"Executive Director"	means an executive director of the Trust appointed in accordance with the Trust Constitution;
"Funds held on Trust"	means those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument or chooses to accept under powers derived under S.90 of the 2006 Act;
"Member"	means a member of the Trust;
"NHS Improvement"	means the body corporate known as NHS Improvement.
"Motion"	means a formal proposition to be discussed and voted on

	during the course of a meeting;
"Nominated Officer"	means an officer charged with the responsibility for discharging specific tasks within the SOs and SFIs;
"Non-Executive Director"	means a non-executive director of the Trust appointed in accordance with the Trust Constitution;
"Officer"	means an employee of the Trust;
"Secretary"	means the Trust Board Secretary or any other person appointed to perform the duties of the secretary of the Trust, including a joint, assistant or deputy secretary;
"SFIs"	means Standing Financial Instructions;
"SOs"	means Standing Orders;
"the Trust"	means Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust.

3 THE BOARD OF DIRECTORS

3.1 All business of the Board of Directors shall be conducted in the name of the Trust.

3.2 All funds received in trust shall be in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

3.3 Directors acting on behalf of the Trust as a corporate trustee are acting as quasi-trustees. Accountability for charitable funds held on trust is to the Charity Commission and to NHS Improvement. Accountability for non-charitable funds held on trust is only to NHS Improvement.

3.4 **Composition of the Board of Directors**
In accordance with the 2006 Act, the 2012 Act, and the Constitution, the composition of the Board of Directors of the Trust shall be:

(a) The Chair of the Trust

(b) 6 non-executive directors

(c) 6 executive directors including:

- the Chief Executive (the Accounting Officer)
- the Director of Finance (the Chief Finance Officer)
- the Medical Director

- the Director of Nursing

3.5 The Board of Directors may appoint corporate directors in addition to the six executive directors described above. Non-voting Corporate directors shall attend meetings of the Board of Directors but shall not have a vote (see SO 5.19).

3.6 **Non-executive Directors**
Non-executive Directors are appointed by the Council of Governors. The appointment shall be in accordance with the Constitution.

3.7 The regulations governing the tenure of office of the Non-executive Directors shall be in accordance with the Constitution.

3.8 **Joint Directors**
Where more than one person is appointed jointly to a post in the Trust which qualifies the holder for executive directorship or in relation to which an executive director is to be appointed, those persons shall become appointed as an executive director jointly, and shall count for the purpose of Standing Order 3.4 as one person.

4 CHAIR OF THE BOARD OF DIRECTORS

4.1 The Chair of the Trust is the Chair of the Board of Directors.

4.2 The Chair is appointed by the Council of Governors. The appointment shall be in accordance with the Constitution.

4.3 The regulations governing the tenure of office of the Chair shall be in accordance with the Constitution.

4.4 At any meeting of the Board of Directors, the Chair, if present, shall preside. If the Chair is absent from the meeting, the Deputy Chair shall preside.

4.5 If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy Chair, if present, shall preside.

4.6 **Deputy Chair**
Where the Chair of the Trust has died or has otherwise ceased to hold office or where he has been unable to perform his duties as Chair owing to illness, absence from England and Wales or any other cause, references to the Chair in the Schedule to these Regulations shall, so long as there is no Chair able to perform his duties, be taken to include references to the Deputy Chair. In such cases the Deputy Chair shall act as Chair of the Board of Directors.

4.7 The appointment of the Deputy Chair shall be as prescribed in the Constitution.

4.8 The regulations governing the tenure of office of the Deputy Chair shall be in accordance with the Constitution.

5 PRACTICE AND PROCEDURE OF MEETINGS

5.1 All business at meetings of the Board of Directors shall be conducted in the name of the Trust.

5.2 **Annual Members Meeting**
The Trust will publicise and hold an annual meeting of its members in accordance with the constitution and the 2012 Act.

5.3 **Admission of the Public and Press**
The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Board of Directors but shall be required to withdraw upon the Board of Directors resolving as follows:

"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".

5.4 The Chair (or Deputy Chair when acting as Chair) shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board of Directors business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on the grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board of Directors resolving as follows:

"That in the interests of public order the meeting adjourns for (the period to be specified) to enable the Board of Directors to complete business without the presence of the public."

5.5 Members of the public or representatives of the press are not permitted to record proceedings in any manner unless with the express prior agreement of the Chair (or Deputy Chair when acting as Chair). Where permission has been granted, the Chair (or Deputy Chair) retains the right to give directions to halt recording of proceedings at any point during the meeting. For the avoidance of doubt, "recording" refers to any audio or visual recording, including still photography.

5.6 **Calling Meetings**
Ordinary meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine.

5.7 The Chair may call a meeting of the Board of Directors at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of directors, has been presented to him, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to him such one third or more directors may forthwith call a meeting. In such cases, meetings shall be held at the Trust's designated headquarters.

5.8 **Notice of Meetings**
Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least fourteen days written notice of the date and place of every meeting of the Board of Directors to all Directors.

5.9 The notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an officer of the Trust authorised by the Chair to sign on his behalf shall be delivered to every director, or sent by post to the usual place of residence of such director, so as to be available to him at least three clear days before the meeting.

5.10 Lack of service of the notice on any director shall not affect the validity of a meeting.

5.11 In the case of a meeting called by directors in default of the Chair, the notice shall be signed by those directors and no business shall be transacted at the meeting other than that specified in the notice.

5.12 Failure to serve such a notice on more than three directors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

5.13 **Chair of Meeting**
At any meeting of the Board of Directors, the Chair, if present, shall preside. If the Chair is absent from the meeting the Deputy Chair, if there is one and he is present, shall preside. If the Chair and Deputy Chair are absent such non-executive director as the directors present shall choose shall preside.

5.14 If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy Chair, if present, shall preside. If the Chair and Deputy Chair are absent, or are disqualified from participating, such non-executive director as the directors present shall choose shall preside.

5.15 **Quorum**
No business shall be transacted at a meeting of the Board of Directors unless at least one-third of the whole number of the directors are present including at least one executive director and one non-executive director.

Directors can participate in meetings by telephone or through the use of video conferencing facilities, where such facilities are available. Participation in a meeting through any of these methods shall be deemed to constitute presence in person at the meeting.

5.16 An officer in attendance for an executive director but without formal acting up status may not count towards the quorum.

5.17 If a director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest, he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business i.e. lack of a quorum for specific items will not invalidate the whole meeting.

5.18 The requirement for at least one executive director to form part of the quorum shall not apply where the executive directors are excluded from a meeting.

5.19 **Voting**

Each executive and non-executive director shall be entitled to exercise one vote. Corporate directors who are not executive directors (as described in SOs 3.4 and 3.5) shall not have a vote.

5.20 Every question at a meeting shall be determined by a majority of the votes of the directors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote.

5.21 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the directors present so request.

5.22 If at least one-third of the directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each director present voted or abstained.

5.23 If a director so requests, his vote shall be recorded by name upon any vote (other than by paper ballot).

5.24 In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

5.25 An officer who has been appointed formally by the Board of Directors to act up for an executive director during a period of incapacity or temporarily to fill an executive director vacancy, shall be entitled to exercise the voting rights of the executive director. An officer attending the Board of Directors to represent an executive director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive director. An officer's status when attending a meeting shall be recorded in the minutes.

5.26 **Setting the Agenda**
The Board of Directors may determine that certain matters shall appear on every agenda for a meeting of the Board of Directors and shall be addressed prior to any other business being conducted.

5.27 A director desiring a matter to be included on an agenda shall make his request in writing to the Chair at least ten clear days before the meeting. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chair.

5.28 **Minutes**
The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

5.29 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

5.30 Minutes shall be circulated in accordance with directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public.

5.31 **Record of Attendance**
The names of the directors present at the meeting shall be recorded in the minutes.

5.32 **Notices of Motion**
A director of the Trust desiring to move or amend a motion shall send a written notice thereof at least ten clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to SO 5.11.

5.33 **Withdrawal of Motion or Amendments**
A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

5.34 **Motion to Rescind a Resolution**

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the director who gives it and also the signature of four other directors. When any such motion has been disposed of by the Board of Directors, it shall not be competent for any director other than the Chair to propose a motion to the same effect within six months; however the Chair may do so if he considers it appropriate.

5.35 **Motions**

The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

5.36 When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

(i) An amendment to the motion.

(ii) The adjournment of the discussion or the meeting.

(iii) The appointment of an ad hoc committee to deal with a specific item of business.

(iv) That the meeting proceed to the next business.*

(v) The appointment of an ad hoc committee to deal with a specific item of business.

(vi) That the motion be now put to a vote.*

In the case of sub-paragraphs denoted by * above, to ensure objectivity motions may only be put by a Director who has not previously taken part in the debate.

5.37 No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

5.38 **Chair's Ruling**

Statements of directors made at meetings of the Board of Directors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

5.39 **Joint Directors**

Where a post of executive director is shared by more than one person:

(a) both persons shall be entitled to attend meetings of the Trust:

(b) either of those persons shall be eligible to vote in the case of agreement between them:

(c) in the case of disagreement between them no vote should be cast;

(d) the presence of either or both of those persons shall count as one person for the purposes of SO 5.15 (Quorum).

5.40 **Suspension of Standing Orders**
Any one or more of the Standing Orders may be suspended at any duly constituted meeting, provided that:

(i) at least two-thirds of the Board of Directors are present, including one executive director and one non-executive director;

(ii) a majority of those present vote in favour of suspension; and

(iii) the variation proposed does not contravene any statutory provision or direction made by NHS Improvement.

5.41 A decision to suspend SOs shall be recorded in the minutes of the meeting.

5.42 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the directors.

5.43 No formal business may be transacted while SOs are suspended.

5.44 The Audit Committee shall review every decision to suspend SOs.

6 ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

6.1 Subject to SO 1.5 and such directions as may be given by NHS Improvement, the Board of Directors may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of SO 1.5 or 6.3 or by a executive director of the Trust in each case subject to such restrictions and conditions as the Board of Directors thinks fit.

6.2 **Emergency Powers**
Those powers of the Trust which the Board of Directors has retained to itself may in urgent circumstances be exercised by the Chief Executive after having consulted the Chair. A decision is urgent where any delay would seriously prejudice the Trust's or the public's interests. The exercise of such powers by the Chief Executive shall be reported to the next formal meeting of the Board of Directors for ratification.

6.3 **Delegation to Committees**

The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board of Directors.

6.4 **Delegation to Officers**

Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions he will perform personally and shall nominate officers to undertake the remaining functions for which he will still retain accountability to the Board of Directors.

6.5 The Chief Executive shall prepare a Scheme of Delegation identifying his proposals, which shall be considered and approved by the Board of Directors, subject to any amendment, agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board of Directors as indicated above.

6.6 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Director of Finance or other executive director to provide information and advise the Board of Directors in accordance with any statutory requirements.

6.7 The arrangements made by the Board of Directors as set out in the Scheme of Delegation shall have effect as if incorporated in these Standing Orders.

7 COMMITTEES

7.1 **Appointment of Committees**

Subject to SO 1.5 and such directions as may be given by NHS Improvement, the Board of Directors may and, if directed to, shall appoint committees of the Board of Directors, consisting wholly or partly of directors of the Trust or wholly of persons who are not directors of the Trust.

7.2 *A committee appointed under SO 7.1 may, subject to such directions as may be given by NHS Improvement or the Board of Directors appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include directors of the Trust or wholly of persons who are not members of the Trust committee).*

7.3 The Standing Orders of the Board of Directors, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committee established by the Board of Directors.

7.4 Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders.

7.5 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board of Directors.

7.6 The Board of Directors shall approve the appointments to each of the committees, which it has formally constituted. Where the Board of Directors determines that persons, who are neither directors nor officers, shall be appointed to a committee, the terms of such appointment shall be determined by the Board of Directors subject to the payment of travelling and other allowances being in accordance with such sum as may be determined.

7.7 Where the Board of Directors is required to appoint persons to a committee and/or to undertake statutory functions as required by NHS Improvement, and where such appointments are to operate independently of the Board of Directors such appointment shall be made in accordance with the regulations laid down by NHS Improvement.

7.8 The committees and sub-committees established by the Board of Directors are:

(a) Audit and Risk
(b) Quality and Effectiveness
(c) Nominations and Remuneration
(d) Charitable Funds
(e) Finance and Performance

7.9 **Confidentiality**
A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

7.10 A Director of the Trust or a member of a committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee shall resolve that it is confidential.

8 DECLARATION OF INTERESTS AND REGISTER OF INTERESTS

8.1 Pursuant to Section 20 of Schedule 7 of the 2006 Act, a register of Directors' interests must be kept by the Trust.

8.2 Pursuant to Section 152 of the 2012 Act, Directors have a duty:

a) to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

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

8.3 **Declaration of Interests**
Directors are required to declare interests, which are relevant and material. All existing Directors should declare relevant and material interests. Any Directors appointed subsequently should do so on appointment.

8.4 Interests which should be regarded as "relevant and material" and which, for the guidance of doubt, should be included in the register, are:

a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).

b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.

d) A position of authority in any organisation, including charity or voluntary organisations, in the field of health and social care.

e) Any connection with a voluntary or other organisation contracting for NHS services.

f) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS Foundation Trust, including but not limited to, lenders or banks.

8.5 If directors have any doubt about the relevance of an interest, this should be discussed with the Chair.

8.6 At the time the interests are declared, they should be recorded as appropriate. Any changes in interests should be declared at the next Board of Directors meeting as appropriate following the change occurring. It is the obligation of the Director to inform the Trust Board Secretary in writing within 7 days of becoming aware of the existence of a relevant or material interest. The Secretary will amend the Register upon receipt within 3 working days.

8.7 During the course of a Board of Directors meeting, if a conflict of interest is established, the director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, this includes voting on such an issue where a conflict is established. If there is a dispute as to whether a conflict of interest does exist, majority will resolve the issue with the Chair having the casting vote.

8.8 There is no requirement for the interests of directors' spouses or partners to be declared.

8.9 **Authorisation of Conflict of Interest**
Where a director has a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust (in contravention of the duty outlined at SO 8.2), this may be authorised if a majority of directors vote in favour of authorisation. If there is a dispute as to whether a conflict or potential conflict of interest exists, majority will resolve the issue with the Chair having the casting vote.

8.10 If a director has a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust that is not authorised by the Board of Directors, the director in question will be deemed to be in breach of the statutory duty outlined at SO 8.2.

8.11 **Register of Interests**
The details of directors' interests recorded in the Register will be kept up to date by means of a monthly review of the Register by the Secretary, during which any changes of interests declared during the preceding month will be incorporated.

8.12 Subject to contrary regulations being passed, the Register will be available for inspection by the public free of charge. The Chair will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it. Copies or extracts of the Register must be provided to members of the Trust free of charge and within a reasonable time period of the request. A reasonable charge may be imposed on non-members for copies or extracts of the Register.

9 DISABILITY OF DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

9.1 If a director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board of Directors at which the contract or other matter is the subject of consideration, he shall at the meeting

and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

9.2 The Trust shall exclude a director from a meeting of the Board of Directors while any contract, proposed contract or other matter in which he has a pecuniary interest, is under consideration.

9.3 For the purpose of this Standing Order, directors shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

(a) he, or a nominee of his, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration;

or

(b) he is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

and in the case of married persons, persons in a civil partnership, or unmarried persons living together as partners, the interest of one spouse or partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

9.4 A director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

(a) of his membership of a company or other body, if he has no beneficial interest in any securities of that company or other body;

(b) of an interest in any company, body or person with which he is connected as mentioned in SO 9.3 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

9.5 Where a director:

(a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

(b) the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

(c) if the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

this Standing Order shall not prohibit him from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his duty to disclose his interest.

9.6 SO 9 applies to a committee or sub-committee of the Board of Directors as it applies to the Board of Directors and applies to any member of any such committee or sub-committee (whether or not he is also a director of the Trust) as it applies to a director of the Trust.

10 STANDARDS OF BUSINESS CONDUCT

10.1 **Policy**
Directors shall act in accordance with the Nolan Principles Governing Conduct of Public Office Holders at all times.

10.2 The Trust has adopted as good practice the national guidance contained in HSG(93)5 `Standards of Business Conduct for NHS staff' and staff must comply with this guidance. The following provisions should be read in conjunction with this document.

10.3 **Interest of Officers in Contracts**
If it comes to the knowledge of a director or an officer of the Trust that a contract in which he has any pecuniary interest not being a contract to which he is himself a party, has been, or is proposed to be, entered into by the Trust he shall, at once, give notice in writing to the Chief Executive of the fact that he is interested therein. In the case of married persons, or persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

10.4 An officer must also declare to the Chief Executive any other employment or business or other relationship of his, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

10.5 The Trust shall require interests, employment or relationships so declared by staff to be entered in a register of interests of staff.

10.6 **Canvassing of, and Recommendations by, Directors in Relation to Appointments**
Canvassing of directors of the Trust or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

10.7 A director of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

10.8 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

10.9 **Relatives of Directors or Officers**
Candidates for any staff appointment shall when making application disclose in writing whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

10.10 The directors and every officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Board of Directors any such disclosure made.

10.11 On appointment, directors (and prior to acceptance of an appointment in the case of executive directors) should disclose to the Trust whether they are related to any other director or holder of any office under the Trust.

10.12 Where the relationship of an officer or another director to a director of the Trust is disclosed, the Standing Order headed `Disability of directors in proceedings on account of pecuniary interest' (SO 9) shall apply.

10.13 In accordance with paragraph 1.1.2 of the Trust's Standards of Business Conduct and Employees Declarations of Interest Policy, any Board member or member of staff who receives or is offered and declines hospitality in excess of £50.00 is required to enter the details of the hospitality in the Trust's Hospitality Register.

11 TENDERING AND CONTRACT PROCEDURES

11.1 **Duty to comply with Standing Orders**
The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders (except where SO 5.40 (Suspension of SOs) is applied).

11.2 **EU Directives Governing Public Procurement**
Directives by the Council of the European Union promulgated by the Department of Health (DoH) or any subsequent public procurement legislation following the UKs exit from the European Union prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders.

11.3 The Trust shall comply as far as is practicable with the requirements of the Capital Investment Manual and with guidance contained in "The Procurement and Management of Consultants within the NHS".

11.4 Financial Thresholds

The Trust shall set financial thresholds above which competitive quotations and tenders are to be invited. The value to be compared to the threshold is the estimated full amount of the goods and/or services to be paid during the life of the contract exclusive of vat.

11.5 The estimated value of the requirement is calculated with reference to the following:

a) all possible options under the contract need are included;

b) where volumes and prices are known in advance, then the value of the contract is the full amount which will be paid during the life of the contract;

c) where the contract is for an indefinite period, or for a period of time which is uncertain when the contract is entered into, or the volumes are uncertain, then the estimated amount to be paid is the estimated monthly value multiplied by 24;

d) where it is proposed to enter into two or more contracts for goods or services of a particular type, then the estimated value of each of the contracts must be added together. This aggregate value is the one which must be applied and assessed against the threshold. Where the aggregate value is above the threshold, each contract has to be put to competition, even if the estimated value of each individual contract is below the threshold;

e) for building or engineering works this is the estimated value of the whole works project, irrespective of whether or not it comprises a number of separate contracts for different activities. For example if the construction of a new building is divided into three phases, site clearance, construction and fitting out, the threshold must be applied to the value of all three phases, even though the activities are different and different contractors may be used.

11.6 If the estimate proves to have been flawed, for example, because bids or the eventual contract value are significantly higher than estimated, there may be a breach of the Regulations and the competition may have to be stopped and started again. There may, for example, be unfairness to contractors who relied upon a flawed estimate in reaching a decision not to bid for a particular contract.

11.7 The current thresholds (exclusive of vat) are 3 written quotes up to £25,000, formal quotes up to £50,000; local tenders £50,000 to EU Threshold and measured term contract for works £250,000.

11.8 **Formal Competitive Tendering and Quotations**

The Trust shall ensure that competitive tenders are invited for the supply of goods, materials and manufactured articles and for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DoH); for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); where the value is expected to exceed the financial threshold (11.7)and for disposals.

11.9 Formal tendering procedures may be waived by officers to whom powers have been delegated by the Chief Executive without reference to the Chief Executive where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed the financial threshold (11.7); or

(b) where the supply is proposed under special arrangements negotiated by the DoH in which event the said special arrangements must be complied with.

11.10 Formal tendering procedures are not required where:

(a) the requirement is covered by an existing contract;

(b) the requirement is covered by an existing framework

11.11 Formal tendering procedures may be waived by the Chief Executive where:

(a) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

(d) the timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender; or

(e) specialist expertise is required and is available from only one source; or

(f) the task is essential to complete the project, AND arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; or

(g) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; or

(h) where provided for in the Capital Investment Manual.

Where it is decided that competitive tendering is not applicable and should be waived by virtue of (d) to (g) above the fact of the waiver and the reasons should be documented and reported by the Chief Executive to the Audit and Risk Committee in the next formal meeting.

11.12 The limited application of the single tender rules (11.9 and 11.10 above) should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

11.13 Quotations are required from at least three suppliers where formal tendering procedures are waived under SO 11.9 (a) and where the intended expenditure or income exceeds, or is reasonably expected to exceed the financial threshold (11.7).

11.14 If a framework agreement is to be used, the selection of the best supplier for the particular need is to be made on the basis of either:

(a) the supplier offering the most economically advantageous offer (using the original award criteria) for the particular need where the terms of the agreement are precise enough; or

(b) through mini competition between those suppliers on the framework capable of meeting the particular need using the terms of the original terms, supplemented or refined as necessary.

11.15 Works requirements falling below the MTC financial threshold (11.7) can be placed with the measured term contract supplier, following the process set out in that contract.

11.16 Except where SOs 11.10 and 11.11, or a requirement under SO 11.2, applies, the Board of Directors shall ensure that invitations to tender are sent to a sufficient number of suppliers to provide fair and adequate competition as appropriate, and in no case less than three written competitive tenders must be obtained, having regard to suppliers capacity to supply the goods or materials or to undertake the services or works required.

11.17 The number of suppliers to be invited to tender for building and engineering schemes valued above the financial threshold (11.7) will be a minimum of six, of which four written competitive tenders must be obtained, unless the requirement is waived in writing by the Chief Executive or Director of Finance.

11.18 The Board of Directors shall ensure that normally the suppliers invited to tender (and where appropriate, quote) for building and engineering schemes are among those on approved lists (see Annex Section 5). Where in the opinion of the Director of Finance it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive.

11.19 Tendering procedures are set out in the Annex.

11.20 Quotations should be in writing or via the e-tendering system for quotes above £25,000 unless the Chief Executive or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotation should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

11.21 All quotations should be treated as confidential and should be retained for inspection.

11.22 The Chief Executive or his nominated officer should evaluate the quotations and select the one that is either the lowest cost or is the most economically advantages to the Trust taking into account quality. If this is not the lowest or economically advantages then this fact and the reasons why should be in a permanent record.

11.23 **Where tendering or competitive quotation is not required**
Where tenders or quotations are not required, because expenditure is below the financial threshold (11.7), the Trust shall procure goods and services in accordance with procurement procedures approved by the Board of Directors.

11.24 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided under contract or in-house. The Board of Directors may also determine from time to time that in-house services should be market tested by competitive tendering (SO 11.8).

11.25 **Private Finance**
When the Board of Directors proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) The proposal must be specifically agreed by the Board of Directors in the light of such professional advice as should reasonably be sought in particular with regard to vires.

(c) The selection of a private sector partner must be on the basis of competitive tendering or quotations.

11.26 **Contracts**
The Trust may only enter into contracts within its statutory powers and shall comply with:

(a) these Standing Orders;

(b) the Trust's SFIs;

(c) EU Directives, their subsequent replacements in UK law and other statutory provisions.

(d) any relevant directions including the Capital Investment Manual and guidance on the Procurement and Management of Consultants;

Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

11.27 In all contracts made by the Trust, the Board of Directors shall endeavour to obtain best value for money. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

11.28 **Personnel and Temporary Staff Contracts**
The Chief Executive shall nominate officers with delegated authority to enter into contracts for the employment of other officers, to authorise regrading of staff, and enter into contracts for the employment of temporary staff.

11.29 **Healthcare Services Contracts**
Healthcare Services Contracts made between two NHS organisations are subject to the provisions of the 2006 Act.

11.30 The Chief Executive shall nominate officers with power to negotiate for the provision of healthcare services with commissioners of healthcare.

11.31 **Contracts Involving Funds Held on Trust**
Contracts Involving Funds Held on Trust shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Acts.

11.32 **Legality of Payments**
It is the responsibility of the Director of Finance to ensure that all payments made by the Trust fall within its powers.

12 DISPOSALS

12.1 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the Trust's condemnation policy;

(c) items to be disposed of with an estimated sale value of less than £5,000;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DoH guidance has been issued but subject to compliance with such guidance.

13 IN HOUSE SERVICES

13.1 In all cases where the Board of Directors determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer(s) and specialist(s).

(b) In-house tender group, comprising representatives of the in-house team, a nominee of the Chief Executive and technical support.

(c) Evaluation group, comprising normally a specialist officer, a supplies officer and a Director of Finance representative. For services having a likely annual expenditure exceeding £250,000, a non-executive director should be a member of the evaluation team.

13.2 All groups should work independently of each other but individual officers may be a member of more than one group. No member of the in-house tender group may, however, participate in the evaluation of tenders.

13.3 The evaluation group shall make recommendations to the Board of Directors.

13.4 The Chief Executive shall nominate an officer to oversee and manage the contract.

14 CUSTODY OF SEAL AND SEALING OF DOCUMENTS

14.1 **Custody of Seal**
The Common Seal of the Trust shall be kept by the Company Secretary in a secure place.

14.2 **Sealing of Documents**
The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board of Directors or of a committee, thereof or where the Board of Directors has delegated its powers.

14.3 The legal requirement to "seal" documents executed as a deed has been removed. The Board of Directors' may however, choose to continue to use the seal.

14.4 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Finance (or an officer nominated by him) and authorised and countersigned by the Chief Executive (or an officer nominated by him). Officers nominated to approve the use of the seal on behalf of either the Director of Finance or Chief Executive shall not be within the originating directorate.

14.5 **Register of Sealing**
An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Board of Directors at least quarterly. (The report shall contain details of the seal number, description of the document, date of sealing, and the directors authorising the use of the seal).

15 SIGNATURE OF DOCUMENTS

15.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.

15.2 The Chief Executive or nominated officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board of Directors or committee or sub-committee to which the Board of Directors has delegated appropriate authority.

16 MISCELLANEOUS

16.1 **Standing Orders to be given to Directors and Officers**
It is the duty of the Chair to ensure that existing Governors and all new Directors are notified of and understand their responsibilities within SOs and SFIs. Updated copies shall be issued to Directors designated by the Chair. New Directors shall be informed in writing and shall receive copies where appropriate of SOs.

16.2 **Documents having the standing of Standing Orders**
Standing Financial Instructions shall have effect as if incorporated into SOs.

16.3 **Review of Standing Orders**
Standing Orders shall be reviewed annually by the Board of Directors. The requirement for review extends to all documents having the effect as if incorporated in SOs.

17 VARIATION AND AMENDMENT OF STANDING ORDERS

17.1 These Standing Orders shall be amended only if:

(i) at least two-thirds of the Board of Directors are present; and

(ii) a majority of those present, including no fewer than half the total of the Trust's non-executive directors, vote in favour of amendment; and

(iii) the variation proposed does not contravene any statutory provision or direction made by NHS Improvement.

Annex - TENDERING PROCEDURE

1 INVITATION TO TENDER

1.1 All invitations to submit a tender on a formal competitive basis by utilising the E-Tender Portal and shall include:

(a) clear instructions of documentation to complete, including pricing information, technical specifications and business continuity plans

(b) details of the closing date, time and place of receipt of submission with a named lead of who to contact should there be submission problems.

1.2 Extensions of time for the period allowed for receipt of tenders shall only be considered where no tenders have been received or, if tenders have been received, on the basis that all parties are notified and all agreed to the proposed extension . Suppliers may re-submit if they wish by the new deadline.

1.3 Each invitation shall include as a minimum (where appropriate) the following:

(a) Instructions to Offer
(b) Terms of offer including Evaluation Criteria
(c) Specification of goods/service
(d) Terms and conditions of contract as appropriate.
(e) Offer schedule(s)
(f) Form of offer

1.4 Other than in exceptional circumstances, all preparation in relation to the specification and the evaluation of product should be conducted prior to invitation to tender.

1.5 Other than in exceptional circumstances, all preparation in relation to the specification and the evaluation of product should be conducted prior to invitation to tender.

1.6 There shall normally be no contact between Officers of the Trust and the candidates invited to tender in relation to the tender or the proposed contract between the issue of the tender documentation and the award of the contract other than via the use of the Electronic Portal to:-

(a) clarify questions relating to the specification, or
(b) clarify questions relating to the completion of the tender documents, or
(c) offer all parties invited to tender a briefing on the Trust's requirements with the opportunity for the Officers of the Trust and such persons as deemed appropriate and parties invited to tender representatives to ask questions of each other at a meeting arranged by the Trust specifically for this purpose:

where this happens an electronic record should be made and retained for future inspection, or

(d) arrange trials of supplies and/or equipment.

No clarification by Officers of the Trust shall be sought with candidates in relation to financial matters including pricing until after tenders have been opened.

2 RECEIPT, SAFE CUSTODY AND RECORD OF FORMAL TENDERS

2.1 All communicating with candidates between invitation to tender and receipt of tender by the Trust shall be channelled through the e-tendering portal.

2.1.1 Unsuccessful tenderers will be notified via the e-tendering portal.

2.1.3 All tenders received and associated documents (or copies of) will be retained by those seeking the tender and stored on the E-Tendering Portal against the unique Contract reference number for future reference, inspection and audit where required along with the evaluation scoring and details of the evaluation team.

2.1.4 By utilising the E-Tendering Portal procedures shall be adopted to ensure that all tenders received are retained in the secure electronic Portal and remain unopened until such time as they are officially opened which shall be as soon as is reasonably practicable following the latest date and time set for receipt of tenders.

2.2 The tenders will be opened and recorded electronically in the e-tendering portal by two Procurement officers.

2.3 Where examination of tenders reveals errors which would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing his offer.

2.4 Where the lowest tender submitted is so much below the estimate it prompts doubts as to whether an error has been made in tendering, especially where it differs substantially from the other tenders, confirmation of price may be sought from the tenderer via the e-tendering portal without disclosing that it is the lowest tenderer, and an assurance that the contractual arrangements and technical documentation have been fully understood. If the tenderer has made an error, he may withdraw his tender. If he stands by his original price, it must be decided whether acceptance would carry too great a risk of subsequent failure before establishing an order of preference.

2.5 Where only one tender/quotation is received the Trust shall, as far as practicable, ensure that the price to be paid is fair and reasonable.

2.6 Wherever the invitation to tender does not demonstrate sufficient competition by reason of an inadequate response to the invitation, the supervising officer/project manager concerned shall set up a fresh competition, and all tenderers submitting a tender from the original invitation shall be invited to re-tender.

3 WORKS TENDERS

3.1 Every tender for building and engineering works, except for maintenance work only where Estmancode guidance should be followed, shall embody or be in the terms of the current edition of either the appropriate Joint Contracts Tribunal (JCT) or Department of the Environment (GC/Wks) standard forms of contract or NEC3 form of contract amended to comply with Concode. When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institutions of Mechanical Engineers, Electrical Engineers and the Association of Consulting Engineers (Form A) or, in the case of civil engineering work, the General Conditions of Contract recommended by the Institution of Civil Engineers. The standard documents should be amended to comply with Concode and, in minor respects, to cover special features of individual projects. Tendering based on other forms of contract may be used only after prior consultation with the DoH.

3.2 Works to a maximum value of £250,000 may alternatively be procured through an agreed Measured Term Contract, based on the provisions of the Joint Contracts Tribunal (JCT) contract form. The current Measured Term Contract award should be renewed in February 2017.

3.3 Works of value greater than £1m may be procured under an EU Public Procurement compliant Procure 22.

4 APPROVED FIRMS

(a) **Building and Engineering Construction Works**

(i) Invitations to tender shall be via compliant procurement routes in conjunction with the procurement team.

(ii) Suppliers that are successful in winning contracts shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of current legislation and regulations.

(iii) All Contractors shall conform with the requirements of the Health and Safety at Work Act etc. 1974, Management of Health & Safety at Work Regulations 1999

and any amending and/or other related legislation concerned with the Health, Safety and Welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution and the Construction (Design & Management) Regulations 2015. Contractors are legally required to provide to the appropriate Estates & Facilities manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested and associated Risk Assessment & Method Statement pertinent to specific projects commensurate with standard Health & Safety methodology.

(b) **Financial Standing and Technical Competence of Contractors**
The Director of Finance may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director of Estates and Facilities will similarly make such enquiries as is felt appropriate to be satisfied as to their technical competence.

5 NEGOTIATED TENDERS

5.1 The use of a negotiated tender leading to a 'continuation' or 'run-on' contract may be appropriate where the need arises for additional work which, if authorised as variation on the existing contract or let to another contractor would be undesirable or unduly disruptive and expensive. This situation can arise in two circumstances:

(a) when the need is for further work of a similar nature to that already being executed and normally on the same or a closely adjoining site; and

(b) when the need is for alteration to the works executed in the original contract which it is important should be carried out by the same contractor in order to safeguard the Trust's rights with regard to defects in the works.

5.2 The following criteria must be observed when considering the use of negotiated tender procedure:

(a) The initial contract must have been awarded as a result of competitive tendering.

(b) The new work must not be of a disproportionately high value (i.e. as a general rule not more than 50%) in relation to the value of the initial contract.

(c) For further work of a similar nature a high proportion (at least 60%) of the value of the new work must be covered by rates included in the initial contract that can be used as basis of negotiation of new rates.

(d) For alteration works, the rates must be based as far as practicable on the same fundamental costing data used for rates in the initial contract.

(e) The aggregate value of contracts awarded for additional works may not exceed 50% of the value of the original contract.

(f) During the negotiations the contractor's agreement must be obtained that the addition of further work will not later be raised by him as a ground for a claim for disruption of the initial contract. (The costs of any necessary reorganisation of the initial contract so as to accommodate the further work must be raised during the negotiations and, if agreed, included in the negotiated amount).

(g) At the conclusion of the negotiations the Trust must have reasonable evidence to show that the negotiated amount is no less favourable than a freshly obtained competitive tender would be.

(h) The procedure must not be used simply to recover time lost during the initial contract or as a means of bringing forward a later scheme, or as a substitute for good planning.

(i) The details of the further work should be fully prepared and meet the normal requirements of readiness to proceed to tender.

(j) The timetable for the negotiations should be linked with the planning of capital expenditure so that this does not place any additional constraint on the Trust's freedom of action.

6 TENDERS NOT STRICTLY IN ACCORDANCE WITH SPECIFICATION

6.1 Tenders not strictly in accordance with the specification may be considered if a marked financial advantage to the Trust would otherwise be lost. A marked financial advantage is a saving in excess of £1000 or 1% of the tender price, whichever is the greater.

6.2 Provided there is no reason to doubt the bona fides of the tenderer, the lowest tenderer to specification may be asked to revise his tender to conform to the revised specification.

6.3 If he is willing to do so but refuses to abide by his original price, his tender must be rejected.

6.4 If he declines to revise his tender to conform with the specification then, in the case of professional Services Contracts or Supplies Contracts, post tender negotiations may be undertaken in accordance with the procedures below. Otherwise his tender should be rejected and the second lowest (or second highest in the case of a sale) should be

considered.

6.5 If so many of the tenderers fail to conform with the specification that the whole basis of the competition is invalidated or post tender negotiations do not take place then consideration should be given to re-commencing competition and inviting further tenders.

7 POST TENDER NEGOTIATION

7.1 At any time prior to acceptance of a tender by the Trust the Chief Executive or any officer authorised by him, may authorise post tender negotiations if it appears that a marked financial advantage as defined above may accrue to the Trust, or, if subsequently there has been a bona fide change in specification which is not so significant as to warrant abandonment of the procedure and the invitation of further tenders.

7.2 Where the negotiation is carried out by officers of the Trust each tenderer shall be notified that the Trust wishes to enter into post tender negotiations, and at least each of the three lowest (or highest in the case of a sale) tenderers, or all the tenderers if less than three submitted valid tenders, shall be invited to attend a separate meeting at the Trust's offices (unless an adverse financial report has been received from the Director of Finance in respect of any tenderer, in which case that tenderer shall be excluded from the invitation). At each such meeting the Trust shall be represented by at least two officers, one of whom shall write a minute of the meeting, which, as soon as practicable thereafter, shall be confirmed as correct by the other officer and each tenderer shall be given equal opportunity on an equal footing insofar as it is reasonably practicable to negotiate his tender, whether as to price, quality or in any other respect. Negotiations with each tenderer may continue over a series of meetings and any amendment finally negotiated shall be confirmed by the tenderer in writing to the Trust.

7.3 The time during which all negotiations shall be completed by receipt of written confirmation of any amendments shall be specified in the invitation referred to in 8.2 above and may be extended by notice in writing from the Trust to all tenderers at any time.

7.4 Post tender negotiation in relation to Estates contracts shall only take place in accordance with the guidance given in the current edition of the Code of Procedure Single Stage Selective Tendering issued by the National Joint Consultative Committee for Building.

7.5 Upon the expiration of the time for negotiation, or any extended period, any amended tender shall be considered in accordance Section 4 on the Acceptance of Tenders.

8 PRESERVATION AND DESTRUCTION OF DOCUMENTS

8.1 **Estates' Tenders**
Documents relating to the successful tender shall not be destroyed. Documents relating to unsuccessful tenders will be destroyed after six successive financial years following the financial year of origin.

8.2 **Supply of Goods and Services**
Documents relating to the successful tender shall not be destroyed. Documents relating to unsuccessful tenders will be destroyed six years after the end of the financial year of origin.

9 FORMS OF CONTRACT

9.1 Supplies contracts may be executed under hand.

9.2 An Official Order or Letter of Acceptance will be sent to the successful tenderer in respect of contracts for estates services up to and including £250,000 in value. In the case of estates services which exceed £250,000 in value but do not exceed £500,000, contracts may be executed underhand.

9.3 Those exceeding £500,000 in value will be executed under the Common Seal of the Trust.

9.4 Every contract for building and engineering works (except contracts for maintenance work only, where Estmancode guidance should be followed) shall embody or be in the same terms and conditions of contract as those on the basis of which tenders were invited.

9.5 In the case of Consultants' commissioning agreements relating to building and engineering works, to which a professional service contract for consultant design services relates, the contract shall be evidenced in writing, so far as is possible having regard to the custom and practice of the profession concerned.

Appendix 1.

Temporary COVID19 Business Continuity Terms of Reference

Trust Board, Board Committee and Governor Meetings
March 2020

Standing Orders: Emergency Powers
The powers which the Board has reserved to itself within its Standing Orders may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Trust Board in public session for formal ratification as per section 6.2 of current Standing Orders.

1. The Terms of Reference and Membership, including quorum arrangements, for the Board and its Committees will be temporarily suspended as of 17th March 2020, until further notice. All other aspects of the Trust Standing orders remains unchanged.

2. During this period, if meetings are to be held, then this will be done through the use of telephone / digital technology.

3. The primary focus of communication with the Board and sub committees will be the organisation's response to COVID19 whilst continuing to have an overview on the safety of all DBTH patients and the wellbeing of staff. The governance assurance for this overview will be provided through the Trusts COVID19 Strategic Management plan.

4. Whilst some effort will be made to continue aspects of 'business as usual' activity, based upon the existing business cycles / forward agenda:

a) All matters for approval will be either:
- Deferred if not urgent or
- Circulated to Board / Committee members via email for approval, whilst allowing sufficient time for review / response or
- Discussed via telephone / digital technology with the decision recorded by Corporate Governance or
- Discussed between the Chief Executive or nominated Executive Director with the Board / Committee chair for Chairs Action

b) In these circumstances the quorum will be two Executive Directors (CEO and DeputyCEO or DoF) and two Non-Executive Directors (Chair or Vice Chair and one other).

5. It is likely that those responsible for preparing assurance papers for Committees and the Board will not be in a position to do so. Therefore:

a) All matters for information or assurance will be either:

- Put on hold until further notice or
- Circulated via email

6. For ad hoc items agreed by the Executive Directors as requiring a decision by the Board:
- Circulated to Board / Committee members via email for approval, whilst allowing sufficient time for review / response or
- Discussed via telephone / digital technology with the decision recorded by Corporate Governance
- Discussed between the Chief Executive or nominated Executive Director with the Board / Committee chair for Chairs Action

c) In these circumstances the quorum will be two Executive Directors (CEO and DeputyCEO or DoF) and two Non-Executive Directors (Chair or Vice Chair and one other).

7. The Business Cycles will be reviewed and updated within Corporate Governance, to maintain an accurate record of items considered / approved or deferred.

8. Council of Governors meeting (including Governor Forum and Governor Briefing) have been put on hold until further notice. The Chair and Company Secretary will keep the Governors informed as required. For example, the Governors will be forwarded a copy of this paper after it is approved at Board on 21 April 2020. The Chair will also contact the lead and deputy lead Governors as required to keep them in the picture.

9. Council of Governor elections – In view of the pressure on the Trust due to COVID19 the recruitment campaign has been suspended (approved at Board 21 March 2020). Social distancing 'rules' make meaningful engagement with prospective governors impossible at the moment, and for the next few weeks, possibly months. COVID19 permitting, the proposal is to pick up planning for the election in June before current governor terms end and set a schedule to run an election around October.
All governors will be able to continue until the end of their current term and those who are eligible will be able to apply to be re-elected once the timetable has been set in the autumn.
This proposal will be reviewed in June in the light of COVID19 issues at that time.

10. The Chairs Appraisal will take place to meet the NHS Providers deadline of 30 June 2020. The Non-Executive Directors appraisals will take place to meet the NHS Providers deadline of 30 September 2020.

11. These COVID19 temporary terms of reference are an addendum to the Trusts current Standing Orders CORP/FIN1 (A) v9 and if it is silent on a matter then the Trusts Standing orders should be referred and complied with.

Date Approved: 21/4/2020 (Board of Directors)
Date for Review: 21/4/2021

APPENDIX 1 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	CSU/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Standing Orders Board of Directors 2020 – CORP/FIN 1 (A) v10	CE/Finance	Jon Sargeant/Matthew Bancroft	Existing Policy	June 2020

1) Who is responsible for this policy? Name of CSU/Directorate – Finance Department

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes? To provide standing orders for the Board and a framework for the delegation of powers from the Board.

3) Are there any associated objectives? Legislation, targets national expectation, standards No

4) What factors contribute or detract from achieving intended outcomes? – Compliance with the policy

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] - No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] – N/A

6) Is there any scope for new measures which would promote equality? [any actions to be taken] N/A

7) Are any of the following groups adversely affected by the policy? No

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: June 2021

Checked by: Jon Sargeant/Matthew Bancroft **Date: June 2020**

FINANCE AND PERFORMANCE COMMITTEE ANNUAL REPORT 2020 21

DATE:	**15th April 2021**
PREPARED BY:	**Neil Rhodes, Chair of the Finance and Performance Committee**

1 INTRODUCTION

1.1 The Finance and Performance Committee was established in June 2017 as a committee of the Board of Directors, replacing the Financial Oversight Committee. The remit of the Committee is to provide assurance on the systems of control and governance specifically in relation to operational performance, workforce and financial planning and reporting. The work plan is continually reviewed at each committee as a standing item.

The purpose of this report is to provide the Board of Directors with a summary of the work of the Finance and Performance Committee ("the committee") for the year 2021/21 including:

a) providing detailed scrutiny of financial matters and operational performance in order to provide assurance and raise concerns to the Board of Directors;

b) making recommendations, as appropriate, on financial and performance matters to the Board of Directors;

c) reviewing and challenging significant business cases before submission to the Trust Board;

d) providing Governors with assurance that the NEDs are holding the Executive Team to account for delivery of the Trust's strategic plan in particular financial and operational performance, and to make recommendations of any changes for the year 2020/21.

It is to be noted that assurance relating to workforce matters have been the responsibility of the new People Committee since November 2020.

Chair's Reflection

This annual report follows a standard approach to sharing the business of the Finance and Performance Committee with the Board. However, I wanted to open with a personal reflection upon what has been a very challenging year, not only for the Committee but also the Trust, and indeed beyond.

It is now just over a year since the first lockdown. The normal battle rhythm of the year with budgets, CIPs, progress sessions and the tracking of both operational and financial performance was set aside as we coped with what was effectively a still continuing twelve month long critical incident. Block provision of finance and a different level and type of scrutiny role was adopted

	as we sought to continue to make best use of public money, support and protect staff and deliver prioritised healthcare under enormous pressure. We moved to managing many aspects of corporate business through Microsoft Teams. We saw our staff and executive colleagues perform in an exemplary manner in both the operational and organisational arena. Over recent months, and now as we look to the year ahead, we have been careful to continue to emphasise the need for service recovery alongside responsible financial discipline. We do this in the context of both significant system change, with a broader, statutory role for the ICS and also in terms of massive operational challenges in coping compassionately with latent demand and significant backlogs of elective need. In this context, oversight of detailed planning for the recovery of service has been a key component of all recent Finance and Performance Committee meetings. The quality of that planning, and the underpinning processes that have been put in place to operationalise it, has given the Committee significant assurance that the Trust is well placed to meet the challenges of the year ahead.
1.2	This report summarises the key information required against last year's recommendations and each of four elements namely: a) The role and the main responsibilities of the Committee; b) Membership of the Committee; c) Number of meetings and attendance.
2	**STRATEGIC CONTEXT**
2.1	The Finance and Performance Committee (F&P) is one of the five Board Committees (Quality and Effectiveness Committee, Audit and Risk Committee, People Committee and Charitable Funds Committee) and is responsible for providing assurance to the Board of Directors on the standards of financial and operation performance; and the assurance of the achievement of the key performance indicators relating to the workforce within the Trust. The Committee is responsible for assisting the Board in identifying and potential or actual risks to financial and operational performance and ensuring that any risks identified are robustly addressed.
2.2	Alongside the Quality and Effectiveness Committee (QEC), Audit and Risk Committee (ARC) and the People Committee (PC), F&P is responsible for ensuring that there are adequate and appropriate financial and operational governance structures, processes and controls in place throughout the Trust to ensure financial security and excellent operational performance.
3	**THE ROLES AND MAIN RESPONSIBILITIES OF THE COMMITTEE**
3.1	The main purpose of the Committee is to:

	a) Provide detailed scrutiny of financial matters and operational performance in order to provide assurance and raise concerns to the Board of Directors; b) Provide detailed scrutiny against the reported performance of workforce management data and internal key performance indicators, and to provide assurance and raise concerns to the Board of Directors; c) Make recommendations, as appropriate, on financial and performance matters to the Board of Directors.
4	**MAIN ACTIVITIES**
4.1	During 2020/21 the Committee has delivered its key responsibilities and duties as outlined in its Terms of Reference with a caveat that normal systems and processes in place were largely affected during the year due to the COVID-19 pandemic. Meetings have been held in accordance with the agreed schedule.
4.2	All issues for escalation have been continuously reported upwards to the Board of Directors with relevant information being shared with QEC, ARC and PC.
4.3	Through monthly review and scrutiny of the Trust's Integrated Performance Report, the Committee has been able to provide the Board of Directors with the assurance that performance is being monitored on a monthly basis, however has been significantly affected by COVID-19 operational pressures. Throughout the year the Committee has continuously scrutinised and challenged the accuracy and robustness of the information being reported, ensuring that financial and operational improvements are being made and organisational learning is being implemented.
4.4	The main areas reviewed over the year can be summarised as: a) The majority of the work undertaken by the Committee has been review and scrutiny of COVID-19 financial and operational plans including start of elective restoration programme; b) Financial matters – the Committee reviewed financial performance as a key part of its monthly meetings; c) Performance Management – the Committee reviewed performance management as a key part of its monthly meetings; d) Workforce Management – the Committee reviewed management data relating to the management of the workforce as a key part of its monthly meetings (until November 2020 when workforce assurance responsibility was moved to the People Committee); e) Contract negotiation and performance – the Committee reviewed contracts periodically as contracts are due for renewal;

	f) Risk management and internal control – the Committee considered this as a key part of its monthly meetings.
4.5	Specific areas covered during 2020/21 on behalf of the Board were: **Performance** • Scrutiny of operational performance; • Scrutiny of the initial operational response to COVID-19, and the elective restoration plans; • Undertaking deep dives into key service areas and areas of performance; • Revised operational performance to include COVID-19 related measured reported through the Integrated Performance Report; • Received information relating to the consultation work for capacity planning for 2021/22 as part of the restoration of elective services. **Finance** • Financial forecasts, budgets and plans in line with block contract arrangements in place due to COVID-19; • Budget setting and annual planning; • A review of reference patient level costing (PLICS) and service line reporting (SLR); • Reviewed and recommended to the Board the Trust draft accounts for 2020/21 before submission to external audit and the DoH in draft format; • Reviewed and recommended to the Trust Board the accounting policies for the Trust; • Through its work the Committee supported the Trust to monitor its financial control total, which was a break-even financial position. **Workforce** • Focused on the scrutiny of workforce data in light of the impact of COVID-19 including sickness absence, staff COVID-19 testing, and the health and wellbeing offer to colleagues;

- Continued to scrutinise bank and agency use, and vacancy rates.

Governance

- A review of the Board Assurance Framework had taken place and any specific risks relevant to the Committee had been reported and reviewed.

5 REPORTING

5.1 Minutes of each of the meetings were formally presented to a subsequent meeting of the Board of Directors, with the Committee Chair drawing any key issues to the attention of the Board.

5.2 Assurance was provided to the Board of Directors through a Chair's Log after each Committee meeting. Board was given the opportunity to question the Chair of the Committee. Following the implementation of a new Board and Committee reporting structure, Chairs Logs ceased in March 2021 and assurance to the Board would be provided in the new front sheet format under the assurance section in the business-as-usual reports.

5.3 The Chair of Finance and Performance Committee attended Council of Governors to answer questions and provide assurance to governors.

6 MEETINGS AND MEMBERSHIP

6.1 The Committee met on 9 occasions during 2020/21 and the Committee's membership and attendance has been as follows:

Name	Role	Meeting attendance
Neil Rhodes – Chair	Non-executive Director	9 of 9
Karen Barnard	Director of People and Organisational Development (until November 2021)	6 of 6
Jon Sargeant	Director of Finance	9 of 9
Rebecca Joyce	Chief Operating Officer (from 3 June 2019)	8 of 9
Pat Drake	Non-executive Director	9 of 9
Kath Smart	Non-executive Director	8 of 9

7 SUB COMMITTEES

7.1 The committee has the following sub-committee:

- Cash Committee
- Capital Monitoring Group
- Workforce Education & Research Committee (until November 2021)
- Effectiveness and Efficiency Committee (All meetings stood down due to COVID-19 during 2020/21)

Minutes of the sub-committees are presented to each meeting of the Committee for information.

	The Committee receives information and assurances from the Trust's internal management and operational committees as required. During 2020/21 this included Corporate Investment Group, Capital Monitoring Group and Workforce Education & Research Committee.
8	**WORK PLAN**
8.1	The Committee's work was largely dictated by the operational and financial pressures present because of the COVID-19 pandemic, however the work-plan was reviewed at each committee and at pre-meetings that took place approximately two weeks before the Committee.
9	**COMMITTEE EFFECTIVENESS**
9.1	The committee has not conducted a committee effectiveness review since 2018/19 however a comprehensive effectiveness review would be undertaken during 2021/22.
10	**CONCLUSION AND RECOMMENDATIONS**
10.1	In conclusion, the Committee delivered well against its key objectives during 2020/21.
11	**WORK FOR 2020/21**
11.1	Work to progress in 2021/22 includes: a) ToR approval; b) Continued development of the F&P work plan ensuring all issues are covered to clearly track matters going forward; c) A Committee Effectiveness Review; d) Continue to monitor operational performance and the restoration of elective activity; e) Continue the monitor financial performance; f) Continue to review the corporate risk register and board assurance framework.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	20 April 2021	**Agenda Reference:**	**H1**		
Report Title:	**Chair & NEDs Report to Board**				
Sponsor:	Suzy Brain England				
Author:	Suzy Brain England				
Appendices:	None				
Executive Summary					
Purpose of report:	To update the Board of Directors on the Chair and NED activities since the last board meeting.				
Summary of key issues:	This report is for information only.				
Recommendation:	The Board is asked to **note** the contents of this report				
Action Require:	~~Approval~~	Information	~~Discussion~~	~~Assurance~~	~~Review~~
Link to True North Objectives:	**TN SA1:** *To provide outstanding care for our patients*	**TN SA2:** *Everybody knows their role in achieving the vision*	**TN SA3:** *Feedback from staff and learners is in the top 10% in the UK*	**TN SA4:** *The Trust is in recurrent surplus to invest in improving patient care*	

Implications	
Board assurance framework:	None
Corporate risk register:	None
Regulation:	None
Legal:	None
Resources:	None

Assurance Route			
Previously considered by:	N/A		
Date:		**Decision:**	
Next Steps:	N/A		
Previously circulated reports to supplement this paper:			

Chair's Report

Since my last report I have chaired two interview panels, for the recruitment of a Consultant in Opthalmology and a Consultant Clinical Biochemst. I am pleased to report successful appointments were made on both occasions.

Audit & Risk

On 25 March I observed the Audit & Risk Committee (ARC), chaired by Non-executive Director, Kath Smart. As a sub-committee of the Board ARC ensures an independent and objective review of internal controls and risks management arrangements relating to:

- Financial systems
- The financial information used by the Trust
- Controls and assurance systems
- Risk management
- Health and Safety, Fire and Security
- Emergency Preparedness Resilience and Response
- Compliance with law, guidance and codes of conduct and
- Counter fraud activity.

Ahead of this meeting, along with my fellow NEDs, I also had the opportunity to meet with the Trust's internal auditors, KPMG, to review the proposed internal audit plan for 2021/22.

Doncaster Chamber

The first virtual Doncaster Chamber Business Awards was a great success, in these difficult times the team hosted an exceptional event, well supported by local businesses and including entertainment from Doncaster artists. James Mason, Chief Executive of Welcome to Yorkshire did an excellent job as host supported by the Dan Fell, Doncaster Chamber Chief Executive, Jill Woods, President and the event sponsors. In addition to the usual award categories which included, Business Start Up, Young Business Person and Apprentice of the Year four additional awards recognised the outstanding efforts over the past 12 months and throughout the Covid pandemic delivered by the local NHS providers of DBTH and RDaSH. The categories and respective winners were as follows:

Compassionate Care Award – Dr Ken Agwuh, Director of Infection, Prevention & Control

Outstanding Contribution Award – Team DBTH

Unsung Hero Award – Adam Tingle, Senior Communications & Engagement Manager

Community Hero Award – Planned & Unplanned Community Nursing Team - RDaSH

I had a thoroughly enjoyable evening and would like to share my own personal thanks and congratulations to all nominees and winners, in fact everyone from Team DBTH for their outstanding contribution!

Governor Briefings

There have been several briefings since the last Board meeting -

- Clinical Strategy Development
- Working with Prisons Update
- Staff Survey 2020/21

The sessions continue to be well received and feedback gathered has indicated the subject matter is topical, relevant and informative. Online delivery provides governors with a convenient and effective means of keeping in touch with trust developments. The use of breakout groups for the Clinical Strategy session worked well to allow a more interactive, contributory approach particularly relevant to this consultative briefing.

Introductory Meeting

At the start of the month I met with Jane Tombleson, Interim Deputy Chief Operating Officer (Surgery & Cancer). Jane brings with her a wealth of NHS experience and will support the Trust until the permanent postholder starts in the summer.

Other meetings

In the last month I have met with fellow Chairs, Kathryn Lavery (Yorkshire Ambulance Service NHS Trust) and Martin Havenhand (The Rotherham NHS Foundation Trust).

I have had a 1:1 discussion with David Purdue, Becky Joyce and Kirby Hussain (EDI Lead) and Non-executive Director colleagues.

I continue to meet with the Lead and Deputy Lead Governors, hold regular updates with the Non-executive Directors and speak to Richard on a weekly basis.

NED Reports

Sheena McDonnell

This month Sheena has participated in a planning meeting for the upcoming meeting of the People Committee. She has also provided comments on papers for both the Quality & Effectiveness Committee and Audit & Risk Committee.

Sheena has been involved in Freedom to Speak Up activity, promoting and reviewing the approach and attending a forum with the Champions and Guardian.

She has participated in a NED catch up with the Chair and met with Jon Sargeant and Dr Noble. Sheena also hosted a Governor briefing session.

Finally, Sheena attended a really useful workshop on GEMBA visits with NEDs, Executive colleagues and the Qi team led by Professor Stephen Singleton.

Mark Bailey

Since the last Board, Mark has continued to work virtually and has participated in the Board Committee meetings covering Quality & Effectiveness and Audit & Risk. Mark also participated in the Board workshop on the introduction of 'Gemba' observations and their role in supporting the continuous improvement ethos of the Trust.

He met separately with the Director of People and Organisational Development in his role as the Trust's Wellbeing Guardian, to agree assurance activities from a health and wellbeing perspective. Mark has also supported the Medicine Division in the appointment of a new Consultant Physician with special interest in the elderly.

Digital enablement of our health services, alongside the People Plan priorities will play an important part in realising our ambition to provide outstanding patient care. During the month, Mark attended the NHS Providers Digital Boards panel discussion examining best practice for boards in overseeing successful digital transformation. In addition, together with fellow NED, Neil Rhodes, he was invited to a consultative workshop with the Acting Chief Information Officer and Director of Finance to listen to the refresh of the Trust's own Digital Strategy and priority areas. Later in the month, he supported the Director of Finance and Chief Operating Officer in the interview process to appoint substantively into the Chief Information Officer position.

In addition to the regular catch-up calls with Non-Executive colleagues, individual calls with governors have been held and he has hosted the Governor briefing and development session on the Trust's Clinical Strategy.

Kath Smart

As Kath chaired the Audit & Risk Committee in March many of her activities were focussed on preparation for this and included meeting with the new partner for our external auditor (EY), an update with the internal auditors (KPMG), a planning session for 2021/22 Internal Audit Plan with other NEDs and KPMG, plus meeting with the Director of Finance to discuss the auditors procurement process.

As part of her buddying arrangements, Kath met with Becky Joyce to discuss the coming year, and they also visited the Radiology department at DRI. This involved meeting with staff in X-ray and CT, visiting the new CT Suite, which opened in February 2020 and continued to thank staff for their efforts during this challenging time. They also visited the Medical Administration teams at DRI, once again taking the opportunity to listen to staff and to feedback thanks from the Board.

Kath also chaired the recruitment panel for a Consultant in Gastroenterology and chaired a Dismissal Hearing Appeal.

Finally, Kath attended the Board session on “Gemba” Board visits and how these support the continuous improvement process in DBTH; the Governor workshop session on the Clinical Strategy, and the regular Finance & Performance Committee meeting.

Pat Drake

This month Pat has had her regular 1:1 with the Chair and attended the NED update meeting.

Pat has attended both Finance & Performance Committees, since the last Board and she has also chaired the Quality & Effectiveness Committee (QEC).

She has continued to keep in touch with Governor buddies and had a meeting with the Governor observers of QEC.

There have been several Governor briefings, Pat has attended the sessions on Prison Work and the Staff Survey 2020/21. She also attended the Gemba Board Workshop, delivered by Professor Stephen Singleton and along with the Chair and her fellow NEDs met with KPMG to discuss the 2021/22 internal audit plans

She has observed the Clinical Governance Committee and continued with her buddy meetings with the Medical Director.

Finally, in her NED role as safety and culture champion she has participated in two conferences and undertaken training to fulfil her responsibilities.

Neil Rhodes

Since the last report Neil has held planning meetings for the Finance and Performance Committee and chaired the meeting on 22 March. He has taken part in a number of NED meetings with the Chair and had 1:1 meetings with Suzy.

Neil participated in a Charitable Funds Committee and has been pleased to support three governor briefing sessions. He was involved in the last meeting of the Audit & Risk Committee and also attended a Clinical Strategy workshop.

Neil has met separately with the Chief Operating Officer and Director of Finance to discuss the Trust's direction of travel in terms of both finance and performance.

Together with fellow NED, Mark Bailey, he has taken part in a small workshop/briefing with Jon Sargeant and Ken Anderson to look at the development of the Trust Digital Strategy and how it could assist us on our journey to be an outstanding Trust.

Chief Executive's Report
March 2021

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

An update on the Trust's response to COVID-19

As has been the case throughout the past few months, the number of patients in our care with COVID-19 has continued to decrease. At the time of writing this report, the overall figure of positive inpatients is under 20 – a comparable figure to that in September 2020.

On Monday 12 April, lockdown restrictions have eased in line with the Governments Roadmap, and as a result we will continue to keep a close eye on admission rates and will communicate with our communities the continued importance of hands, face and space.

In this period of reducing Covid activity we continue to work hard to ensure that we recover the planned activity impacted by COVID-19, working to reduce waiting times and ensure patients receive timely access to diagnosis, care and treatment.

As of 11 April, the UK has seen the sharpest decline in COVID-19 cases from its peak in the world (97%), with antibody levels within the general population estimated to be at around 55% and at roughly 85% for those over-65. Clearly we have gained ground against COVID-19 and it is my sincere hope that we are able to keep it, and begin the process of returning to some level of normality, both in our personal lives as well as our professional.

COVID-19 vaccination

At the time of writing, more than 120,000 local people in Doncaster have received their COVID-19 vaccine, with the figure standing at more than 60,000 in Bassetlaw. This is a fantastic achievement and a true testament to the hard work of our staff and partners in health and social care in both boroughs.

For our own part, as an organisation we have vaccinated more than 6,500 of our colleagues, and it is our intention to complete all second doses by the end of the month. Our vaccination team have worked tirelessly since late December and deserve a huge thanks for their efforts.

As we move to vaccinate those under the age of 50, our partners at Healthwatch Doncaster have developed a short survey asking for the views of local people on the vaccine – something which will help the further roll-out of the programme as we head further into spring.

An update on visiting restrictions

I am pleased to note that our visiting restrictions eased somewhat on Monday 29 March, allowing for one named person per day for all adult inpatients, for a maximum of one hour, with the full guidance available here: https://www.dbth.nhs.uk/patients-visitors/

Similarly, on Tuesday 6 April, we were able to invite partners to 12 and 20 week antenatal scans. As an organisation, we have been acutely aware of the strength of feeling within our communities about this matter, and our radiology colleagues have pulled out all the stops to ensure that we have been able to ease our restrictions in this way. We hope to communicate further updates in the coming weeks.

Bassetlaw Hospital takes delivery of new CT scanner

In March, we installed a new state-of-the-art Computerised Tomography (CT) scanner in the Medical Imaging Department at Bassetlaw Hospital, which will benefit patients by providing speedier results.

The Siemens Edge scanner offers all the essential features and has advanced technology, including larger gantry dimensions to support bariatric scanning and software to support complex cardiac techniques.

This project has also incorporated a scheme to improve the environment for patients undergoing scans. Keane Creative were commissioned to undertake bespoke artwork to help aide patient distraction and enhance the environment using art and design in the inpatient waiting area and scan room. Patients can at times be on a CT scanner for up to thirty minutes for some procedures and it's important they are as relaxed as possible.

The above project follows further investment in our Worksop site, with a magnetic resonance imaging (MRI) scanner also delivered to Bassetlaw Hospital in March.

Marking one year since the passing of our colleague Kevin Smith

On Monday 12 April, we marked one year since our colleague Kevin Smith passed away following a brief but brave battle with COVID-19.

A Plaster Technician at Doncaster Royal Infirmary and a valued and respected member of the team since 1983, Kev, as he was known to friends, cared for thousands of patients throughout his career. So well-known, and thought of, was the Doncaster resident that he was often stopped and thanked whenever he was out and about by those he had so expertly patched-up, potted and plastered.

Following the announcement of Kevin's passing, thousands of colleagues across DBTH came together and clapped for him for one minute, and again this happened on Monday 12 April 2021. This was in addition to the countless messages left on Facebook, describing him as the town's 'very best pot man' amongst other heartfelt tributes.

Diane Smith, Kev's wife, also launched a Just Giving appeal in her husband's honour, to raise money for much-needed wheelchairs at the Trust, ultimately donating over £15,000 to the Trust. The project, known as Kev's Wheels, is nearing completion and will provide a suitable space for the storing of our brand new wheel chairs, as well as a loving tribute to a much-missed colleague.

Local Muslim community donate over £4,000 worth of equipment and goodies to local hospitals

Spearheaded by local resident, Mohammed Khateeb, over £4,000 has been raised by the Muslim community within Doncaster, with the money used to purchase a range of items including medical equipment, storage lockers, as well as sweet treats for hospital staff, as a way to share thanks for the NHS' hard work throughout the pandemic.

The fundraising began following a visit to Doncaster Royal Infirmary's Endoscopy Unit by Mohammed and his father last year. Chatting with health professionals within the service, one of the Trust's nurses, Clare, mentioned that they could make use of an additional echocardiogram machine, which monitors activity within the heart, as well as lockers for staff to store their personal items whilst working.

With an idea in mind, Mohammed reached out to friends, family and his local community and together they were able to raise £4,200 for the Trust.

In all, the local fundraisers were able to purchase an echocardiogram machine, staff lockers, toys for the Emergency Department, a number of Qur'an cubes for Muslim patients, as well as present a cheque for £1,000 to the Paediatrics team in order to purchase an additional echocardiogram device.

Mohammed was accompanied by his fundraising team, Muhammad Sarfraz, Parveen Shafiq, Nasim Aftab and Nareen Akhtar as well as Councillor Majid Khan, on Wednesday 31 March 2021 to present and donate the items to hospital staff and our Chief Nurse, David Purdue.

On behalf of all at the Trust, I want to thank Mohammed, and the Muslim community within Doncaster, for their kindness and generosity.

If you wish to support Doncaster and Bassetlaw Teaching Hospital's Charity, please go to dbth.nhs.uk/charity to download a fundraising pack or email dbth.charity@nhs.net to find out how you can get involved.

Marking the passing of our colleague and friend Elaine

Finally in this report, I am truly saddened to share the news that Elaine Doughty, a former colleague of many years and volunteer, has passed away following a courageous battle with COVID-19.

A Health Care Assistant of significant skill and experience, Elaine was a popular and valued member of our surgical team. Retiring in 2017 following a period of ill health, the Doncaster resident returned shortly after to the Trust as a volunteer, supporting our colorectal services.

Described as having a 'heart of gold' by those who worked alongside her, Elaine would sit with patients following surgical procedures related to cancer and other conditions, talking to and supporting them throughout their hospital stay. So valuable was her bedside manner, many former patients have described Elaine's companionship, compassion and listening ear as one of the crucial factors in their recovery.

In all, we remember Elaine's warm, encouraging and caring nature and as someone who always put people first. Colleagues describe her as the person you wanted with you through challenging times, and fondly recall Elaine's partiality for a cup of tea with seven sugars. She will be so sorely missed by us all.

To Elaine's husband Richard, her friends, family and loved ones, as a team we share our deepest condolences and sympathies at this truly sad time.

South Yorkshire and Bassetlaw Integrated Care System

Chief Executive Report

Health Executive Group

13 April 2021

Author(s)	**Andrew Cash**
Sponsor	

Is your report for Approval / Consideration / Noting

For noting and discussion

Links to the ICS Five Year Plan (please tick)

Developing a population health system

- ☑ **Understanding health in SYB including prevention, health inequalities and population health management**
- ☑ **Getting the best start in life**
- ☑ **Better care for major health conditions**
- ☑ **Reshaping and rethinking how we flex resources**

Strengthening our foundations

- ☑ **Working with patients and the public**
- ☑ **Empowering our workforce**
- ☑ **Digitally enabling our system**
- ☑ **Innovation and improvement**

Building a sustainable health and care system

- ☑ **Delivering a new service model**
- ☑ **Transforming care**
- ☑ **Making the best use of resources**

Broadening and strengthening our partnerships to increase our opportunity

- ☑ **Partnership with the Sheffield City Region**
- ☑ **Anchor institutions and wider contributions**
- ☑ **Partnership with the voluntary sector**
- ☑ **Committment to work together**

Are there any resource implications (including Financial, Staffing etc)?

N/A

Summary of key issues

This monthly paper from the System Lead of the South Yorkshire and Bassetlaw Integrated Care

System provides a summary update on the work of the South Yorkshire and Bassetlaw health and care partners for the month of March 2021.

Recommendations

The SYB ICS Health Executive Group (HEG) partners are asked to note the update and Chief Executives and Accountable Officers are asked to share the paper with their individual Boards, Governing Bodies and Committees.

Chief Executive Report

SOUTH YORKSHIRE AND BASSETLAW
INTEGRATED CARE SYSTEM

Health Executive Group

13th April 2021

1. Purpose

This paper from the South Yorkshire and Bassetlaw Integrated Care System System Lead provides an update on the work of the South Yorkshire and Bassetlaw health and care partners for the month of March 2021.

2. Summary update for activity during March

2.1 Coronavirus (COVID-19): The South Yorkshire and Bassetlaw position

The South Yorkshire and Bassetlaw (SYB) vaccination programme continues to make good progress with efforts recently focused on encouraging people to take up the offer in cohorts 1-9 who have not yet been vaccinated. While the overall uptake is high (86 per cent across cohorts 1-9) teams continue to work incredibly hard to encourage as many people as possible to take up the offer.

Cases continue to fall across Yorkshire and the Humber region. Three months ago the regional seven-day rolling average was between 2000-2200 cases a day and it is now between 850-650. In SYB, the latest data (April 6th) shows a 90 per cent reduction in COVID-19 cases in over-70s age groups. The over-50s and 60s age-ranges, school and working age groups are also showing a similar steady decline in new cases.

As the lockdown restrictions ease, it remains vital that communities across SYB continue to follow the public safety guidance.

2.2 Regional update

The North East and Humber Regional ICS Leaders meet weekly with the NHS England and Improvement Regional Director. During March discussions focused on the ongoing COVID-19 response and vaccination programme, the planning guidance and operational priorities for 2021/22, ICS development and People Framework.

2.3 National update

The NHS 2021/22 priorities and operational planning guidance were published on 25th March. The guidance sets out six priority areas for the year ahead:

- Supporting the health and wellbeing of staff and taking action on recruitment and retention
- Delivering the NHS COVID-19 vaccination programme and continuing to meet the needs of patients with COVID-19
- Building on what we have learned during the pandemic to improve the delivery of services, provide elective and cancer care, manage the increasing demand on mental health services, and continue to improve maternity care

- Expanding primary care capacity to improve access, local health outcomes and address health inequalities
- Transforming community and urgent and emergency care
- Working collaboratively across systems to deliver on these priorities

In SYB ICS, partners are now coming together to develop a plan for SYB which puts these priorities into action, with final plans expected to be completed by early June.

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2.4 Voluntary, Community and Social Enterprise SRO Update

Following the departure of Catherine Burn as the Voluntary, Community and Social Enterprise Senior Responsible Officer (SRO, I am pleased to welcome Shafiq Hussein, as the new SRO. Shafiq, who is the CEO of Rotherham VCSE, was recommended by the SYB VSE Leaders Group as the new SRO.

Once again I would like to thank Catherine for her leadership and the instrumental role she has played throughout the last five years in establishing strategic partnerships both in the ICS and also in Bassetlaw.

2.5 Cancer Alliance: Supporting Rapid Diagnostics within the Lower Gastrointestinal (GI) Pathway and Lung Health Checks

Faecal Immunochemical Testing (FIT) has been used over the last few years to help assess the risk of colorectal cancer and since the COVID-19 pandemic the use of FIT has been expanded. From Monday 8th March, across SYB and Chesterfield, the change adopted during the pandemic (to cover more high risk patient groups) was enhanced further. The SYB Cancer Alliance agreed that GPs should request that a patient completes a FIT before they are referred for further investigations.

The SYB Cancer Alliance is also helping to support efforts in Doncaster to detect lung cancer earlier, with COVID-19 secure mobile scanning trucks servicing the local population. The new Lung Health Check service started at the end of March and will run for 12 months until March 2022.

2.6 Academic Health Science Network (AHSN) update

Richard Stubbs, Chief Executive Officer of Yorkshire and Humber Academic Health Science Network (AHSN), has taken on the role of Vice Chair of the AHSN Network. Richard will remain the CEO of the Yorkshire & Humber AHSN whilst in the new role and will be supporting Gary Ford who will take up the role of Chair. The Chair and Vice Chair remit is to lead and maintain the collective ambition of the Network's 15 AHSNs.

Richard has also recently published his reflections on the main findings that emerged from the AHSN's work to evaluate the impact of the rapid innovations adopted across health and care systems in North East and Yorkshire healthcare systems, including South Yorkshire and Bassetlaw. More information can be found here: https://www.yhahsn.org.uk/news/understanding-covid-19/?ref=

In addition, the national AHSN Network and LGBT Foundation have joined forces to launch a nationwide call for innovations to help address health inequalities facing lesbian, gay, bisexual and trans (LGBT+) communities. Examples of developments in this area will be showcased in a new report to be published later this year.

3. Finance update

The system is still on track to achieve operating within the system revenue and capital envelopes. The latest forecast is to achieve an adjusted revenue surplus of £32.4m and anunderspend against the capital envelope of £13.7m. The system has been notified of its funding envelope for

the first half of the year which is £1.45b and represents a 1.9% increase over the system funding for the second half of 20/21. Work is ongoing to develop draft system plans for submission to NHS England and Improvement by 6 May.

Andrew Cash
System Lead, South Yorkshire and Bassetlaw Integrated Care System

Date: 8th April 2021

FINAL

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

AUDIT AND RISK COMMITTEE

Minutes of the meeting of the Audit and Risk Committee
Held on Friday 29 January 2021 at 13:30 via Microsoft Teams

Present: Kath Smart, Non-Executive Director (Chair)
Sheena McDonnell, Non-Executive Director
Neil Rhodes, Non-Executive Director
Mark Bailey, Non-Executive Director (MCB)

In attendance: Jon Sargeant, Director of Finance
Matthew Bancroft, Head of Financial Services (MB)
Mark Bishop, NHS Accredited Counter Fraud Specialist
Fiona Dunn, Deputy Director of Quality and Governance/Company Secretary
Kirsty Edmondson Jones, Director of Estates and Facilities (Item AR21/01/E1)
Harriet Fisher, Internal Audit Manager, KPMG
Rob Jones, Internal Audit Manager, KPMG
Katie Shepherd, Corporate Governance Officer (Minutes)
Sean Tyler, Head of Compliance, Estates (Item AR21/01/E1)

To Observe: Dennis Atkin, Public Governor
Bev Marshall, Public Governor

Apologies: Dan Spiller, External Audit Manager, Ernst Young

ACTION

AR21/01/A1 **Welcome and Apologies for Absence (Verbal)**

Kath Smart welcomed the members and attendees. The apologies for absence were noted. The Committee welcomed Dennis Atkin as a new Governor observer of the Committee.

AR21/01/A2 **Conflict of Interest**

No conflicts of interest were declared.

AR21/01/A3 **Request for any other business**

There were no requests for any other business.

AR21/01/A4 **Action Log from Previous Meeting (Enclosure A4)**

The following actions were closed:

Action 3 – Quality Accounts,
Action 4 – LCFA Progress Report Q1 2020/21,
Action 6 – Q1 LSMS Security Management Report,

Action 7 – Quarterly Report on Security Management,
Action 8 – Informatics Update,
Action 9 – Single Tender Waivers,
Action 10 – Thank you cards,
Action 12 – NHS Core Standards for Emergency Preparedness, Resilience and Response.

Bev Marshall raised that the Council of Governors had not been in receipt of the Quality Accounts. It was confirmed that due to the COVID19 pandemic, the usual annual reporting process had been altered and submission dates moved back by the centre. The Council of Governors had received the annual report and accounts; however, the quality accounts had not been published until December 2020. It was agreed that the quality accounts would be circulated to Governors once it had been seen at the Quality and Effectiveness Committee on 2 February 2021.

Action: The quality accounts would be circulated to the Council of Governors following the Quality and Effectiveness Committee on 2 February 2021. **FD**

The Committee:

- ***Noted the updates and agreed, as above, which actions would be closed.***

AR21/01/B1 **External Audit Progress Report (Verbal)**

The Chair noted the apologies of the external auditors and deferred the item until the next meeting.

The Committee:

- ***Noted the External Audit Progress Report update.***

AR21/01/C1 **Local Counter Fraud Specialist (LCFS) Progress Report Q3 2020/2021 (Enclosure C1)**

The Counter Fraud and Security Services Manager provided the highlights from the report which included:

- Further to the unavoidable delay in the appointment of an LCFS for Lincolnshire Partnership NHS Trust and Lincoln Community Health Services NHS Trust due to the unexpected withdrawal of a successful applicant, it was confirmed that following a successful recruitment exercise, Taelor Martin was appointed and commence din post during December 2020,

- A new Counter Fraud Functional Standard would be in place from April 2021. The receipt of the publication was expected that month. An update would be provided at the March committee meeting,

- Statutory and essential training (SET) compliance for Fraud Awareness remained high at 98%. The eLearning package had recently been updated to provide colleagues with up to date information. The new SET package would be released in February 2021,

- Four new Fraud Prevention Notices had been issued by the NHS Counter Fraud Authority since the previous report, however none were a cause for concern for the Trust. They related to timesheet overpayments, mandate fraud, credit card management and private purchase of COVID19 vaccinations,

- It was identified by the NHSCFA that due to the COVID-19 crisis that fraudsters would use the situation to their advantage. As a result, a dedicated information portal for NHS Counter Fraud Specialists to facilitate regular sources of relevant information had been set up. Where appropriate, information had been extracted and cascaded to appropriate departmental leads for dissemination to staff,

- A number of LCFS alerts had been issued to appropriate staff as a result of COVID-19 and following relevant checks no issues for DBTH had been identified,

- Since the last committee meeting, there had been nine updates to investigation referrals and two new referrals. In summary, two were pending sanction outcomes, eight had been closed and one remained open for further development.

In response to a question from Mark Bailey questioning if there was automation in HR systems to flag up if employees offering their services to agencies/other organisations whilst on sick leave, that the LCFS worked closely with the recruitment team who did flag anything up of concern.

Sheena McDonnell noted that the investigation referral had closed related to the deposit of monies destined for the charitable fund into their personal account, and asked if any further work was required to ensure that this did not happen again. The Counter Fraud and Security Services Manager advised that as there had been no identification of fraud in this instance, it had been closed and transferred to the HR disciplinary team for follow up. The team involved were involved in discussions and it appeared that there had been a lack of understanding of the rules related to the collation of charitable funds monies. It was expected that this would be an isolated case, however it was agreed that the Director of Finance would speak with the Head of Communications and Engagements to advise staff of the rules related to fundraising and collation of charitable funds monies.

Neil Rhodes commended the well-structured report, and asked what the Trust's level of exposure to fraud was at any given time and asked how the Trust could be assured of this risk. The Counter Fraud and Security Services Manager advised that a risk assessment undertaken with the Director of Finance, underpinned the counter fraud annual plan. There were 76 risks to date. These were shared amongst organisations. There would be changes recognised over the coming 12-month as the NHS Counter Fraud Authority moved to a risk management approach.

In response to a question by the Chair in relation to the Fraud Champion Role that Fiona Dunn had taken on, it was advised that Fiona had undertaken the training required for the role.

Following a request from the Chair regarding the assurance required on the bank mandate process and robustness of the process, it was confirmed that through SBS, there

was written assurance that they have liability built into the process and through financial control and Procurement there were robust checks carried out on bank accounts.

The Chair noted that on case reference 84978 the issue with unsigned and unagreed job plans, and whether the audit on job planning would identify if this was a wider issue? The Director of Finance advised that the work on this was almost complete & would review job plans and the audit report would come back to the next ARC meeting.

Action: Jon Sargeant would speak with the Head of Communications and Engagements to advise staff of the rules related to fundraising and collation of charitable funds monies. **JS**

Action: An update would be provided on the job planning audit outcome to the next ARC. **JS**

The Committee:

- ***Noted the information provided in the Local Counter Fraud Specialist (LCFS) Progress Report Q3 2020/2021.***

AR21/01/D1 **Internal Audit Progress Report and Sector Update (Enclosure D1)**
AR21/01/D2 **Clinical and Quality Governance Audit Report: Waiting List Prioritisation (Enclosure D2)**
AR21/01/D3 **Data Quality Report (Enclosure D3)**
AR21/01/D4 **Corporate Governance Audit Report (Enclosure D4)**

Progress Report

Rob Jones presented the KPMG progress report and noted that the level of progress, notwithstanding the COVID19 pandemic was good in year, and in relation to the number of days left to complete. The reviews still to be completed were well underway and there were few reviews to commence in quarter 4.

The KPMG benchmark for the 2019/20 DSP toolkit covered the period from April 2019 to September 2020, with the field work to take place closer to the revised submission date of June 2021. It was noted that this would not impact the opinion.

Since the previous committee meeting in October 2020 a comprehensive follow-up of prior internal audit recommendations had been undertaken, however there were few areas that a response had not received for, which was reflective of the current climate. Further updates would be requested again in time for the next committee meeting in March 2021.

Sheena McDonnell noted her concerns that there hadn't been a response on the WHO checklist given the medium level priority. The Director of Finance advised that he had met the Chief Nurse who believed the work to be complete; and would therefore review to ensure that it had.

Sheena McDonnell noted that an update on the recruitment and staff records: TRAC and ESR 2020/21 audit had been provided to the People Committee and had been reported as completed, so although no update had been given, assurance had been provided to the People Committee regarding this.

Sheena McDonnell noted that the referral to access 2019/20 audit felt important in light in the current COVID19 context and noted that it was important to check on progress.

It was noted that the People Committee had not been in receipt of an update on the P&OD HR Systems and Team Review 2019/20, and Sheena McDonnell asked for clarification on the management response that the interface was not fit for purpose and if there was capital investment attached to that. The Director of Finance advised that this formed part of the move form SBS to Sheffield Teaching Hospitals to provide the pay service however the Trust would remain on ESR. Sheena McDonnell and the Director of Finance would pick this up as an action to discuss outside of the meeting how this would be taken forward.

Sheena McDonnnell advised that the COVID19 pandemic had impacted the delivery of actions but noted the original due date for the Risk Management 2019/20 audit was 30th April 2020 and actions should have been underway before then. Rob Jones advised that management hadn't felt able to give a date for completion and emphasised that not providing updates on actions didn't present a big issue. The Chair noted that the report looked disappointing due to the number, however the Director of Finance noted that upon review it was clear that the outstanding responses were focused on few overall actions. The Company Secretary advised that the management response for the Risk Management 2019/20 actions had been relevant to the current COVID19 situation. The Director of Finance noted that the responsible officers should have responded in advance of the meeting.

It was agreed that the recommendation tracker would be circulated again prior to the next committee for further updates and responses.

<u>Audit Reports</u>

It was noted that all three reports received **"significant assurance with minor improvement opportunities"** which was viewed as positive. A number of recommendations were made but there were no areas of concern on the following audits:

- **Clinical and Quality Governance**: **Waiting List Prioritisation** – it was noted that good evidence was provided in terms of the systems in place. Sheena McDonnell made an observation regarding the waiting list prioritisation within the Clinical and Quality Governance audit, and how it linked to the Referral to Access. Harriet Fisher advised that these two audits do link intrinsically, however noted that there wasn't a re-audit of Referral to Access as the approach to each audit was different

- **Data Quality** – once again a positive report with all actions agreed. Sheena McDonnell advised that it stated in the report that although there were no mandatory reporting requirements of sepsis to the Board, and there were no reporting processes in place to do so currently, didn't give a sense of the culture that the Board wished to achieve, and noted that although the Board had not asked for such an update, it didn't mean that they didn't want to receive updates relating to such topics. It was noted by KPMG that, although the comment was

brief, it was in relation to sepsis not being a mandated indicator for reports to Board.

-Corporate Governance – it was noted that the Trust put in place reasonable measures to prepare for a no-deal Brexit and responded to relevant Governance guidance as and when it was issued. In response to a question from Sheena McDonnell about where the annual review of the provider license would be reviewed, it was noted that it would be undertaken at this committee as part of the annual cycle of business. It was agreed that the committee work plan would reflect this to ensure that an assessment of the full criteria of the provide license takes place.

-

The Chairs noted that all three reported audits had received substantial assurance and provided a good sense of internal control and risk management in the organisation, in particular the Data Quality report and Clinical and Quality Governance report with the link into True North objectives. The Chair noted that audits were not required to be referred to other Committees when substantial assurance was received, however felt sure the Chair of QEC would be interested in the outcomes and asked for D2 and D3 be shared.

The Chair noted the delay on the Internal Audit Plan for 2021/22. Harriet Fisher advised that a draft plan would be provided for approval at the next committee meeting. Prior to this consultation with Executives and Non-Executives would be required to build the plan and take into account risk. The Chair requested the Non-Execs not present at ARC were also consulted.

Neil Rhodes echoed the good performance identified for the receipt of substantial performance on the three reports.

It was noted by Mark Bailey that good to see that action would be taken to warn colleagues about not leaving machines unattended whilst logged in, and added that there was increased exposure to cyber attacks in light of the increase of remote working. NHS Digital had this as a priority.

<u>Health Technical Update</u>

Rob Jones noted that an area of focus for the following year would be that the NHS became the world's first health system to become 'carbon net zero' backed by clear deliverables and milestones. It was noted that this was on the Board's agenda and were due to hold a workshop during 2020 however due to other priorities related to COVID19, this was postponed.

The Director of Finance noted that discussions regarding the approach the and going concern continued on how it would work this year and how stock valuations might be managed. It was expected that national guidance would be received soon.

It was noted by Sheena McDonnell that it would be good if the Health Technical Update Report could be shared more widely with Board members as it would prove useful for transformation and what the wider strategy might be.

Action: Sheena McDonnell and the Director of Finance would take an action to discuss outside of the meeting how the P&OD HR Systems and Team Review 2019/20 would be taken forward. **SM / JS**

Action: The AR committee work plan would be updated to reflect that an assessment of the full criteria of the provide license takes place as part of the annual cycle of business. **KS**

Action: A draft plan would be provided to the committee on the Internal Audit Plan for 21/22 for approval. **HF**

Action: A meeting would be organised for KPMG and Non-Executive Directors to provide input to the Internal Audit Plan for 2021/22. **KS**

Action: The Health Technical Update would be circulated to the Board as it was thought it would provide useful for transformation and what the wider strategy would be. **FD**

The Committee

- ***Reviewed and noted the information in the Internal Audit Progress Report and Sector Update,***
- ***Noted the Clinical and Quality Governance Audit Report: Waiting List Prioritisation,***
- ***Noted the Data Quality Audit Report,***
- ***Noted the Corporate Governance Audit Report.***

AR21/01/D5 **Informatics Update (Enclosure D5)**

Following at the discussion at the previous committee meeting, it was agreed that an update would be provided. Due to the onset of COVID19 in March 2020, some of the recommendations were delayed due to the additional COVID19 related work that was commissioned from the Information & Performance Team. There had been approval of the business case in December 2020 for investment in a new data warehouse and reporting platform. This was a 5-year plan with procurement commencing in Q4 2020/2021. The Implementation of the restructure of the Information Team, including provision of an Information and Performance Business Partner to each of the Clinical Divisions was underway. All four posts now offered pending satisfactory pre-employment checks, with a view to launching new model from April 2021. The Performance Assurance Framework was launched in April 2020 which detailed how the Trust would manage clinical and corporate areas in terms of performance monitoring and escalation. The draft had been shared with the Finance and Performance Committee.

Sheena McDonnell noted the good progress made and asked if the original recommendations should be reviewed as they may not be relevant in the same was as they were prior to the COVID19 pandemic.

Mark Bailey noted the good progress made and wished to feedback to the Information and Performance Team on the work they had undertaken following a presentation received at the Finance and Performance Committee detailing how data had been used

to manage the operations of the Trust through the pandemic. The Director of Finance would provide this feedback to the team. Neil Rhodes noted the exceptional presentation received at the Finance and Performance Committee and advised that his experience had proven that the team had been reactive to the crisis and were supportive of providing positive feedback to the team.

The Committee:

- ***Noted the Informatics Update.***

AR21/01/D6 **Governor Observations**

Bev Marshall noted that in spite of all pressures that the Trust were facing, the work of internal audit had factored in that. Bev Marshall noted the interesting report on waiting list prioritisation and advised that Governors would be assured from the information, and whilst it wasn't necessary to share the full report, it would be appreciated if Governors could receive a briefing on the subject including the outcomes. It was agreed that Kath Smart would include this update as part of her presentation to the Council of Governors on 29 April 2021.

Dennis Atkin noted that he was impressed with how matters were monitored and addressed as they arose, and was looking forward to attending future committee meetings.

Action: Kath Smart would include as part of the presentation to the Council of Governors on 29 April 2021, ad update on the waiting list prioritisation process. **KS**

AR21/01/E1 **Quarter 3 LSMS Security Management Report (Enclosure E1)**

The Director of Estates and Facilities provided the highlights of the Quarterly Report on Security Management.
Following concerns raised by colleagues on the staff Facebook page that visitors were attending site without the correct face coverings, a review took place and a new process had been implemented which included standardised wording for staff to use in these events when challenging visitors. The trust had been in contact with South Yorkshire Police and they were supportive unhappy, within their resources to attend site to support the security staff. There had been some incidents where staff had used this standardised terminology in challenging patients and visitors, however security had been called on these occasions to support the staff. Neil Rhodes welcomed the implementation of standard terminology for staff to use in these instances, and asked if the impact of these instances were tracked. It was noted that there were key performance indicators within the Saba contract that report where they had been involved in an incident of challenge, however it wasn't tracked every time a member of staff did challenge a patient or visitor. It was agreed that the quarter-4 report include the key performance indicators related to the challenge of compliance with mask wearing to identify if there had been a reduction in the instances that Saba were called to.

Progress had been made regarding concerns raised by South Yorkshire Police over the high number of missing patients reported by the Trust. A meeting took place which was well received, and actions were agreed following acknowledgment that staff were not following current policy in procedures when a patient left trust premises.

It was noted that there had been a number of additional CCTV cameras installed within the quarter, which included three to the rear of the South block to cover the new park and ride pickup point, and 29 in DRI main theatres to increase security provisions following arson incidents. It was noted by Sheena McDonnel that there hadn't been a resolution to the arson incidents, and that the case was still open with the police.

The trust had changed its supplier of lone working devices however it was noted that the uptake of these devices had been disappointing. The health and safety officer had undertaken work with managers where the uptake of these devices should take place and action plans were in place for training and usage. It was confirmed that a lone working devices was a fob-like device that colleagues would activate/deactivate at the start/finish of their shift, and activate during this time if they wish to activate an alert to the call centre that manages the devices.

Although they had been a slight fall in the number of security related incidents, it was noted that the 75% of these incidents were within the category of "Missing, believed, lost, damaged or stolen".

Following a question from Sheena McDonnell regarding the scale of the missing patient's issue, it was agreed that this would be escalated to the Quality and Effectiveness Committee to identify the patient safety impact and to ensure that the actions taken to review the process and procedures of how patients leave the Trust was reported. It was noted that the actual figures were unknown however work was underway to split the data down to actual missing patients as opposed to misreported figures.

Following a question by Sheena McDonnell, if colleagues now felt safe with the installation of two CCTV cameras at the Park & Ride stop at the DRI site, it was confirmed that there had been no issues escalated to the Director of Estates and Facilities since the installation and therefore it was expected that staff felt safe.

It was noted that the reported violence and aggression toward colleagues was high, and a discussion took place regarding this. It was noted that enhanced conflict resolution training would be sought for colleagues at risk. The Director of Estates and Facilities advised that benchmarking data had been received and therefore would provide an update on this in the quarter-4 report. Mark Bailey asked if risk assessments were undertaken on patients to identify the level of risk they post to staff in relation to potential violence and aggression. It was confirmed that the majority of cases were from patients that were confused as a result of medical or as a result of their condition. It was confirmed that the police were involved in instances. It was agreed, following a question from Mark Bailey, that the Director of Finance would liaise with the Chief Nurse to identify if risk assessments were undertaken during the induction process of the patient to identify if their medication would post a threat of potential violence or aggression towards colleagues. It was noted by the Head of Compliance that there would be new violence and aggression standards received and it was recognised, not only as a national problem but a worldwide problem that health care staff faced. It was confirmed that Saba staff did wear body-cam devices and where required would advise the perpetrator that they were about to activate it if required. ARC members showed concern for staff safety and asked for an utmost focus to ensure V&A incident were managed and escalated appropriately.

A discussion took place regarding lone working devices and following a question from Sheena McDonnell regarding the barriers for use and engagement in choosing them in the first place, it was advised that the devices in use supplied by a previous supplier hadn't been used as colleagues felt safe, however with the change to the new supplier, it had been agreed that a focus would be taken to increase the uptake and usage of the devices.

It was noted, following a request from the Chair, that the theft of catalytic converters from cars was a national issue. The Trust had in place robust CCTV cameras to capture the thefts, however as it takes under three-minutes to commit the crime, whilst covering their faces there had been no clear identification of perpetrators. There had been an incident at the park and ride car park, where a member of staff had witnesses and prevented the crime from taking place. Colleagues had been informed that if they witnessed these instances to call the police immediately.

Action: The issue of missing patients would be escalated to the Quality and Effectiveness Committee to identify the patient safety impact and to ensure that the actions taken to review the process and procedures of how patients leave the Trust was reported. **KS**

Action: A review of benchmarking data of reported violence and aggression against staff would be reported in the quarter 4 report. **KEJ**

Action: The Director of Finance would liaise with the Chief Nurse to identify if risk assessments were undertaken during the induction process of the patient to identify if their medication would post a threat of potential violence or aggression towards colleagues. **KEJ**

Action: The quarter-4 report would include the key performance indicators related to the challenge of compliance with mask wearing to identify if there had been a reduction in the instances that Saba were called to. **KEJ**

The Committee:

- ***Noted the information within, and the progress made, in the Quarterly Report on Security Management & Health & Safety Committee Biannual Report***

AR21/01/F1 **Risk Management Update including Corporate Risk Register (Enclosure F1)**

The Deputy Director Corporate Governance/Company Secretary provided the highlights of the report:

- An audit had been scheduled for quarter-4 on risk management and compliance processes,
- The Board review work had progressed, and the style of reporting had been agreed,
- The Risk Management Policy, although past the review date, was still fit for purpose, however it was noted that this review would not take place until all changes to risk management processes had been agreed,

- There had been a movement in risk management and risk owners had progressed with plans to review their risks.

The Chair noted that risk ID 1854 and 1855 had been discussed at Board in January 2021 and an action had been taken to provide a progress update report at the next Board meeting.

Sheena McDonnell also noted previous comments made at Board and ARC in relation to the visibility of the management and mitigation of critical risk. Sheena noted that there had not been any movement for some time, and asked if changes and updates could be seen in a live way as the Board didn't receive an indication of how action had been taken which would allow for a difference in the understanding of the overall key risks. Rob Jones advised that he had looked at the DATIX system and took on board the comments related to a suggestion that the Board could review risks in a live way. It was noted that KPMG Audit was due to commence and that Kath Smart had also met with KPMG to feed in Non-Executive perspective.

Neil Rhodes requested an opinion regarding the maturity of risk management within the Trust. Rob Jones advised that within the NHS there was a big steer of from DHSC regarding risk management and would ensure that the maturity of risk management was considered in the report. It was noted that the management of COVID19 had been a good example of dynamic risk management however it hadn't necessarily been reflected in the DATIX system.

The Committee:

- ***Noted the information provided in the Risk Management update,***
- ***Noted the corporate risk register.***

AR21/01/F2 **<u>Declarations of Interest Update (Enclosure F2)</u>**

It was confirmed that following the report, an update had been received that morning that the coverall compliance was at 92%, with Consultant compliance at 89% which had been a significant improvement.

Following a comment from the Chair regarding the process in place the declaration of interests, it was advised that the Company Secretary, Medical Director and Director of Finance would take this forward to look at a streamlined solution to this task for future years.

Neil Rhodes noted the great progress made.

Sheena McDonnell advised that this was an annual process and noted that this would need to be undertaken again during the next financial year and asked if this could be done by exception. The Deputy Director Corporate Governance/Company Secretary advised that moving forward there would be considerations made of different approaches that could be taken.

The Committee:

- ***Noted the information provided in the Declarations of Interest update.***

AR21/01/F3 **Audit Tender (Verbal)**

The Director of Finance advised the committee that a process would commence to undergo the audit tender process for both internal and external audit in tandem. The Council of Governors had been informed of this, and it was advised that at least two Governors would be required for the panel, with a maximum of three. It was suggested that the two Governor observers of this committee take on that role, but once this had been agreed with the Council of Governors, the process would commence. To align the two tenders for both internal and external audit would require a short extension with KPMG.

Rob Jones noted that although the KPMG contract was due to end part way through the year, the intention was to provide a full year plan to the next meeting for discussion which would advise in writing, of knowledge that there was a contract break during this period. It was noted that it made more sense to provide a full-year plan, and that it would not disturb the tender process. The Director of Finance agreed that a full year plan should be provided as it was the Trust's internal audit plan and if there were any changes to provider made following the tender process, there would be a planned process of handover.

The Committee:

- ***Noted the update provided on the audit tender process.***

AR21/01/G1 **Single Tender Waver Report (Enclosure G2)**

The Director of Finance presented the single tender waiver report and advised that work had been undertaken to make the 'key drivers/reason for request in detail' information more concise.

It was noted that the single tender waiver raised against the ED works, had been done so as the original contractor left the Trust down at late notice, leaving no time for competition as the work was required in a very short amount of time.

A request was made by the Chair that a link be added to the report that would take the reader to the Trust's SFIs categories plus an explanation on the covering paper of the process that the Trust undergoes to sign off STW.

In response to a query from Neil Rhodes regarding better management of procurement processes, and the likelihood that it may have not needed to result in a single tender waiver, it was confirmed by the Director of Finance that there may be reasons that a single tender waiver was required for emergencies, however assured the committee of the process in place was robust and that the Head of Procurement undertook this process in line with the standing financial instructions and the law, with final sign of by the Director of Finance, or another senior executive if within the Director of Finance' portfolio.

Action: Links to the SFIs categories would be added to the single tender waiver report plus an explanation on the covering paper of the process that the Trust undergoes to sign off STW. **JS/RS**

The Committee:

- ***Considered and noted the information provided in the single tender waiver report.***

AR21/01/G2 **Losses and Compensation (Enclosure G2)**

The Director of Finance presented the losses and compensation report. It was noted that the accompanying front sheet could be amended to reflect the sign off process. It was reiterated that the report was counter signed by the Medical Director or Chief Operating Officer before final sign off by the Director of Finance. There were no questions raised.

Action: An explanation on the covering paper of the process that the Trust undergoes to sign off losses and comps **JS/MB**
The Committee:

- ***Noted the information provided on losses and compensation.***

Governor Observations

Bev Marshall noted the reference to security measures in place was informative, and suggested it was a bigger issue for the Trust in the short-term as opposed to a reduced issue.

Dennis Atkin asked if there was a process in place to monitor colleagues subjected to abuse in their personal life. Sheena McDonnell advised that the People Committee had discussed this matter when review of the health and wellbeing offer to colleagues had been undertaken. It was reiterated that there were a number of offerings to colleagues for support for both workplace and personal circumstances, and a policy on this particular matter would be written.

AR21/01/H1 **Escalation (Verbal)**

Issues identified for escalation to/from the below had been considered and outcomes on the action log:

- H1.1 ARC Sub-Committees;
- H1.2 Board Sub-Committees; QEC – Missing Patients and also forward D2 & D3 to the Chair of QEC, although didn't require to be reported at QEC.
- H1.3 Board of Directors.

AR21/01/I1 – I2 **Information Items (Enclosure I1 – I2)**

- ***Information Governance Group – 09/10/2020***
- ***Health and Safety Committee Minutes – 01/10/2020***

4.7 of the Health and Safety Committee Minutes – 01/10/2020, Sheena McDonnell queried where it was recorded that corridors and basement areas were being utilised for storage and removal of equipment, which posed a risk to fire escape routes and KEJ

updated that a post had now been filled who was responsible for ensuring that these areas were kept clear.

Further to a query by Sheena McDonnell a discussion took replace regarding item 4.8 of the Health and Safety Committee Minutes – 01/10/2020, regarding Lister Court accommodation provided for certain staff groups. Communal accommodation areas has reduced number of staff living there due to COVID19 infection prevention and control measures. KEJ commented that the accommodation required some investment as it was tired and shabby. The Trust would develop a ten-year capital programme which would include a consideration of accommodation facilities. It was noted that the Trust did not have an accommodation policy and therefore was being written in draft format and would be presented to the Estates and Facilities committee for review. It was advised that there would be standards of living conditions which applied to Landlords that would need to form part of the policy. KPMG agreed to forward details of landlord standards to KEJ. The Committee asked for an update in future reports.

	Actions	**KPMG**
	KPMG agreed to provide Landlord standards for properties to KEJ	
	KEJ to provide an update in future reports on staff accommodation in relation to Health & Safety and standards for Landlords.	**KEJ**

AR21/01/J1 **Minutes of the Audit and Risk Committee - 22 October 2020.**

The committee:

- ***Approved the minutes of the Audit and Risk Committee – 22 October 2020.***

AR21/01/J2 **Any Other Business (Verbal)**

There were no items of any other business.

AR21/01/J3 **Date and time of next meeting (Verbal)**

Date:	**25 March 2021**
Time:	**09:30**
Venue:	**Microsoft Teams**

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 26 January 2021 at 09:00am via Microsoft Teams

Present:	Neil Rhodes, Non-Executive Director (Chair) Pat Drake, Non-Executive Director Rebecca Joyce, Chief Operating Officer Jon Sargeant, Director of Finance Kath Smart, Non-Executive Director
In attendance:	Mark Bailey, Non-Executive Director Alex Crickmar, Deputy Director of Finance Fiona Dunn, Deputy Director Corporate Governance/Company Secretary Catherine Huby, Senior Project and Redesign Manager (Item FP21/01/D3) Paul Mapley, Efficiency Director (Item FP21/01/C2) Ellen Rockley, Costing and SLR Manager (Item FP21/01/C5) Katie Shepherd, Corporate Governance Officer (Minutes) (KAS) Marie Purdue, Director of Strategy and Transformation (Item FP21/01/D3)
To Observe:	Bev Marshall, Public Governor Lynne Schuller, Public Governor
Apologies:	None

		ACTION
FP21/01/A1	**Welcome and Apologies for Absence (Verbal)**	
	The Chair welcomed the members and attendees. Lynne Schuller was welcomed in her first meeting as Governor Observer. There were no apologies for absence.	
FP21/01/A2	**Conflict of Interest**	
	No conflicts of interest were declared.	
FP21/01/A3	**Action Notes from Previous Meeting (Enclosure A3)** Action 1 – Quality and Improvement Feedback Report – This would be reflected in the Board terms of reference and would therefore be closed, Action 2 – Diagnostic Targets – This was reflected in the Integrated Performance Report, and was therefore closed, Action 3 – Nominated Individual Contact – An update was reflected as part of Item B1. The action was closed,	

	Action 4 – Financial Regime 2021/22 – This action was closed.	
	The Committee: - ***Noted the updates and agreed, as above, which actions would be closed.***	
	Action: Katie Shepherd would update the Action Log.	
FP21/01/A4	**Request for Any Other Business (Verbal)** Pat Drake noted the absence of assurance provided on the maintenance and management of patient facing medical equipment within the estates and facilities quarter 3 report and requested further information on the management of this at the next meeting. Fiona Dunn advised that this information was provided to the patient safety review group, however it was agreed that a request would be made for further information at the next meeting for assurance.	
	Action: An update would be provided on the maintenance and management of patient facing medical equipment.	**KEJ**
FP21/01/B1	**COVID19 Operational Update and Eave 2 Plans 2020 (Presentation)**	
	The Chief Operating Officer presented to the Committee an update on the operational position of the Trust in relation to Covid19, which highlighted that there had been an increase in community infection rates of Covid19 since the Christmas period, which was now levelling off. This hospital admissions were now also flattening. The total Covid19 bed occupancy was reported as 25.8%, with an active case occupancy of 19.5%. There was significant continued pressure within the intensive care units, although it had reduced slightly since the peak of wave 2. It was noted that the length of stay during wave 2 had reduced and the average mortality had decreased in comparison to wave 1. Whilst the Trust continued to manage the Covid19 operational challenges, it had maintained all Cat 1 and 2 cancer and urgent elective activity throughout and had commenced plans to carefully increase the elective activity. Long waiting routine activity would commence in February 2021 within the Park Hill facility. The Trust continued to provide mutual aid where required for urgent elective cases from across SYB. Staff absence remained a challenge, and levels of staff absence follow the trend of community infections. The Trust had undertaken a scenario planning exercise, using NHS England models and local data, to identify expected Covid19 bed occupancy on a best case, middle case and worst-case basis. The Trust was following the best-case scenario trend. The wave 2 plans had been refined in preparation for wave 3 and included working with divisions to refine their plans. Refreshed elective plan for February onwards and refined emergency planning arrangements were in place. In response to a question from Pat Drake regarding the utilisation of winter beds, the Chief Operating Officer advised that winter beds had not been fully utilised which was a deliberate	

	action due to acuity and staffing. However, surge beds had been opened on some wards. The critical care unit was still within its surge capacity and daily internal mutual aid discussions between the respiratory ward and department of critical care took place, alongside the external daily critical care meetings coordinated by the network.	
	The Committee: - ***Noted the information received from the Covid19 operational update and wave 3 plans presentation.***	
FP21/01/B2	**<u>Extended Bed Waits (Verbal)</u>**	
	The Chief Operating Officer advised that an audit had been completed within the emergency Department an extended bed waits. This had presented the opportunity to tighten up the process of patient flow from the emergency Department to the wards. It was noted that there was a harm review in place for any patient who had waited for an extended period. Quality improvement work would support this to ensure that there were robust processes in place. The Chief Operating Officer proposed to provide a full of paper to include the next steps at the next meeting. Pat Drake advised that she was assured on this matter following a discussion with the Chief Operating Officer.	
	The Committee: - ***Noted the update provided on extended bed waits.***	
FP21/01/B3	**<u>COVID19 Indicators Stock Take (Enclosure B3)</u>**	
	The Chief Operating Officer provided an update on the current status of elective activity and performance in response to the significant impact of the COVID-19 pandemic. The COVID-19 indicators were in place were to provide assurance regarding clinical safety, elective backlog and activity delivery. The paper benchmarked our performance against regional and national data where available. The trust was a national outlier on the growth of the active waiting list (PTL), and an action plan was in place to address this. The trust was behind trajectory on outpatient work however, since the implementation of escalation meetings this performance had improved for December 2020. The COVID-19 pandemic had left the trust with a significant backlog of patients. A single patient list would be devised to aid oversight and reduce the long-standing risk associated with administrative processes. Day case performance had been reasonably strong, but inpatient elective work had been significantly affected due to Wave 2 which impacted further on the 52-week position. This position was likely to worsen, although there would be a focus on preventing outpatient breaches and steps would be taken to reduce these numbers. Cancer teams were doing well in terms of cancer recovery within the exceptionally challenging circumstances and had established an approach to reviewing clinical harm. The Trust was awaiting further national benchmarking data but compared to South Yorkshire & Bassetlaw providers, the Trust was performing strongly.	

	The Trust's diagnostic teams had returned services to a high level of activity compared to the previous year, but significant backlogs remained in the radiology modalities. The clinical risk categorisation process continued to work well, and significant efforts had been put into the communications plan for long-waiting patients. Letters would be circulated to all long waiting patients over 34 weeks to validate their preferences and waiting status. The Chief Operating Officer would identify a way to incorporate and update on the action plan into the integrated performance report. The chair noted the important of this been incorporated into the integrated performance report going forward and asked that the Chief Operating Officer and Director of Finance Provide an update on the work commissioned with Four Eyes and what the expected outcomes were. The director of finance advised that this update would be provided as part of item C2 planning and budget setting. Following a question from Kath smart, the Chief Operating Officer advised that staff had been redeployed from data quality to support divisions as part of the process to validated the waiting list. The production of a single waiting list was in progress, and once complete it would provide the opportunity to create an action plan to reduce the size of the waiting list. Kath Smart noted that KPMG had almost completed their audit on capacity and demand planning. Following a question from Kath Smart regarding the 18-week position, specifically the size of the waiting list within Trauma and Orthopaedics, the Chief Operating Officer confirmed that this was the area with the highest number of waiters, however noted that management arrangements were strong within the department and a meeting would take place to look at the possibility of outsourcing arrangements. It was expected that the position would start to improve once elective activity increased. In response to a question from Kath Smart regarding any concerns of patients on the waiting list, the Chief Operating Officer advised that the level of clinical risk was low. The Director of Finance advised that the auditors gave significant assurance on the process and that there was a clinical process in place for the review of patients. Kath Smart supported the move to a single patient waiting list but asked if the Trust had the right level of resource in place to fulfil this action. It was noted that recruitment to all vacancies was underway and training/upskilling of colleagues would take place so that they were equipped to do this. The Committee commended the graphical format of the report. In response to a question from Mark Bailey regarding planning assumptions for staff fatigue, recovery and annual leave, it was advised that the Trust had a comprehensive health and wellbeing support programme for colleagues but noted that whilst assumptions had not yet been made, it was an important point and would be considered. In response to a question from Pat Drake regarding patient communications, it was agreed that the communications plan for patients would be provided to the Committee. Pat Drake noted that whilst the delivery of national targets was not currently achievable, identification of the actual waiting time should be identified. The Director of Finance advised	

	that the Trust was working with the CCGs to review referred patients to identify if they could be cared for in primary care. The Director of Finance noted that the data quality team had been redeployed to provide support to operations in validating the waiting list, and therefore the core tasks of the team had been affected.	
	<u>Action</u>: It was agreed that an update on the elective restoration action would be built into the Integrated Performance Report as an appendix. ***Action: It was agreed that the communications plan for patients would be provided to the Committee.***	**RJ** **RJ**
	The Committee: - ***Noted the information provided on COVID19 indicators.***	
FP21/01/B4	**<u>Integrated Performance Report – December 2020 (Enclosure B4)</u>**	
	The Chief Operating Officer provided the performance highlights for December 2020. The Trust did not meet its Phase 3 Elective activity standards due to COVID19 related pressures (except for non-obstetric ultrasound and flexi-sigmoidoscopy). The Trust delivered 64.6% performance within 18-weeks, a 2% improvement from the previous month. Key action had been taken in the improvement of the elective activity plan. The 52-week wait position remained a challenge with 986 breaches recorded in month, which breached the phase 3 plan of 477. Emergency pathways remained a challenge which reflected the COVID19 context. Three main actions were underway and included a focus on patient flow, partnership working and team and leadership working. Data from other organisations had been reviewed and dialogue continued with YAS to improve the ambulance position. The Trust achieved all 31-day nationally reported measures for cancer in November 2020, and one out of two 62-day nationally reported measures. The Chair noted that during the recovery phase from the pandemic, this report should be an information paper that supports the other information received on the COVID19 indicators and operational update, and asked that a meeting take place for the Chair of the committee, Chief Operating Officer and Director of Finance to identify the information that the committee would continue to receive. It was noted that the format that had been received at this meeting worked well. Kath Smart noted that the Chief Nurse had advised at the Board meeting that the new emergency department care bundle standards to commence from 1st April would be monitored and asked if that would take place at this committee or the Quality and Effectiveness Committee. The Chief Operating Officer advised that she would provide a report at the next committee meeting for a review of the new emergency department care bundle standards. In response to a query from Kath Smart regarding the continued challenges with ambulance delays, it was noted that an audit had been undertaken by EMAS which identified that conveyance rates had reduced since the previous year. Collaborative partnership working continued and remained an area of focus.	

	Pat Drake noted the red indicator of performance on the proportion of patients directly admitted to a stroke unit within 4-hours of clock start. It was confirmed that there had been an increase in stroke admissions. It was advised that whilst there was no designated capacity in Bassetlaw for the discharge of COVID19 positive patients, access to Doncaster and Nottinghamshire beds was an option in the interim. Improvements had been seen at Doncaster, and a system perfect week was underway at Bassetlaw to test the improvements made at Doncaster, at Bassetlaw. *Mark Bailey left the meeting.*	
	Action: A meeting would be organised for the Chair of the committee, Chief Operating Officer and Director of Finance to identify the information and the format that the committee would continue to receive whilst in the recovery phase of the COVID19 pandemic.	**NR RJ JS**
	Action: The Chief Operating Officer would provide a report at the next committee meeting to review of the new emergency department care bundle standards.	**RJ**
	The Committee: - ***Noted the information provided in the Integrated Performance Report.***	
FP21/01/B5	**EU Exit (Enclosure B5)**	
	An update was provided that the transition period of the UKs exit from the EU had passed without incident. Further scenario testing had taken place in December and there were robust systems in place. Next steps would include the step down of the EU Exit governance group however would be ready to reconvene if required. The Committee wished to pass their thanks to the emergency planning colleagues who had undertaken this planning work over several years.	
	The Committee: - ***Noted the information provided in the EU Exit Update.***	
FP21/01/C1	**Financial Performance – December 2020 (Enclosure C1)**	
	The Trust's surplus for month 9 (December 2020) was £274k (£138k deficit in Month 8). The in-month financial position was c. £1.7m favourable to plan. The Trust's YTD position was a £253k surplus and the YTD position was c. £4.5m favourable to plan. Based on communications received in month from NHSI/E and the ICS, the Trust and the SYB system does not expect to incur any fines under the Elective Incentive Scheme (and thereby no fines have been included in the position). The favourable variance against plan continued to be driven by activity being lower than Divisional plans, business cases/commitments not being spent in month, vacancies, underspend against the winter plan and non-clinical income being above plan. In month the Trust had also recalculated its PDC charge considering the	

	cash advance received earlier in the year (to support COVID19) having yet to be clawed back centrally by NHSI/E. The cash balance at the end of December 2020 was £64.2m, which remained high due to the Trust receiving two-months' worth of the block income in April 2020. Following a comment from Kath Smart regarding the confidence of the recovery of the capital plan by year-end, the Director of Finance advised that the Trust was on target to achieve the revised plan. The schemes behind plan had been due to access and winter pressures. Alex Crickmar advised that through the capital monitoring group, the estates team had put together a process to ensure that capital plans would be delivered which would be monitored very carefully. Kath Smart advised that the detail section of Divisional financial performance assured her that the budgetary control systems in place were working well despite the income challenges and thanked the finance team for providing that information. The Chair noted that it was important that the Trust retained the culture of control and discipline seen prior to the introduction of block contracts. Overdue aged debtors had increased by c. £0.6m as a result of a rise in invoices just becoming overdue, likely to be as a result of the Christmas period. It was felt that this would be resolved in time for January month-end. Overdue creditors had decreased by £0.2m. The Chair asked if the claw back of money would have a significant cash balance impact if done at short notice. It was confirmed by the Director of Finance that this would not be an issue. A review of the forecast year-end position had been undertaken, with a range of scenarios and risks developed. The most likely case (before risks for annual leave and flowers) would suggest the Trust would deliver a close to break-even position. It was noted that annual leave would not form part of performance monitoring. The Director of Finance advised that as the flowers case had not yet been to court, there was no provision for this on the accounts. Following a request from Kath Smart on when there would be certainly on the key risk of flowers and CPD as this would be of interest to the auditors, it was confirmed that it was unknown at present, and it was expected that there would be a process in place that the audit would be managed nationally.	
	The Committee: - ***Noted the financial performance for December 2020.***	
FP21/01/C2	**<u>Planning and Budget Setting (Enclosure C2)</u>**	
	<u>Planning Process</u> Paul Mapley informed the Committee that the Trust had initiated a business planning process to help develop a robust plan for the 2021/22 financial year. Due to the pressures on the NHS across the country the official planning round and release of guidance had been delayed however the Trust would continue with its internal processes to ensure robust plans	

	were in place and that the Trust was prepared for the planning round once it resumed. A timeline had been presented which set out the approach agreed prior to the national delay to business planning, however it was expected that it may be revised as more guidance was released. To date the Trust had only received some very high-level guidance on operational priorities and the financial framework. The business planning approach developed and agreed by the Trust was based on the completion of workforce, performance and capacity / demand templates at a speciality level which provided a base case view of the services performance. Key developments, efficiencies, quality improvement work and investments were then developed and included to produce the Trust's plan and forecast performance. The budget setting approach was heavily linked to and built off the business planning process. The starting point for budgets follows similar principles to previous years however will use 19/20 as the starting point due to the volatility in 2020/21. The key operational priorities for winter and 2021/22 were the recovery of non-COVID19 services, to strengthen the delivery of the local People Plan, to address the health inequalities that COVID19 had exposed and to build on the development of effectiveness partnership working at place and system level. Alex Crickmar advised that following the receipt of the summary of financial guidance letter received in December 2020, it was expected that the full financial settlement would not be known until closer to the beginning of the new financial year due to the uncertainty over the direct COVID19 costs. The key features of the financial framework were that revenue funding would be distributed at system level consistent with the long-term plan, for quarter-1 or 2021/22 the Trust would remain on a block contract, with further guidance expected towards the end of March 2021, and that systems and organisations should develop plans to reduce and eliminate COVID19 costs. Following the spending review (excluding COVID19 costs) in which £3bn was allocated to the NHS to support backlog elective work was broken down as £1.5bn to ease pressures on NHS caused by COVID19, £1bn for elective backlog and £0.5bn to ease the waiting times for mental health care. The SYB ICS would receive an overall an indicative share of £90m. There were some risks in the framework which included that it would not cover underlying deficits and affordability issues, the efficiency requirement remained high, and there would be a re-established contract process with the use of a blended payment-model. A budget would be set for the year; however, it wouldn't be known for some time, however it was expected that it would be like the budget received for 2020/21. Kath Smart noted that basing the budget on 2019/20 could be problematic. The Director of Finance advised that the gap was funded for the latter part of this year and advised that in the basis that it was accepted that it had been incorrect previously, there would be a node adjustment made. Following a question from Pat Drake regarding the efficiencies and the cost improvement programme, it was advised that the efficiency team had benchmarked the Trust and although there were no ongoing programmes set up as it was prior to the COVID19 pandemic, it had been agreed that basic efficiency programmes would commence in areas to look at the standardisation of process and supporting programmes in areas for improvements. Meetings would take place to identify priorities to take forward. the first quarter would be like the previous quarter in terms of the funding.	

	Following a question from the Chair, it was confirmed that four eyes were a consulting company, the Chief Executive Officer an experienced Chief Operating officer, that had a contract with NHSEI to run the national theatre database and benchmarking service. The Trust had commissioned four eyes to review the Trust's operations to understand core capacity translated into what activity could be delivered. They would then make suggestion on how plans could be achieved in a streamlined way, with the transference of skills to colleagues during the process. There would be clear trajectories which would link back to robust plans. The cost of this was £250k which includes the review of diagnostics, elective and emergency, beds, theatres and outpatients. It was agreed that once the conclusions and recommendations had been achieved, it would be presented back to the Committee on a monthly basis against the milestones and tasks outlined. Each Division would be provided with the outcome of the information based on a capacity and demand basis which would be aligned to job planning. <u>Budget Setting Approach</u> Alex Crickmar outlined the Trust's overall approach to budget setting for 2021/22, which was dependant on future funding arrangements. The approach was discussed in relation to clinical income, non-clinical income, pay, non-pay and capital, which highlighted that the baseline of clinical income would be based on 2019/20 figures, however, would be adjusted for nonrecurrent income and service developments. Pay budget would align to business planning and be triangulated with workforce plans and capacity and demand plans. A review had been undertaken against the 2019/20 outturn, 2020/21 run rate and previous budgets to understanding any pressures. Divisions/Departments would be required to bid for capital money as part of the normal process through the relevant capital sub-groups aligned to their business plans. Bids would initially be considered by these sub-groups, followed by the executive team, this Committee and finally Board for sign off. The Chair noted the comprehensive approach to planning. Kath Smart echoed this, however asked for assurance on how the mismatch between eRoster and finance had been actioned. Alex Crickmar advised that work had been undertaken to rectify this and once the budgets were set for 2021/22 this would be set up in the eRoster system so that the finance and workforce allocation was accurate. The Director of Finance noted that the support of the Chief Nurse had allowed for this to be achieved. The Director of Finance highlighted that a risk that once the Trust was in receipt of the planning guidance the plan may need to change.	
	<u>Action</u>: The outcome of the four eyes consultation and recommendations would be presented to the Finance and Performance Committee once complete.	**<u>JS</u>**
	<u>Action</u>: A monthly update on progress against the milestone/tasks outlined within the planning and budget setting plan would be presented.	**<u>JS</u>**
	The Committee: - ***Noted the information provided on planning and budget setting.***	
FP21/01/C3	**<u>ICS Financial Position (Enclosure C3)</u>**	

	The Director of Finance provided an update on the ICS financial position which highlighted the potential financial risk around transformation funding and delivery of the financial plan for months 7-12 of 2020/21. It was noted that there had been significant underspend. The system capital forecast shows a potential year end slippage of £11.2m on capital, which was unlikely to be carried over into 2021/22 if unspent.	
	<u>Action</u>: An update on the ICS financial position would be received at each Finance and Performance Committee meeting.	**JS**
	The Committee: - ***Noted the information provided on the ICS financial position.***	
FP21/01/C4	**<u>Annual Leave Financial Risk (Enclosure C4)</u>**	
	Alex Crickmar informed the Committee that new temporary statutory rules had been introduced by the Government in light of COVID-19 pressures, that meant that any employees who were unable to take their annual leave entitlement due to COVID19 could carry over up to 20 days (pro-rated for part time staff) of annual leave over a two-year period. Three scenarios and assumptions had been developed to calculate the potential year-end position, mainly based on data from the eRoster system which accounted for 75% of the headcount. Current data indicated that the average un-booked annual leave was a period of five-days. It had been raised by the Management Board that several medical colleagues had up to 20 days unused annual leave, and this had been accounted for in the assumptions. A survey would be sent out to all Divisions and Corporate Departments to identify how much annual leave would be carried forward into the next financial year. This information would be calibrated in readiness for the next Committee meeting. It was noted by Pat Drake that colleagues had worked extremely hard during the COVID19 pandemic, and noted that carry over of annual leave could lead to an impact on performance and the Trust's ability to deliver plans and the annual leave would need to be taken during the following two-years. It was noted that it could have an impact on the Trust's performance however it would be unknown until the actual number to carry over was known. The Chair noted the need to balance colleague's wellbeing and the need to take time off. Kath Smart advised that the People Committee should review how to encourage colleagues to take their annual leave in the interest of their health and wellbeing. A comprehensive discussion took place regarding the time scales for filling vacancies. The Director of Finance advised that the vacancy control panel met weekly and either approved or rejected vacancies on a basis of evidence submitted into the Trac system. It was likely that any delays were due to the lack of information provided at the point vacancies were submitted for the vacancy control panel. It was agreed that Kath Smart and Pat Drake would raise this at the People Committee. It was agreed that the Director of Finance and Chief Operating Officer would review the timescales to fill vacancies to identify if the vacancy control process caused any delays. If not, it would be passed to the People Committee to review the timescales prior to approval/rejection at the vacancy control panel.	

	Action: An update would be provided on the Trust's annual leave accrual position.	**JS**
	Action: The People Committee would discuss how the Trust could further encourage colleagues to take their annual leave in the interest of their health and wellbeing.	**KB**
	Action: The Director of Finance and Chief Operating Officer would review the timescales to fill vacancies to identify if the vacancy control process caused any delays. If not, it would be passed to the People Committee to review the timescales prior to approval/rejection at the vacancy control panel.	**KS/ PD**
	The Committee: - ***Noted the***	
FP21/01/C5	**PLICS Update (Enclosure C4)**	
	The Committee welcomed Ellen Rockley, Costing and Service Line Reporting Manager to present an update which highlighted that outputs from the Trusts patient level costing system (PLICS) and service line reporting (SLR) to support further analysis and understanding the cost drivers within each service in the Trust. This included a review of fixed, semi-fixed and variable costs and included the defining and separation of costs. Data had been reviewed over an 18-month period from April 2019 and September 2020. A standard set of reports had been developed to show this data, which was presented to the Committee using trauma and orthopaedics as an example. Further developments were ongoing to put the information and dashboards into an online business intelligence platform, to both increase the functionality of the reports, as well as improved ease of use. The Director of Finance added that a lot of work had gone into this development and allowed the team to pinpoint areas that were less efficient. The Chair noted the progress made with the development of PLICS which provided a deeper understanding of a way to interrogate data. Kath Smart noted that she had previously reviewed the system with Ellen Rockley and advised that it would provide the Trust with an opportunity to explore where efficiencies could be made, and processes further improved. It was noted following a question from Kath Smart regarding clinical team engagement with PLICS, that there had been mixed buy in from different clinical teams however work to further engage them would continue. Kath Smart suggested that PLICS data could be embedded into the QI process as it provided lots of valuable information at granular level. The Director of Finance advised that the Directorate of Strategy and Improvement were undertaking service line reviews with the use of this data. Kath – Qi when do work with teams – embedding this data in qi process – lots of valuable information at granular level – might be an opportunity to embed this into qi process to build into an improvement process that works. Pat Drake noted the information received in the presentation and advised that identification of indicators that teams could beneficially work from would be a powerful tool for use.	

	The Director of Finance added that this information would, in the future weave into the planning and performance framework process. The Committee thanked Ellen Rockley for the comprehensive presentation. *Ellen Rockley left the meeting.*	
	The Committee: - ***Noted the information provided in the update on PLICS.***	
FP21/01/D1	**Corporate Risk Register (Enclosure D1)**	
	It was clarified that the corporate risk register was the register for operational risks with a risk rating of 15+, whereas the board assurance framework held the risks that could prevent the Trust achievement of the strategic aims were recorded. All risks were reported on DATIX and should be managed on the system also. It was at the Management Board meeting that risk were considered for escalation to the corporate risk register. A large piece of work to review the risk management processes within the Trust continued to be implemented. This had included the cleansing of risks and the recording and management of risks at source (on DATIX), the management of risks by those with accountability, the escalation of risks to the Corporate Risk Register and the reporting of risks to groups, committees and the Board. Some areas continued to manage their risks via a risk log, but the overall aim was the use DATIX as the singular risk management system. Over the previous six-months Divisions had been asked to review all operational risks to ensure that they were appropriate considering the COVID19 pandemic. This work continued and further action was required. At present there were 101 risks logged rated 15+ in DATIX, 18 of which were monitored on the corporate risk register. KPMG would undertake an audit on this during quarter-4 of 2020/21. It was noted that the Trust had a good understanding of risk management and had performed well with risks associated to the EU exit and COVID19 pandemic, but further work was required operationally to ensure that risks were managed as opposed to reported. It was noted by the Chair that for a period there had been no significant changes to the corporate risk register, and it was unknown if Executive colleagues had reviewed risks.	
	The Committee: - ***Considered and noted the information in the corporate risk register.***	
FP21/01/D2	**Board Assurance Framework – Financial Risk (Enclosure D1)**	
	The Director of Finance advised that the Company Secretary had commenced this work to review the board assurance framework financial risks in November 2020, and a finance directorate risk team had been set up to review risk relating to finance, IT and Estates to standardise the approach to risk management. Each department would then have	

	departmental risk to manage, which would follow the normal process of escalation to the corporate risk register if required. The recommended financial risks for the board assurance framework were, lack of clarity regarding the future NHS financial regime, uncertainty with regards to the future of commissioning arrangements and culture risk – impact of COVID19. Kath Smart noted that the strategic objective was missing from the paper and recommendations, however the proposed risks were sensible. Kath Smart asked if cyber security and fraud had been considered and discounted as part of this review. It was confirmed that this work would continue, and cyber security and fraud would be reviewed as part of the roll out process. The committee agreed that the process was suitable and agreed that a further paper be provided at the next meeting to highlight the controls and mitigations of the board assurance framework financial risks. Pat Drake thanked the Director of Finance for taking the first review on and asked that the same be rolled out for review at the Quality and Effectiveness Committee. This would be picked up in the roll out plan.	
	<u>Action</u>: A further paper would be provided to highlight the controls and mitigations of the board assurance framework financial risk.	**JS**
	The Committee: - ***Considered and noted the information on finance risks in the board assurance framework.***	
FP21/01/D3	**<u>Bassetlaw Emergency Care Village (Enclosure D1)</u>**	
	The Committee welcomed the Director of Strategy and Transformation, and Catherine Huby, Senior Project and Redesign Manager to provide an update on the Bassetlaw Emergency Care Village. Following the announcement by the government that funding would be provided for this scheme, the trust had progressed plans, however capital funding had not yet been received. the project timeline had been revised due to the COVID-19 pandemic. A project board and steering group had been set up and collaborative Qi work had taken place within the department. The purpose of the report was to ensure that the committee was cited on the programme's governance arrangements and the revised timetable. The Director of Finance advised that NHSEI had advised that no funding decisions would be taken until November 2021. The chair noted his support with the current direction of travel with the project. In response to a question by Kath Smart regarding communications to staff on the delay of the project, the Director of Strategy and Improvement advised that there was a communications groups as part of the task and finish groups. The Department had been engaged with, to ensure that the design was appropriate and sustainable for paediatric services for the future. Catherine Huby advised that the paediatric team had been engaged	

	in the project and the milestones and had also been consulted on the design in relation to patient flow. Pat Drake added that this development for the future should form part of the Trust's objectives. It was agreed that an update would be provided to the Council of Governors home be progress of the project. Kath Smart asked if the Trust had enlisted the support of local MPs. It was confirmed that the Chief Executive had a meeting planned for discussion with the Bassetlaw MP, however it was noted that it was not likely that funding would be received until after November 2021. Bev Marshall observed that he was staggered by the fees the consultants charged for projects. It was agreed that Governors would appreciate a briefing on this to identify if there was any support that they could provide in the interest of the Bassetlaw community.	
	Action: The Council of Governors would receive a briefing on progress of the Bassetlaw Emergency Care Village project.	**FD / MP**
	The Committee: - ***Noted the Bassetlaw Emergency Care Village Update.***	
FP21/01/E1	**Escalation (Verbal)** No issues were identified for escalation to/from: - E1.1 F&P Sub-Committees; - E1.2 Board Sub-Committees; - E1.3 Board of Directors. Pat Drake asked that an update be provided on the Bassetlaw Emergency Care Village at public Board of Directors.	
	Action: Neil Rhodes would discuss with the Chief Executive Officer and Chair of the Board whether an update at the public Board on the Bassetlaw Emergency Care Village would be feasible.	**NR**
FP21/01/F1	**Sub-Committee Meetings (Enclosure F1):** ***The Committee noted the sub-committee meeting minutes:*** - ***Capital Monitoring Group 17/09/2020, 17/11/2020,*** - ***Cash Committee 13/11/2020, 11/12/2020.***	
FP21/01/F2	**Minutes of the meeting held on 24 November 2020 (Enclosure f2)**	
	The Committee: - ***Noted and approved the minutes from the meeting held on 24 November2020.***	
FP21/01/G3	**Committee Work Plan (Enclosure G3)**	

	The Committee: - ***Noted the Committee Work Plan.***		
FP21/01/G4	**<u>Any Other Business (Verbal)</u>**		
FP21/01/G4i	<u>Estates and Facilities KPIs</u>		
	<u>Action</u>: The Director of Finance advised that the Estates and Facilities key performance indicators would be reviewed as part of the business planning process and asked that if there were any suggestions/amendments for inclusion, to send directly to him.		**ALL**
FP21/01/G4ii	<u>Governor Observations</u>		
	Bev Marshall observed the comprehensive meeting and emphasised the importance of the communication with long-wating patients so that they know they haven't been forgotten. Bev also noted the outputs from the patient level costing and service line reporting system on how it could be used for identification of spending levels. Lynne Schuller advised that RDaSH step down beds could be used for some Bassetlaw hospital patients as the geography supported it, however, was concerned that there were no Bassetlaw based step down beds. Lynne also reiterated the benefits of Governors receiving a briefing on the Bassetlaw Emergency Care Village as it would be helpful in the management of public perception and understanding public knowledge.		
FP21/01/G4i	**<u>Date and time of next meeting (Verbal)</u>**		
	Date: Time: Venue:	**Tuesday 23 February 2021** **09:00** **Videoconference**	

FINAL

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

EXTENDED MANAGEMENT BOARD

Minutes of the meeting of the Management Board
Held on Monday 8th March 2021 at 14:00 via Microsoft Teams

Present:

Richard Parker – Chief Executive (Chair)
David Purdue – Deputy Chief Executive and Chief Nurse
Karen Barnard – Director People, Organisational Development
Marie Purdue – Director of Transformation and Strategy
Dr Tim Noble – Medical Director
Mr Eki Emovon, Divisional Director, Children and Families
Ken Anderson – Acting Chief Information Officer
Dr Jochen Seidel – Divisional Director, Clinical Specialities
Alasdair Strachan – Director of Education and Research
Dr Nick Mallaband – Divisional Director, Medicine
Ms Antonia Durham–Hall – Divisional Director, Surgery & Cancer Division
Rebecca Joyce – Chief Operating Officer

In attendance:

Lauren Ackroyd - General Manager - O&G (Item A1-A3 only)
Dr Anurag Agrawal - Endoscopy and Gastro Clinical Director (Item A1-A3 only)
Kenneth Agwuh - Director of Infection Prevention and Control (Item A1-A3 only)
Srinivasan Balchandra – Gastro Surgical Consultant
Simon Brown - Deputy Director of Nursing - Clinical Specialities
Helen Burroughs - General Manager - Paediatrics and TriHealth (Item A1-A3 only)
Mark Brookes - Associate Director of P&OD (Item A1-A3 only)
Kate Carville - Deputy Director of Nursing for Medicine (Item A1-A3 only)
Kirsty Clarke - Deputy Director of Nursing for Surgery (Item A1-A3 only)
Jayne Collingwood - Head of Leadership and Organisational Development (Item A1-A3 only)
Alex Crickmar - Deputy Director of Finance
Ray Cuschieri - Deputy Medical Director - Clinical Standards (Item A1-A3 only)
Vivek Desai – Children's Consultant (Item A1-A3 only)
Fiona Dunn – Deputy Director Corporate Governance/Company Secretary
Sara Elliott - Head of Radiology Mandy Espey – Acting Chief Allied Health Professional (Item A1-A3 only)
Marie Hardacre - Head of Nursing – Medicine (Item A1-A3 only)
Mr Paul Haslam - Trauma and Orthopaedics Clinical Director (Item A1-A3 only)
Kirby Hussain - Equality, Diversity and Inclusion Lead (Item A1-A3 only)
Mr Omar Hussain – Ear Nose Throat, Ophthalmology, OMFS, Dentistry and Audiology Clinical Director
Anthony Jones – Deputy Director of People and Organisational Development (Item A1-A3 only)
Paul Mapley – Efficiency Director (Item A1-A3 only)
Robert Mason - Head of Quality Improvement (Item A1-A3 only)
Lois Mellor – Director of Midwifery
Karen McAlpine – General Manager for Patient Access (Item A1-A3 only)
Sally Munro – Staff Governor – Nursing - (Item A1 only)
Dr Gillian Payne - Deputy Medical Director - Efficiency and Effectiveness (Item A1-A3 only)
Willy Pillay – Deputy Medical Director (Workforce and Productivity) (Item A1-A3 only)
Jodie Roberts – Deputy Chief Operating Officer (Item A1-A3 only)
Claire Ryan - Lead consultant GU medicine (Trihealth) (Item A1-A3 only)
Jon Sargeant – Director of Finance (Item A1-A3 only)
Emma Shaheen – Head of Communications and Engagement
Katie Shepherd – Corporate Governance Officer (Minutes)
Manju Singh – O&G Consultant (Item A1-A3 only)
Cindy Storer – Deputy Director of Nursing (Patient Safety) (Item A1-A3 only)
Richard Somerset - Head of Procurement (Item A1-A3 only)
Dr Ian Stott – Speciality Medicine Clinical Director (Item A1-A3 only)
Prakash Subedi – Emergency Department Consultant (Item A1-A3 only)

Julie Thornton – Head of Performance (Item A1-A3 only)
Abigail Trainer- Deputy Chief Nurse

Apologies: Kirsty Edmondson Jones – Director of Estates and Facilities

ACTION

MB21/03/A1 Reciprocal Mentoring Workshop

The extended Management Board welcomed Karl George, Managing Director from The Governance Forum to host a workshop on the work the Trust had been undertaking with the Governance Forum on a RACE Equality Code. The Trust is the first NHS organisation to sign up to programme. As part of the process the Trust had undergone a pre-assessment, facilitated self-assessment and a review of resources. The Trust would receive the RACE Equality Code Action plan following a feedback session and an Early Adopters Focus Group would commence in May 2021.

Karl George outlined the RACE Equality Code which would provide the organisation with the opportunity to use a robust and comprehensive framework of measures and methodology for transparent implementation of actions to which the organisation can demonstrate accountability.

The Trust had undertaken a diagnostic against the seven drivers for change of the code, that organisations should demonstrate diversity, responsibility, integrity, values, equity, reality and society.

The race principles should be adhered to on an apply or explain basis against:

- **Report:** A clear commitment to be transparent and to disclose required and concise information and updates on the progress of RACE initiatives across the organisation.

- **Action:** A list of the measurable actions and outcomes that contribute to and enable a shift in the organisation's approach to and success in delivering change.

- **Composition:** Identifying the key indicators that would make a real impact over the long-term, creating tangible differences to the existing landscape around race diversity of the board and senior leadership team.

- **Education:** Developing a robust education framework that develops the ethical and moral reasoning behind a programme of development for every organisation (using the Principles).

The vision was to create transformational, sustainable and lasting change, to achieve a competitive and truly diverse board and organisational leadership team.

A reflective discussion took place amongst those in attendance on the current environment. The Chief Executive identified that everyone on the call were the senior leaders in the Trust and therefore were the allies to the implementation of the code.

The management board thanked Karl George for his presentation.

MB21/03/A2 Clinical Strategy Development

The Director of Strategy and Transformation presented to the management board the framing and scoping process for the development of a new clinical strategy using a seven-stage framework for foundation trusts.

The scope of the review would be the re-creation of the strategy, as opposed to recommitting to the existing strategy. Some areas of the current strategy would only require refreshing as opposed to a re-creation. The strategy would inform, and be informed by, the emergent plans for site redevelopment and the service line assessment process.

The Clinical Strategy Preparation governance process was outlined and would include a Strategy Development and Implementation Steering Group underpinned by four task and finish groups: Communications and Engagement, Diagnose and Forecast, Options Generation and Strategy Delivery.

The process and timescales were outlined, for delivery in November 2021.

Andrew Potts provided an update on the service line review which was a review to be undertaken specific to each clinical service. It was in place to help services to better able it to realise its vision but also to inform and improve organisational processes. The initial assessment phase would be complete in three months' time and would then move into the development stage.

The potential risks and issues associated with the development process were outlined. The Chief Executive discussed several options that would be reviewed as part of this process to ensure that the services were fit for the future.

There were no questions.

MB21/03/A3 **<u>Breakthrough Objectives 2021/22</u>**

The Chief Executive advised the extended management board that the process to determine the breakthrough objectives for 2021/22 was underway. Work had been undertaken to align the Trust's strategic direction with the Trust's risk profile and as part of this the Board and Board committee papers and reports had been reconfigured to link with the delivery of the True North – Strategic direction. The updated breakthrough objectives for 2021/22 would include a consideration of the previous challenging year due to COVID-19 and would be centred around the following:

- Improvement in the quality and safety of services aligned to how the Trust would be assessed by regulators,
- Workforce – health, wellbeing, training and development, reflecting on the impact that the COVID-19 pandemic had on the workforce.
- Restoration of elective services,
- Financial delivery and efficiency.

The intention was to formalise the breakthrough objective for 2021/22 by the end of March 2021 to be presented to the Board of Directors during April 2021. Following this each corporate and clinical division would have key metrics that would be reported on in an open and transparent way.

The Chief Executive outlined a proposal to change the format of the current planned meetings for 21/ 22 to include:

- The once a month extended executive team meeting on a Wednesday would be used to create up to six senior leadership team meetings per year, for the Directorate Leadership Teams. The other six remaining free for development time,
- Monthly management board meetings would be with the executive team and divisional directors, with a renewed focus on the delivery of objectives and where key challenges would be discussed and resolved.
- There would be a bi weekly informal meeting between Divisional and Executive Directors to provide a forum to get ahead on issues and challenges.

The Medical Director added that the new format would provide the opportunity to connect teams together, as currently there was no forum where clinical directors and divisional directors come together.

Following a question from Mandy Espey regarding the organisation's role in the health inequalities agenda, it was advised that the Trust had links through partners to reach hard to reach populations, and to ensure that work was not duplicated.

Concerns were raised by Ken Agwuh relating to the pathology systems and the current clinical workforce numbers within the area, and asked if the recruitment strategy could be reviewed in relation to the specific roles required. The Chief Executive advised that part of the breakthrough objectives for 2021/22 would include a significant focus on the workforce and recruitment and retention would form a large part of that. Ken Anderson advised that there was plenty of opportunity post-COVID-19 and how investments would be utilised in hospitals and it had been suggested that there be two areas of focus: electronic health record and tele-health, digitally embedded in the community.

Dr Jochen Seidel asked for discussion with the wider teams on how realistic a new build would be for the Trust, the time it would take to achieve, in light of the current estate. The Chief Executive advised that the Trust continued work on the business case for a potential new build should the opportunity arise so that it would be in a position to mobilise quickly. However, it was acknowledged that capital work would continue to be needed to maintain the estate and this was a priority for the 21/22 capital programme. It was noted that as a potential alternative to a new build any major refurbishments would also need to secure additional external capital funding and as a result were not necessarily an easier option.

MB21/03/B1 **Welcome and Apologies for Absence (Verbal)**

The Chair welcomed the members and attendees. The apologies for absence were noted.

MB21/03/B2 **Matters Arising / Action Log**

Updates were received on actions:

Action 1 – ICS Update – Paediatrics – The Trust had joined up to a hosted level 3 network to work closely with Sheffield Children's Hospital.

Action 2- SAS Doctors Charter – This had progressed; however, it was unknown when independent ordering on ICE could commence.

Action 3, 4, 5 and 6 were closed.

The Committee:

- ***Noted the updates and agreed, as above, which actions would be closed.***

Action: Katie Shepherd would update the Action Log.

MB21/03/B3 Conflict of Interest

No conflicts of interest were declared.

MB21/03/B4 Requests for any other business (Verbal)

Eki Emovon:
- Step down of ICS Children's Surgery,
- Level 6 works.

Nick Mallaband:
- Divisional objectives,
- VCF process.

Antonia Durham-Hall:
- Chancellors Budget 2021/22
- Life Time Allowance

Karen Barnard:
- COVID-19 vaccinations.

MB21/03/C1 Finance Update (Verbal)

Alex Crickmar provided an update which highlighted that the Trust achieved a surplus in-month-10 of £292k, with the year-to-date position circa. £500k. All elective incentive scheme fines had stopped. It was expected that the Trust would be in a break-even position at year-end, however there were many unknowns as the Trust headed toward year-end. Funding would be received for lost non-clinical income, which would be circa. £1.5m, the final number to be determined after year-end.

Thanks were given to those that had responded to the request for information on annual leave carry, the initial response rate was 85%. The outcome would be determined in the coming weeks. It had been suggested that there would be national funding attached to annual leave accrual up to a maximum of between five-and-seven days, which contributed to the unknown year-end position.

There had been no updates on the ongoing Flowers appeal regarding overtime, which could lead to a £3m pressure to the Trust.

Whilst it was expected that the Trust would be in a break-even position at year-end, it was noted that this was following the receipt of £29m top-up money. This excluded money for COVID-19 related expenses such as testing and PPE.

The financial allocations and budgets for 2021/22 had not yet been concluded, however it was expected that the Trust would receive the information in the coming weeks.

Quarter 1 of 2021/22 would remain as a block contract, with an expectation that this would run into Quarter 2. It was expected that the system envelope would run similar to Q3 of 2020/21 and where there was a surplus within the ICS envelope, this would be allocated out via the ICS. It was unknown how this allocation would be calculated.

The capital position had been agreed and would be provided on an ICS basis.

There were no questions.

The Committee:

- ***Noted the finance update.***

MB21/03/C2 **Operational Update/Looking Forward (Present)**

The Chief Operating Officer provided an update which highlighted that COVID-19 admissions to the Trust continued to fall at a quicker pace to previously, as was the bed occupancy. As of 28th February, 91,000 members of the Doncaster population had received the COVID-19 vaccination. A small uptick in non-COVID-19 demand for beds had been seen, and staff absence was reported as 7.4%, 41.8% of which was COVID-19 related. An increase had been seen in attendance to the emergency department, however, were below the rates seen in summer 2020.

Whilst COVID-19 admissions had reduced, there continued to be pressure on the intensive care units and within the respiratory and high-dependency units.

The Trust was steadily increasing its elective work, however noted the number of patients waiting over 52-weeks was over 2,000. There had been outsourcing and insourcing taking place for outpatient activity during March 2021.

It was expected that theatre sessions would increase throughout March and April 2021, and the Trust would establish strong capacity plans for April 2021 onwards to restore activity. Letters to patients would be send week commencing 8th March 2021 to validate their waiting position. There would be a resumed focus on administrative processes, validation and training.

Support to the workforce would continue through the restoration phase, and collaborative work would continue at Place and ICS level.

There were no questions.
The Committee:

- ***Noted the operational update/looking forward presentation.***

MB21/03/C3 **RACE Equality Code Action Plan (Verbal)**

The Director of People and Organisational Development advised that she had received the RACE Equality Code Action Plan just prior to the workshop that took place during the meeting. It would be circulated out once the language had been tailored to the organisation, and it had been seen at equality groups within the Trust. Sign off from the Board of Directors was required and progress would be monitored through the People Committee. The Equality, Diversity and Inclusion Forum would play a crucial role in the delivery of actions. The Equality, Diversity and Inclusion Forum would refresh its terms of reference in include this narrative and to ensure that the group was representative of the organisation.

Jochen Seidel noted that it was encouraging that an external diagnostic had been undertaken, and asked if the Trust's decision to sign up to the code and take informed action could be made public knowledge, to inform colleagues of these steps taken in light of information which had been circulated and which may not have been factual information.

Karen identified that the staff survey results were to be released in the coming week and would include benchmarking data. Similarly, Freedom to Speak Up data had been received at Board and provided external assurance that the Trust was one of the most improved organisations. It was noted that the Trust had a duty to put full, accurate and factual information into the public domain so that members of the public could draw their own conclusions from it and staff should be encouraged to consider this information.

The Director of People and Organisational Development advised that the RACE Equality Code was not specific only to the NHS, however DBTH had been the first Trust to adopt the code.

Emma Shaheen left the meeting.

The Committee:

- ***Noted the RACE Equality Code Action Plan.***

MB21/03/D **Divisional Matters**

None identified.

MB21/03/E1 **Information Items to Note (Enclosure E1)**

The Committee noted:

- ***CIG minutes 25/01/21***

MB21/03/F1 **Minutes of the Meeting 8 February 2021 (Enclosure F2)**

The Committee:

- ***Approved the minutes of the last meeting dated 8 February 2021.***

MB21/03/G 1 **Any Other Business**

Divisional Objectives

Nick Mallaband advised that his question objectives had been answered as part of item A3.

VCF Process

Nick Mallaband suggested that he felt that the VCF process was no fit for purpose and that a formal review should take place due to the length of time it took to get approval for posts providing the example that he had put a request in to recruit to band 5 nurse posts and that they had been rejected on three occasions, although money was spent on bank nurses on a daily basis. The Chief Nurse confirmed that he was aware of this issue and would recommence attending the VCF panel, following a slight amendment to the process during the COVID-19 pandemic. The CN advised that the posts for the band 5 nurses were approved.

The Chief Executive advised that the Trust did need to maintain an effective VCF process and that when previous examples had been reviewed problems and issues were often before and after the VCF panel, rather than at it. The CEO confirmed that the new meeting structure, discussed earlier in the meeting, would provide the opportunity for such issues to be raised and dealt with in an efficient manner, and it was agreed that the VCF process would be picked up at the first meeting. The Medical Director agreed to confirm the dates with Exec colleagues and DD's.

The Director of Strategy and Transformation offered the services of her team to facilitate a quality improvement review of the process so that it was LEAN. It was confirmed that the process was undertaken on Trac, and was auditable, and therefore data could be pulled to identify the time it took to recruit, it didn't include the pre-Trac process such as writing job descriptions and that it was important to consider the end to end process to be clear where any delays occurred.

Step down of ICS Children's Surgery Pathway

A discussion took place regarding the step down of the ICS Children's Surgery pathway and the potential implications for the Trust. It was noted that although the return to Children's Surgery in the Trust was planned a CQC requirement was that there be a dedicated area for paediatric recovery separate to the adult recovery area. The CN agreed to look into the requirements and confirm any required changes to recovery areas.

Level 6 theatre works

Following a query from Eki Emovon on lift availability during the theatre work, it was confirmed that training had taken place that day and therefore the query was mitigated.

Chancellors Budget 2021/22 and Pensions

Antonia Durham-Hall raised the impact that the Chancellors announcement relating to NHS pensions would have on clinicians offering their services for additional sessions and suggested that this could impact the efficient management of the restoration of elective activity.

It was noted that the Trust already had a policy in respect of Annual Allowance and that the Executive Team were due to consider Lifetime Allowance issues on 10 March and an outcome would be provided in due course.

COVID-19 Vaccinations

80% of colleagues had received their COVID-19 vaccination as a part of the first dose programme within the Trust. Where colleagues had been unable to receive a first dose vaccine due to the time lapse between COVID-19 positive and in receipt of the vaccine, or those that had changed their mind, vaccination could be accessed through the national booking service.

A discussion took place regarding the 20% of colleagues that had not yet received a first dose vaccine and it was confirmed that this was reflected in all staff groups. Wider conversations would continue to take place to encourage all colleague to receive the vaccine whilst ensuring that GDPR rules were met. A Q and A would be provided to managers to facilitate a conversations with staff who hadn't received the vaccine.

The Chief Nurse advised that several care homes had stopped students entering into care homes if they had not received their COVID-19 vaccination.

The Committee:

- ***Noted the items of any other business.***

MB21/03/G2 **Items for escalation from sub-committees (Verbal)**

There were no items of escalation from sub-committees.

The Committee:

- ***Noted the items of escalation to the management board.***

MB21/03/G3 **Items for escalation to the Corporate Risk Register (Verbal)**

Jochen Seidel asked that Risk ID 2664 – Consultant staffing shortages in DCC be escalated to the corporate risk register. It was agreed that a robust action plan needed to be developed to address and mitigate the risks. The Medical Director, as lead for this risk agreed for it to be escalated to the risk register and to lead work with the Division to take forward the mitigating actions.

Action: Risk ID 2664 would be escalated to the corporate risk register and reported to the Board of Directors. **FD**

MB21/03/G4 **Date and time of next meeting (Verbal)**

Date: **Monday 12 April 2021**
Time: **15:00**
Venue: **Videoconference**

The meeting closed at 17:20.

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Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

QUALITY AND EFFECTIVENESS COMMITTEE

Minutes of the meeting of the Quality and Effectiveness Committee
Held on Tuesday 2 February 2021 at 13:00 via Microsoft Teams

Present:	Mark Bailey, Non-Executive Director Pat Drake, Non-Executive Director (Chair) Dr T J Noble, Medical Director David Purdue, Chief Nurse Sheena McDonnell, Non-Executive Director
In attendance:	Sam Debbage, Deputy Director of Research and Education Fiona Dunn, Company Secretary Karen Humphries, Clinical Governance & Professional Standards Co-ordinator Lois Mellor, Director of Midwifery (Item QEC21/01/B1) Stacey Nutt, Deputy Director of Nursing (Patient Experience) Katie Shepherd, Corporate Governance Officer (Minutes) (KAS) Cindy Storer, Deputy Director of Nursing (Patient Safety) Abigail Trainer, Deputy Chief Nurse
To Observe:	Peter Abell, Governor Lynne Logan, Governor Suzy Brain England OBE, Chair (Part meeting)
Apologies:	Marie Purdue, Director of Strategy and Transformation

		ACTION
QEC21/01/A1	**Welcome and Apologies for Absence (Verbal)**	
	The Chair welcomed the members, attendees and governor observers. The apologies for absence were noted. The Chair noted that the past year had been difficult and asked that colleagues in attendance pass on the heartfelt thanks for all that they do.	
QEC21/01/A2	**Conflict of Interest**	
	No conflicts of interest were declared.	
QEC21/01/A3	**Action Notes from Previous Meeting (Enclosure A3)**	
	The Committee: - ***Reviewed the action log and agreed to close actions 1 and 3 to 10.***	
	Action: Katie Shepherd would update the Action Log.	

QEC21/ 01/A4	**Request for Any Other Business (Verbal)** There were no requests for any other business.	
QEC21/ 01/B1	**Trust Response to the Ockenden Report (Enclosure B1) (Presentation)**	
	The Committee welcomed the Director of Midwifery to the Committee to present the Trust's response to the Ockenden report that was received in December 2020. From 1827 cases, the initial 250 cases form this report. Once all the cases have been reviewed there would be a further report which is expected at the end of 2021. The report raised significant issues and the Trust had fulfilled its duty to respond to the report to provide assurance and identify gaps. The report outlined seven immediate actions to take: 1. Enhanced safety – no issues identified in the achievement of this standard, 2. Listening to women and their families – the Maternity Voices Partnership was set up (Doncaster and Bassetlaw respectively) and had started to meet, 3. Staff training and working together – there were no issues identified as there were four-hand over periods throughout each day, however actions would be tightened, and discussion points documented, 4. Managing complex pregnancy – A large cohort of Doncaster patients had complex pregnancies who follow a pathway to determine if their care would be nurse led or consultant led. There had been the development of a maternal medicine service within the ICS which was a centre of excellence for foetal medicine, 5. Risk assessment throughout pregnancy – this was linked to the previous action in terms of place of birth and personalised care planning. All patients have access to their maternity notes via their smart devices. Risk assessments were undertaken on the K2 system. An audit mechanism would be devised to follow, 6. Monitor foetal wellbeing – This would involve the implementation of the saving babies lives bundle, 7. Informed consent – This was to ensure that patients understood the risks associated with their pregnancies and ensuring that they have access to the information they require. The Trust utilises the website and Facebook to provide information. The information on these two portals were under review to ensure that it was the best it could be. <u>Maternity Workforce and Leadership</u> Further assurance required was on maternity workforce planning, midwifery leadership and compliance with NICE guidance. There were plans to create a public health midwife post who would provide education prior to pregnancy. There was the potential for a Consultant Midwife post who would lead on the creation of a midwife led care unit. There continued to be a national shortage of midwives which the services managed through the use of NHS Professionals and ongoing recruitment. It was noted that the national shortage was circa. 4,500, however a national effort was in place to expand the number of midwives in training. There was a three-year established NICE guidance group in place which sought help of the library staff to source all of the latest evidence. All guidance was updated in advance through the governance midwife. The Chief Nurse noted that the Trust's compliance with the guidance fed into CNST and there was a lot of engagement with multidisciplinary teams on this.	

	A presentation on maternity transformation had been received at Board and the Chair recognised that there was lots of work to do and would keep supporting the efforts. A gap analysis had been undertaken since the Ockenden Report had been received and this would be triangulated with the East Kent Report so that it can be identified where care improvement can be made. It was agreed that an update on Ockenden Report actions at the April Quality and Effectiveness Committee, followed by an update to Board**.** It was noted by Sheena McDonnell that in a short space if time since the receipt of the report, the Trust had reported being fairly compliant in terms of the expectations, however, asked how much involvement patients had in the risk assessment process. It was confirmed that the risk assessments were undertaken by medics and patients do have access to their notes, were part of the process and have control over what they want during their pregnancy. Lois Mellor advised that some women do have home births against advice, however the aim was to give them what they wanted whilst ensuring that they had a full understanding of the associated risks when making decisions about their care. Each patient had a comprehensive individual plan. In response to a question by Sheena McDonnell regarding future pathways into midwifery, it was advised that there were few routes into midwifery but included an 18-month course transfer from nursing to midwifery. It was expected that this course would cease to continue, however this had been pushed back on as there were nurses that wished to change their professional practice. Sheena McDonnell noted that the shortage of midwives was contradicted by the competitiveness to entry to the midwifery training programme. It was noted that in the first review of the staff survey results, the positives were that employees felt supported by management, there were no reported instances of bullying and harassment and felt they were able to raise any concerns. Areas for improvement included that there was work required for employees to feel that they were involved in changes, although there had been lots of team quality improvement work. Mark Bailey expressed that it there appeared to be assurance against the seven immediate actions to be taken and asked for confirmation if there wasn't anything that provided a level of worry. The Director of Midwifery advised that the main concern included multidisciplinary working and that the relationships between paediatricians, midwives, consultants and obstetricians could be improved. Another area for improvement was in the escalation of concern, however this would be actioned through prompt training. The final area for improvement was in CTG training which was the identification of when foetal monitoring was not as it should be. Sam Debbage advised that the Trust was working with the University of Sheffield regarding a pre-registration programme for midwives.	
	Action: An update would be provided on progress on Ockenden Report actions at the April Quality and Effectiveness Committee, followed by an update to Board.	**LM / DP**
	The Committee: - ***Noted the information provided in the presentation on the Trust's response to the Ockenden Report.***	
QEC21/ 01/B2	**<u>Patient Safety Deep Dive (Enclosure B2) (Presentation)</u>**	

The Chief Nurse presented to the committee, an update on patient safety which highlighted that the National Patient Safety Strategy was launched in July 2019. An annual progress report was completed in September 2020 which highlighted issues caused by COVID-19, but also included problem solving at pace and enhanced collaborative working. One aspect that was required as part of this was to ensure that there was a safety culture and that everyone felt psychologically safe and valued, which was measured through the staff survey, CQC and a new patient safety measuring unit. The patient safety measuring unit was in the final stages of being completed. A CQC consultation was underway to review how they would be assured going forward. This would be aligned closely to the patient safety strategy.
A presentation would be provided to Board on 16 February 2021 on patient safety to provide an update on the next steps for the organisation.

<u>Patient Falls</u>

Following a review of falls, it was expected that the number of falls in year would exceed that of subsequent years from 2018, however noted that the average falls with harm was lower than the previous year to date. An analysis had been undertaken to identify where the most falls had occurred in relation to the location of the Ward. The respiratory ward had been identified as the area that had the most reported falls. Work had been undertaken in areas reporting high numbers of falls, to identify where further support could be provided so that the numbers of falls could be reduced.

Ward A5 had opened in October 2020 as a pathway for elective care. Soon after opening, it had been escalated that there had been a high level of falls. Staff had been redeployed from a combination of surgical wards and training and support had since been provided by the trust falls practitioner, the programme due to be complete at year end.

It was noted that the number of falls had increased during the COVID-19 pandemic and were due to the following:

- Infection control measures including the addition of doors and reduced visiting measures,
- Staffing levels had been a continued challenge during the pandemic and although colleagues endeavoured to provide a person centre approach, this had been a difficult to deliver as a result of the pandemic. Sickness absence had also contributed to this,
- Patient presentation – there had been a reduction in emergency department presentation during the pandemic, however those that did come to hospital, were more acutely ill and required higher levels of supervision. The length of stay also increased due to discharge pathways,
- Staff training and education had been mostly paused due to the pandemic. A new approach would be taken to identify how more training could move to a virtual platform,
- Risk assessment and documentation had previously been a lengthy task however this had been simplified and digitalised to make the use of this simpler,
- Enhanced supervision had been reduced due to infection prevention and control measures; however intentional rounding had been implemented so that every patient was reviewed at fifteen-minutes intervals.

The Chief Nurse provided assurance that the falls team had been expanded to ensure that staff areas were supported. The team had combined resources from the existing falls team, patient centred care practitioner and dementia lead to for a Holistic Care Team. This would reduce the time required for each individual practitioner to review the falls. Quality improvement work had been undertaken across ten areas with the highest reported falls as part of the True North

	breakthrough objectives. Assessments would be digitalised through Nerve Centre. An internal audit had taken place on falls and hospital acquired pressure ulcers in which significant assurance was received. Only one issue had been identified related to data quality. Hospital Acquired Pressure Ulcers It was noted that category three hospital acquired pressure ulcers had only been classed as moderate harm since November 2020. Only one category four hospital acquired pressure ulcers serious incident had been reported in year, in August 2020. The key learning points were that within critical care hospital acquired pressure ulcers had increased significantly on previous years and following investigations no changes could be identified. The respiratory unit had increase numbers of hospital acquired pressure ulcers due to patient presentation and equipment. The Chief Nurse provided assurance that assessment documents had been digitalised. Flagging of high-risk patients was now undertaken via the 'at a glance boards'. Equipment was in ready supply, audits continued to show equipment getting to the patients in good time. Investigation reviews had taken place, but no changes could be identified in critical care and respiratory wards. Face protection was available for all patients and staff to use and additional support was available for staff within training on key areas. It was noted by the Chief Nurse that there had been good engagement from Ward 24. It was agreed that the training and support provided emphasised that this was a no blame culture and that measures were in place to ensure that as an organisation, development was key. Infection Prevention and Control The Infection Prevention and Control board assurance framework had been refreshed and reported to Board in December 2020. The assurance toolkit had been developed and submitted monthly. Learning from COVID-19 outbreaks had been shared across all departments. The C-DIFF position was reported above trajectory, with 49 year-to-date cases. 44 in total were reported for 2019/20. The Chief Nurse advised that the Trust was compliant with all areas of the assurance toolkit. In relation to infection prevention and control assurance, there were two areas for improvement following spot checks. Work was being undertaken with Nerve Centre for a flag to be in place for those patients that require a further COVID-19 test. The second amber rating was due to the lack of designated beds at Bassetlaw for COVID-19, although it was noted that Doncaster beds could be used for this purpose. The Chief Nurse provided assurance that learning from outbreaks had been shared across the Trust. There were currently four areas with an outbreak of COVID-19, although it as noted that this was the lowest reported number for Trusts in the north of England. The Infection Prevention and Control board assurance framework had been refreshed and reported to Board in December 2020. Investigations had been undertaken for all C-DIFF cases and there had been no lapses in care identified. The Chair noted the helpful presentation. Following a comment and question from Sheena McDonnell regarding the increase in falls due to the COVID-19 pandemic and the potential compromise on patient safety, the Chief Nurse advised that information would be triangulate to ensure that there had been no lapses in patient	

	safety and noted that the merge of the teams to create the Holistic Care Team would be highly beneficial. The process had been simplified and there was a proactive approach to prevent falls. Sheena McDonnell advised that the audit and risk committee on 29 January 2021 were assured by the data quality internal audit. Sheena McDonnell noted that there was no mention in the health and safety update at the audit and risk committee of estates challenges in regard to falls. The Chief Nurse advised that falls had been contributed to due to estates and infection prevention and control measures and work in the emergency department would be completed in March 2021. Sheena McDonnell noted the expansion of the Holistic Care Team and suggested that introduction of a band 4 role be made a priority as it was due to evaluation in April 2021 and would be highly beneficial. In response to a question from Mark Bailey regarding risk assessments, the Chief Nurse advised that the aim was to make the process of risk assessing simpler. A pilot was in place to end at year end which would include a digital risk bundle of all nursing documentation. Mark Bailey highlighted that there had been a discussion at the audit and risk committee on 29 January 2021 regarding the assault of staff from patients and asked for further information. The Chief Nurse advised that there was a zero-tolerance policy on this. The Deputy Chief Nurse advised that a summit was to take place with two pilot wards to reduce falls. There would be pharmacy input as factors contributed to could be related to medication. The teams were excited for this work to start. It was noted by the Chair that risk assessments were at a point in time and that independent human behaviour could not be discounted, however enhanced supervision and ward rounds were key to supporting the reduction in falls. The Chair noted the comprehensive update on infection prevention and control and noted that C-DIFF numbers were higher than the trajectory, but could have been contributed to by the prescription of antibiotics early in the COVID-19 pandemic. It was requested that a short update be provided at each quality and effectiveness committee on falls and hospital acquired pressure ulcers. A full update on the falls quality improvement work would be reported back in September 2021.	
	<u>Action</u>: A short update be provided at each quality and effectiveness committee on falls and hospital acquired pressure ulcers.	**DP**
	<u>Action:</u> A full update on the falls quality improvement work would be reported back in September 2021.	**DP**
	The Committee: - ***Noted the information provided in the patient safety deep dive.*** - ***Noted the update provided on falls, hospital acquired pressure ulcers and infection prevention and control.***	
QEC21/ 01/C1	**<u>Falls Update (Enclosure C1)</u>**	

	Discussed as part of item QEC21/01/B2.	
QEC21/ 01/C2	**<u>Stabilisation and Recovery (Enclosure C2)</u>**	
	<u>Risk Stratification Assurance Body (including Ethical Committee)</u> As of 27.1.2021, 94% of patients on the admitted RTT active waiting list (excluding planned waiters & diagnostics) had been stratified using the guidance issued by the Royal College of Surgeons, using categories 1a – 4. A draft flow chart demonstrating the management of diagnostic patients (all referrals) was presented which highlighted the process for the consideration of patient pathways. The Chair noted that staff issues remained and would be discussed at the finance and performance committee. It was noted by the Medical Director that attendance at appointments had improved. The Chair welcomed the good levels of communication with patients. Sheena McDonnell noted that through the internal audit on this process, significant assurance was received and was supported as good practice on risk stratification of patients.	
	The Committee: - ***Noted and update provided on stabilisation and recovery: risk stratification assurance body, including the ethical committee.***	
QEC21/ 01/C3	**<u>Quality Assurance Report (Enclosure C3)</u>**	
	The Medical Director provided the summary of the Clinical Governance Committee activity for November and December 2020. The patient safety review group continued to meet throughout the COVID-19 pandemic. Some policies had now expired and were under review. Normal safeguarding processes continued. During April to November 2020 the drug and therapeutics committee had been suspended, except for urgent business conducted under the chairman's action arrangements. The medical examiner process continued and 86% of deaths had been scrutinised during Q2. A review would be provided to the next quality and effectiveness committee of the clinical governance committee process as it had been identified that there was an element of duplication that could be improved upon. Following a question from the Chair regarding any risk associated with policy expiration, it was noted that the work to determine the risk levels was underway. Following the review of the Q2 Strategic Safeguarding Board Report, the Chair noted her concern regarding level 3 safeguarding training delivery. It was noted alternative training options were being reviewed. An update on this would be provided at a later meeting. The Chair requested further information on the key risk associated with wrong dose administration what process was in place to support and provide training on that. The Medical Director advised that prescribing was mostly electronic which provided an element of safety as only certain doses could be prescribed, however suggested that an update be provided at the June 2021 meeting as work would be undertaken with operational teams on administration.	

	The Chair noted that domestic violence referrals had not increased as previously expected. Sheena McDonnell advised that this was raised at the People Committee as an issue, and therefore advised not to assume that all cases would be reported. The Deputy Chief Nurse advised that that there was a need for a domestic violence lead to ensure that reporting of cases was done correctly. The Deputy Director of Nursing (Patient Experience) provided assurance that the review of all overdue policies would include the risk mitigation process to identify policies that were still fit for purpose and could therefore have an extended expiry date. There was no indication at present that any of the expired policies posed a risk. There were 2,578 incidents open with the Trust, which excluded serious incidents and inquests. The Chair noted the breach of QEC target 2, as 218 incidents had been open longer than six-months. The Chair requested a position statement in April 2021 on the closure of these 218 incidents with a target date of three-months. It was noted that any exceptions would need to be clearly identified in the report.	
	Action: An update would be provided on the position of safeguarding level 3 training at a later quality and effectiveness committee meeting.	**AT**
	Action: An update would be provided on the development of the medicine safety committee and on the process to support and provide training related to wrong dose administration at the quality and effectiveness committee in June 2021.	**AT / TN**
	Action: The Chair requested a position statement in April 2021 on the action to be taken to close the 218 incidents that had been open longer than six-months, with a target date of three-months.	**DP/ TN**
	Quality Assurance Report – Patient Safety Learning - Joint Incident and Learning report The Deputy Director of Nursing (Patient Safety) advised that the National Patient Safety Strategy was launched in June 2019. The first evaluation was in September 2020. The evaluation confirmed strong progress on the strategy, despite the obvious challenges of COVID-19. The ability of NHS hospitals and other services to deliver care safely was evidenced as around 110,000 patients got treatment for the virus in England (746 patients at DBTH). As of 24 January 2021, the impact of the second wave resulted in many more patients being treated as an inpatient for COVID-19, with 317,908 patients being admitted to hospital in England (2,707 patients at DBTH). There had been an increasing emphasis on the importance of safety culture. Learning from incidents were shared as quickly as possible and this also include learning from good practice. Following two notifications for the prevention of future deaths by Doncaster Coroner, the composite action plan was developed and monitored by the corporate nursing team. Updates for the action plan have been presented at Patient Safety Review Group and with the Clinical Governance Committee and CQC. There were two serious incidents reported in December 2020, one of which was under investigation by the Health Service Investigation Branch. Year to date figures was 19 serious incidents. In response to a query from the Chair regarding junior doctors and documentation, it was confirmed that there had been a good response rate from medical staff, which should filter down to the junior doctor workforce.	

	A Medication Safety Officer was in post and there may be the opportunity to implement a medical safety improvement committee. The Learning Disability Strategy and Mental Health Strategy would be an area of focus by the CQC. The Sharing How We Care newsletter had restarted in November 2020 following a brief pause during the COVID-19 pandemic. A reflective practice called 'Team Time' had been developed in response to the COVID-19 pandemic, which was a 45-minute online facilitated reflective practice session to provide the opportunity for individuals to share their experiences of working in the health and social care sector. In response to a question from Sheena McDonnell regarding the conclusions being drawn from the draft staff survey results in relation to culture, it was advised that work was still to be undertaken to understand the results and decipher next steps.	
	<u>Infection Prevention and Control Board Assurance Framework</u> The Chair noted that there were no gaps in control and no changes identified. It was confirmed that this would be reported to Board on a quarterly basis.	
	The Committee: - ***Considered and noted the summary of clinical governance committee activity,*** - ***Considered and noted the Quality Assurance Report – Patient Safety Learning joint incident and learning report,*** - ***Considered and noted the infection prevention and control board assurance framework.***	
QEC21/ 01/C4	**<u>Trust Winter Plan (Enclosure C4)</u>**	
	The Chief Nurse provided an update on the Trust's winter plan and advised that quality improvement work had taken place in regard to discharge to smooth the process. The lack of positive beds at Bassetlaw remained an issue, however beds at Doncaster were accessible for these patients. There was no cause for concern with delayed transfer of care and the system was working well.	
	The Committee noted the update provided on: - ***Trust Winter Plan.***	
QEC21/ 01/C5	**<u>Safer Staffing (Enclosure C5)</u>**	
	The Deputy Chief Nurse provided an update on safer staffing levels and skill mix relating to the nursing and midwifery workforce. During November and December 2020, areas were risk assessed using professional judgement, redeployed staff or utilisation of other key roles such as therapy staff to ensure that patient safety wasn't compromised. The on-going risk around nurse and midwifery staffing remained a challenge for the nursing leadership teams, however mitigation had been put in place to support clinical areas and the risk was reviewed as part of the x4 daily operational site meetings that take place. Nurse staffing was also reported monthly via our mandated safe staffing return and at this committee. A suite of interventions were in place to mitigate the risks associated with safer staffing, and how staff would be supported. It was noted that a live risk assessment was required to ensure that decisions were made on a real-time data basis.	

	Sheena McDonnell was assured that there were good mitigations in place to ensure that patient safety wasn't compromised. Sheena McDonnell noted that a presentation had been received at the People Committee on the Allocate software which provided real time information and was assured on how that was used to base decisions on. The Deputy Chief Nurse advised that key to this was clinical engagement as it offers real-time assurance which would support patient care. In response to a question from the Chair regarding the monitoring of additional hours worked, it was clarified that there were parameters in place with NHS Professionals so that it was flagged if a staff member was booked to work more than their allocated hours so there was no additional risk of staff wellbeing from that. It was likely that the Trust would undertake international recruitment programme in India in partnership with NHS Professionals and ICS partners which an expectation of forty by October 2021.	
	The Committee: - ***Noted the update on safer staffing.***	
QEC21/ 01/C6	**Learning from Deaths Report – Quarter 2 (Enclosure C6)**	
	The Medical Director presented the report which highlighted that the Medical Examiner Team had scrutinised 86% of all inpatient deaths which had a significant increase from last quarter (63%). The bereavement team and medical examiner team had benefitted greatly by being located together, ensuring good and efficient team working. Telephone conversations with bereaved families continue to be a challenge. The HM Coroner received a Medical Examiner Scrutiny for 100% of referrals and feedback had been very positive with regards this. The Chair asked if prompts would be given to increase the number of structured judgement reviews return. It was agreed that an update would be provided in the next Clinical Governance Report. The Chair wished to pass on their thanks to the teams for their hard work. In response to a question from the Chair regarding the absence of patient ID bands on several occasions, it was noted that the Deputy Directors of Nursing for Patient Safety and Patient Experience would pick this up as part of inquest mapping and the ID policy. The Deputy Director of Nursing (Patient Experience) noted that the top five causes of death recorded that quarter included cancer/metastatic cancer, which had caused the need to undertake a deep dive. It was thought that during the pandemic, patients had not been attending their general practitioner due to many reasons and were now presenting with advanced cancers. It was requested that the outcome of this deep dive be presented to the Quality and Effectiveness Committee once concluded. The Chair commended the report.	
	Action: An update would be provided in the Clinical Governance Report on how the number of structured judgement reviews could be increased through prompts.	**TN**
	Action: The outcome of the deep dive into the increase in metastatic cancers as a cause of death be presented to the Quality and Effectiveness Committee once concluded.	**SN**
	The Committee:	

	- ***Noted the Learning from Deaths Report for Quarter 2.***	
QEC21/ 01/C7	**<u>Hospital Acquired Pressure Ulcers Update (Enclosure C7)</u>**	
	No questions raised.	
	The Committee: - ***Noted the Hospital Acquired Pressure Ulcers update.***	
QEC21/ 01/D1	**<u>Patient Experience Quarterly Report including Patient Story (Enclosure D1)</u>**	
	The Deputy Director of Nursing (Patient Experience) presented the report. The patient story report had been retitled patient feedback report to ensure that there was a focus on all forms of feedback as opposed to only complaints. The patient feedback report highlighted the level of support that wards and support services provide to ensure that both patients and their families have the best experience possible during the difficult times of no visiting. The Complaints Standard Framework was included in the report and emphasised the promotion of learning and culture through fair and accountable decisions. The Friends and Family Test had returned in December 2020 and the data should be made available to the Trust to review in April 2021. The Communications and Engagement Team continued to work on patient and public engagement which included the recording of a film for Remembrance Sunday. This would move to be an annual service. There had been a baby memorial service provided by the Chaplaincy Department in which positive feedback had been received. Comments and feedback had been shared with Divisional Leads to share with their teams so colleagues could see the level of appreciation from members of the public to the work that they undertake. Charitable donations had been received from patients and their families through the good experience that they had received from the Trust. From 1st October – 31 December 2020 the Trust had received the following reactions to Trust Facebook posts: - From 501 posts, 7,399 negative reactions, - From 501 posts, 375,001 positive reactions, - Total reach was 15,953,577, - 13 reviews were received, all positive. In relation to overdue cases, of the 226 'out of time' or breaching the original agreed timeframe (6:1), there had been 105 cases, with one renegotiation. A further 14 had two renegotiations and five underwent a third renegotiation. A complaints panel had been implemented to ratify the time frames and investigating officer and to ensure that they were on DATIX accurately. There were currently four ongoing investigations to be undertake by the Parliamentary and Health Service Ombudsman. Mark Bailey commended the clear report which balanced positive outcomes against areas for further action, and commented that it would be helpful to see some identification of things that have made a difference for patients.	

	Sheena McDonnell noted that all feedback was good as it would help the Trust to understand the service received. Sheena McDonnel noted that the amount of time taken to respond and close complaints, and in some cases renegotiate cases was too lengthy and should be by exception and not the norm and asked if there was any action that could be taken to reduce the timeframe down. A common theme of feedback from complaints was that communication was key and could turn around the patient experience in the way that they receive a response. The Deputy Director of Nursing (Patient Experience) advised that the bedside patient information would be revised to include a QR code link to the Friend and Family Test. It was advised that there would be a recruitment programme for ward-based volunteers to help with communication between patients and their families. This role would provide a friend/visitor to the patient, with the aim to prompt patient with the completion of the Friends and Family Test. Following a question from Mark Bailey regarding the options to feedback positive comments to the workforce, it was confirmed that this was undertaken in the Sharing How We Care newsletter. This includes learning from doing good, not just learning from complaints. It was noted that an internal audit was underway on complaints. A deep dive would be provided on complaints at the April 2021 meeting.	
	The Committee: - ***Noted the Patient Experience Quarterly Report including Patient Story.***	
QEC21/ 01/D2	**<u>Accessible Information Standard (Enclosure D2) (Presentation)</u>**	
	The Deputy Director of Nursing (Patient Experience) presented to the committee an update on the accessible information standard, which highlighted that there were five stages to reduce inequalities: - Identify – what disabilities people have, - Record – how do we record this information, - Flag – how do we flag the information so that we can understand patient needs, - Share – how do we share across different healthcare settings, - Meet – how do we need the requirements. In 2019 a gap analysis had been undertaken against each standard, which resulted in the implementation of the accessible information standard steering group who meet regularly. Following this an accessible information action plan was developed and consisted of six objectives. There was still work to be undertaken and would include the gathering of information through IT systems, however, there had been progress made also. The Accessible Information Standard policy was in draft format. Accessibility information was now available to all via the Trust website and new patient information poster had been devised. Next steps would include a review and rebrand of the work plan in accordance with the 'five steps', the accessible information steering group would be expanded to include the Equality, Diversity and Inclusion Lead, Dementia Lead and Learning Disability Nurse. There would be complete mapping with IT of referrals and referral systems. Collaborative work would be undertaken with Healthwatch and Health Ambassadors to develop an Accessible Information Board that would be community based and include collaboration from the CCGs, Trust and other healthcare providers.	

	The embedded process would be fully implemented within the next six-months and following this the task and finish group would be phased out. It was agreed that an update be provided at the August 2021 meeting, and that the approved policy be presented for noting at the Quality and Effectiveness Committee. It was noted that letters and communications should reflect be reflective of accessible information requests.	
	<u>Action</u>: The final Accessible Information Policy would be presented to the Quality and Effectiveness Committee for noting once approved.	**SN**
	The Committee: - ***Noted the update on the Accessible Information Standard.***	
QEC21/ 01/E1	**<u>Research and Innovation – Agreed Future Plans (Enclosure E1)</u>**	
	The Deputy Director of Education and Research provided an update on agreed future plans for reporting to the Quality and Effectiveness Committee. A deep dive would be undertaken in April and November which would provide the opportunity share progress on research activity. The first Teaching Hospital Board would take place on 22nd April 2021. It was noted that a focus had been on COVID-19 related studies and the Trust had positively contributed to practice throughout the pandemic. A review would take place on how other studies could recommence in a managed way. Work would be undertaken to engage and embed the Education and Research Strategy.	
	The Committee: - ***Noted the update on the agreed future plans of research and innovation.***	
QEC21/ 01/E2	**<u>Clinical Research Network – Trust Annual Review (Enclosure E2)</u>**	
	The Deputy Director of Education and Research presented the Clinical Research Network annual financial review report. It was noted that the clinical academic business case was approved. It was suggested that the Knowledge, Library & Information Service Interim Report April—October 2020 be circulated to committee members for information which raised the value of the clinical library services. A strategic initiative was in place for 2021/22 called 'Born in Doncaster' which was based on the 'Bord in Bradford' concept. It would be as inclusive as possible and have a strong engagement from maternity services. The Trust was involved in a vaccine study It was unlikely to run at the Trust, however the Trust was keen to support other Trusts in this study. It was noted that the Teaching Hospital Board Committee would commence in April 2021.	
	<u>Action</u>: Sam Debbage would circulate to the committee, the Knowledge, Library & Information Service Interim Report April—October 2020.	**SD**
	The Committee: - ***Noted the update Clinical Research Network Trust Annual Review.***	

QEC21/ 01/G1	**<u>Corporate Risk Register and Board Assurance Framework (Enclosure G1)</u>**	
	A large piece of work to review the risk management processes within the Trust continued to be implemented. This had included the cleansing of risks and the recording and management of risks at source (on DATIX), the management of risks by those with accountability, the escalation of risks to the Corporate Risk Register and the reporting of risks to groups, committees and the Board. The review addressed the actions arising from the 2019 Internal Audit on risk management. There were 101 risks logged rated 15+ in the Trust. The process for these risks to be reviewed was via speciality governance meetings that a higher profile of risk management was required and would form part of the patient safety strategy in the future. KPMG had undertaken two audits on the risk management system over the previous 2-years and recommendations had been implemented. A further audit was due to commence in Q4 that would include a review of all 15+ risks to ensure that the Trust was compliant with the risk management policy. The key risks to note were COVID-19, workforce and finance. It was noted that the EU Exit risk was no longer a high risk, and the COVID-19 risk continued to be managed through the appropriate risk plans. Following approval at January's Board meeting, the new report layout would be trialled at the February Board meeting in which the front sheet would be aligned to the board assurance framework, that would be reviewed as part of the process to write the report by the responsible executive.	
	The Committee: - ***Considered and noted the corporate risk register and board assurance framework.***	
QEC21/ 01/G2	**<u>CQC and Regulatory Visits – including CQC Action Plan Update (Enclosure G2)</u>**	
	The Deputy Director Corporate Governance/Company Secretary presented the CQC action plan update report that was presented to the CQC in December 2020. This central action plan had been collated so that all 'must' and 'should' actions were in once place and would be shared with the CQC on a regular basis. Most actions had been completed and evidence was forwarded by Divisions for sign off and assurance. The CQC were assured with the update provided and no concerns were raised. The CQC had adapted their monitoring arrangements and would only undertake inspection activity that either helped to create capacity to respond to the COVID-19 pandemic, or that responded to significant risk or harm to the public. The CQC had undertaken some focused inspection activity in the emergency department and assessed the Infection Prevention and Control board assurance framework. Other areas of focus were Mental Health Act monitoring visits and would be discussed at the next CQC engagement meeting. From 26th February 2021, there would be a new Relationship Manager and Inspection Manager. A proactive approach to informing the CQC of any incidents and complaints was in place. There was a workshop planned for 10th February to discuss and share views towards the CQC consultation. In response to a question from the Chair regarding how often the CQC Report Action Plan was presented to the Board, it was suggested that the Deputy Director Corporate	

	Governance/Company Secretary identify when this would be suitable, and the frequency required.	
	Action: The Deputy Director Corporate Governance/Company Secretary would identify the suitability and frequency of when the CQC Action Plan Report should be presented to the Board.	**FD**
	The Committee: - ***Considered and noted the update provided on CQC and regulatory visits.***	
QEC21/ 01/G3	**Quality Accounts (Enclosure G3)**	
	The Chief Nurse presented the Quality Accounts. It was noted that this year did not follow the normal process and was therefore not required for audit purposes. Indicators had been rolled over to 2021/22. Governors and members of the public had access to the Annual Report and Accounts via the public website.	
	The Committee: - ***Noted the Quality Accounts.***	
QEC21/ 01/H1	**Who Checklist Audit Update (Enclosure H1)**	
	The policy was written and would be launched late February 2021.	
	The Committee: - ***Noted the update provided on the WHO Checklist Audit.***	
QEC21/ 01/I1	**Governor Observations (Verbal)**	
	Follow a question from Peter Abell regarding the circulation of the Quality Accounts to Governors, it was agreed the link to the report was accessible via the Governor Portal, however, would be circulated to Governors. Peter Abell commented on the good use of data and suggested it would be useful for the Committee to receive an update on the use of live data. Lynne Logan had enjoyed the meeting and looked forward to the next.	
	Action: The link to the Quality Accounts would be circulated to Governors.	**FD**
QEC21/ 01/J1	**Sub-Committee Meetings (Enclosure F1):**	
	The Committee noted: - ***Minutes of the Clinical Governance Committee – October, November and December 2020,*** - ***Patient Safety Report – December 2020,*** - ***Strategic Safeguarding Board Report,*** - ***Drug and Therapeutic Committee Report.***	

QEC21/ 01/K1	**Minutes of the meeting held on 29 November 2020 (Enclosure G2)**		
	The Committee: - ***Noted and approved the minutes from the meeting held on 29 November 2020.***		
QEC21/ 01/I1	**Issues escalated from/to (Verbal)** i) QEC Sub-Committees – no items ii) Board Sub-Committees Audit and Risk Committee 29 January 2021 – The outcome of the clinical governance and quality governance audit and the data quality audit were forwarded to the Chair of the quality and effectiveness committee for information. Audit and Risk Committee 29 January 2021 – Sheena McDonnell advised that in Section 4 of the Health and Safety Committee minutes, it was stated that there was an issue with missing patients and the numbers involved were high. The explanation was that there were some patients that wanted to discharge themselves but did not follow the correct procedure. The audit and risk committee were not assured of this and therefore wish to escalate at this committee. The Chief Nurse advised that the Trust worked with South Yorkshire Police and Nottinghamshire Police in these instances, and local security checks took place with escalation to the police if there was a concern. It was noted that this was not a regular occurrence however, the issue had not been escalated to the Chief Nurse. The Chief Nurse would identify the issue and provide an update at the next quality and effectiveness committee meeting. iii) Board of Directors – no items		
	Action: The Chief Nurse would identify if there was an issue with missing patients and provide and update at the subsequent meeting.		**DP**
QEC21/ 01/G4	**Any Other Business (Verbal)**		
	There were no items of any other business.		
QEC21/ 01/G4i	**Date and time of next meeting (Verbal)**		
	Date: Time: Venue:	**Tuesday 6 April 2021** **09:00** **Video-Conference**	

Report Cover Page					
Meeting Title:	*Board of directors*				
Meeting Date:	*20th April 2021*	**Agenda Reference:**	**H8**		
Report Title:	*Board Assurance Framework for IPC*				
Sponsor:	*David Purdue – Chief Nurse and Deputy Chief Executive*				
Author:	David Purdue, Chief Nurse and Deputy Chief Executive				
Appendices:	*0*				
Report Summary					
Purpose of report:	*Quarterly update to QEC on IPC assurance*				
Summary of key issues/positive highlights:	All elements under control of the Trust now rated as compliant.				
Recommendation:	None				
Action Require:	~~Approval~~	Information	~~Discussion~~	~~Assurance~~	~~Review~~
Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**	
	To provide outstanding care for our patients	*Everybody knows their role in achieving the vision*	*Feedback from staff and learners is in the top 10% in the UK*	*The Trust is in recurrent surplus to invest in improving patient care*	

Implications	
Board assurance framework:	*None*
Corporate risk register:	*None*
Regulation:	*CQC – Safe Care and Treatment and Patient Centred Care. Achievement of Outstanding.*
Legal:	*Trusts licence to operate*
Resources:	*Nil*

Assurance Route			
Previously considered by:	*Board of Directors, Quality and Effectiveness Committee*		
Date:	*December 2020, April 2021*	**Decision:**	*Regular updates required to QEC*
Next Steps:	*Update progress to QEC*		
Previously circulated reports to supplement this paper:	None		

Key Actions: Infection Prevention and Control and Testing

	Action	1		2		3		4	
ICS	Trust	Staff consistently practice good hand hygiene and all high touch surfaces and items are decontaminated multiple times every day – once or twice a day is insufficient.		Staff maintain social distancing in the workplace, when travelling to work (including avoiding car sharing) and to remind staff to follow public health guidance outside of the workplace.		Staff wear the right level of PPE when in clinical settings, including use of face masks in non-clinical settings.		Patients are not moved until at least two negative test results are obtained, unless clinically justified.	
SYB	Doncaster & Bassetlaw Hospitals NHS Trust	Compliant	Audits undertaken across all wardson handwashing	Compliant	Regular updates available on the Trust internet, posters identifying the PHE rules displayed across the sites. All rest areas risk assessed	Compliant	PHE guidance followed in all areas. Regularly updated on the hive	Compliant	SOP available for staff to follow. Clinically highrisk areas have operational guidance

						Staff Testing			
		5		6		7.a		7.b	
		Daily data submissions have been signed off by the Chief Executive, the Medical Director or the Chief Nurse, and the Board Assurance Framework is reviewed and evidence of reviews is available.		Where bays with high numbers of beds are in use, these must be risk assessed, and where 2m can't be achieved, physical segregation of patients is considered, and wards are effectively ventilated.		Twice weekly lateral flow antigen testing for NHS patient facing staff is implemented. Whilst lateral flow technology is the main mechanism for staff testing, this can continue to be used alongside PCR and LAMP testing.		If your trust has a high nosocomial rate you should undertake additional targeted testing of all NHS staff, as recommended by your local and regional infection prevention and control team. Such cases must be appropriately recorded, managed and reported back.	
		Compliant		Compliant	In phase one, beds were removed from wards if non compliant with the 2 metre rule, A total of 18 beds removed. Additional doors on bays and partitions in place on more open wards.	Compliant	Updated test results reported on the National Framework	Compliant	Part of any outbreak practice is to test all staff in those areas.

		Patient Testing									
		8.a		8.b		8.c		8.d		8.e		
		All patients must be tested at emergency admission, whether or not they have symptoms.		Those with symptoms of COVID-19 must be retested at the point symptoms arise after admission.		Those who test negative upon admission must have a second test 3 days after admission, and a third test 5-7 days post admission.		All patients must be tested 48 hours prior to discharge directly to a care home and must only be discharged when their test result is available. Care home patients testing positive can only be discharged to CQC-designated facilities. Care homes must not accept discharged patients unless they have that person's test result and can safely care for them.		Elective patient testing must happen within 3 days before admission and patients must be asked to self-isolate from the day of the test until the day of admission.		Additional comments.
		Compliant	SOP in place, Nudge tests available in ED but all admitted patients have PCR tests	Compliant	SOP in place	Compliant	SOP inplace	In progress	Testing in place for all discharge patients. Doncaster place has designated care home beds. 6 nursing and 10 residential beds. Bassetlaw patients have no designated beds at present time.	Compliant	Designated pathways and SOP for elective tesing	

Minutes from the Acute Federation Chairs and Chief Executives
Held 1 February 2021 via Zoom

Attendees

BHFT CiC
Trevor Lake, Chair, Barnsley Hospital NHS Foundation Trust (chair)
Richard Jenkins, Chief Executive, Barnsley Hospital NHS Foundation Trust & The Rotherham NHS Foundation Trust

DBTHFT CiC
Suzy Brain England, Chair, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
Richard Parker, Chief Executive, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

STHFT CiC
Annette Laban, Chair, Sheffield Teaching Hospitals NHS Foundation Trust
Chris Morley, Chief Nurse, Sheffield Teaching Hospitals NHS Foundation Trust

SCHFT CiC
Sarah Jones, Chair, Sheffield Children's NHS Foundation Trust
John Somers, Chief Executive, Sheffield Children's NHS Foundation Trust

TRFT CiC
Martin Havenhand, Chair, The Rotherham NHS Foundation Trust

In attendance
Matthew Kane, Associate Director – Corporate Affairs and Trust Secretary, Sheffield Children's NHS Foundation Trust

Apologies

Kirsten Major, Chief Executive, Sheffield Teaching Hospitals NHS Foundation Trust

Minutes and Actions

1. **Apologies for Absence and Declarations of Interest**

   Apologies were noted.

   No declarations of interest were made.

2. **Notes of meetings on 7 and 23 December 2020**

   The notes were agreed as a correct record.

3. **The establishment of a "Provider Alliance" through a Strategy / Structure / People approach**

   The chairs and chief executives considered their future as an acute federation / provider alliance having consideration to a number of themes:

- Strategy
- Structure
- People
- Operations

The following observations were made during the discussion:

- Provider collaboratives were the future of the NHS and providers should put their energies into moving these forward, defining and agreeing objectives, aims and outcomes and working with the ICS where they can bring system benefits, rather than them being driven by the ICS.
- There was a recognition that the acute federation had spent a lot of time getting its governance structures right, but now there was a need to refocus activity on to joint working and delivery across the Acute Trusts.
- Other acute federations (e.g. WYAT) had been more successful at framing their own conversation and driving their agenda. There was a need to step up control and establish a compelling set of priorities around patients.
- Some of these priorities were already set out in the joint working agreement from 2016 e.g. informatics, shared practice, sustainable care and sustainable service configuration.
- Priorities would also be driven to a degree by Covid including around ensuring the right staffing mix and an appropriate estate for future service delivery. This would require much closer working by specialists.
- There was also a need to prioritise to ensure the acute federation was in the best place possible when transformational monies were being allocated for estates and IT and other services.
- Following further discussion, the meeting coalesced around three general priority areas: recovery; workforce and digital, which broadly fitted with the original joint working agreement priorities.
- Resource was recognised as an issue for the acute federation. Following the end of the Vanguard, the acute federation was without a dedicated programme manager/associate director and this was something that would need to be rectified quickly, with one of the trusts acting as a host but all contributing financial support. Dedicated admin support would also be necessary.
- This could be supplemented in time with other ICS staff and staff that had been displaced through the abolition of CCGs. In the first instance the chair would discuss the requirement with the ICS exec lead., If there was no transformational money available to utilise then the trusts agreed to contribute equally to fund the role of the acute federation programme manager/associate director and admin support for that role.
- The admin support to the meeting of the CiC of the AF to be finalised outside of the meeting.
- There was also a need to meet more frequently to drive forward work at pace. Further refinement of the identified priorities would be considered at another meeting on 1st March, and then on 12th April.

It was agreed that:

1. A small working party, led by the Chair, be established to recommend the acute federation programme manager/associate director role profile to be brought back to a meeting on 1st March which would also move forward agreement of the priorities and future workplan.
2. The Chair to discuss with the ICS exec lead to check if any available transformation funding for acute federation programme manager/associate director and admin support roles before going to advert with provider trusts agreeing to host such a role themselves if unsuccessful.

4. AOB

There was a need to refresh the administrative support for these meetings. *

Chief executives had agreed that whoever was the lead exec would provide the support. This would be taken forward by the Chair.

*Postscript meeting - the Chair has reviewed the role requirements and identified that it appeared more workable, in the light of no trust offering any dedicated support, that it should fall to the incumbent Chair's organisation to provide that support for the duration of the Chair's term of office (i.e. one year).

Analysis of the requirement indicates that this support can be provided by a band 5/6 level PA for the meetings with access to further advice from a Director of Corporate Governance/Trust Secretary as required/necessary. It would be proposed to introduce this from April 2021.

Minutes from the Acute Federation Chairs and Chief Executives
Held 1 March 2021 via Zoom

Attendees

BHFT CiC
Trevor Lake, Chair, Barnsley Hospital NHS Foundation Trust (chair)
Richard Jenkins, Chief Executive, Barnsley Hospital NHS Foundation Trust & The Rotherham NHS Foundation Trust

DBTHFT CiC
Suzy Brain England, Chair, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
Richard Parker, Chief Executive, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

STHFT CiC
Annette Laban, Chair, Sheffield Teaching Hospitals NHS Foundation Trust
Kirsten Major, Chief Executive, Sheffield Teaching Hospitals NHS Foundation Trust

SCHFT CiC
Sarah Jones, Chair, Sheffield Children's NHS Foundation Trust
Ruth Brown, Deputy Chief Executive, Sheffield Children's NHS Foundation Trust

TRFT CiC
Martin Havenhand, Chair, The Rotherham NHS Foundation Trust

In attendance
Matthew Kane, Associate Director – Corporate Affairs and Trust Secretary, Sheffield Children's NHS Foundation Trust

Apologies

John Somers, Chief Executive, Sheffield Children's NHS Foundation Trust

Minutes and Actions

1. **Apologies for Absence and Declarations of Interest**

   Apologies were noted.

   No declarations of interest were made.

2. **Notes of meeting on 1 February 2021**

   The notes were agreed as a correct record.

   In relation to action 2 of minute 3, the chair was meeting with the ICS executive lead on 3 March to discuss resourcing for the Acute Federation.

   It was agreed and noted that in future responsibility for administrative support to the meeting would revert to being provided by the office of the incumbent chair, in this case a B5/6 member of staff at Barnsley. Company secretarial advice would be sought as required.

In relation to a letter from the ICS executive lead it was clarified that the existing CCG framework would continue until they were abolished in law however the meeting expressed concern as to the lack of engagement around the decision not to seek a merger of all the CCGs in SYB.

It was also understood that CCG staff had been provided with a guarantee of employment but their destination was uncertain. The general feeling was that they should be deployed at Place rather than in an expanded ICS.

Current challenges relating to which ICS Bassetlaw CCG would come under and Nottinghamshire Healthcare NHS Foundation Trust's decision to move patients out of their Bassetlaw site were noted. It was noted that DBTH risked bad publicity from a situation outside of their control.

It was **agreed** that the Chair would speak to the ICS executive lead outlining concerns about:

1. The providers' lack of involvement in the decision not to merge CCGs in SYB.
2. The current situation affecting Bassetlaw CCG and Notts Healthcare.
3. The transfer of staff from the CCGs and the need for clarity as to their final destination.

In relation to an email regarding the process for appointment of an ICS independent chair, it was clarified that Mr Tony Pedder had remained chair of the Health Oversight Board (HOB) after December 2021 despite not being the providers' representative (this was now moving to Ms Sarah Jones).

There was consensus that the process had not been communicated well and some providers felt alienated by it. On a separate note it was also felt that the Regional Director should have communicated in advance about Mr Pedder chairing the appointments process for the ICS Independent Chair.

It was **agreed** the chair would raise with Mr Barker privately.

3. Priorities and resourcing of the Acute Federation

The Committees in Common considered its priorities and how it would move forward as a provider collaborative under the legislation. Central to this discussion was a need for consensus around the priorities and the role of any support brought in to deliver them.

There was a brief discussion about whether the priorities should exist at a strategic or operational level or both and what resource would be needed to take those forward.

Proposals for priorities were around the following themes:

- Covid recovery
- Workforce
- Digital

In addition there would be a need to consider specific workstreams including pathlogy and the Hosted Networks. Specialised commissioning was an issue for a number of trusts and this should also be given focus.

Furthermore, it was felt that an annual report setting out the work of the Acute Federation over the past 12 months together with future priorities and aspirations that was professionally produced would provide a good basis for the Federation to set out its stall.

It was **agreed** that:

1. The chair would bring forward an options appraisal for the resource to support the Acute Federation to the next meeting for consideration.
2. The chair would source quotes for a professionally produced annual report and forward plan of Acute Federation activity, for production by the end of April 2021.

4. NHS White Paper

Each of the documents enclosed with the agenda were considered in turn. A draft provider collaborative framework would be sent round the membership once available.

5. AOB

There were none.

DRAFT

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS – PUBLIC MEETING

Minutes of the meeting of the Trust's Board of Directors held in Public on Tuesday 16 March 2021 at 09:30 via Star Leaf Video Conferencing

Present:	Suzy Brain England OBE - Chair of the Board (In the Chair) Mark Bailey – Non-Executive Director Karen Barnard - Director of People and Organisational Development Pat Drake - Non-Executive Director Rebecca Joyce – Chief Operating Officer Sheena McDonnell – Non-Executive Director Dr T J Noble - Medical Director Neil Rhodes – Non-Executive Director and Deputy Chair Richard Parker OBE – Chief Executive David Purdue – Deputy Chief Executive and Chief Nurse Jon Sargeant – Director of Finance Kath Smart – Non-Executive Director	
In attendance:	Ken Anderson (Interim Chief Information Officer (Item P21/03/B1) Lee Cutler, Consultant Nurse / Lead Nurse Critical Care Services (Item P21/03/B1) Fiona Dunn – Deputy Director Corporate Governance/Company Secretary Paul Hill – Freedom to Speak Up Guardian (Item P21/03/D4) Emma Shaheen – Head of Communications and Engagement Katie Shepherd – Corporate Governance Officer (Minutes)	
Public in attendance:	Peter Abell – Public Governor – Bassetlaw Dennis Atkin – Public Governor - Doncaster Hazel Brand – Lead Governor/Public Governor – Bassetlaw Mark Bright – Public Governor – Doncaster Gina Holmes – Staff Side Chair Lynne Logan – Public Governor – Doncaster Adele Marsh – NHS Professionals Steven Marsh – Public Governor - Bassetlaw Bianca Mohamed – NHS Professionals Pauline Riley – Public Governor – Doncaster (until P21/03/D4) Lynne Schuller – Public Governor – Bassetlaw Clive Tattley – Partner Governor Susan McCreadie – Public Governor - Doncaster Ann-Louise Bayley – Public Governor - Doncaster Sue Shaw – Public Governor – Nottinghamshire County Council	
Apologies:	Marie Purdue – Director of Strategy and Transformation	
P21/03/A1	**Welcome, apologies for absence and declaration of interest (Verbal)**	

	The Chair of the Board welcomed all in attendance at the virtual Board of Directors and extended the welcome to the Governors and members of the public in attendance via the audience functionality. The Chair advised those present that sadly Cllr Nuala Fennelly, Lead Member for Children, Young People and School had passed away after a short illness. For those that knew Nuala would recall how passionate she was about children's services, and was an advocate for the borough, particularly in areas such as 'First 1,000 days' and gaining the most opportunities in life. Nuala was a very much respected colleague and Councillor, and leaves behind her husband, children and grandchildren. The Board's thoughts were with Nuala's family and colleagues at this sad time. The Chair advised that if members of the public and Governors in the audience had any questions arising in relation to the business of the meeting, which were not answered in the meeting, they could contact the Trust Board Office and all answers would be collated for tabling at a future CoG meeting. The apologies for absence were noted. No declarations of interest were declared, pursuant to Section 30 of the Standing Orders. The Chair and the Chief Executive attended the Doncaster Chamber Annual Award Event, in which for the first time four awards were dedicated to the NHS for all that had been achieved over the previous year. It was noted that the Trust had won the Outstanding Contribution Award, Dr Ken Agwuh, Director of Infection and Prevention and Control had won the Compassionate Care Award and Adam Tingle, Senior Communications and Engagement Manager had won the Unsung Hero Award. A video was shared with the Board and attendees as a tribute to the hard work undertaken by colleagues during the previous year.	
P21/03/A2	**<u>Actions from Previous Meetings (Enclosure A3)</u>**	
	Actions 2 to 4 and 7 and 8 were closed. Action 1 – Corporate Risk Register – There were some reviews still be logged on DATIX. Action 5 – People Plan Priorities for 2021/22 would be presented to the Board in April 2021. Action 6 was not due until April 2021.	
	The Board: - ***Noted the updates and agreed which actions would be closed.***	
P21/03/B1	**<u>eObservations (Presentation)</u>**	
	Ken Anderson, Interim Chief Information Officer, and Lee Cutler, Consultant Nurse / Lead Nurse Critical Care Services provided the Board with a progress update on the roll out of eObservations within the Trust, the system used to facilitate the capture of patient's vital signs in real-time at the bedside. Automatic early warning score calculations were used to cascade escalations to clinical staff so they can monitor and attend deteriorating patients. The roll out programme had reached the half-way point, with a further 18-months to go. The	

	focus was very much on safety with clinician input into the configuration on an individual ward requirement basis, and full training and support was included in the roll-out process. Work had been undertaken to evaluate the outcomes, and a total of 500k e-observations had been undertaken between 8th October 2019 and 15th March 2021. It was expected that this would significantly increase once elective activity increased. A total of 776 colleagues had been trained on the use of the system. A key benefit of the system was that it provided the ability to monitor safety performance with the option to drill down to individual ward level and various parameters. Feedback had been collated from e-observation users with 90%+ agreeing that the use of the system was better than the use of paper. There had been no concerns raised from patients regarding the mobile device use of colleagues and feedback had been collated from patients and included comments such as *'gives more time for us'* and *'I think it was marvellous, I'm a big believer in technology'*. Pat Drake commended the work undertaken to date and advised the Board that the Quality and Effectiveness Committee had received an update on the roll out of the programme. Following a question from Pat Drake regarding the timeline for full roll out, it was confirmed that roll out was in the final stages at Doncaster and Bassetlaw, then a focus would be taken on the roll out at Mexborough. It was expected that the programme would be rolled out fully within 18-months. Pat Drake added that the provision of support and direction to colleagues, would optimise the value of the system with a focus on patient care. Kath Smart noted that the continued roll out during the COVID-19 pandemic had been fantastic but asked if there were any benefits for areas such as the emergency department that would not use e-observations. It was advised that the Trust was looking for a separate software solution for use in the emergency department. Neil Rhodes commended the team for their efforts. Mark Bailey asked for further information on the ability to connect the e-observations system to other parts of the system. It was advised that the implementation of enterprise wide systems had both benefits and disadvantages, the most significant disadvantage being the cost implication. The Trust did have in place integrated engines between respective systems; however, this was not provided in a seamless way. Over the next 18-months further work would be undertaken to progress towards the digital transformation objectives which would include linking with existing contracts and suppliers to make improvements. Sheena McDonnell noted that the progress seen was great and added that the biggest message taken from the presentation was that 90%+ colleagues using e-observations had agreed that its use was much better than the previous method using paper, and asked if this message had been shared more widely with colleagues. It was advised that it been in Buzz each week, presentations had been delivered in the Lecture Theatre prior to the COVID-19 pandemic, but since then, the benefits had been discussed amongst colleagues and areas where e-observations had not yet been rolled out in now wished to take part and embrace the change. Looking forward, the focus would be on integrating care across the community. The Medical Director echoed the positive comments received and thanked those involved in the roll out for the remarkable efforts in a bid to make the delivery of care safer. The Chief Nurse advised that the support from the digital nursing team had been fundamental to the programme's success.	

	The Chief Executive and the remaining Board members wished to thank all those involved in the roll out, and advised that the implementation of the programme was supported from a safety of care aspect to remove the potential for errors in calculations. Following the full implementation of the system, a focus would remain on the safety benefits.	
	The Board: - ***Noted the update on eObservations.***	
True North SA1 - QUALITY AND EFFECTIVENESS		
P21/03/C1	**Board Assurance Framework**	
	The Board received the up-to-date board assurance framework risks to the achievement of the Trust's strategic aim 1 – to provide outstanding care and improve patient experience. The Chief Nurse advised that there had been no specific changes since the last Board meeting. The format of the Quality and Effectiveness Committee would change in line with the Board process. It was expected that the internal audit report on complaints would be received that week. Some risks had been downgraded from the corporate risk register. Kath Smart asked if an addition could be made to the 'assurance' section to include the two-audit reported issued earlier that year on financial governance and remote working in the gold and silver command arrangements, as significant assurance was received. Following a query from Kath Smart, it was agreed that under the 'assurance' section of the board assurance frameworks, a date would be added to inform of when assurance was provided to the Board committees.	
	Action: The two internal audit reports undertaken in-year on financial governance and remote working arrangements would be added under the 'assurance' section of the COVID-19 major incident board assurance framework.	**DP**
	Action: A date would be added to the 'assurances' within the board assurance framework inform of when assurance was provided to the Board committees.	**FD**
P21/03/C2	**Chief Nurse Update (Enclosure C2)**	
	The format of the report was in line with national safety principles of performance and improvement. The national strategy translated into the high-level objectives for the safety culture and safety system strands into more tangible deliverables. The Safety Culture Index, a psychometrically-sound measure designed to assess the extend of shared attitudes, values and beliefs that support safety at work was available to health organisations on a commercial basis. Due to the new network of Patient Safety Specialists, this toll had been offered to DBTH free of charge. The first two test areas were confirmed (NNU and Main Theatres) to analyse how far cultural values influence safety at work. Results would be monitored through the Clinical Governance Committee and included in the Quality and Effectiveness Committee quarterly learning from patient safety report. There was one serious incident reported in February 2021, which related to maternity. The brought the total number of serious incidents for care issues, year-to-date to 26. A piece of	

	work had been undertaken within the ICS in January 2021 using comparative data for January 2020, the biggest decrease in serious incidents being that of slips, trips and falls. For 2020/21 there had been 69 actions as a result of serious incident investigations, 45 of which had been completed, 24 still to be completed and would be followed up. The serious incident action themes included policy, education and training, reflection and documentation amongst others. The Trust had purchased two hydrogen peroxide decontamination machines and two ultra-violet systems to increase the effectiveness of cleaning in ward and departmental areas. The Maternity and Neonatal Safety Improvement Programme was undertaking a national review reduce the rate of still births, neonatal deaths and brain injury by 50% by 2025. This work was continuing with the Local Maternity System (LMS) in conjunction with other recent safety improvement recommendations. An element of focus for this year was medication errors and a sub-group of the Clinical Governance Committee would be formed. The findings of a review of all perinatal deaths using the real time data monitoring tool had been presented, and of those reviewed, there were no areas identified for improvement. One report received back from the Healthcare Safety Investigation Branch (HSIB) had raised concerns regarding neonatal equipment in the emergency department, however this had already been identified and actions put in place to address this. There were two outstanding HSIB report). Maternity statutory and essential training compliance was reported as 85.57%, however a concern was raised regarding prompt training due to high acuity and workload for anaesthetic staff in light of the COVID-19 pandemic. It was suggested that the Trust may not achieve 90% compliance in PROMPT for anaesthetic staff. There were 13 WTE vacancies within the midwifery workforce, however five had been appointed, and group led recruitment would take place this year for newly qualified. There had been an overall reduction in maternity related complaints. Pat Drake commended the report, however noted that an amendment was required to remove the terminology 'this year' be amended to date the financial year that it was referring to. Following a question from Pat Drake regarding the ICS framework for complaints, it was confirmed that the Trust would adapt the criteria in terms of how the Trust categorised complaints. Following a request from Pat Drake regarding a timeline for the implementation of safe care, the digital solution within Allocate, it was advised that the risk assessments were underway to be added to nerve centre and a pilot in areas would follow. Pat Drake noted that there were some serious incident overdue actions by six-months. The Chief Nurse advised that the work to action these would be completed by 1st April 2021. Following a request from Pat Drake it was agreed that the Medicine Safety Committee structure would be presented to the Quality and Effectiveness Committee. The Chief Nurse advised that there would be new terms of reference for the meetings and a change of title to a Patient Safety Board that would identify medicine committee on that. In response to a question from Sheena McDonnell regarding the response rate of the Friends and Family Test (FFT) and any further action to be taken to improve it, it was advised that	

	whilst a good indicator, the FFT was only indicative of one question and therefore more in depth patient and public involvement would take place. It was agreed following a request from Sheena McDonell that feedback would be provided on the ReSPECT form which had replaced the DNACPR form, following a suggestion that the use of 'DNACPR' meant that progress hadn't been made. This would be picked up at the Quality and Effectiveness Committee. Following a question from Mark Bailey it was confirmed that the patient safety index was part of the new national patient safety campaign, and that the organisation was one of twenty pilot sites for this. Kath Smart asked in relation to falls prevention, if clinical audit had a role in the assurance aspect of falls management. The Chief Nurse advised that the quality improvement team were supporting a programme of work in the top ten wards with the highest number of falls. The process would ensure measures were in place and be auditable.	
	Action: The use of 'this year' within reports to Board would be changed to reflect the financial year being discussed (e.g. 2020/21).	**All**
	Action: Feedback would be provided on the ReSPECT form which had replaced the DNACPR form, following a suggestion that the use of 'DNACPR' meant that progress hadn't been made.	**DP**
	The Board: - ***Noted and took assurance from the Chief Nurse update.***	
P21/03/C3	**Medical Director Update (Enclosure C3)**	
	Overall the HSMR (rolling 12-months) continued to rise slightly, although compared with neighbouring Trust's, this remained at a reasonably expected level. A double peak was identified within the crude mortality data, reflective of the two waves of the COVID-19 pandemic. All deaths continued to be reviewed through the Medical Examiner function. There was an awareness of the difficulties that the use of HSMR brought, as the data lagged three-months behind, however assurance was provided that mortality was closely monitored through the Mortality Review Group. Medical appraisals had continued throughout the pandemic where appropriate, and Medical Appraiser training would take place throughout April-to-June 2021 to increase the numbers of appraisers within the Trust. Positive feedback on the continuation of appraisals had been received from colleagues. 96.7% compliance was reported for the standards of business conduct, and the process would be reviewed to simply it. A lot of work had been undertaken throughout the Clinical Governance Review to align to the national patient safety strategy to redesign the meeting structure and terms of reference to avoid duplication to make effective use of time. The serious incident panel had continued throughout the COVID-19 pandemic. Pat Drake asked if the Divisional Directors and Clinical Governance Leads had been engaged with over the Clinical Governance Review. The Medical Director advised that the Divisional Directors were aware of the review and further work would be undertaken to engage colleagues to understand the new structure.	

	It was agreed following a question from Mark Bailey regarding the Clinical Governance meeting structure, that work would be undertaken with the Communications and Engagement Team to devise a clear and understandable outline of the committee structure and each committees purpose. It was clarified that the new posts within the Medical Director team would be finalised and advertised shortly. The first Medical Advisory Committee meeting took place the previous week, in which the Equality and Diversity Lead attended to present development work to be undertaken which was well received.	
	Action: ***Following the discussion of the Clinical Governance meeting structure, it was agreed that work would be undertaken with the Communications and Engagement Team to devise a clear and understandable outline of the committee structure and each committees purpose.***	**TN / ES**
	The Board: - ***Noted and took assurance from the Medical Director Update.***	
True North SA2 & 3- PEOPLE AND ORGANISATIONAL DEVELOPMENT		
P21/03/D1	**Board Assurance Framework**	
	The Board received the up-to-date board assurance framework risks to the achievement of the Trust's strategic aim 2 – everybody knows their role in achieving the vision and strategic aim 3 - feedback from staff and learning in top 10% in UK. This would be reviewed in light of the staff survey results to ensure that the outcome aligned to the strategic risks. The question relating to appraisals was not part of the staff survey questions for 2020/21.	
P21/03/D2	**Our People Update (Enclosure C2)**	
	A small rise had been seen in COVID-19 related absence in January 2021, however it was noted that non-COVID-19 related absence continued at a similar rate to previous years, with the usual seasonal rise. Further shielding letters had been sent to colleagues, issued nationally, which had impacted the number of staff absences, totalling approximately 2% of the workforce. Some were able to work from home, whilst others weren't. Lateral flow testing continued, and many staff were now in receipt of their second kit. The positive return rate was low at 0.4%. Second doses of the COVID-19 vaccinations were being administered to colleagues. Detailed work was underway to identify the proportion of staff that had taken up the COVID-19 vaccination, however it was noted that the information was from various sources, as there was no current central system in place to manage this. Early indication was that there had been 85% uptake from colleagues. Data had been sent to managers asking them to have conversations with individuals that it appeared had not had the COVID-19 vaccine to identify why and encourage them. In line with national data, BAME colleague uptake of the COVID-19 vaccination was lower than other ethnic groups and therefore efforts continued to encourage BAME colleagues to have the vaccine.	

	In response to a query from Kath Smart it was agreed that the total number of Positive Staff by Ethnicity would be reported to the People Committee. It was clarified, in response to a question from Kath Smart regarding the health life assurance schemes in place for families of bereaved colleagues, that the Trust had supported the families of colleagues that had passed away due to COVID-19 and all three claims had been successful. Following a question from Sheena McDonnell regarding the response rate of lateral flow testing for colleagues, it was confirmed that the highest response rate nationally was 49%, with the Trust slightly behind at 42%, the 9th best in the country. Efforts had been made to remind colleagues to report their test results, however it was noted that if positive, colleagues then go on to have a PCR test to confirm the result. Colleagues have been informed that the reporting of lateral flow test results was a statutory requirement and a Trust requirement and staff had signed to confirm that they would report the results as requested. Neil Rhodes requested that the Board be sighted on vacancy levels within the Trust. The Director of People and Organisational Development advised that a recruitment plan would be devised for 2021/22 which would give a clear indication on how vacancies would be monitored. The recruitment strategy was under review.	
	Action: The total number of Positive Staff by Ethnicity would be reported to the People Committee.	**KB**
	The Board: - ***Noted and took assurance from the 'our people' update.***	
P21/03/D3	**Staff Survey Results (Enclosure C3)**	
	The Trust had received the staff survey results benchmarked against 128 acute and acute community Trusts. The Trust had returned a 50% response rate, which was above the median of 45.4% for acute Trusts. Previously benchmarking had only been against other acute Trusts and not acute community Trusts. A 4% overall positive improvement was seen in people reporting that patient care was the organisations top priority, that they were happy with the standards of care provided, and they would recommend DBTH as a place to work. The results strongly suggest that people were positive advocates and ambassadors for the Trust. There was a statically significant improvement in the health and wellbeing domain, however there were no statically significant changes in the domains of equality, diversity and inclusion, immediate managers, morale, safe environment (bullying, harassment and violence), safety culture and staff engagement. Whilst there hadn't been the level of improvements as seen the previous year, the results have been maintained which indicated that there was the opportunity for further improvements over the coming year. The key priorities for the Trust in relation to people, was ensuring that the HR processes were robust and that there was strong leadership/development, talent management and organisational development offers. There had been a reduction in the percentage of both white and BAME colleagues reporting bullying or abuse from patients, relatives and the public in the previous 12-months. It was reported that the Trust had been one of ten most improved Trust's against a reduction in BAME discrimination by management. The Chief Executive confirmed that whilst the Trust was in the top ten most improved organisations, that it wasn't from an initial poor position.	

	Neil Rhodes commended that there was positive themes seen in the results and was a testament that whilst colleagues had worked under incredible pressure over the previous year, the Trust managed the situation well, and reflected that colleagues felt supported. Following a request from the Chief Operating Officer it was agreed that an analysis would be undertaken on the 'free-text' comments received within the staff survey results. The general themes would be reported back to the Board in May 2021.	
	Action: An analysis would be undertaken on the 'free-text' comments received within the staff survey results. The general themes would be reported back to the Board in May 2021.	**KB**
	The Board: - ***Noted and took assurance from the staff survey results.***	
P21/03/D4	**Freedom to Speak Up – Annual Report**	
	Paula Hill, Freedom to Speak Up (FTSU) Guardian presented the freedom to speak up annual report which highlighted that there had been a focus on a partnership approach with the strategy to ensure that colleagues were sign-posted to the appropriate partner to support with their concern. A Champions Network had been introduced to increase staff awareness, reflected in the staff survey results. Education, learning and development plans had been revised to include the introduction of Health Education England's FTSU training to include the three levels of training; Level 1 – Speaking Up, Level 2 – Listening Up, and Level 3 – Following Up. Positive outcomes had been seen from the self-assessment; however, this did not mean that further improvements weren't requirement. Of the 141 individuals, from 46 cases to date, who had been supported since April 2020, 36 cases had been successfully resolved. A number of cases remained open with outstanding issues that needed to be resolved before the cases could be closed. The Trust had performed similarly to the previous year in regards to the FTSU index, however it was noted that the Trust had a robust approach to utilising the staff survey as a positive engagement tool. Sheena McDonnell commented that it was good to see the work undertaken despite the COVID-19 pandemic and recognised that people felt comfortable in the culture to raise issues. In response to a question from Sheena McDonnell, it was advised that the FTSU data was shared with Staff Side as a representative of the FTSU forum, however it was suggested that it would be useful for it to be shared more widely with the BAME network and Equality, Diversity and Inclusion Group. In response to a question from Neil Rhodes regarding the appropriateness of cases, it was confirmed that there were a couple of cases that were not appropriate for that FTSU route, but that individuals were always sign-posted to the most appropriate route. Work was underway with the Communications and Engagement Team to ensure that people could understand the different between FTSU and whistleblowing. The Director of People and Organisational Development noted that good progress had been made and different approaches to communications had been taken.	
	The Board:	

	- ***Noted and took assurance from the freedom to speak up annual report.***	
True North SA4 - FINANCE AND PERFORMANCE		
P21/03/E1	**Board Assurance Framework**	
	The Board received the up-to-date board assurance framework risks to the achievement of the Trust's strategic aim 4 – in recurrent surplus to invest in improving patient care. The framework was similar to that of the previous month, however had additional controls in place. It was noted that the risk profile relating to finance was not in relation to the current financial year, but future years due to a lack of clarity on financial regimes. No formal communication had been received on the funding streams yet which raised a concern on how the financial regime would be managed locally.	
P21/03/E2	**Covid19 Update / Recovery of Elective Work – Looking Forward (Presentation)**	
	The Chief Operating Officer provided an operational update which highlighted that the number of COVID-19 admissions to the Trust were decreasing in line with the community infection rate. The vaccination programme had progressed well to date in Doncaster and Bassetlaw. The COVID-19 occupancy rate continued to decrease at a faster rate, however it was noted that there had been an increase in the demand for non-COVID-19 emergency beds. Staff absence was reported as 7.4%, 42.3% of which was COVID-19 related. Attendance in the emergency department had continued to increase, however was below the rates seen during summer 2020. Pressure on the intensive care units had decreased, however, it was noted that rates were higher than pre-COVID-19 rates. Demand was still seen in the high dependency units. National mutual aid arrangements had ceased in late February 2021. The Trust had provided colorectal mutual aid to two Chesterfield patients in late February 2021, however not further requests had been received. The Trust continued to steadily increase elective work, and the 52-week wait challenge remained. Outsourcing/insourcing had taken place to support this with increase outpatient activity on site. Regional mutual aid continued. The Trust would continue to step up the theatre plan throughout March and April 2021. There would be a further focus on outpatient throughput. A national contract on outsourcing was expected to continue into the new financial year. The Foureyes consultation would continue to establish strong capacity plans. The validation of long-waiting patients commenced on 8th March 2021, through letters to each patient. There would be a focus on return to business as usual, and include a focus on the patient tracking list, followed by a resulted focus on administrative processes, validation and training. Colleagues would continue to be supported through the recovery phase. Collaborative work would continue at Place and ICS level. In reference to the Elective Action Plan, Neil Rhodes asked the Chief Operating Officer what the critical success factors would be in the delivery of this action plan. The Chief Operating Officer advised of four things that were important to the achievement of the plan: - Leadership gaps – recruitment to senior leadership posts was underway as they were critical to the delivery of plans. An appointment had been made to the post of	

	Deputy Chief Operating Officer that would commence in post in the new financial year, - The basics of the process needed to be right including the booking process, - Trajectories needed to be identified through the business planning process to understand how it could be achieved, - An understanding of the funding envelope was required, - Embedding different ways of working and transformation to work efficiently. The Chief Executive added that an important consideration was the 10% loss of bed stock due to revised infection prevention and control measures due to COVID-19, meaning that the levels of work achieved prior to COVID-19 may not be achievable. Work was underway at local, regional and national level to identify the priorities for the Trust and the ICS. Whilst there had been capital works in the Emergency Department to create more space, increased attendance at record levels meant that the speed and timeliness seen prior to the COVID-19 pandemic were affected by the infection prevention and control measures. Clarity was required on expectations and deliverability, and until the planning guidance and financial framework was received, there was a level of uncertainty to this. Following a query from Sheena McDonnell it was agreed that a report would be provided on the service changes made during the COVID-19 pandemic, and any fundamental changes that would form how services would be delivered in the future. Kath Smart provided assurance that the Finance and Performance Committee had been in receipt of such information. Following a question from Kath Smart regarding the impact of COVID-19 and future arrangements of pathways, it was confirmed that the consultation work with Foureyes would establish demand and capacity plans in line with winter expectations and the bed base. In response to a query from Mark Bailey regarding the management of expectations of the wider community, it was noted that this would form part of the assessment following the consultation. Pat Drake commented that performance should be aligned to the vacancy challenge seen in areas such as Anaesthetics, because plans would be undeliverable without the right amount of staff to provide care. The Chief Executive advised that part of the process would make certain what can be delivered to meet or exceed expectations. Workforce would form a significant consideration and include the support that workforce requirement following the COVID-19 pandemic.	
	<u>Action:</u> A report would be provided on the service changes made during the COVID-19 pandemic, and any fundamental changes that would form how services would be delivered in the future.	**RJ**
	The Board: - ***Noted and took assurance from the information provided in the Covid19 Update/ Recovery of Elective Work – Looking Forward presentation***	
P21/03/E3	**<u>Performance Update – December2020 (Enclosure E3)</u>**	
	The Chief Operating Officer summarised the areas of performance for elective, emergency and cancer services which highlighted that performance across all metrics had been impacted by COVID-19. The Trust's focused recovery restoration plan would outline	

	refreshed trajectories for all areas and key recovery metrics, which would enable Board to review more tailored performance monitoring. <u>Elective</u> For January 2021, the Trust did not meet its phase 3 elective activity standards due to COVID-19 related pressures. The Trust reported 1635 52-week breaches due to COVID-19 related delays, a continued challenge comparable of other SYB providers. The Trust delivered 62.5% for RTT against a target of 92%. The Trust achieved 56.06% against a target of 99% in diagnostics. <u>Emergency</u> The Trust delivered 80.7% against a national target of 95% for 4-hour access, showing an improvement compared to the previous month, however slightly below peer benchmarking, but above the national average. A wide-ranging action plan was in place. There were continued challenged on ambulance delays related to COVID-19 pressures. Similar challenges had been seen in other North East and Yorkshire Trusts. A join action plan was in place for DBTH and the Yorkshire Ambulance Service. The Finance and Performance Committee had undertaken a deep dive on this at the last meeting. <u>Cancer</u> In December 2020, the Trust achieved 3 out of 3 31-day nationally reported measures, 1 out of 2 62-days nationally reported measures, and the number of open pathways over 104-days had been reduced for January 2021 to 6 declared breaches. Performance remained the best for SYB. Pat Drake noted that there had been super stranded patients not medically fit for discharge and asked if this would likely affect the bed base in the future. The Chief Nurse advised that there had been some delays due to COVID-19 testing and retesting however good work had been undertaken with partners and a group had been set up to look at assessments. There was a need to re-embed good practice systems and processes in relation to length of stay.	
	<u>Action</u>: The Finance and Performance Committee would receive a deep dive into cancer services.	**RJ**
	The Board: - ***Noted and took assurance from the performance report for January 2021.***	
P21/03/E4	**<u>Finance Update – January 2021 (Enclosure E4)</u>**	
	The Trust's deficit for month 11 (February 2020) was £452k, which was c. £1.1m favourable to plan (£1.9m favourable to plan in month 10). The Trust's year to date position was a £107k surplus which was c. £7.7m favourable to plan. The Trust had not included any fines under the Elective Incentive Scheme within the position since NHSI/E had confirmed the scheme had been suspended for the rest of the year. The favourable variance against plan continued to be driven by activity being lower than previous Divisional plans to reinstate activity, continued unfilled vacancies, underspend against the winter plan, lower PDC (due to the cash advance) and non-clinical income being above plan. In month 11, additional income of c£1.3m had been received from NHS England which had been provided to support Trusts who have achieved lower levels of non-clinical income in year compared with historical levels	

	as a result of COVID. The Trust was forecasting a break-even financial position for year-end; however, this was subject to several outstanding national funding arrangements being confirmed including annual leave, Flowers, outsourcing clawback and non-clinical income. It was noted that the Flowers case had been settled and the Trust was waiting for guidance. £4.5m had been received to cover the annual leave position, however it was not clear if this could be counted as income or cash to help with the position. Capital expenditure spend in month 11 was £5.8m. This was £1m ahead of the original £4.8m plan and £1.5m ahead of the forecast. Year to date capital expenditure spend was £25.3m, including COVID-19 capital spend of £1.5m. This was £5.1m behind the £30.4m plan and £1.7m ahead of the forecast. Estates were £686k ahead of the YTD forecast and Medical Equipment and IT were £185k and £801k ahead of the YTD forecast respectively. The Trust was currently forecasting to deliver its revised capital plan at year end. The Chair noted that throughout the following financial year there would be continued focus on savings whilst dealing with the underlying deficit. Neil Rhodes noted that financial leadership was required from budget holders and Divisional Directors in the year ahead to ensure that a focused remained on elective pathways. The Chief Executive added that there was a training gap to reduce in relation to ensuring that at each level, colleagues have the skills and abilities to undertake different functions. A focus would remain on the training and development offer. A revised management meeting structure had also been agreed. Delivery plans would be monitored through the Programme Management Office. Following a question from Karen Barnard regarding the £4.5m received for annual leave, it was confirmed that it was to cover the annual leave accrual work completed, however the Trust was awaiting full guidance on this. Following a question from Kath Smart regarding identified surplus at CCG level, it was confirmed that all providers were working to manage the year-end in preparedness for the following financial year.	
	The Board: - ***Noted and took assurance from the finance report for February 2021.***	
P21/03/G1	**<u>Proposal of Committee Effectiveness Review Framework (Enclosure G1)</u>**	
	A new committee effectiveness review framework was proposed as there was no effective procedure in place for assessing the effectiveness and functioning of all Board committees in a standardised way. The standardised approach had previously been used for the Audit and Risk Committee. If approved the framework would run between April and May 2021, with an aim to start on an annual cycle in January 2021. If approved the checklists would be set up as an electronic survey. Following a comment from Kath Smart it was agreed that the Committee Effectiveness Review Framework would be updated to include feedback from members and attendees of Committees.	

	<u>Action</u>: The Committee Effectiveness Review Framework would be updated to include feedback from members and attendees of Committees.	**FD**
	The Board: - ***Considered and approved the committee effectiveness review framework.***	
P21/03/G2	**<u>Corporate Risk Register (Enclosure G2)</u>**	
	One new corporate risk had been added, escalated from the Management Board: Risk ID 2644 – Consultant Staffing Shortage on DCC. A robust action plan would be developed to address risk mitigations. The Medical Director was the lead for this risk, with the Divisional Director for Clinical Specialities.	
	The Board: - ***Considered and noted the information in the Corporate Risk Register.***	
P21/03/G3	**<u>Charitable Funds Committee Annual Report (Enclosure G3)</u>**	
	The Board: - ***Noted the Charitable Funds Committee Annual Report.***	
P21/03/H1 -H6	**<u>Information Items (Enclosures G1 – G7)</u>**	
	The Board noted: - ***H1 Chair and NEDs Report*** - ***H2 Chief Executives Report*** - ***H3 ICS Update*** - ***H4 Minutes of the People Committee – 12 January 2021*** - ***H5 Minutes of the Charitable Funds Committee – 16 June 2021*** - ***H6 Minutes of the Management Board Meeting – 8 February 2021***	
P21/03/I1	**<u>Minutes of the Meeting held on 16 February 2021 (Enclosure I1)</u>**	
	The Board: - ***Received and Approved the Minutes of the Public Meeting held on 16 February 2021.***	
P21/03/I2	**<u>Any Other Business (Verbal)</u>**	
	There were no other items of business.	
P21/03/I3	**<u>Governor Questions Regarding the Business of the Meeting (Verbal)</u>**	

P21/03/I3(i)	The Lead Governor wished to congratulate those who had received a Doncaster Chamber award, and proceeded to ask questions relating to the business of the meeting on behalf of the Council of Governors: <u>The vaccination take-up by staff was 85%, which may not be an accurate figure, but there were probably some staff that were hesitant, and the question relates to why this might be? Do you agree that staff have a professional duty to be vaccinated?</u> It was advised that vaccinations were mandated, however efforts have been put into encouraging colleagues to have the vaccination, recognising that some colleagues do have good reasons why they don't wish to have it at this time. The Chief Nurse advised that there was a national debate regarding this topic regarding whether certain staff groups should be required to have the vaccination such as students who rotate or bank staff who work across different sites, which would be reviewed within the ICS. <u>Upon review of the Freedom to Speak Up data, it shows that during quarter 1 of 2020/21, there was a significant increase in concerns raised. Can this be explained?</u> The Director of People and Organisational Development advised that the significant increase relates to the same concern raised by a number of staff within the Emergency Department. The figures relate to the number of individuals that have raised a concern, as opposed to the number of individual concerns raised.	
	The Board: - ***Noted the comments raised, and information provided in response.***	
P21/03/I4	**<u>Date and Time of Next meeting (Verbal)</u>** **Date:** Tuesday 20 April 2021. **Time:** TBC **Venue:** Star Leaf Videoconferencing	
	The Board: - ***Noted the date of the next meeting.***	
P21/03/I5	**<u>Withdrawal of Press and Public (Verbal)</u>**	
	The Board: - ***Resolved 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.***	
P21/03/J	**<u>Close of meeting (Verbal)</u>**	
	The meeting closed at 12:45.	