Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting Held in Public
To be held on Tuesday 21st September 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*		-	10
A2	Actions from previous meeting *Suzy Brain England OBE, Chair*	*Review*	5	
B	**PRESENTATION**			
	None			
C	**True North SA1 - QUALITY AND EFFECTIVENESS**			**09:40**
C1	Board Assurance Framework *David Purdue, Deputy Chief Executive and Chief Nurse / Dr T J Noble, Executive Medical Director*	*Assurance*	7	5
C2	Chief Nurse Update *David Purdue, Deputy Chief Executive and Chief Nurse*	*Assurance*	10	10
C3	Executive Medical Director Update *Dr T J Noble, Executive Medical Director*	*Assurance*	30	10
D	**True North SA2 & 3- PEOPLE AND ORGANISATIONAL DEVELOPMENT**			**10:05**
D1	Board Assurance Framework *Karen Barnard, Director of People and Organisational Development*	*Assurance*	36	5
D2	Our People Update *Karen Barnard, Director of People and Organisational Development*	*Assurance*	38	10
D3	Report from Guardian for Safe Working *Anna Pryce – Guardian for Safe Working & Consultant in Sexual Health*	*Assurance*	56	10
D4	Workforce Race Equality Standard / Workforce Disability Equality Standard *Karen Barnard, Director of People and Organisational Development*	*Assurance*	65	10

BREAK 10:40 – 10:50				
E	**True North SA4 - FINANCE AND PERFORMANCE**			**10:50**
E1	Board Assurance Framework *Jon Sargeant, Director of Finance & Rebecca Joyce, Chief Operating Officer*	*Assurance*	86	5
E2	Finance Update *Jon Sargeant, Director of Finance*	*Note*	88	10
E3	Operational Update – Looking Forward *Rebecca Joyce, Chief Operating Officer*	*Assurance*	95	10
E4	Performance Update *Rebecca Joyce, Chief Operating Officer*	*Assurance*	105	10
F	**STRATEGY**			**11:25**
F1	SYB Pathology Transformation Outline Business Case *Marie Purdue, Director of Strategy and Improvement*	*Approve*	108	15
F2	Collaborative Working with RDaSH *Marie Purdue, Director of Strategy and Improvement*	*Note*	183	5
F3	Teaching Hospital Board Update *David Purdue, Deputy Chief Executive and Chief Nurse/Mark Bailey, Non-Executive Director*	*Assurance*	187	5
G	**GOVERNANCE AND ASSURANCE**			**11:50**
G1	Corporate Risk Register *Fiona Dunn, Deputy Director Corporate Governance/Company Secretary*	*Review*	188	5
G2	Director Register of Interests *Fiona Dunn, Deputy Director Corporate Governance/Company Secretary*	*Assurance*	192	5
G3	Use of Trust Seal *Fiona Dunn, Deputy Director Corporate Governance/Company Secretary*	*Approve*	196	5
G4	Internal Audit Report Status: Job Planning update *Dr T J Noble, Executive Medical Director*	*Assurance*	?	10
BREAK 12:15-12:25				
H	**INFORMATION ITEMS (To be taken as read)**			**12:25**
H1	Chair and NEDs Report *Suzy Brain England OBE, Chair*	*Information*	197	
H2	Chief Executives Report *Richard Parker OBE, Chief Executive*	*Information*	204	

H3	ICS Update *Richard Parker OBE, Chief Executive*	*Information*	211	
H4	Performance Update Appendices *Rebecca Joyce, Chief Operating Officer*	*Information*	218	
H5	Minutes of the Finance and Performance Committee – 17th June 2021 *Neil Rhodes, Non-Executive Director*	*Information*	240	
H6	Minutes of the Quality and Effectiveness Committee – 14th June 2021 *Pat Drake, Non-Executive Director*	*Information*	250	
H7	Minutes of the People Committee – 6th July 2021 *Sheena McDonnell, Non-Executive Director*	*Information*	266	
H8	Minutes of the Trust Executive Group – 12th July 2021 and 9th August 2021 *Richard Parker OBE, Chief Executive*	*Information*	281	
H9	Minutes of the Teaching Hospital Board – 11th June 2021 *Mark Bailey, Non-Executive Director*	*Information*	308	
I	**OTHER ITEMS**			**12:35**
I1	Minutes of the meeting held on 20th July 2021 *Suzy Brain England OBE, Chair*	*Approval*	313	10
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 19th October 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**			**12:55**

*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: Angela O'Mara
Updated: 16 September 2021

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Action Log

Meeting:	Public Board of Directors
Date of latest meeting:	20th July 2021

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

No.	Minute No.	Action	Lead	Target Date	Update
1.	**AR21/05/E 2i**	**Escalation to Board – Job Planning Internal Audit Report** The internal audit report on Job Planning would be escalated to the Board for review.	**TN**	**September 2021**	Board Agenda 21.9.2021
2.	**QEC21/06/ D2ii**	**Inpatient Survey Action Plan** An update to be included as part of the Chief Nurse Report to Board.	**DP**	**September 2021**	Chief Nurse to update 21.9.2021
3.	**P21/07/C4**	**Escalation to the Finance and Performance Committee** The Finance and Performance Committee would take an action to follow up on the funding arrangements in place to support the expansion of the Medical Examiner function to include the scrutiny of all community deaths.	**JS**	**September 2021**	**Closed.** Added to the Finance and Performance Committee action log and work plan.
4.	**P21/07/D2i**	**Diagnostic Framework Self-Assessment – Board Leadership** Action would be taken to determine the information provided to arrive at the outcome of the Diagnostic Framework Self-Assessment for Board Leadership and what steps would be required to make improvements.	**KB**	**September 2021**	In order to move this assessment to overall green there will be explicit inclusion of the importance and specific priority areas for health and wellbeing within the refreshed People Strategy together with an explicit funding stream.

Action notes prepared by: Angela O'Mara
Updated: 16 September 2021

No.	Minute No.	Action	Lead	Target Date	Update
5.	**P21/07/D2i**	**COVID-19 Positive Colleagues** The Director of People and Organisational Development would identify of the number of staff that had tested positive for COVID-19, how many received the COVID-19 vaccination.	**KB**	**September 2021**	Included in Our People Update – the data indicates that the majority of staff testing positive for Covid have been double vaccinated
6.	**QEC21/08/ B1**	**Mental Health Support** The Chief Nurse would include an update at the next Board meeting on the challenges surrounding increased mental health needs, recruitment to RDaSH posts and the number of mental health beds.	**DP**	**September 2021**	Included within the Chief Nurse's Update paper
7.	**QEC21/08/ D3i**	**NHS Food Strategy Update** This would be included in the Chief Nurse Report to Board in September 2021.	**DP**	**September 2021**	Included within the Chief Nurse's Update paper
8.	**QEC21/08/ C4i**	**Safeguarding Information to Board** Following a discussion regarding the lack of safeguarding information received at Board, a decision would be made on whether a presentation update be provided to Board, or if regular information would be provided as part of the Chief Nurse report.	**DP**	**November 2021**	Not yet due

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 July 2021 reviewed alongside the corporate risk register.

The entire BAF and CRR were reviewed at Board Sub Committee meetings during July/Aug 2021 and by the Strategic aim sponsors in July/Aug 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 SEPT Trust Board .

There has been no change in the BAF risk level during quarter 2 2021/2022.

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				2664	COVID 2472

Overall change per Strategic Aim (SA)

	Q1 2021/22	Q2 2020/21	Q3 2020/21	Q4 2020/21	No of risks/SA	Change
SA1	⟺	⟺	⟺	⟺		⟺
SA2	⟺	⟺	⟺	⟺		⟺
SA3	⟺	⟺	⟺	⟺		⟺
SA4	⟺	⟺	⟺	⟺		⟺
COVID	⟺	⟺	⟺	⟺	several	⟺

Appendix Level1

COVID19 Major incident

Risk Owner: Trust Board **Committee: Q&E, F&P,**	**COVID19 - Addition to SA1**	**Date last reviewed : SEPT 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 –
  - Changes to rules of the elective incentive fund with increase of thresholds to 95% impacting on funding available to deliver additional activity as per accelerator plans – impact for waiting lists and associated patient care. Potential risk of long waiting patients presenting as emergencies or developing further complications.
- Impact on staff & Inability to provide viable service
- High number of staff absence (due to COVID related reasons) with impact on services across the board – impact on elective services which may affect ability to deliver the elective activity plan and supporting accelerator activity

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
- 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
- 17/5/21: Operational Update / Delivery of Elective Restoration Update (Presentation)given to F&P Committee on monthly basis. Covers risk areas of Theatre staffing, Be Plan, Risk to patients & Oversight & Governance. Mitigation via high level actions from COO led Performance & Access Board.
- High level actions from Performance and Access Board
- Finalisation of 52 week trajectories and wider issuing of IQPR
- Confirm & Challenge events on Annual Plan end of May
- Clinically urgent care being prioritised
- Ongoing daily operational reviews to allocate or redeploy staff to maintain safe care, or mitigate risks in a particular service

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

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 : SEPT 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 division's 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 • Staff working in separate areas following the incident in the womens hospital. **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 o 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. Action plans completed against internal audit and reviewed at QEC in June. Positive feedback from people on the services BAF completion on specific areas, evaluated by CQC, IPC BAF reviewed at Board of Directors December 2020. BAF reassessed 14th July 2021 Trust plan against the Ockenden Report, plan reviewed at Board February 2021 and QEC April 2021. Ockenden information uploaded to national portal on 1st July 2021. CNST 10 elements to be uploaded on the 22nd of July. SNCT undertaken to ensure safe staffing completed in June 2021. Action plans to respond to CQC patient surveys **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:	*21st September 2021*	**Agenda Reference:**	**C2**		
Report Title:	*Chief Nurse Report*				
Sponsor:	*David Purdue – Chief Nurse and Deputy Chief Executive*				
Author:	Lois Mellor, Director of Midwifery Abigail Trainer, Director of Nursing Cindy Storer, Deputy Director of Nursing, Patient Safety Stacey Nutt, Deputy Director of Nursing, Patient Experience David Purdue, Chief Nurse and Deputy Chief Executive				
Appendices:	*0*				
Report Summary					
Purpose of report:	*To provide information and assurance on the key deliverables for patient experience and safety.* *To provide assurance against the outcome measures for Maternity Services* *To provide assurance against safe staffing numbers for nursing and midwifery*				
Summary of key issues/positive highlights:	• Good progress is being made in relation to objectives. • Current performance against Maternity Dashboard • Learning areas from reports and incidents				
Recommendation:	To approve				
Action Require:	Approve	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:	*May/June2021*	**Decision:**	*Regular updates required to QEC*
Next Steps:	*Update progress to QEC*		

Previously circulated reports to supplement this paper:	None

Chief Nurse Board Report

In July 2019, NHS Improvement launched the national patient safety strategy defining patient safety as **maximising the things that go right and minimising the things that go wrong.** It is integral to the NHS' definition of quality in healthcare, alongside effectiveness and patient experience.

Work is ongoing in the Trust for the key milestones of the patient safety strategy to be delivered, including the national syllabus and the end of the serious incident framework.

Safer Culture, Safer Systems

The national 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.

Division questions for the Safety Culture index are now included in the Division Framework for the Quality and Effectives Committee.

INSIGHT

Serious Incidents

There was one serious incident in August, this related to a patient who had a supplementary report issued on their biopsy, resulting in a significant delay in follow up.

This brings the total number of serious incidents for care issues, year to date to 10. There have been no never events this year.

After Action Review (AAR)

There was one After Action Review in August. This related to a patient who did not receive a regular screening appointment and was referred into the system with symptoms, later confirmed as cancer.

The total number of AAR this year has been six.

Patient Safety Incident Response Framework (PSIRF)

Following guidance from the national patient safety team, a workshop was held on 13 September to analyse the past three years of data on patient safety incidents, serious incidents, moderate harms, complaints and inquests. This analysis will form part of the Trust proposal on a patient safety incident response plan, in readiness for the launch of the national framework for PSIRF next year.

Falls

There were 115 falls in August. Of these, 85 resulted in no harm and five of these were non-inpatient. There were two moderate harms this month on AMU and ward A5.
Learning from falls is collated at a monthly falls panel and included in the SHWC newsletter.

Hospital Acquired Pressure Ulcers (HAPU)

There were 107 HAPU in August 2021 affecting 85 patients. Of these, there was one Category four HAPU.
A full investigation process is being undertaken to identify the route cause of the category four ulcer.

This brings the total number of HAPU year to date to 416, affecting 336 patients. Of these, there were 11 Category three HAPU and one Category four HAPU

Learning from HAPU continues with the use of a Trust social media page, which has been well received by ward staff.

Infection Prevention and Control

Clostridium difficile
There were six cases of Clostridium difficile in August 2921. One case was Hospital Onset, Hospital Acquired (HOHA). Five cases were Community Onset, Hospital Acquired (COHA).

Ribotypes have been cross-matched and there is no obvious links. We have had type 014 identified 4 times this year, which was the most common ribotype in 2020/21. Further work looking at geographical locations is being undertaken to see if there is any common trend.

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

This brings the total number of cases of Clostridium difficile to 22 against a trajectory of 44 (11 HOHA and 11 COHA)

e-Coli Bacteraemia

There were five cases of eColi bacteraemia in August 2021, which are now having a PIR in the same way as Cdiff to establish learning.

The total number of cases, year to date is nineteen.

MRSA bacteraemia
There were no MRSA bacteraemia reported in August 2021.

MRSA Colonisation
There were two reported MRSA colonisations within the same area at DRI. Additional IPC measures are being undertaken alongside observations of practice and deep cleaning of the areas.

Nosocomial Covid
One ward area reported an outbreak of Covid 19 affecting two patients. Post infection review was undertaken to assess compliance with the PHE guidance.
No issues were identified.

Following national guidance the Trust has written a duty of candour letter to 90 relatives of patients who dies of Covid 19 whilst an inpatient. 3 letters have been received to clarify issues raised as a result.

INVOLVEMENT

The framework for involving patients in patient safety

This was released in June and is split into two parts

- Part A: Involving patients in their own safety
- Part B: Patient safety partner (PSP) involvement in organisational safety
- https://www.england.nhs.uk/publication/framework-for-involving-patients-in-patient-safety/

Part B of the framework 'PSP involvement in organisational safety' relates to the role that patients, carers and other lay people can play in supporting and contributing to a healthcare organisation's governance and management processes for patient safety.

Roles for PSPs can include:

- membership of safety and quality committees whose responsibilities include the review and analysis of safety data
- involvement in patient safety improvement projects
- working with organisation boards to consider how to improve safety
- involvement in staff patient safety training
- participation in investigation oversight groups

The ambition is to have the PSs in place by the end of Q1 2022/23

Patient Safety Syllabus

The Trust wide Learning Needs Analysis has been completed and this will apply to all Trust staff, including a module for the Board of Directors. Work has been completed to ensure this will be available on ESR. Level one and two will be available in the autumn.

IMPROVEMENT

Shared Learning

Following investigation, recommendations and learning from patient safety incidents, the monthly patient safety newsletter Sharing How We Care (SHWC) continues to be written and published each month (August 2021 saw issue 28 being released).

SHWC is sent to all Trust staff and is designed around Insights, Involvement and Improvement. https://extranet.dbth.nhs.uk/safety-quality/sharing-how-we-care-newsletter/

To celebrate the third World Patient Safety Day in September, the third Sharing How We Care Conference will go ahead on Thursday 16 September, with various celebrations going ahead on the following day. https://extranet.dbth.nhs.uk/shwc2021/

Organ Donation Week

The 20th of September is the start of Organ Donation week. A number of events are planned across both DRI and BDGH, including the lighting up of both Trusts in pink. Permanent memorials are planned on both sites to remember the patients who donated organs.

Mental Health Support

The Trust Mental Health Strategy has been reviewed in light of the significant increase in patients presenting with mental health conditions through the Trust. Working jointly with our 2 mental health partners several workstreams are in place to ensure that core 24 standards are met.

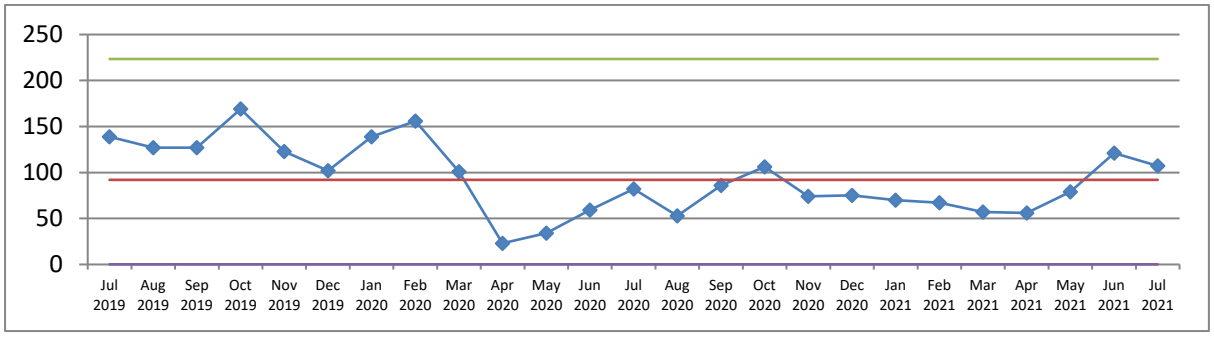
- These include
  - Crisis team in place
  - Drug and Alcohol services
  - On site mental health team with a dedicated psychiatrist

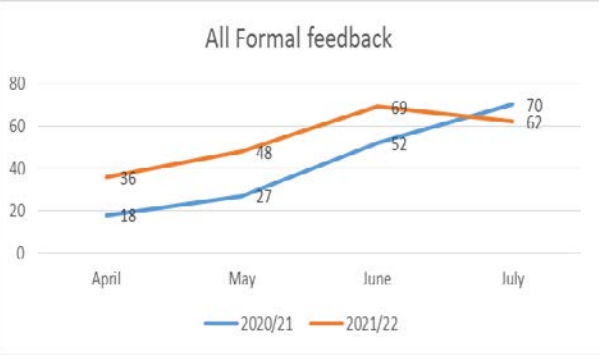
Unfortunately, due to staffing shortfalls the Mental Health Hub is currently unable to be opened.

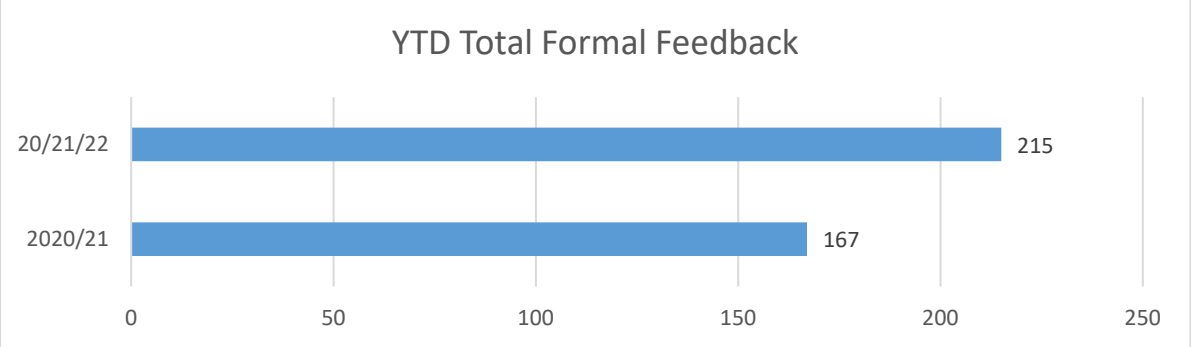
Training for staff to support mental health patients is being reviewed. RDASH have been commissioned to undertake de-escalation training. The mental health first aid toolkit is being offered to staff in key areas.

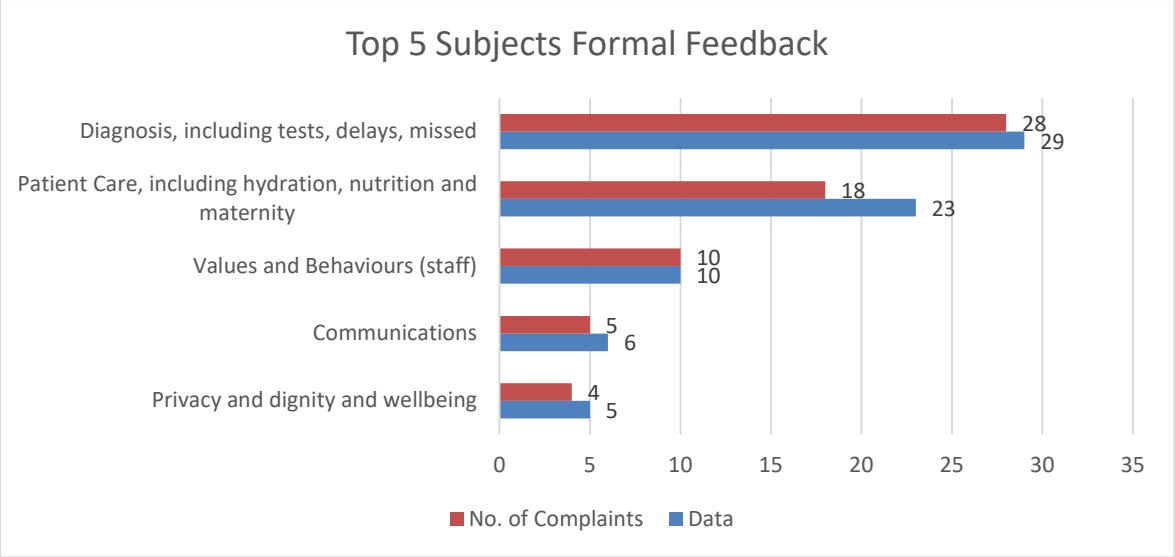
Patient Experience Report

ALL feedback received 1st July – 31st July 2021









The Trust currently have 2 ; Values and Behaviours and Nutrition. From a values and behaviours perspective it is noted that 50% of the complaints made are about medical staff and are subcategorised to 'insensitive to patients needs' and 'abruptness and rudeness'. This will be monitored over the next few months and actions agreed with the Medical Director.

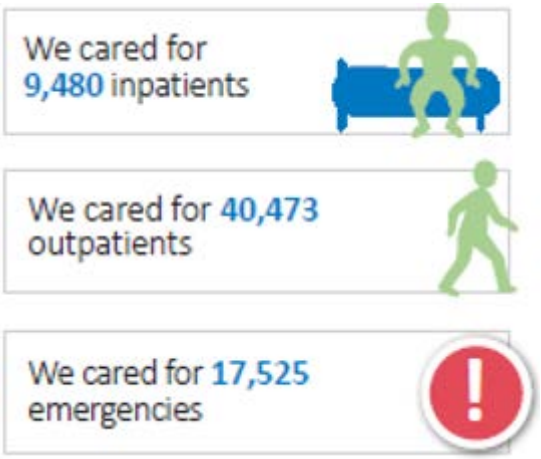
Patient care is quite a diverse subject but there are 4 complaints that relate to nutrition and hydration. The sub-subjects don't specifically demonstrate a trend or theme; with mouth care, poor quality food, lack of understanding of needs and lack of assistance all having 1 complaint each.

Internal Timeframe Compliance

The following table identifies compliance of complaints against the initial timeframe allocated that were due for response in July 2021. During COVID organisations could opt out of responding to complaints immediately and although we as a Trust continued to do this the length of time it took to respond was severely impacted due to clinical priorities.

July 2021 Compliance Original Timeframe	In Time	Out of Time	Grand Total	Compliance (%)
Children and Families Services	5	2	7	71%
Clinical Specialist Services	5	0	5	100%
Medical Services	14	10	24	58%
Surgical and Cancer Services	8	3	11	73%
External to DBH	1	0	1	100%
Grand Total	**33**	**15**	**48**	**69%**

What Have We Learnt?

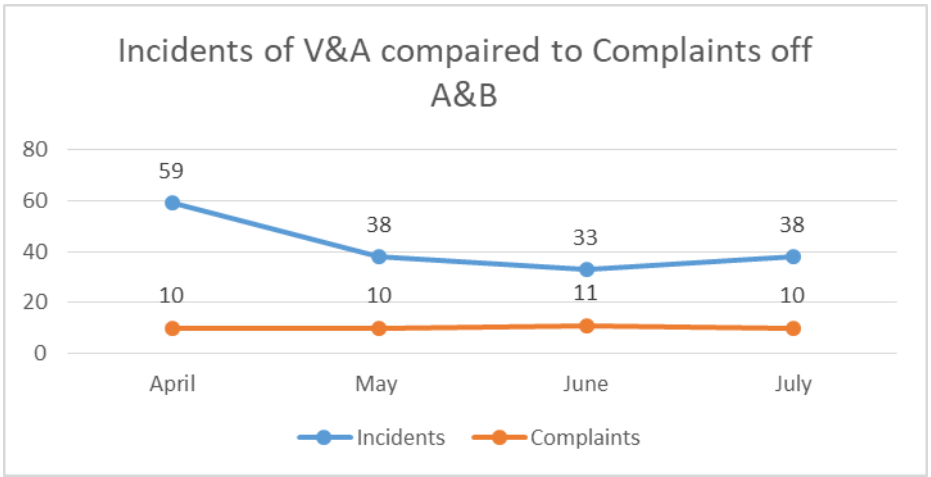


In total the Trust cared for 67,478 patients and received a total of 107 negative feedback.

This converts to 0.158%Communication with families/patients

This month the overwhelming theme of complaints has been around Diagnosis but is closely linked to communication, in particular with families. The Trust is still experiencing many challenges due to the lack of visiting, in particular in the Division of Medicine and Surgery and Cancer. Some areas of learning and actions are highlighted below:

- An Administration manager in surgery has introduced protected time for the admin team in Morning to answer telephone calls. It is anticipated that this will reduce calls through the day.
- Reintroduce Matron ward rounds in order to give continual feedback to staff on attitudes and behaviours, reviewing compliance with medication policies.
- Individual feedback to staff members who have been noted in complaints so that they can reflect on their own personal communication and the impact of poor attitudes and behaviours to the patient experience. We need to triangulate this with incidents of poor attitudes and behaviours towards staff as there is an obvious increase.



- There have also been a lot of contacts with PALS and feedback from volunteers about issues relating to signage of departments, wards and clinics. Therefore, the Director of Estates and Facilities, Deputy Director of Nursing for Patient Experience, Deputy Director of Estates and Facilities and the Sign Writer undertook at walk round of the site to walk the patient's journey. We found inappropriate temporary signage causing confusion to patients, signage to departments that had been moved and missing signage. Therefore, we have initiated a phased plan of responding to this issue
    - Phase 1 – clear signage from Main Entrance, South Block Entrance and Emergency Department (ED) entrance directing the public to 'Main Outpatients'. The removal of temporary signage that is causing confusion and also untidiness.
    - Phase 2 – Pull up banners at 'junctions' and at clinic corridor entrances clearly identifying what clinics are held there.
    - Phase 3 – Review of hospital site maps with potential to use external contractors to make sure it meets the information needs of patients and external visitors.

It is anticipated that Phase 1 will be completed by September, Phase 2 by the end of September and Phase 3 by spring 2022.

NHS Food Strategy Update

•The requirement of a Food and Drink Strategy was identified in the NHS standard Contract

•The Trust Food and Drink Strategy has now been approved

•Delivery of the strategy is monitored by the Nutrition Steering Committee and is part of the overall Trust Nutrition Action Plan for 2021-2024

•5 Key Standards: Patient nutrition and hydration; Nutrition and hydration 'Digest'; Nutritional screening tool; Healthier eating across hospitals and Sustainable food and catering services.

Monthly Maternity Board Report

1. Findings of review of all perinatal deaths using the real time data monitoring tool

Quarter 1 – 1st Apr to 30th June 2021

Antenatal /Intrapartum	Initial review findings	PMRT and investigation /review outcome
AN	Smoker at booking. 999 transfer –. Head Entrapment. Cervical Incisions. No Signs of life 500g	Grading of care A,A however still awaiting response from Yorkshire Ambulance Service.
AN	Attended with DFM. 1st Episode. IUD confirmed GDM. Polyhydramnious	Grading of care to be discussed at next PMRT
AN	Change in pattern of movements. IUD confirmed. Currently being Scoped ?SI	To be discussed and investigation completed

Action Plan for Quarter 4

Case	Issue	Action
	This mother and her partner were not able to be cared for in either a sound proofed room or a room away from other mother and crying babies because the facilities were not available	Review of bereavement facilities has begun

2. Findings of review all cases eligible for referral to HSIB.

Cases to date	
Total referrals	17
referrals / cases rejected	4
Total investigations to date	13
Total investigations completed	10
Current active cases	2
Exception reporting	0

2.1 Reports Received since last report

None

2.2 Current investigations

HSIB criteria: Neonatal Death
Trust site: Doncaster
Update

- Comments from Trust have been reviewed and amendments made to the draft report
- Draft report shared with the family on 1/9/2021

HSIB criteria: HIE/Cooling
Trust site: Doncaster
Update

- Draft report shared with the Trust on 31 August 2021
- Feedback due 14 September 2021

-

2.3 Completed investigations

HSIB criteria: HIE/ cooled baby
Trust site: Bassetlaw

Recommendations

1. The Trust to ensure that the staffing model enables the labour ward coordinator to remain supernumery at all times
2. The Trust to ensure that junior staff and newly qualified clinicians have a personalised support plan in place to consolidate their sills and confidence
3. The Trust to ensure that there is escalation to the obstetric team when there are concerns regarding a CTG. An obstetric review with a clear management plan, agreed with the mother should be documented, ensuring that there is oversight of the full clinical picture
4. The Trust to ensure that the staff are supported to categorise CTG, real time and in line with current guidance. The local policy and training programmes should reflect these changes
5. The Trust to ensure that staff are supported to make clinical assessments in real time, and that these assessments are documented contemporaneously
6. The Trust to ensure essential equipment that may be required during birth is immediately available in the labour rooms
7. The trust to ensure a; members of the clinical working team in maternity understand the risks of expectation bias and the key principles of maintain situation awareness to ensure safe management of complex clinical situations.

This action plan is being developed currently

2.4 Identified Key Learning Themes

Senior review / oversight of care
Helicopter view of complex situations
Confirmation bias in decision making
CTG interpretation / escalation

Plans are in place to address these areas:

- Training on PROMPT
- External training being sourced

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3. <u>Training compliance</u> for all staff groups in maternity related to the core competency framework and wider job essential training

PROMPT Compliance

MDT Role	Number of staff available to train	Number of staff that have attended PROMPT	Compliance
Consultants & Staff Grades	17	17	**100%**
SPRs + SHOs	22	19	**86.3% ↓**
Midwives	175	152	**86.8% ↑**
Anaesthetists	32	24	**75% ↑**
Maternity Theatre ODPs	58	10	
HCAs/MSWs	65	32	**49.2% ↑**
<u>DIVISIONAL</u>	**<u>311</u>**	**<u>244</u>**	**<u>78.4% ↑</u>**

CTG Compliance

MDT Role	Number of staff available to train	Number of staff undertaken Intrapartum CTG training	Compliance %
Consultants & Staff Grades	17	13	**76.4% ↑**
SPRs + SHOs	20	14	**70% ↔**
Midwives	175	135	**77.1% ↑**
<u>DIVISIONAL</u>	**<u>212</u>**	**<u>158</u>**	**<u>74.5% ↑</u>**

<u>Concerns & Actions:</u>

<u>CNST</u>

- Revised standards released in March – 90% threshold has now been removed. MIS contacted to clarify if new minimum threshold in place. No minimum but we need to provide a statement in regards to any shortfall of 90%.

<u>PROMPT</u>

- **<u>Consultant attendance 100% - thank you to all for their ongoing commitment</u>**
- Anaesthetic staff now being rostered on to attend. Compliance increasing.
- All PROMPT training will be delivered via MS Teams until further notice. This gives us scope to have up to 40 attendees per session.
- MSW numbers very low – all managers given dates and asked to allocate staff to attend.
- New PROMPT material coming July 2021

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CTG

- Escalation of non-compliance currently being discussed with SLT

SET

- Until further risk assessment has been completed SET numbers in classroom are to remain reduced

4. Service User Voice feedback

No further meetings since last report

5. HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust

None

6. Coroner Reg 28 made directly to Trust

7. Progress in achievement of CNST 10

Submission was completed on 20th July 2021 declaring full compliance

Year 4 Incentive Scheme standards were released on Monday 8th August for submission on 22nd June 2021

Staffing in maternity has been a significant issue in July and August. The Trust supported by the LMNS to stop continuity of carer until December to allow staff to be based in the hospital.

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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.

40 inpatient wards were open throughout July.

- ***16 (40%) were on green for planned v actual staffing***
- ***9 (22.5%) wards were on amber for being 5% under planned v actual staffing (NNU, G5, ITU, 17, FAU, C1, S10, S11, 1&3).***
- ***2 (5%) wards were amber for being 5% over planned v actual staffing (Rehab 2, SAW).***
- ***12 (30%) wards were red for being 10% under planned v actual staffing (CDS, M2, M1, B5, DCC, ATC, 32, Respiratory 20, 24, A4, A5, S12).***
- ***1 (2.5%) ward (Rehab 1) was red due to being 10% over planned v actual staffing.***

40 inpatient wards were open throughout August.

- ***16 (40%) were on green for planned v actual staffing***
- ***8 (20%) wards were on amber for being 5% under planned v actual staffing (A5, AMU, Rehab 1, 20, C1, S10, S11, 1&3)***
- ***4 (10%) wards were amber for being 5% over planned v actual staffing (Rehab 2, 19, 18/CCU, 27).***
- ***12 (30%) wards were red for being 10% under planned v actual staffing (CDS, M2, M1, G5, ITU, ATC, Respiratory 21, 24, A4, 25, 16, C2/CCU).***
- ***There were no wards in August which were over 10% of their planned v actual staffing.***

The number of areas reporting 10% reduction against planned versus actual has continued to decline. The data for July and August is a worsening position due to factors that are described further in the report. 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 less than 40% (average) 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 are sent to bank and agency. Due to on-going pressures from the pandemic and staff isolation 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. The number of staff Covid positive or isolating has continued to decline. Currently 1.7 % of the workforce are off work due to Covid related sickness. This is across all staff groups not just nursing and midwifery.

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.

There continues to be areas of risk across all the divisions. This is having a direct impact on patient care. The requirement for staff to take annual leave across the summer months has compounded availability in all areas. This coupled with an increase in general sickness, vacancy factor (especially in the medical division), extra beds opened and the increase in activity and acuity has put nursing and midwifery teams under considerable pressure across this time period.

To mitigate these risks the pool ward has been extended as this offer enhanced rates to staff and they are allocated on a shift by shift basis to the area with the greatest risk. The agency cascade has been reviewed to ensure all vacant registered nurse shifts are shared earlier with the agencies to improve fill rates. Other enhancements in key areas such as respiratory, orthopaedics maternity and theatres have also been extended to try and improved fill rates for registered nurse and midwifery shifts. The Director of Nursing is undertaking a deep dive with the E roster team to review any areas that have anomalies around annual leave usage, rest days and hours owed. This work will be completed by the end of September.

There has been a planned approach to utilise the first cohort of international nurses in key areas of risk such as gastroenterology, respiratory medicine, theatres and also 1 cohort of 10 staff at Bassetlaw. The first two cohorts have commenced in post with the final three starting before the end of December 2021. This staff group will need to undertake their OSCEs and obtain their NMC pin number so would be a midterm solution for key areas of risk.

The impact of the major incident in the Women's and Children block (flood damage to the estate) has had a detrimental impact on nurse staffing in all services. Due to the relocation of Paediatric services onto the main site this has put some pressure on nurse staffing due to services not being co-located. Work is ongoing to ensure the estate is fit for purpose and the senior nursing leadership team in paediatrics are continually risk assessing staffing to ensure patient demand is met.

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.

The mitigation includes:

- Senior nurse oversight for the wider staffing picture from the duty matron 7 days per week
- Scrutiny by Divisional Nurse Directors to assess risk in their areas and staff redeployment put in place to mitigate the risk
- Incentivised pay rates for registered and unregistered nurses working additional bank hours
- Active on going recruitment campaigns including alternative roles such as Trainee Nurse Associates and RN apprenticeship roles

- Redeployment of clinical staff from teams such as education, out patients and theatres as required
- Utilisation of agency nurses in some areas, this is balanced against the quality metrics to ensure patient care isn't compromised
- Supporting critical care around GPICs guidance around nurse to patient ratios to aim to maintain 1:1 or 1:2 nurse to patient ratio
- Cross site working to ensure staffing is flexed to meet the demands in service
- Reduction in ward managers supervisory time to support clinical hands per shift
- Support from Enhanced Care Nurse to ensure complex patients receive the correct plan of care
- Rapid cohorting of Covid 19 patients to minimise outbreaks and reduce risk to patients and staff

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. Recruitment to the workforce matron wasn't successful so a hybrid role is being developed by the Director of Nursing. The post would lead on workforce and ward accreditation. This will be at 8B level and initially a secondment for 12 months. The workforce matron funding would be utilised for this post and the difference between the 8A to 8B met by back fill monies from the Chief Nurses secondment to NHSI. This post holder has now been appointed and will commence in October 2021. Their first priority is the roll out of SafeCare to all inpatient areas.

The Trust has also entered into a partnership with NHS Professionals to recruit 50 international nurses by the end of the calendar year. This cohort of nurses are predominantly from India. Due to the impact on Covid in India the recruitment pipeline was temporarily paused by NHSI in May, but this has now been reactivated and the first 20 nurses arrived In the Trust early August 2021. There will be 3 more cohorts of 10 nurses that will all arrive by the end of the calendar year.

A review of Health Care Assistant (HCA) recruitment is taking place. This is being led by the Director of Nursing. Due to ongoing recruitment issues in all areas of the care sector our pipeline for qualified HCA staff has diminished significantly. A review of our training offer is being undertaken and there is a plan to undertake a HCA trainee scheme for applicants who have no formal care experience. This recruitment drive will be values based and a training plan will be tailored for these staff across a 6 month period.

The Director of Nursing 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

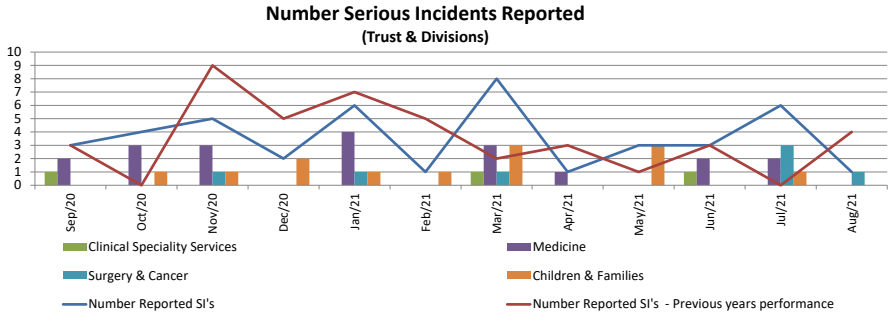
are scrutinised by a senior nurse before being approved and that patient safety is maintained. There is an expected financial return from this work as the current model isn't always cost effective. A business case planning session has taken place with key stakeholders and it's expected that the business case will be shared at the relevant internal forums in October 2021.

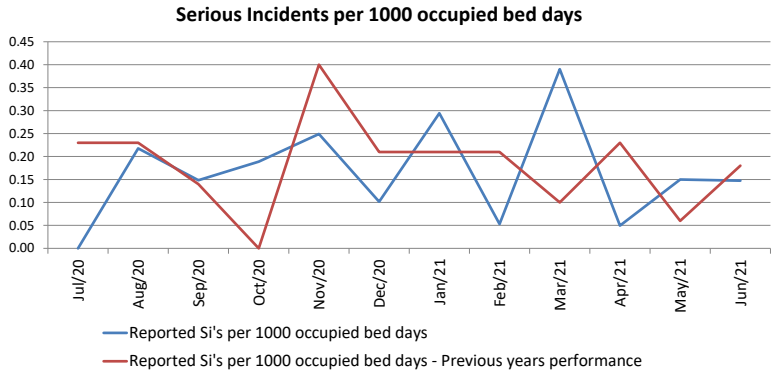
Serious Incidents - August 2021 (Month 5)

(Data accurate as at 17/09/2021)

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



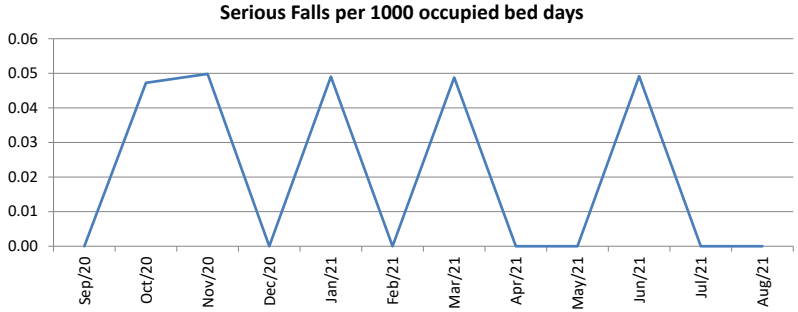


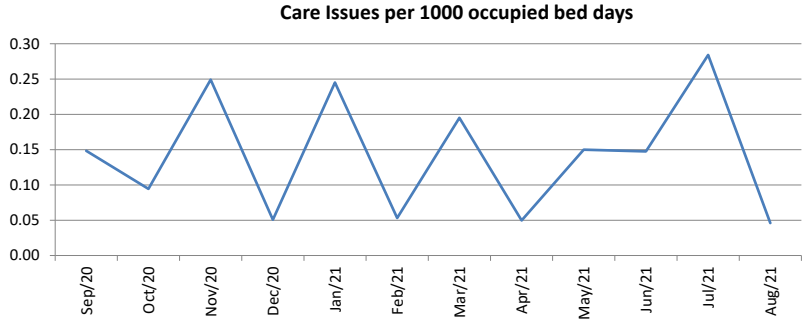
Current YTD reported SI's (April - August 21)	14	Number reported SI's (Apr 20 - August 20)	11
Current YTD delogged SI's (April - August 21)	0	Number delogged SI's (Apr 20 - August 20)	0

Maternity Serious Incidents

There have been no Serious Incidents in Maternity during August

Serious Incident Themes

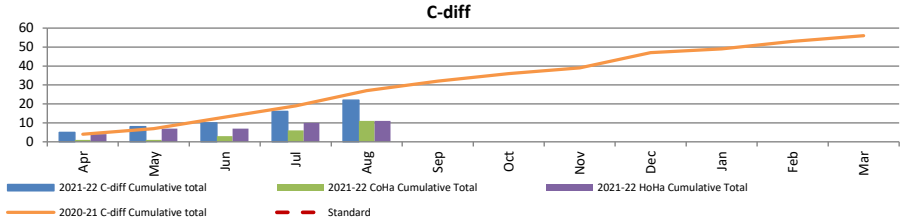


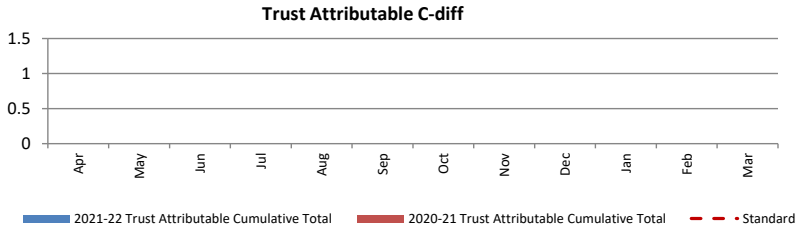


Infection Control C.Diff - August 2021 (Month 5)
(Data accurate as at 17/09/2021)

	Standard	Apr	May	Jun	Jul	Aug	Sep	YTD
2021-22 Infection Control - C-diff	44 Full Year	5	3	2	6	6		22
2020-21 Infection Control - C-diff	39 Full Year	4	3	6	6	8		27
2021-22 Trust Attributable	12	0	0	0	0	0		0
2020-21 Trust Attributable	12	0	0	0	0	0		0

	Apr	May	Jun	Jul	Aug	Sep	YTD
2021-22 - HOHA	4	3	0	3	1		11
2020-21 - HOHA	3	2	5	4	7		21
2021-22 COHA	1	0	2	3	5		11
2020-21 COHA	1	1	1	2	1		6

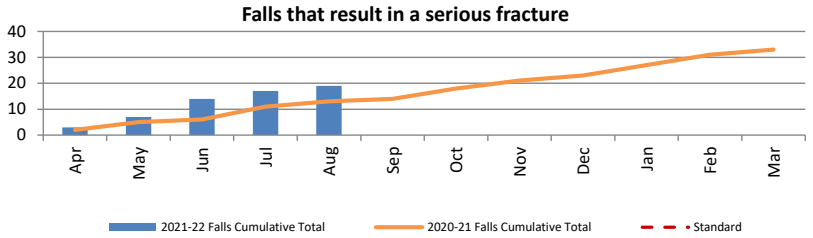




Pressure Ulcers & Falls (Moderate/Servere Harm) - August 2021 (Month 5)
(Data accurate as at 02/09/2021)

	Standard	Apr	May	Jun	Jul	Aug	Sep	YTD
2021-22 Serious Falls (moderate/severe harm)	TBC	3	4	7	3	2		19
2020-21 Serious Falls (moderate/severe harm)	40	2	3	1	5	2		13

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



	Standard	Apr	May	Jun	Jul	Aug	Sep	YTD
2021-22 Pressure Ulcers	TBC	83	70	81	75	107		416
2021-22 Pressure Ulcers (Cat 4)		0	0	0	1	0		1
2021-22 Pressure Ulcers (Cat 3)		4	3	0	0	4		11
2021-22 Pressure Ulcers (DTI Low Harm/Cat 2)		77	67	81	74	96		395
2021-22 Pressure Ulcers (UNS)		2	0	0	0	7		9

	Standard	Apr	May	Jun	Jul	Aug	Sep	YTD
2021-22 Number of patients with Pressure Ulcers	TBC	66	60	63	62	85		336
2021-22 Number of patients - Pressure Ulcers (Cat 4)		0	0	0	1	0		1
2021-22 Number of patients - Pressure Ulcers (Cat 3)		3	3	0	0	4		10
2021-22 Number of patients - Pressure Ulcers (DTI/low Harm/Cat 2)		61	57	63	61	75		317
2021-22 Number of patients - Pressure Ulcers (UNS)		2	0	0	0	6		8

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	Board of Directors				
Meeting Date:	21 September 2021	**Agenda Reference:**	**C3**		
Report Title:	Medical Director Update				
Sponsor:	Dr Timothy Noble, Executive Medical Director & Responsible Officer				
Author:	Dr Timothy Noble				
Appendices:	n/a				
Report Summary					
Purpose of report:	To update the Board on work led by the Executive Medical Director's Office				
Summary of key issues/positive highlights:	▪ 94% of patients on the admitted RTT active waiting list (excluding planned waiters & diagnostics) have been stratified ▪ The HSMR rolling 12 month figure shows a stable level after a prolonged fall and is at 105. ▪ The Executive Medical Director's office re-structure is complete and to full capacity.				
Recommendation:	The Board is asked to note the update.				
Action Require: *Strikethrough irrelevant actions:*	~~Approval~~	Information √	Discussion	Assurance √	~~Review~~

Link to True North Objectives: *Indicate which SA this report provides assurance for:*	**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 change
Corporate risk register:	No risk identified.
Regulation:	
Legal:	n/a
Resources:	n/a

Assurance Route	
Previously considered by:	▪ Mortality reports to the Mortality Governance Group (17.9.21) and Clinical Governance Committee (17.9.21).

		▪ RSAB reports directly to the Clinical Governance Committee (17.9.21) ▪ Progress on the Clinical Governance review is reported to Clinical Governance Committee & Quality & Effectiveness Committee ▪ Progress on Executive Medical Director's office is shared with the Trust Executive Team	
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 Executive Medical Director's office.

1. Risk Stratification

The Risk Stratification Assurance Body reports that as of 8th September 2021, 94% 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. This is consistent with previous months. The process is overseen by the Executive Medical Directors office from a governance perspective. Work is underway to assess the Terms of reference of the RSAB to align with perceived future expectations and the governance needs for waiting patients.

Exceptions

- A request has been submitted to remove Endoscopy patients from the General Surgery waiting list as they are normally treated as a day case.
- Specialities continue to be encouraged to identify any reporting anomalies and confirm the accurate position in terms of the delay in stratification.

Work is currently being undertaken with the Divisional Directors for a proposed a governance framework to aid discussions in respect of prioritisation of cancellations of any therapeutic interventions.

2. Mortality

The HSMR rolling 12 month figure is stable after a prolonged reduction and is at 105. This is reflected in the rolling non-elective figure of 104 over the same period. It is positive to see a continued fall in the elective figures. The monthly figure for **June is 96.15** lower than the corresponding month in 2019 and 2020, ie before and during the pandemic. A slight rise in the overall crude figure is noted this August consistent with the increase in Covid cases.

3. Medical Examiner

The Medical Examiner (ME) Team has now achieved scrutiny of 100% of all adult in-hospital deaths. Work is currently being undertaken to include the scrutiny of paediatric deaths. The next milestone is to scrutinise all non-coronial deaths to include deaths in the community and to that end, with the support of the regional office, the ME Team has been provided with funding to undertake this process. In light of this, three new Medical Examiners have been recruited from primary care to assist in this process.

The ME Team continues to spend an increasing amount of time talking to bereaved families, an exercise which highlights areas where improvements can be made through the learning process. Whenever the ME Team conclude that a death has been potentially avoidable or that any care provided has resulted in significant harm, the Patient Safety Team is immediately notified and the case will be reviewed in more detail in line with the governance process for a potential Serious Incident.

4. Caldicott Guardian Activity

The Executive Medical Director is the Trust's appointed Caldicott Guardian and has responsibility for safeguarding patient confidential data. Below is a summary of recent activity in terms of the role.

	Jul	Aug	Work undertaken
Data protection impact assessments	10	4	A DPIA is a legal requirement of the UK GDPR Article 25: Privacy by Design and is the forerunner to most new Trust projects or tasks involving the "processing of patient or staff confidential data". The Caldicott Guardian has a knowledge of and an active interest in the signing-off of every DPIA
Data processing/information sharing agreements	**8**	**3**	All data or information processing agreements require review and sign-off by the Caldicott Guardian.
Confidentiality agreements	**0**	**1**	As above.
Policy reviews	**0**	**3**	All IM&T Policy reviews fall under the stewardship and authority of the Information Governance Committee which is overseen by the Caldicott Guardian and Trust SIRO
Adverse DATIX incidents	**13**	**8**	
Externally reported issues requiring Trust input	**2**	**1**	As above, notified by a 3rd party.
Datix incidents requiring SIRI action	**1**	**1**	As above
Datix incidents requiring ICO action	**0**	**1**	As above

5. Clinical Governance Review

A thorough and in-depth review of the clinical governance processes is almost complete with a review meeting scheduled for week ending 17th September in order to finalise the new structure in readiness for the planned presentation and approval by the Quality & Effectiveness Committee in October.

6. Executive Medical Directors office re-structure

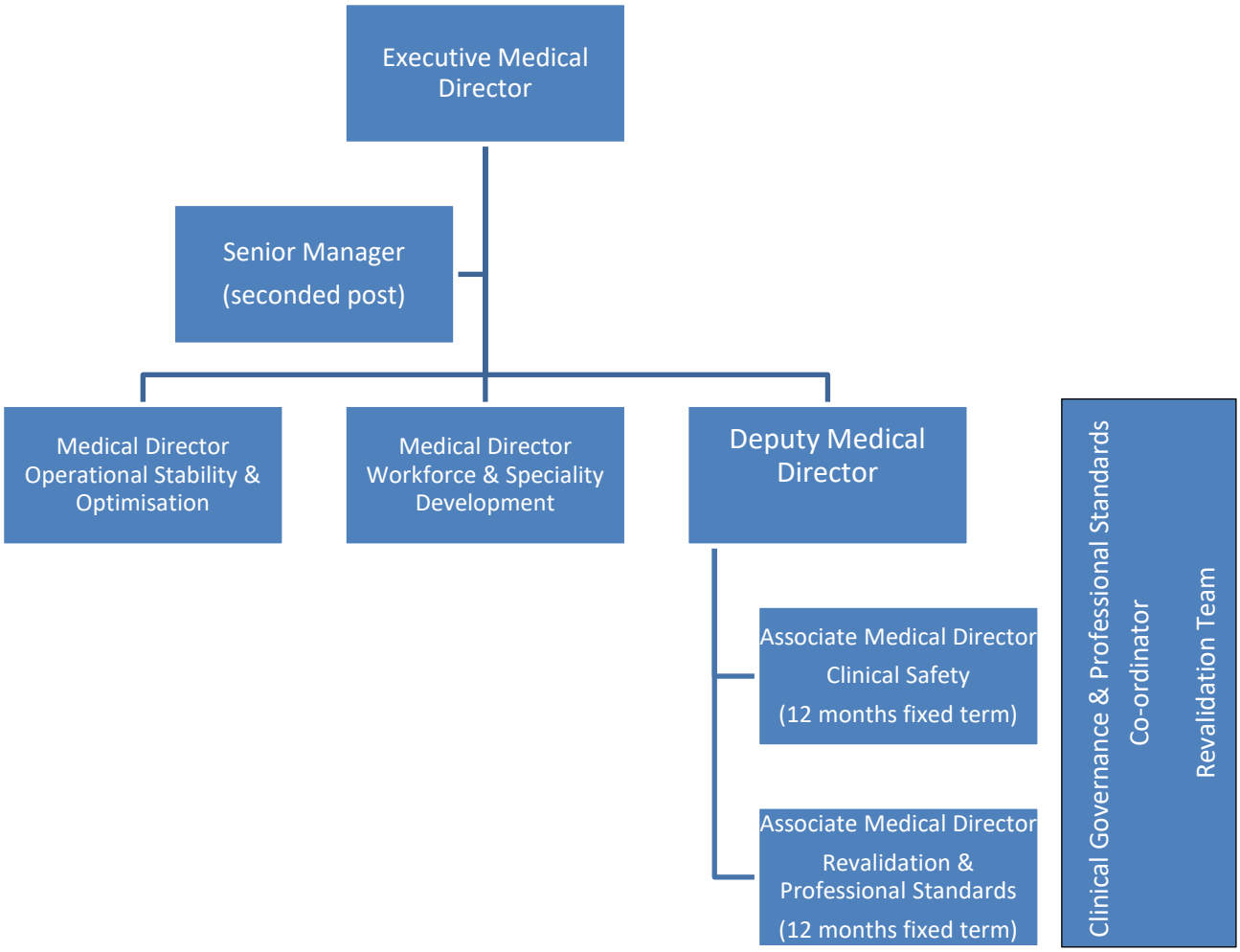
The revised structure of the Executive Medical Directors office is now complete with all posts appointed. More than 20 separate interviews were held with several panels with representatives including executives, consultants, SAS doctors, staff governor, CCG and an external Medical Director.

- **Medical Director Operational Stability & Optimisation** - start date is being discussed, clearance received
- **Medical Director for Workforce & Speciality Development** -Commenced in post 6th September

- **Associate Medical Director for Professional Standards** and Revalidation -Expected in post 4th October
- **Associate Medical Director for Clinical Standards**- Expected in post 4th October
  Both posts are appointed on a 12 month basis and will work closely with the current incumbent in a phased handover

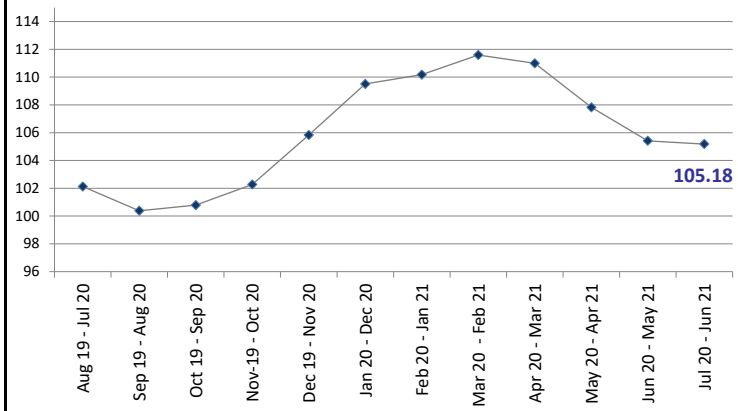
- A **Senior Manager** has been appointed on a 12 month secondment and will be in post late November

I am pleased to confirm the Medical Director's Office is now fully established with support from an Executive Personal Assistant managed by the Corporate Secretariat.

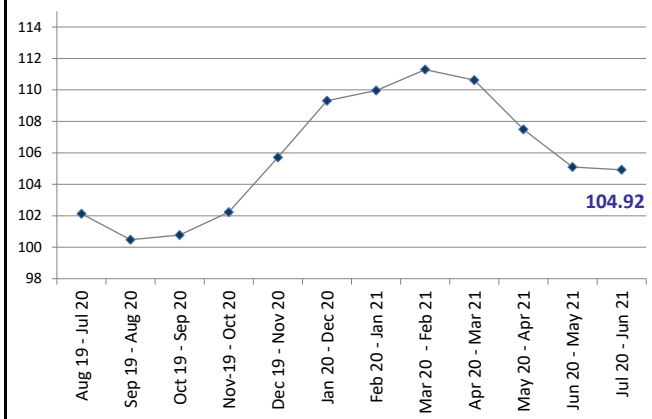

Executive Medical Director
Senior Manager (seconded post)
Medical Director Operational Stability & Optimisation
Medical Director Workforce & Speciality Development
Deputy Medical Director
Associate Medical Director Clinical Safety (12 months fixed term)
Associate Medical Director Revalidation & Professional Standards (12 months fixed term)
Clinical Governance & Professional Standards Co-ordinator
Revalidation Team

Hospital Standardised Mortality Ratio (HSMR) - June 2021 (Month 3)

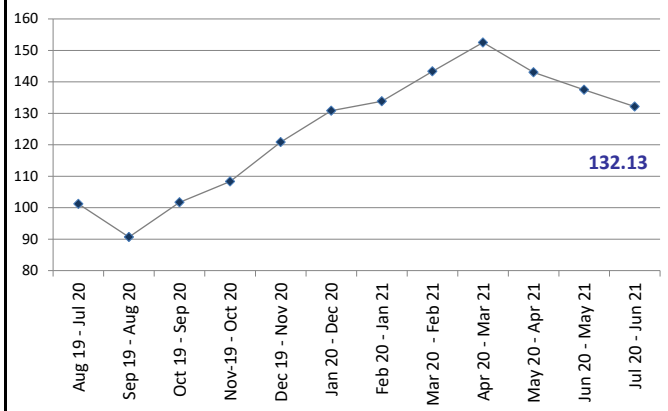
Overall HSMR (Rolling 12 months)



HSMR - Non-elective Admission (Rolling 12 months)



HSMR - Elective Admission (Rolling 12 months)

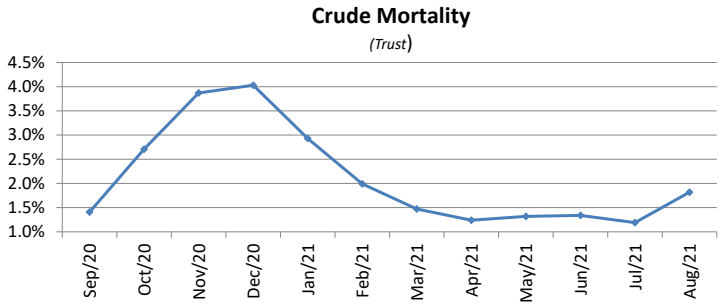


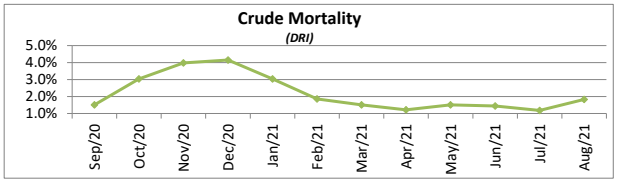
HSMR Trend (monthly)

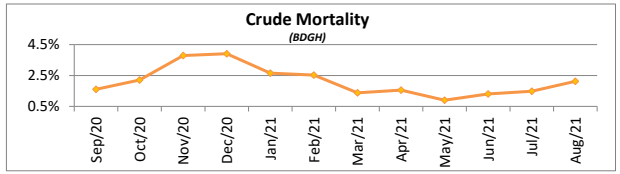
	2017	2018	2019	2020	2021
January	99.21	94.86	105.78	110.26	118.93
February	97.73	105.44	98.13	92.56	104.21
March	97.37	88.42	101.87	102.51	93.32
April	88.50	98.37	100.70	118.40	80.78
May	96.60	91.20	91.36	132.00	97.44
June	93.67	89.98	98.32	97.72	96.15
July	97.73	107.07	104.77	91.35	
August	87.52	94.65	112.17	87.99	
September	95.34	90.09	83.64	87.36	
October	88.66	96.74	100.24	117.17	
November	82.30	99.04	88.64	131.21	
December	93.52	80.45	103.24	144.31	

Crude Mortality (monthly) - August 2021 (Month 5)

(number of deaths/number of patient discharged)







	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Trust	**1.41%**	**2.71%**	**3.87%**	**4.03%**	2.93%	1.99%	1.47%	1.24%	1.32%	1.34%	1.19%	1.82%
DRI	1.51%	3.04%	3.98%	4.15%	3.04%	1.86%	1.51%	1.22%	1.51%	1.44%	1.18%	1.83%
BDGH	1.61%	2.21%	3.79%	3.91%	2.65%	2.53%	1.38%	1.55%	0.90%	1.30%	1.48%	2.12%

Appendix Level1

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 our vision			
Risk Owner: Trust Board **Committee: People**	**People, Partners, Performance, Patients**	**Date last reviewed : September 2021**	
Strategic Objective Everybody knows their role in achieving our vision **Breakthrough Objective** **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.**	**Risk Appetite:** The Trust has a **low appetite** for risks TBC **Measures:** • At least 90% of colleagues have an appraisal linked to the Trust's objectives and values • 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. • 90% of the Divisional and Directorate leaders will have undertaken QI training as part of leadership development programme.	**Initial Risk Rating** **Current Risk Rating** **Target Risk Rating**	4(C) x 4(L) = 16 extr 4(C) x 4(L) = 16 extr 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 • Ongoing impact of restoration of services post Covid • Capacity of teams to undertake appraisals in a timely manner • Colleagues being redeployed from their teams in order to meet operational pressures	**Rationale for risk current score:** Impact: • Impact on performance • Impact on Trust reputation • Impact on safety of patients & their experience • Possible Regulatory action • Recruitment and retention issues • Increased staff sickness levels • Deterioration in management-colleague/team 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 Trust Executive Group development sessions • Wellbeing built into core appraisal process • Leadership development programmes to include QI	**Comments:** Considerations – capacity & capability of workforce including our leaders	**Assurance (evidence of making an impact):** Feedback from the appraisal season and quarterly staff survey results **Gaps in controls / assurance (actions to achieve target risk score):** • Regular feedback on appraisal discussions • Impact on COVID of appraisals not taking place during the year • Impact of recovery phase post covid • Impact of long covid	

Appendix Level1

OUR VISION : To be the safest trust in England, outstanding in all that we do		
True North Strategic Aim 3 – Team DBTH feel valued and feedback from staff and learners in top 10% in UK		
Risk Owner: Trust Board **Committee: People**	**People, Partners, Performance, Patients**	**Date last reviewed :September 2021**
Strategic Objective Team DBTH feel valued and feedback from staff and learners in top 10% in UK **Breakthrough Objective** Team DBTH feel valued and the Trust is within the top 25% for staff & learner feedback	**Risk Appetite:** The Trust has a **low appetite** for risks TBC **Measures:** • 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	**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 & their experience • Possible Regulatory action • Recruitment and retention issues • Increased staff sickness levels • Deterioration in management-staff relationships • Financial impact for the Trust if increased levels of absence and gaps	**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 incl agile working • Future new build • Focus on wellbeing and EDI across the Trust • Focus on opportunities for flexible working
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 and action plans as appropriate • GMC trainee survey and action plans • Delivery of health and wellbeing action plan and strategy • Improvement in payroll KPIs • Prompt management of grievances	**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

Report Cover Page					
Meeting Title:	Board of Directors				
Meeting Date:	September 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				
Summary of key issues:	The report this month provides an update to the Board in relation to: • Widening Participation update with particular reference to work with schools, apprenticeship numbers and work experience • SET compliance rates – currently sitting at 85% • Quarterly staff survey results • Freedom to Speak Up • RACE equality code update • Covid absence and swabbing data • Covid and flu vaccination programme.				
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 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.				

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

Regulation:	None		
Legal:	None		
Resources:	None		
Assurance Route			
Previously considered by:	People Committee		
Date:	7th September 2021	**Decision:**	Assurance
Next Steps:	Ongoing discussions at People Committee		
Previously circulated reports to supplement this paper:		None	

GENERAL UPDATE

1. Widening participation

Schools engagement

As restrictions begin to ease, DBTH have participated in a number of virtual and face to face activities with schools and Colleges to promote career opportunities at DBTH.

In addition to the activities above DBTH have worked in collaboration with the SYREC schools engagement team to replicate the patient journey that was showcased at the 'We Care into the Future' Careers event that DBTH facilitated for all Y7s across the borough prior to COVID. The re-enactment and filming of the patient's journey showcasing the myriad of roles involved in the patients care is now complete and a national launch across all schools is anticipated to take place early in the upcoming academic year.

DBTH continue to develop a model for all schools in partnership with Hall Cross Academy 'A Foundation School in Health', despite the barriers presented by COVID students have been interviewing DBTH staff in an attempt to capture their career journey. The information gathered will be presented on external facing platforms and case studies will be created that will be embedded within the curriculum. The partnership will now revise 21/22 activities as we begin our recovery through COVID which will be published in the Foundation School in Health Annual report in August 2021.

Apprentices

Following a financial review of the 5 year plan and estimated levy funds, the finance department have confirmed that there is sufficient levy to continue with all planned activity with the potential for additional starts. A new forecasting tool has been developed by the finance department which allows the department to illustrate funding projections over a 5 year period. It must be noted that apprenticeship plans are subject to change and are reliant on workforce plans and recruitment into entry level jobs and beyond. Failure to recruit will result in the plans not being realised. Requests for additional starts not listed within the plans will be submitted to the finance department for approval of funding to negate any risk of overspend.

Apprenticeship activity continues to rise with Q1 seeing its biggest number of apprentice starts for this time of year since the introduction of the levy, with a total of 23 starts across DBTH (see breakdown below):

Q1 Actual Starts - Apprenticeship Standard	Apprenticeship Level	No. of Actual Starts in Q1
Customer Service Practitioner	2	4
Business and Admin	3	3
Healthcare Support Worker	2	14
Operational Department Manager	5	1
Team Leader	3	1
	Total:	**23**

In its entirety DBTH 2021/2022 apprenticeship plans illustrate a diverse range of planned apprenticeship starts. If achieved DBTH will be nearing 2% of the 2.3% public sector target as a minimum at the end of 21/22 (excluding any additional unplanned starts). The 2020/2021 Public Sector Target report has now been submitted to government on behalf of DBTH and the target achieved was lower than the previous year of 1.77%.

Work experience

Although many work experience opportunities remain suspended, a review is underway to explore capacity and to agree a recovery plan. In the meantime placements for Clinical Attachments have been expanded to include provision for individuals from across the UK, placements for overseas applicants remain suspended.

Over the past 2 years, DBTH has provided placements for individuals with special education needs working alongside Project Choice. This project will conclude at the end of July and the work experience review will consider wider opportunities for SEND students across Doncaster and Bassetlaw.

As the first cohort of T Level students approach commencement of programme, DBTH are working with employer partners and the Education provider to explore industry placement opportunities for this cohort of learners including Health T Levels and Digital T levels, the introduction of a government employer incentive payment will be invaluable in introducing this new vocational education pathway into both the curriculum and the workplace.

Partnership working

DBTH have been a Cornerstone Employer in Doncaster for over 2 years now, due to the success of Cornerstone Employers nationally, an expansion is underway and DBTH have been invited to become a Cornerstone employer for Bassetlaw. This expansion will allow DBTH to continue to share with other businesses the opportunities afforded by DBTH to the communities they work with.

2. SET report

Although it is disappointing to see that overall compliance for SET has fallen by 2% over the last two months taking us to an overall compliance of just over 85%, it is positive that within this our overall resuscitation training, specifically for adult compliance has increased significantly (improving by 20%) taking us to 76% overall compliance. Fire compliance is the one topic area where with some focused effort could see our overall compliance improve to our overall ambition of 90% compliance. The People Committee receive a more detailed report by topic and division/directorate.

SET Compliance 31.07.2021		Chief Executive Directorate	Children & Families Division	Clinical Support Services Division	Directorate Of Strategy & Imp.	Education & Research Directorate	Estates & Facilities	Finance & Healthcare Contracting Directorate	IT Info. & Telecoms Directorate	Medical Director	Medical Division	Nursing Services	People & OD	Performance	Surgical Division	Overall
31.07.2021	%	96.28%	84.01%	88.16%	87.83%	93.36%	74.52%	92.72%	93.86%	85.71%	84.70%	89.33%	94.42%	91.10%	83.19%	85.20%
30.06.2021	%	91.49%	86.52%	89.20%	82.11%	96.24%	77.16%	90.39%	91.07%	85.71%	85.89%	89.45%	93.48%	94.78%	83.24%	86.36%
31.05.2021	%	92.02%	86.16%	89.25%	87.80%	96.69%	84.77%	92.82%	93.88%	85.71%	85.39%	89.47%	90.11%	95.77%	83.41%	87.03%

3. STAFF SURVEY

The People Plan 2020/21: action for us all, set out how we intend to enhance activities to better understand employee experience, which included the introduction of a quarterly survey. 'We each have a voice that counts' is one of the seven elements of the People Promise – our ambition to make our NHS the workplace we all want it to be by 2024.

With this in mind, a National Quarterly Pulse Survey, which was previously referred to as the Quarterly Staff Survey, has replaced the paused Staff Friends and Family Test (SFFT), providing a more robust and valid data set on capturing employee experience. Organisations were expected to implement the National Quarterly Pulse Survey in July 2021. The National Staff Survey will take place in quarter three 2021/22, using a refreshed set of questions which align with the seven elements of the People Promise. This will go live on 4 October 2021.

The survey consists of the nine engagement theme questions which are the same as those included in the National NHS Staff Survey, and measures motivation, advocacy, and involvement. The reason why we want to measure staff engagement in the survey is that it has been researched in detail over the last few decades and has been proven to have strong links with positive individual and organisational outcomes including lower patient mortality, lower sickness levels and lower patient complaints.

Advocacy

- Would recommend organisation as place to work
- If friend/relative needed treatment would be happy with standard of care provided by organisation
- Care of patients/service users is organisation's top priority.

Involvement

- Able to make suggestions to improve the work of my team/department
- Opportunities to show initiative frequently in my role
- Able to make improvements happen in my area of work.

Motivations

- Often/always look forward to going to work
- Often/always enthusiastic about my job
- Time often/always passes quickly when I am working.

Listening well to all our NHS people, learning from what they tell us, and acting on what is learnt is essential if we are to support all our NHS people through recovery, encourage those in our current workforce to stay and stay well, and attract new people to join us in providing high-quality care for patients and service users.

Summary

The quarterly pulse survey received a response rate of only 19% with the lowest response rates being within the divisions and estates and facilities. However even in corporate areas the highest response rate was only 54%. We need to pay attention to this in planning our annual campaign. Disappointingly only the question of care of patients being the Trust's top priority maintained the same response rate and the annual survey with all other questions seeing a deterioration, albeit that it is pleasing in itself. Discussions on these results has taken place at TEG in order to consider what actions we need to take in preparation for the annual survey. We should be cautious of relying too heavily on these results bearing in mind the low response rate.

Comparison to last survey

Section	Q	Description	Last full staff survey n = 3665	This survey n =1185	Change
Advocacy	Q18c	Would recommend organisation as place to work	6.5	6.14	
	Q18d	If friend/relative needed treatment would be happy with standard of care provided by organisation	6.9	6.63	
	Q18a	Care of patients/service users is organisation's top priority	7.3	7.38	
	N/A	**Overall**	**6.9**	**6.72**	**Sl worse**
Involvement	Q4b	Able to make suggestions to improve the work of my team/dept	7.0	6.38	
	Q4a	Opportunities to show initiative frequently in my role	7.0	6.37	
	Q4d	Able to make improvements happen in my area of work	6.1	5.7	
	N/A	**Overall**	**6.7**	**6.15**	**Worse**
Motivation	Q2a	Often/always look forward to going to work	6.5	5.69	
	Q2b	Often/always enthusiastic about my job	7.7	6.89	
	Q2c	Time often/always passes quickly when I am working	7.8	7.10	
	N/A	**Overall**	**7.3**	**6.56**	**Worse**
Staff Engagement Score			**7.0**	**6.47**	**Worse**

4. Freedom to Speak Up

Performance against strategy

The People Committee received an update from the Freedom to Speak Up Guardian – the headlines of that update are provided below. FTSU activity and performance has predominately been through the FTSU forum meetings, champions network and responses to individual cases that have been raised.

Communications have been revised to lead positively with "Speaking up" branding, moving away from any constraints associated with "freedom to" and the legacy of whistle blowing

- Revised policy and introduction of more detailed policy on a page. Currently going out to consultation with key staff groups and staff side representatives.
- Continued provision of education, awareness sessions.
- Continued use of slogans including:
- **"Speak up to me"** (displayed on badges worn by FTSU partners and senior leaders) – promote an open door and encourages staff to come forward to discuss their concerns.
- **"Speak up to make a difference"** (used in the strategy/policy and all promotional materials) – promotes working in partnership to explore issues and engage in service improvement and or personal development. Moving away from a "Blame Culture" and promotes learning culture.
- "**I support speaking up because……."** (used for senior leader/partner/managers) – creates an environment where it is seen as okay to speak up as this will be supported by the organisation and its senior leaders.

The above is set to be rolled out to all DBTH staff as part of Speak up month in October 2021. This year's slogan is linked to the HEE training and is known as "Speak Up", "Listen Up" and "Follow Up". Staff will be asked to complete the relevant training and then pledge to support an open and transparent FTSU culture. The follow up element of this is also planned to be an integral part of the DBTH board development.

Education, learning and development

FTSU awareness sessions form an integral part of the revised Trusts "Values based Induction" program.

Internal awareness level training and FTSU information sessions have been successfully delivered throughout 2021. This has included all corporate induction programs, vocational programs, preceptorship and the education program for international nurses.

The introduction of Health Education England's FTSU training has been slow due to the pandemic and the competing priorities for completion of e-learning modules. This has been discussed with the Education and research lead who is currently supporting the FTSU Forum. The modules will, however, still be made available on ESR and in paper format as follows:

Level 1 - speaking up (for all staff, learners, appropriate volunteers, and contractors)

Level 2 – listening up (for line and middle managers). These will then be supported by local elements to share the DBTH values, by utilising staff voices and sharing personal FTSU experiences.

Manager's toolkits- from case review and peer review recommendations, are being developed with Leadership &OD and will form part of the DBTH leadership offer. Currently two courses are developed but capacity has not allowed these to be delivered at present.

The HEE, Level 3 – Following up (for senior leaders, executives, and board members) was expected to be available from June 2021. However, this has been delayed but should be available to coincide with National Speak up month under the Follow up section.

Data to support who is Speaking Up

In early 2021 the NGO changed the way it records data to provide a clearer picture of who is speaking up. This has seen a re-categorisation into workers, managers, senior leaders, and anonymous cases, as well as the professional groups that were previously reported.

At the end of 1021/22 we reported that the percentage of both nurses and wider healthcare staff remained high, but there had been a significant increase in the number of medical and administration staff who have been involved in cases at that time.

Category of staff	**Q1 2021/2022**	**Q2 2021/2022 (to date)**	**Total numbers (to date)**
Workers	21	9	30
Managers	0	2	2
Senior Leaders	0	0	0
Not disclosed	0	0	0
Professional groups	**Q1 2021/2022**	**Q2 2021/2022 (to date)**	**Total numbers**
Allied Health Professionals	1	0	1
Medical and dental	0	4	4
Ambulance (operational)	0	0	0
Public health	0	0	0
Commissioning	0	0	0
Registered Nurses and Midwives	6	4	10
Nursing Assistants or Healthcare Assistants	6	2	8
Social care	0	0	0
Administration, Clerical & Maintenance/Ancillary	7	1	8
Corporate Services	0	0	0
Not known	0	0	0
Other	1	0	0

This also compares favourably with the NGO quarterly submissions, which suggest the majority of cases are recorded as workers with a smaller number reported as Managers.

Data to support what people are speaking up about

Throughout the last 5 months (Q1 and Q2 to date) the following themes and trends were identified:

	Patient Safety	**Staff Safety**	**B & Harassment**	**Conduct & Behaviour**	**Relation-ships**	**Systems & Processes**	**Environment & Org structure**	**Culture & Leadership**
Q 1	3	2	6	4	4	3	2	4
Q2	4	3	3	7	1	6		7

It is important to note that some individuals or cases raised concerns across more than one theme.

Some of these themes mirror those reported quarterly to the NGO but others including Bullying and Harassment are seeing an opposing trend at DBTH. Nationally these figures are reducing but ours continue to rise. Further work is required to understand this better. Our increase in Culture and Leadership is mirrored nationally.

FTSU Index

In 2019 the National Guardians office introduced the FTSU index as a method of measuring an organisations FTSU culture through 4 key questions from the annual staff survey.

DBTH has a robust approach to utilising the Annual Staff Survey as a positive staff engagement tool and as such, has committed ongoing time and resource to providing an appropriate divisional and organisational response to the feedback they receive.

However, this is only the second year that a focus has been placed on the four questions now identified as the FTSU Index markers.

Applying this new focus shows where significant improvements have been made from 2018 to 2019 and where this result has seen yet again a small increase in 2020 despite the COVID pandemic. However, the table below still highlights where improvements can be made across all questions when compare the national averages for acute and acute/community Trusts.

FTSU Index Overall Organisational Results

Number	Question	2018	2019	2020	National Comparison
17a (Q16a - 2020)	My organisation treats staff who are involved in an error, near miss or incident fairly	55%	60%	61%	Above average (60.9%)
17b (Q16b - 2020)	My organisation encourages us to report errors, near misses or incidents.	86.1%	88%	87%	Below average (88.3%
18a (Q17a - 2020)	If you were concerned about unsafe clinical practice, would you know how to report it?	92.3%	93%	93%	Below average (94.9%)
18b (Q17b -2020)	I would feel secure raising concerns about unsafe clinical practice.	68.1%	72%	72%	Below average (72.5%)
Mean Average	Overall Index score	75.85%	78.25%	78.80%	Below average (79.2)
Additional questions in 2020					
18f	I feel safe to speak up about anything that concerns me in this organisation			68.1%	Above average (65.6%)

5. RACE Code Update

The Trust has received feedback that Doncaster & Bassetlaw Teaching Hospitals has demonstrated good levels of compliance with the RACE Equality Code (REC) principles and framework. As an outcome we are now able to utilise the REC code quality mark on literature and promotional materials.

The **RACE** **Equality** Code 2020

Members will recall that the REC assessment highlighted seventy-one (71) actions in total that Doncaster and Bassetlaw need to complete. The People Committee received a detailed update of progress against that action plan. A summary of that progress is below.

The progress made against the action plan has helped to increase visibility and the profile of the work on diversity and inclusion at DBTH. There has been a strengthened level of engagement from the divisional teams at the EDI committee which continues to drive EDI activity in DBTH. There continues to be increased engagement and expansion of the 3 DBTH staff networks:

- BAME staff network chaired by Ruby Faruqi - Matron CSS
- LGBT?+ co-chaired by Christine White, Senior People Business Partner and Adam Evans, People Business Partner
- Dyslexia, Ability and Long Terms conditions staff network currently chaired by Kirby Hussain - Head of EDI.

Other areas of progress are:

- more collaborative work happening across EDI and recruitment to review and strengthen our systems and processes alongside work with local community groups to widen the pool of applicants for roles in our organisation.
- work ongoing with the Freedom to Speak Up Guardian to recruit and train BAME FTSU champions
- significant improvements in supporting our international recruits to make their experience better.

The Board is asked to note the significant progress made against the RACE Action Plan (RAP) and the further work needed to continue to:

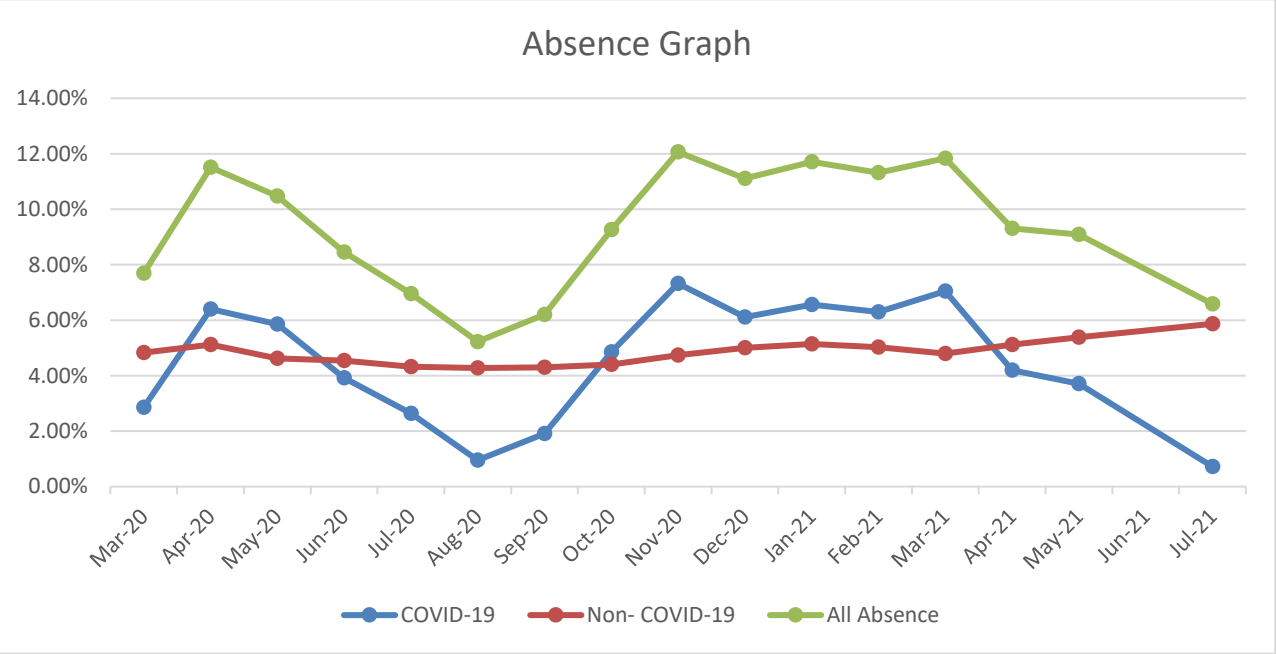
- Improve disclosure rates for staff in relation to Race
- Refresh the Fair Treatment for all policy
- Introduce a clear Anti-racism statement
- Adopt and make visible the meaning of the RACE Code and the underpinning principles
- Review our Talent development strategy and approach
- Introduce Race as a clear objective for all leaders in appraisal systems and supporting documentation for season 2022/23.

COVID UPDATE

6. STAFF ABSENCE

As can be seen Covid related absence rose from August 2020 and was fairly static between November and March when it reduced due to shielding ceasing. During June and July we experienced a small rise both in terms of colleagues self isolating but also testing positive. It should be noted that non Covid related sickness absence continues at a similar rate to previous years, with usual seasonal rise. More recently we have seen an upwards trend of staff testing positive.

Figure 1 – Absence Graph, March 2020 – June 2021



7. STAFF TESTING

This section details the numbers of staff who have been swabbed whilst the figures following report the details on 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. More recently we are starting to experience a small increase in the numbers of colleagues testing positive.

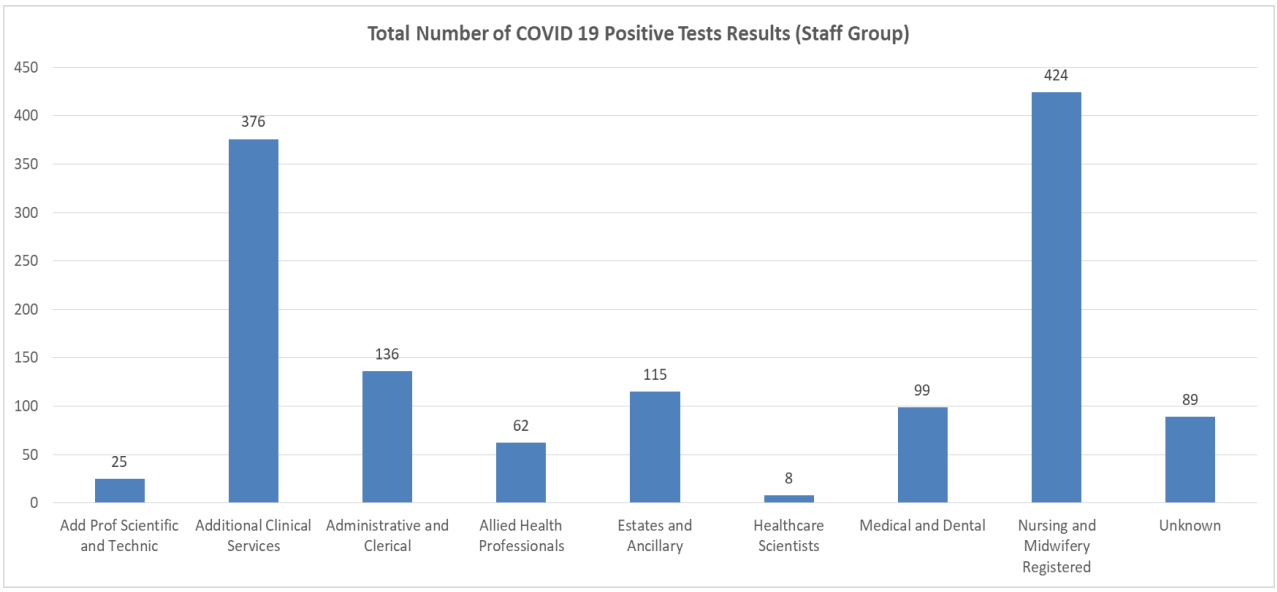
Table 1 – Staff Testing Figures

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	123
Date	**May**	**June**	**July**	**August**	**September**	**October**	**November**
Total	142	102	85	21			

Table 2 – Number of Covid 19 Positive Test Results, by Staff Group

Year	2020										2021							No Date	Total
Month	03	04	05	06	07	08	09	10	11	12	01	02	03	05	06	07	08		
	7	17	7					11	13	11	3	3	4		2	9	2		89
Add Prof Scientific & Technic	3	4	3				1	3	2	4	3	1			1				25
Additional Clinical Services	5	41	53	24	2		3	80	58	54	21	7	2			19	7		376
Administrative and Clerical	4	17	6	1	1		1	18	22	20	8	7	6		3	21	1		136
Allied Health Professionals	3	4	15	1			1	6	9	7	5	3			1	6	1		62
Estates and Ancillary	2	11	15	6			1	22	12	15	16	3				7	5		115
Healthcare Scientists	2		2							1	1	2							8
Medical and Dental	20	16	10	1			1	10	7	20	5	1	1		1	4	1	1	99
Nursing and Midwifery	16	68	62	13	4	1	5	70	62	47	25	16	9	1	2	19	4		424
Grand Total	**62**	**178**	**173**	**46**	**7**	**1**	**13**	**220**	**185**	**179**	**87**	**43**	**22**	**1**	**10**	**85**	**21**	**1**	**1334**

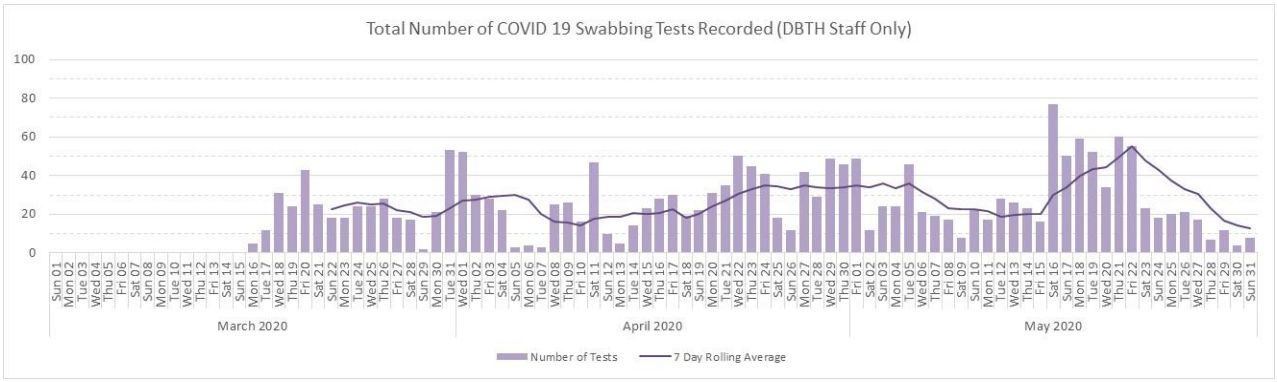
Figure 2 – Total number of Covid 19 Positive results, Mar 20 – current

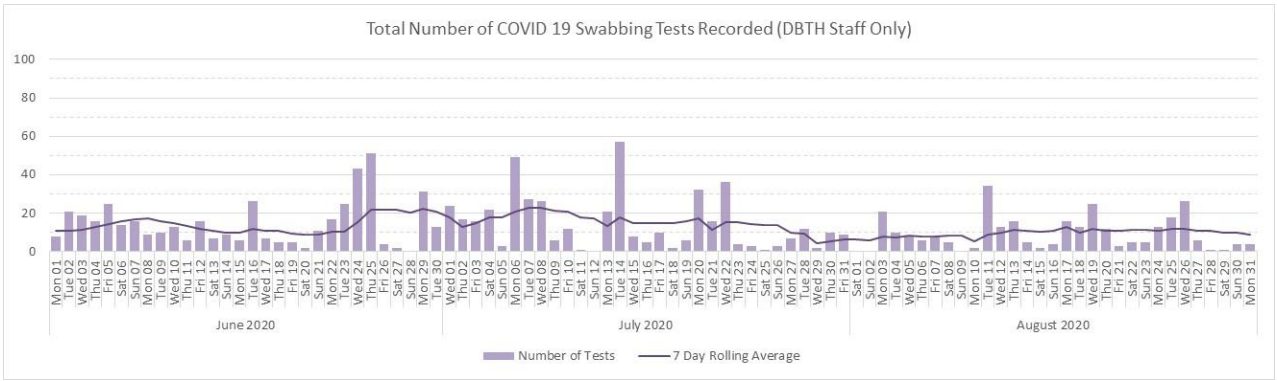


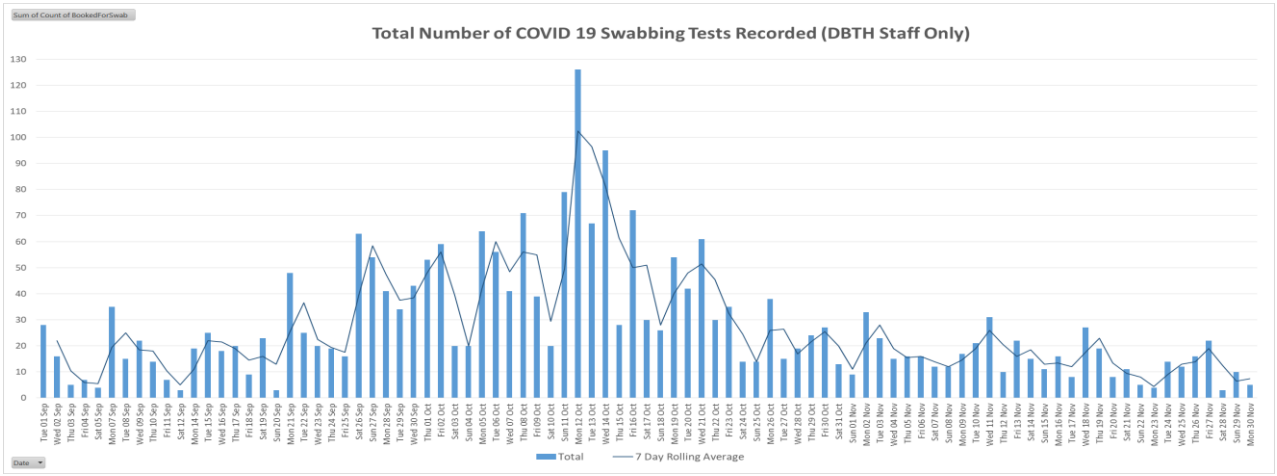
This details the numbers of staff who have been swabbed whilst the tables further in the report details the levels of positive results.

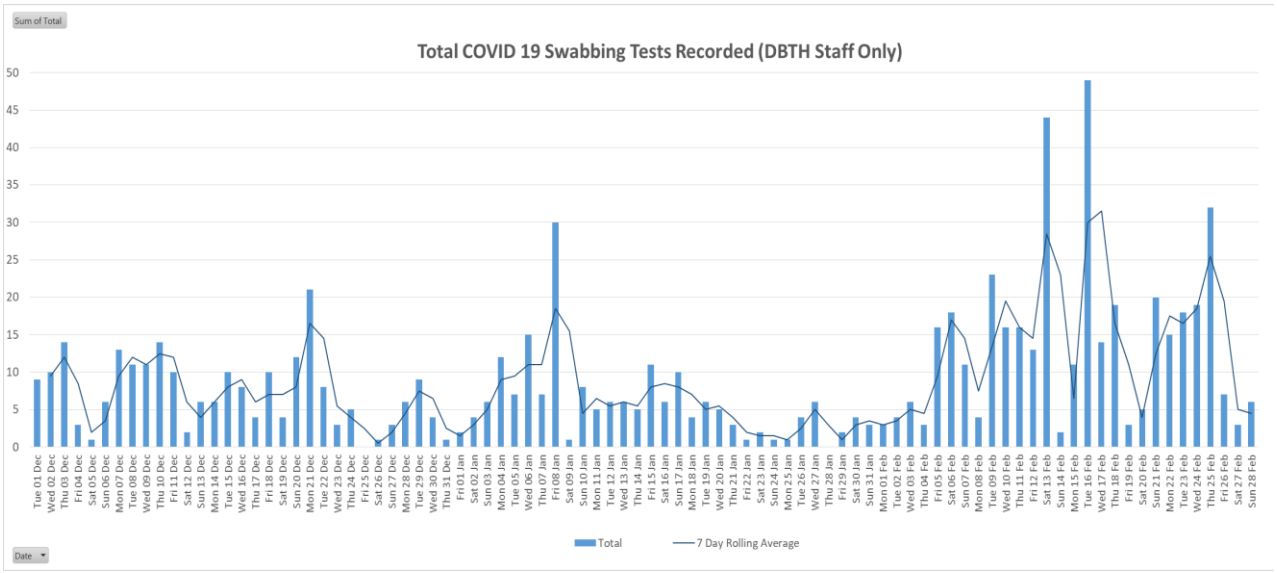
Between 23 March 2020 and the mid August 2021 there were circa 7646 DBTH staff swabbed of which 1334 were positive for Covid 19. Below are details of the numbers of staff who have tested positive within each Division and Directorate together with a breakdown by staff group, as requested by the committee. In the main staff who are testing positive have been double vaccinated.

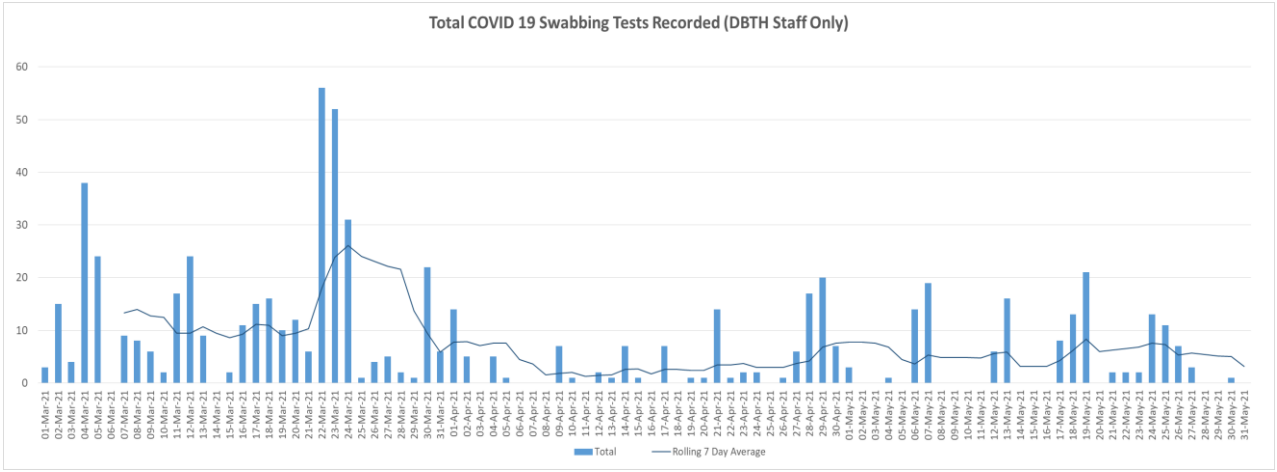
Figure 11 – Swabbing data March 2020 to August 2021

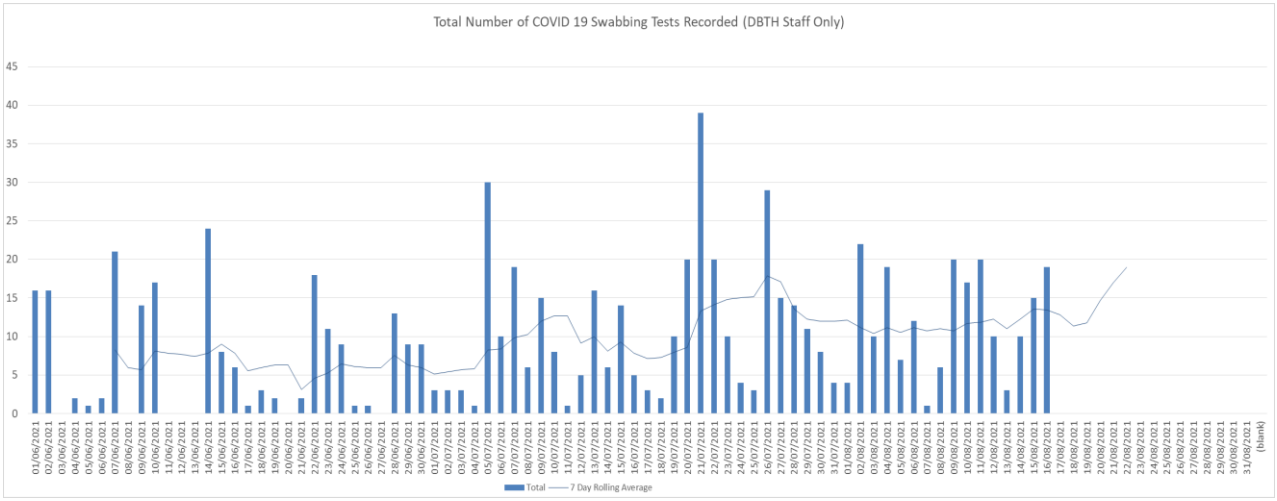





Total Number of COVID 19 Swabbing Tests Recorded (DBTH Staff Only)
Total
7 Day Rolling Average


Total COVID 19 Swabbing Tests Recorded (DBTH Staff Only)
Total
7 Day Rolling Average


Total COVID 19 Swabbing Tests Recorded (DBTH Staff Only)
Total
Rolling 7 Day Average



Please take due regard of the axis sizes as they vary by graph due to the volume of swabs being taken.

Table 7 – Total Number of Staff Testing Positive by Month & Area of Work

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	2021/05	2021/06	2021/07	2021/08	No Date	Grand Total
	7	17	7					11	13	11	3	3	4		2	9	2		89
272 Chief Executive Directorate																1			1
272 Children & Families Division	2	7	4	1				7	6	10	8	5	13		1	14	5	1	84
272 Clinical Specialties Division	13	16	32	2			6	27	22	19	22	11			3	19	3		195
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				6	3		106
272 Executive Team Board	3	2	1					1		2			1			1			11
272 Finance & Healthcare Contracting Directorat	1	1			1			1	4	1		1			1	2			13
272 IT Information & Telecoms Directorate		1							1		1					2	1		6
272 Medicine Division	16	90	44	21	3	1	4	102	77	73	20	11	1	1	1	15	4		484
272 Nursing Services Directorate			2					1	3	4		1			1	3			15
272 People & Organisational Directorate								1		1			1		1	1			5
272 Performance Directorate		1	5					3	6	4	3	2	2			2	1		29
272 Surgery and Cancer Division	15	32	63	16	3		2	40	38	34	14	7				10	2		276
Grand Total	**62**	**178**	**173**	**46**	**7**	**1**	**13**	**220**	**185**	**179**	**87**	**43**	**22**	**1**	**10**	**85**	**21**	**1**	**1334**

Table 8 – Positive Staff by Staff Group

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	2021/05	2021/06	2021/07	2021/08	No Date	Grand Total
	7	17	7					11	13	11	3	3	4		2	9	2		89
Add Prof Scientific and Technic	3	4	3				1	3	2	4	3	1			1				25
Additional Clinical Services	5	41	53	24	2		3	80	58	54	21	7	2			19	7		376
Administrative and Clerical	4	17	6	1	1		1	18	22	20	8	7	6		3	21	1		136
Allied Health Professionals	3	4	15	1			1	6	9	7	5	3			1	6	1		62
Estates and Ancillary	2	11	15	6			1	22	12	15	16	3				7	5		115
Healthcare Scientists	2		2							1	1	2							8
Medical and Dental	20	16	10	1			1	10	7	20	5	1	1		1	4	1	1	99
Nursing and Midwifery Registere	16	68	62	13	4	1	5	70	62	47	25	16	9	1	2	19	4		424
Grand Total	**62**	**178**	**173**	**46**	**7**	**1**	**13**	**220**	**185**	**179**	**87**	**43**	**22**	**1**	**10**	**85**	**21**	**1**	**1334**

As can be seen there was a rise in July of staff testing positive which has continued into August with numbers reaching a level not seen since January 2021.

8. COVID AND FLU VACCINATION

All DBTH staff have now had the opportunity to have their vaccination with circa 90% of all staff having received a first vaccine and the same colleagues having had the opportunity to receive a second dose. As we are no longer vaccinating on site (having completed our vaccination programme) colleagues who do now wish to receive the vaccine are being directed to the national booking service and locally through the PCNs and their GPs. Discussions have now commenced about the flu vaccination and whether a booster covid vaccination is required.

The Joint Committee on Vaccination and Immunisation have now published their interim guidance on booster vaccinations which states:

> *'JCVI advises that any potential booster programme should begin in September 2021, in order to maximise protection in those who are most vulnerable to serious COVID-19 ahead of the winter months. Influenza vaccines are also delivered in autumn, and JCVI considers that, where possible, a synergistic approach to the delivery of COVID-19 and influenza vaccination could support delivery and maximise uptake of both vaccines.*

As such, pending further details we have started to plan to provide the third booster dose and flu vaccinations from September onwards. Due to the delays in decisions being taken nationally about the booster vaccination programme we are planning to deliver the flu and covid vaccine separately. At the time of writing this paper an update is anticipated and will be shared at the meeting.

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	Board of Directors				
Meeting Date:	September 2021		**Agenda Reference:**	D3	
Report Title:	Guardian for Safe Working Quarterly Report				
Sponsor:	Karen Barnard, Director of People & OD				
Author:	Dr Anna Pryce, Guardian for Safe Working				
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				
Summary of key issues:	The Guardian for Safe Working is required to provide quarterly reports to the Board of Directors to provide assurance as to whether our trainees have access to a safe working environment. Our new Guardian Dr Anna Pryce has provided her first report as detailed below. Within Dr Pryce's report she draws attention to there being low levels of exception reporting during the quarter. Dr Pryce advises that no specific areas of concern have been highlighted as a result of exception reporting in relation to working hours. An absence of exception reports regarding education suggests good access to educational opportunities for trainees. Those exception reports received in the last 2 quarters indicate that staff absence due to sickness has resulted in individuals working beyond their rostered hours and the impact of the Coronavirus pandemic on staffing over the coming winter months is likely to exacerbate this problem. The specialties with the highest numbers of exception reports are not those with the highest numbers of rota vacancies, suggesting that understaffed rotas are not the main cause of prolonged working hours.				
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 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:		N/A – direct feedback to the Board followed by discussion at the Junior Doctor Forum	
Date:		**Decision:**	
Next Steps:			
Previously circulated reports to supplement this paper:		None	

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING, DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

Author: Dr Anna Pryce, Guardian of Safe Working

Report date: Sept 2021

Executive summary

The number of exception reports continues to be low and they are not concentrated within a single specialty. No reports were made in relation to education and, of the twelve reports received over the past 2 quarters, all were in relation to doctors working overtime and none raised immediate safety concerns. Staff absence due to sickness has impacted upon rotas and the resultant understaffing has led to prolonged working hours. The impact of the Coronavirus pandemic on staffing over the coming winter months is likely to exacerbate this problem. The specialties with the highest numbers of exception reports are not those with the highest numbers of rota vacancies, suggesting that understaffed rotas are not the main cause of prolonged working hours.

The low number of exception reports could be due to the Coronavirus pandemic causing altered working patterns and a lower workload due to restricted elective activity. However, some neighboring Trusts have witnessed an increase in exception reporting over the past 2 quarters. This may indicate that our low number of exception reports is due to different reasons, for example compliant rotas and safe working practices.

Introduction

This report sets outs the information from the Guardian of Safe Working with regard to the 2016 Terms and Conditions for Junior Doctors to assure the board of the safe working of junior doctors. This report is for the period 1st April 2021 to 31st July 2021. The Board should receive a quarterly report from the Guardian as per the 2016 contract, which will include:

• Aggregated data on exception reports (including outcomes), broken down by categories such as specialty, department and grade

• Details of fines levied against departments with safety issues

• Data on rota gaps, staff vacancies and locum usage

• A qualitative narrative highlighting areas of good practice and / or persistent concern.

High level data

Number of posts contracted by DBH (inc 125 LU doctors*):	204
Number of posts contracted by other organisations:	163
Number of doctors / dentists in training on 2016 TCS:	137
Amount of time available in job plan for guardian to do the role:	2 PAs
Admin support provided to the guardian (if any):	Through medical HR
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

a) Exception reports (with regard to working hours)

Table 1. Number of exception reports by month (data included for the last 2 quarters for comparison).

Exception reports by month	Complete	Pending	Unresolved	Grand Total
Feb-21				0
Mar-21	2	1		3
Apr-21	1		1	2
May-21		1		1
June-21	6			6
July-21	1			1
Grand Total	**9**	**2**	**1**	**12**

Table 2. Number of exception reports by specialty

Exception reports by specialty							
Specialty	**Feb-21**	**Mar-21**	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Total**
Gastroenterology							0
General medicine		2	1			1	4
General surgery					6		6
Cardiology			1				1
Geriatric medicine							0
Renal Medicine							0
Accident and emergency							0
Obstetrics and gynaecology				1			1
Grand Total	**0**	**2**	**2**	**1**	**6**	**1**	**12**

No exception reports were received from both the GP training schemes for which the Trust is the lead employer. For the past 2 quarters, exception reports have been submitted by individuals across Medicine, Surgery and Children and Families Divisions. A total of only 8 exception reports have been raised within the last quarter, of which none have been related to education. It should be noted that the six General Surgery exception reports in June were made by one FY1 over the course of a week.

b) Work schedule reviews

No work Schedule reviews have been initiated in this reporting period.

c) Locum bookings

Locum and bank usage.

The data below details bank and agency shifts covered by training grade doctors. This data is for information and difficult to comment on due to different working patterns, pressures and activity due to the Coronavirus pandemic. Emergency Medicine, Acute Medicine and Paediatrics required the highest numbers of locum/bank hours from October 2020 to June 2021 with Emergency Medicine far exceeding other specialties in costs. Rota vacancies accounted for a very high percentage of locum/bank hours required.

Table 3. Hours of work

Specialty	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Grand Total
Acute Medicine	867	1668.3	1457.8	1008	1054	1033.3	735	686.25	700.25	9209.5
Anaesthetics		260		15						275
Anaesthetics and Critical Care	709.5	967.5	713.5	550	487	704	506.5	382.5	172.5	5193
Anaesthetics and Maternity	272.5	407	393.5	362.5	227.5	254	305	242	267.5	2731.5
Anaesthetics and Theatres	649.5	225	339	441	278.5	94	230	461.5	543.5	3262
Cardiology (Medical)	91.5	82	173.5	192	190	164.5	181.75	158.25	140.75	1374.25
Care of the Elderly	822	897.5	714.5	628	797	1041	619	587	807.25	6913.25
Clinical Haematology					7		12			19
Dermatology		10.5	6		4	47				67.5
Emergency Medicine	4444.8	4420.8	4288.8	4699	3918.8	3977.5	3545.3	3440.5	3266.3	36001
Endocrinology and Diabetes	390.5	369.75	334	310.5	352.25	215	359.5	373.5	373.5	3078.5
Endoscopy - Medicine	4	4			32	20				60
Endoscopy - Surgical	100	104	52	48	40	76	60	60	101	641
ENT	683.5	338.5	632.5	393.3	532.5	649.5	500.5	555.5	402.5	4688.25
Gastroenterology				8	169	213	200.5	285.5	394.25	1270.25
General Medicine	57.5	207	487.5	438.3	304.75	368	211.25	61.5		2135.75
General Surgery	497	725	828	402	450	220.5	614.5	892	659	5288
Genitourinary Medicine	12	12	4			30	32	28		118
Intensive Care					13	195				208

Microbiology (Medical)	11									11
Obstetrics and Gynaecology	459.5	236	766	929.5	825.5	794	630.5	932.5	1134.3	6707.75
Ophthalmology	34.5	19	102	15	30	103.5	168.5	153	133	758.5
Oral and Maxillofacial Surgery		84	41.75		21.5	19	37	64.25	176.5	444
Orthopaedic & Trauma for Emed	172.25	254	286.5	260	270.5	356.5	191.25	421.5	351.25	2563.75
Orthopaedic and Trauma Surgery	1205.8	743	388	310	432	647.5	842	841.75	981.25	6391.25
Paediatrics and Neonates	845.5	777.5	872.5	833	1101	1257	1128	949.5	1096.3	8860.25
Pathology	31	6								37
Renal Medicine	264	235	9.5	30		4	178.5	207		928
Respiratory Medicine	532	591.75	717.5	714.5	704.5	879.5	703.75	676.25	733.25	6253
Stroke Medicine	381.5	436.25	461.75	392.3	181.75	144.5	149.5	198.5	178.5	2524.5
Urology	147	77	185	185.5	93	320.5	258.5	140	69	1475.5
Vascular Surgery						30	213	176	204	623
Haematology									25.5	25.5
Paediatrics								12		12
Grand Total	**13685**	**14158**	**14255**	**13165**	**12517**	**13858**	**12613**	**12986**	**12911**	**120148.75**

Table 4. Costs

Specialty	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Acute Medicine	£50,614.18	£53,990.80	£55,428.23	£33,514.04	£35,822.19	£36,309.38
Anaesthetics	£990.00					
Anaesthetics and Critical Care	£28,718.88	£17,786.05	£41,193.94	£34,959.48	£26,739.41	£12,542.06
Anaesthetics and Maternity	£24,000.75	£15,430.88	£15,939.00	£18,562.50	£16,339.05	£16,989.26
Anaesthetics and Theatres	£33,404.82	£21,745.99	£6,400.09	£16,595.00	£34,412.50	£44,276.25
Cardiology (Medical)	£7,680.00	£7,600.00	£6,580.00	£7,270.00	£6,330.00	£5,877.98
Care of the Elderly	£28,811.20	£40,478.50	£51,837.21	£29,869.54	£28,523.54	£42,460.29
Clinical Haematology		£577.50		£870.00		
Dermatology		£330.00	£3,877.50			
Emergency Medicine	£314,950.73	£254,348.52	£259,075.07	£245,056.68	£232,070.89	£211,039.67
Endocrinology and Diabetes	£14,370.00	£16,026.17	£10,754.30	£16,706.68	£18,085.72	£19,394.56
Endoscopy - Medicine		£2,080.00	£1,300.00			
Endoscopy - Surgical	£3,360.00	£2,800.00	£5,640.00	£3,900.00	£4,400.00	£8,490.00
ENT	£21,442.91	£33,245.29	£44,715.48	£33,090.61	£35,627.64	£26,877.16
Gastroenterology	£520.00	£13,430.45	£16,927.16	£15,933.78	£20,392.85	£26,479.84
General Medicine	£21,989.13	£16,250.02	£19,245.68	£10,256.48	£3,093.64	
General Surgery	£17,206.84	£23,435.12	£13,542.48	£27,598.73	£38,973.02	£27,033.55
Genitourinary Medicine			£1,950.00	£2,080.00	£1,820.00	

Intensive Care		£624.00	£1,300.00			
Microbiology (Medical)						
Obstetrics and Gynaecology	£55,387.28	£54,751.05	£51,102.75	£35,646.61	£60,731.42	£74,466.70
Ophthalmology	£1,237.50	£2,475.00	£8,538.75	£13,901.25	£12,622.50	£10,972.50
Oral and Maxillofacial Surgery		£1,773.74	£1,567.50	£3,052.50	£5,300.64	£14,561.26
Orthopaedic & Trauma for Emed	£20,400.09	£21,012.62	£27,058.81	£15,429.72	£31,529.10	£26,284.96
Orthopaedic and Trauma Surgery	£21,704.43	£27,338.56	£39,787.89	£51,181.58	£52,505.83	£61,482.69
Paediatrics and Neonates	£59,361.24	£70,928.90	£75,742.33	£66,908.32	£50,717.90	£65,461.66
Pathology						
Renal Medicine	£1,707.74		£200.00	£9,762.13	£11,320.77	
Respiratory Medicine	£33,814.28	£32,618.76	£38,936.88	£33,220.36	£31,407.31	£33,557.26
Stroke Medicine	£19,218.16	£7,376.18	£5,780.00	£5,980.00	£7,940.00	£7,140.00
Urology	£9,160.00	£5,763.80	£19,932.88	£15,842.64	£9,255.08	£3,705.00
Vascular Surgery			£1,509.90	£11,538.60	£9,604.32	£11,132.28
Haematology						£444.55
Paediatrics					£600.00	
Grand Total	**£790,050.16**	**£744,217.90**	**£825,863.83**	**£758,727.23**	**£786,165.32**	**£786,978.86**

Table 5. Reason for locum/bank

Specialty	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Grand Total
Additional session Endoscopy				12	4		15	14	26	71
Additional session Outpatients	2	6	15	1	6	30	16	18	33	127
Additional session Theatres		3								3
Annual Leave	4	10	11	39	3	24	15	13	18	137
Compassionate/Special leave	1	1	1	4		1	2	2		12
Covid Escalation	13	6	3	13				2		37
Covid Training			2							2
Extra Cover	59	88	30	24	23	43	84	139	176	666
Induction			7		15	11				33
Maternity/Pregnancy leave				8		3	1		4	16
Paternity Leave		4	13	8	1			5		31
Restricted Duties	16	3	19	21	20	17	5	20	17	138
Seasonal Pressures	2	11	10	10	8					41
Sick	28	40	89	26	28	31	34	40	38	354
Sickness - Covid-19	33	93	96	25	19	10	11	10	13	310
Study Leave	7	9	6	6		11	6	5	13	63
Vacancy	1259	1247	1181	1165	1166	1259	1096	1077	1070	10520
Grand Total	**1424**	**1521**	**1483**	**1362**	**1293**	**1440**	**1285**	**1345**	**1408**	**12561**

d) Vacancies

Rota vacancies have not fluctuated significantly over the course of the last 7 months. The highest number of vacancies have occurred in O+G and Paediatrics.

Table 6. Trainee vacancies by specialty.

	VACANCIES (WTE)	January	February	March	April	May	June	July
Medicine	Medicine (all sub-specialties)	3.6	2.8	1	0.5	3.1	3.3	3.3
	Emergency medicine	2	2	2	3.2	4.2	4.2	4.2
	Elderly Medicine	0.4	2.6	3.6	3.6	2.6	2.6	2.6
	Renal	0	0	0	1	1	0.2	0.2
Children & Family	Obstetrics & Gynaecology	7.2	7.4	7.4	8.4	8.4	8.4	8.4
	Paediatrics	4.4	6.4	5.1	5.6	5.6	5.1	5.1
	GU Medicine	0	0	0	0	0	0	0
Surgery & Cancer	ENT	1	2	2	1	1	1	1
	General Surgery	1	2	2	1	1.4	1.4	1.4
	Urology	0.4	0.4	0.4	0.4	1	1	1
	Trauma & Orthopaedics	1	1	1	1	2	2	2
	Vascular	1	1					
Clinical Specialties	Anaesthetics	3.7	1.1	1.1	1.1	1.1	0.8	0.8
	Radiology (POSTS DIS-ETABLISHED Oct 19-Oct 21)							
	ICT							
	Total	**25.7**	**28.7**	**25.6**	**26.8**	**31.4**	**30**	**30**

e) **Fines**

No fines have been levied within the last quarter.

Qualitative information

It is reassuring that no instance of immediate safety concern has been raised by junior doctors in relation to working hours on either the 2002 or the 2016 contract. The number of exception reports are low. This could be due to the Coronavirus pandemic causing altered working patterns and a lower workload due to restricted elective activity. However, some neighboring Trusts have witnessed an increase in exception reporting over the past 2 quarters which may indicate that our low number of exception reports is due to different reasons, for example compliant rotas and safe working practices.

I have been assured by the Medical HR department that all doctors are rostered on a rota which is compliant with 2002 and 2016 contracts, as applicable. The previous concern raised by junior doctors regarding rest and working space being shared by a large number of colleagues has, in part, been remedied by the new doctors mess/rest area at Silks at DRI.

The concerns raised regarding the poor quality of on call rooms is being addressed by the refurbishment of on site accommodation.

Summary

No specific areas of concern have been highlighted as a result of exception reporting in relation to working hours. An absence of exception reports regarding education suggests good access to educational opportunities for trainees. Those exception reports received in the last 2 quarters indicate that staff absence due to sickness has resulted in individuals working beyond their rostered hours and the impact of the Coronavirus pandemic on staffing over the coming winter months is likely to exacerbate this problem. The specialties with the highest numbers of exception reports are not those with the highest numbers of rota vacancies, suggesting that understaffed rotas are not the main cause of prolonged working hours.

Engagement

The regional Guardian forum now takes place online and the next meeting is on the 6th October. The Junior Doctors' Forum (JDF) took place via MS Teams on August 19th. A joint meeting with the Trainee Management meeting has been implemented since December 2020. The JDF is open to all trainee Junior Doctors with the aim of improving engagement. Training sessions and induction for Junior Doctors has been provided using a recorded presentation and powerpoint and a face to face session was delivered in August for Foundation Trainees.

Recommendation

The Board of Directors can be assured that the trainee doctors are able to work safely and access educational opportunities as envisaged in the 2016 contract.

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

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Report Cover Page			
Meeting Title:	Board of Directors		
Meeting Date:	September 2021	**Agenda Reference:**	D4
Report Title:	Workforce Race Equality Standards (WRES), Workforce Disability Equality Standards (WDES) and Gender Pay Gap Report		
Sponsor:	Karen Barnard, Director of People & OD		
Author:	Jayne Collingwood, Head of Leadership & OD and Qurban Hussain, Head of EDI		
Appendices:	None		
Report 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. The purpose of this report is to update the Board of Directors on the Workforce Race Equality Standards (WRES), Workforce Disability Equality Standards (WDES) and Gender Pay Gap submissions.		
Summary of key issues/positive highlights:	All NHS providers are expected to show progress against a set of indicators of workforce race and disability. **Workforce Race Equality Standards (WRES)** • Our data shows we have 9.6% Black Minority Ethnic (BME) staff in the workforce, which is an improvement from last year's figure of 8.5%. • We have increased the number of BME staff appointed to roles within our organisation by 41 people across the total workforce. • There has been a deterioration in the percentage of staff with a recorded ethnicity status on their electronic staff record which is now 4.8% from 2.1% in 2020. • There are low numbers of applicants shortlisted for jobs from both BME (205 applicants) and people with a disability (79 applicants) from a total of 1740. • BME applicants have a 25.85% chance of successful appointment from shortlisting. This is a slight decrease compared to 2020 when it was 28.06%. • White staff are 1.4% more likely to be appointed compared to BME staff • In the Consultant roles, Non-Consultant career grade doctors and trainees roles there is a much higher representation of BME staff. • There is no BME representation in the Non-Executive Director roles but to address this deficiency a BME colleague is on placement to a new associate NED role which will strengthen the BME voice and presence at board level.		

	Workforce –Workforce Disability Equality Standard (WDES) • At DBTH we currently employ 2.97% (208) with a declared disability. We have (1168) 16.86 % of staff with a 'Disability status not recorded'. • There are low numbers of applicants shortlisted for jobs from both BME (205 applicants) and people with a declared disability (79 applicants) • Disabled applicants have a 0.33% chance of successful appointment from shortlisting (26 shortlisted applicants in total). As part of our disability confident employer status all applicants disclosing a disability upon application are guaranteed an interview if they meet the essential criteria. • The full staff survey in 2020 shows a positive improvement terms of the percentage of disabled staff reporting that adequate adjustments were made from 66.5% to 69%. **Gender Pay Gap** • In 2020 there is a larger % gender pay gap between Medical and Dental staff (including consultants) at 15.2% compared to the consultants as a group at 7.19% and the AFC gender pay gap of 7.67%. • Fewer male and female consultants were in receipt of the Clinical Excellence Award in 2020 compared to 2019. This could be attributed to several staff retiring and fewer applications for the CEA during the 2019 round which was heavily impacted by the covid19 pandemic. o Males are most of the recipients of Clinical Excellence Awards which equate to 86 of the 104 awarded. o In 2018 there was a national review of pay and reward system, which means that these bonus payments are now non-pensionable and is a non-recurrent payment paid as a lump sum over a 3-year period. As the Trust did not make the payments related to 2018 until later in 2020 the new awards will not be reflected within this report. o National negotiations are taking place in respect of a new scheme which is anticipated to come into place for 2022. o There has been a narrowing of the gender pay gap between male and female average hourly bonus rate of -0.1020 % when comparing March 19 to March 20. • Bonus Gender pay gap in 18/19 it was 10.45% and when comparing the 2019 to 2020 bonus payments the gender pay gap is 4.63% which is a positive shift. • Overall fewer eligible females were in receipt of the bonus payment and in real terms to payments are less than those in 2018 at £3016 and are now £2239.03.				
Recommendation:	The Board is asked to note the work needed to improve staff disclosure rates, the attraction and recruitment of staff, volunteers and governors from protected groups and diverse backgrounds to strengthen our organisational culture, but also the positive work in place related to the RACE equality code.				
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:	SA1, 2 & 3 – future risks in relation to staff and patient experience and organisational reputation, recruitment, and retention		
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:	None		
Legal:	None		
Resources:	None		
Assurance Route			
Previously considered by:	People Committee		
Date:	September 2021	**Decision:**	Regular updates to be received by the People Committee
Next Steps:	Ongoing discussions at People Committee		
Previously circulated reports to supplement this paper:			

EXECUTIVE SUMMARY

The Standard NHS Contract mandates that all NHS provider organisations implement the Workforce Race Equality Standards (WRES) and the Workforce Disability Standards (WDES). Both sets of standards are important because studies show that the extent to which an organisation values and engages its staff is a good barometer of how well patients are likely to feel cared for and has a direct impact upon mortality rates. As a large employer in the local area, we recognise that there is work to do to grow and develop a diverse workforce that more accurately reflects the make-up of the population and the community we serve. Our ambition to be the safest hospital in England and Outstanding in all that we do, is dependent upon creating a fair and inclusive culture where all our people thrive and realise their full potential.

All NHS providers are expected to show progress against a set of indicators of workforce race and disability. This report pulls together an overview of the 2019/2020/2021 Workforce Race Equality Standards (WRES) data for DBTH alongside the Workforce Disability Equality Standards (WDES) data 2020-2021 which has been collated for the second year. It is helpful that we are now more able to begin to map our trends over time and review how we are progressing in this area.

Gender Pay Gap legislation requires all employers of 250 or more employees to publish their gender pay gap data annually. Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust employs around 6656 staff in a range of roles, including administrative, medical, nursing, allied health, and managerial roles. The Trust uses the national job evaluation framework for Agenda for Change (AFC) staff to determine appropriate pay bandings; this provides a clear process of paying employees equally for the same or equivalent work. Each grade has a set of pay points for annual progression, the longer period that someone has been in a grade the higher their salary is likely to be irrespective of their gender.

It is important to note that gender pay gap reporting is different from equal pay which deals with the pay differences between men and women who carry out the same job, similar job, or work of equal value. It is prohibited under UK law to pay people unequally because they are a man or a woman.

The gender pay gap shows the differences in the average pay between males and females and the regulations require both median and mean figures to be reported. The median shows the mid-point salary of any sample, calculated through sorting the hourly rates from lowest to highest and calculating the middle value. The mean is the overall average of the sample and therefore the overall figure can be influenced by any extremely high or low hourly rates of pay. It is therefore possible to have genuine pay equality but still have a significant gender pay gap.

WORKFORCE RACE EQUALITY STANDARDS (WRES)

The data presented in the table below reflects that we have 9.6% Black, Minority Ethnic Groups (BME) staff in the workforce, which is an improvement from last year's figure of 8.5%. Therefore, we can safely say that we have slightly increased the number of BME staff appointed to roles within our organisation, but in real terms this is an increase of 41 people across the total workforce 6656.

Workforce WRES

Table 1 – Staff ethnicity

DBTH Staff	White			BME			Ethnicity unknown		
	2019	2020	2021	2019	2020	2021	2019	2020	2021
Headcount	5833	5873	5923	566	641	664	233	142	331
% of total workforce	86.9%	84.1%	85.6%	8.5%	8.5%	9.6%	8%	2.1%	4.8%

The table above reflects we have a deterioration in the percentage of staff with a recorded ethnicity status on their staff record, which is now 4.8% and 2020 was 2.1%. This would suggest there is still work to do to

improve the capture and quality of the data we hold so staff are clear why this data matters and how it is utilised to drive our decision making and focus our efforts.

Trust Board WRES

Table 2 –Ethnicity of Trust Board

Board Members	White			BME			Ethnicity unknown		
	2019	2020	2021	2019	2020	2021	2019	2020	2021
Headcount	10	10	11	2	1	0	1	1	1
Exec Board	4	4	5	1	1	0	1	1	1
Non-Exec Board	6	6	6	1	0	0	0	0	0

The above table reflects the make-up of Trust board and that there is currently no BME representation at Trust Board level. However, the table does not reflect currently that to address this deficiency a BME colleague is on placement to a new associate NED role which will strengthen the BME voice and lived experience at board level.

WORKFORCE –WORKFORCE DISABILITY EQUALITY STANDARD (WDES)

At DBTH we currently employ (208) 2.97% with a recorded disability compared to 3% in 2020.

Table 3 – Disability data

2020 Criteria	Headcount 2020	2020 %
Non-disabled staff	5522	83% (declared status)
Disabled	187	3% (declared status)
Not Known	1183	14% (not known)
2021Criteria	Headcount 2021	2021%
Non-disabled staff	5554	80.17% (declared)
Disabled	208	2.97% (declared)
Not Known	1168	16.86% (not known)

We have (1168) 16.86 % of staff with a 'Disability status not known', which is significantly higher than the Ethnicity 'unknown' data at (331) 4.8%.

Key Findings

- There are significant gaps in the data we hold regarding Ethnicity of staff (4.8% not known) and Disability status (16.86% not known)
- There are low numbers of applicants shortlisted for jobs from both BME (205 applicants) and People with a disability (79 applicants) from a total of 1740
- Disabled applicants have a 0.33% chance of successful appointment from shortlisting (26 shortlisted applicants in total)
- BME applicants have a 25.85% chance of successful appointment from shortlisting. This is a slight decrease compared to 2020 when it was 28.06%. There was also a rise in the number of applicants shortlisted (205 in 2021 compared to 139 shortlisted applicants in 2020)
- White staff are 1.4% more likely to be appointed compared to BME staff

- When reviewing those staff entering formal disciplinary process it is apparent that 2 BME staff entered this process compared to 56 white staff – 0.65 relative likelihood which is positive

- Within non-clinical roles the highest numbers of BME staff are in pay bands 2 (26) and band 7 (5). In non-clinical roles we have a higher number of disabled staff in Bands 1-4. In clinical roles the majority of BME staff are in Bands 2 and Band 5 which would suggest Health Care Assistant roles and Band 5 Registered Nurses roles. The higher number of disabled staff are also in clinical roles spread across bands 1- 7.

- In the Consultant roles, Non-Consultant career grade doctors and trainees there is a much higher representation of BME staff than across the general workforce.

- BME staff (91.27%) are slightly less likely to access non-mandatory training than white staff (95.27%)

- With regard to formal capability processes there was no-one with a declared disability during 2020/2021

The summary findings from the WRES and WDES suggest that there is work to do to improve our data quality and capture and our representation of both BAME colleagues and disabled colleagues on our workforce. It is notable that there the data suggests a positive shift in the numbers of BAME and disabled staff recruited into our organisation. From our full staff survey in 2020 we have also seen a positive shift in terms of adequate adjustments for our disabled colleagues from 66.5% to 69%, however we still acknowledge there is more work to do improve further.

Key pieces of work underway is the RACE code action plan in respect of our BAME colleagues and a review of our Sickness Absence policy, together with our approach to reasonable adjustments.

WORKFORCE –GENDER PAY GAP

NHS Pay Structure

The majority of DBTH staff work under the central NHS terms and conditions known as 'Agenda for Change'. These arrangements were introduced in 2004 with the express intention of avoiding pay inequalities. Agenda for Change covers more than 1 million people and harmonises their pay scales and career progression arrangements across traditionally separate pay groups. Staff are expected to move up the pay bands irrespective of gender. Medical and Dental staff have different sets of Terms and Conditions, depending on their seniority. However, these too are set across several pay scales for basic pay, which have varying thresholds within them.

Our Data

On 31 March 2020, the Trust employed a total headcount of 6656 staff including AFC and Medical and Dental staff which includes consultants. Of the AFC staff 87% (5036) are female and 13% male (752), 604 Medical and Dental staff of which 35% (212) are female and 65% (392) male. The table below reflects the overall numbers of Full Time Equivalent (FTE) males and females in each quartile.

WRES/WDES & Gender Pay Gap Report Author: **Jayne Collingwood & Qurban Hussain** Report Date: **September 2021**

Proportion of FTE Males and Females in each pay quartile

Quartile	Female	Male	Female %	Male %
1	1391.00	200.00	87.43%	12.57%
2	1378.00	218.00	86.34%	13.66%
3	1394.00	151.00	90.23%	9.77%
4	873.00	183.00	82.67%	17.33%
Total	5036	752	87%	13%

Gender Pay Gap

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	15.3800	12.5400
Female	14.2000	12.3800
Difference	1.1800	0.1600
Pay Gap %	7.67	1.27

The above table reflects the % gender pay gap between male and female employees based upon average hourly rates of pay. Currently it reflects a 7.67% pay gap which equates to £1.18 per hour in favour of male employees. There is less of a gap when comparing the median hourly rate of males and females of 1.27% which equates to £0.16 per hour.

In 2020 there is a larger % gender pay gap between Medical and Dental staff (including consultants) at 15.2% compared to the consultants as a group at 7.19% and the AFC gender pay gap of 7.67%. It is interesting to note that fewer male and female consultants were in receipt of the Clinical Excellence Award in 2020 compared to 2019. This could be attributed to several staff retiring and fewer applications for the CEA during the 2019 which was heavily impacted by the covid19 pandemic.

Males are most of the recipients of Clinical Excellence Awards which equate to 86 of the 104 awarded. These bonuses are received by 6% of all males employed compared to 0.32% of females. The bonus payments will have the impact of inflating the average salaries. In 2018 there was a national review of pay and reward system, which means that these bonus payments are non-pensionable and is a non-recurrent payment paid as a lump sum over a 3-year period. As the Trust did not make the payments related to 2018 until later in 2020 the new awards will not be reflected within this report. It was then agreed that the process for 2019 and 2020 would be amended such that all eligible consultants would receive a lump sum payment without an application process – this was due to the impact of covid and was a national decision. The same process will be applied for 2021. National negotiations are taking place in respect of a new scheme which is anticipated to come into place for 2022.

There has been a narrowing of the gender pay gap between male and female average hourly bonus rate of -0.1020 % when comparing March 19 to March 20. Looking back to the bonus gender pay gap in 18/19 it was 10.45% and when comparing the 2019 to 2020 bonus payments the gender pay gap is 4.63% which is a positive shift. However overall fewer eligible females were in receipt of the bonus payment and in real terms to payments are less than those in 2018 at £3016 and are now £2239.03. However, it is important to note as already mentioned the national changes to the CEA scheme will influence the payment structure and amounts paid.

GENDER PAY GAP ACTION PLAN

- Through our approaches to hybrid and agile working practices we wish to ensure females are supported and given the opportunity to apply to become Consultants and senior leaders in the organisation. Alongside this our leadership development programmes, coaching and mentoring schemes will assist the female talent to develop into senior roles.

- The Trust continues to actively participate in the national work reviewing reasons for disparity in the achievement of Clinical Excellence Awards.
- The full staff survey results and staff engagement outputs are used to shape and inform plans, strategies, and policies to empower the female workforce and develop an inclusive culture.
- The introduction of the Reciprocal Mentoring Programme is designed to engender a culture of shared learning and experience to develop our culture and talent of all genders.
- The introduction of a variety of Staff Networks is helping to inform the development of the organisation and provides insight and learning to support the development of our people.

Appendix 1 - WRES Data

WRES/WDES & Gender Pay Gap Report Author: **Jayne Collingwood & Qurban Hussain** Report Date: **September 2021**

Data Tables - Comparison data 2019/2020/2021

Table 1 – Non-Clinical Staff

	Total Number of white staff			Total Number of BME staff			Staff without declared status		
Staff Group	**2019**	**2020**	**2021**	**2019**	**2020**	**2021**	**2019**	**2020**	**2021**
Under Band 1	16	14	5	1	1	0	1	0	0
Band 1	495	165	132	11	2	2	25	10	7
Band 2	364	802	860	14	23	26	26	11	11
Band 3	362	366	349	2	3	1	14	5	6
Band 4	139	158	173	3	3	3	6	1	0
Band 5	53	49	49	1	0	1	1	0	0
Band 6	65	69	74	2	1	2	1	2	1
Band 7	44	50	57	3	4	5	1	1	0
Band 8a	42	44	44	0	1	2	0	0	0
Band 8b	17	18	18	0	0	0	0	0	0
Band 8c	14	19	22	0	0	0	0	0	0
Band 8d	9	8	9	0	0	0	0	0	0
Band 9	0	2	2	0	0	0	0	0	0
VSM	8	5	5	0	0	0	7	0	0

Table 2 - Clinical Staff

	Total Number of white staff			Total Number of BME staff			Staff without declared status	
Staff Group	**2019**	**2020**	**2021**	**2019**	**2020**	**2021**	**2020**	**2021**
Under Band 1	10	2	5	0	0	1	0	0
Band 1	3	18	15	0	0	0	0	0
Band 2	956	1095	1092	28	32	41	25	25
Band 3	239	335	356	2	16	7	3	3
Band 4	94	96	97	2	2	1	3	2
Band 5	1104	1015	1002	128	134	151	21	17
Band 6	779	804	815	24	35	38	18	8
Band 7	371	406	406	12	9	7	8	6
Band 8a	79	79	85	7	7	7	1	0
Band 8b	12	11	11	0	2	2	0	0
Band 8c	13	14	13	0	0	0	0	0
Band 8d	2	3	2	0	0	0	0	0
Band 9	1	2	2	1	1	1	0	0
VSM	0	1	1	1	1	0	0	0

Table 3 – Senior Medical Staff

	Total Number of white staff	Total Number of BME staff	Staff without declared status

Staff Group	2019	2020	2021	2019	2020	2021	2019	2020	2021
Consultants	105	101	102	148	155	159	329	13	211
Senior Medical Manager	0	0	0	1	0	0	0	0	0
Non-consultant career grade	22	24	15	170	68	64	19	2	7
Trainee Grades	100	98	95	16	141	143	5	18	27
Other	0	0	0	0	0	0	0	0	0

Table 4 - Recruitment and Selection

	White			BME			Ethnicity unknown		
Recruitment and Selection	**2019**	**2020**	**2021**	**2019**	**2020**	**2021**	**2019**	**2020**	**2021**
Number of shortlisted applicants	533	1132	1449	70	139	205	6	60	86
Number appointed from shortlisting	266	403	524	18	39	53	0	30	35
Relative likelihood of appointment from shortlisting	49.9%	35.60%	36.16%	25.7%	28.06%	25.85%	0%	50.0%	40.70%
Relative likelihood of white staff being appointed compared to BME staff	1.94	1.27	1.40						

Table 5 - Formal Disciplinary

	White			BME			Unknown		
Disciplinary	**2019**	**2020**	**2021**	**2019**	**2020**	**2021**	**2019**	**2020**	**2021**
Number in workforce	5809	5732	5838	564	575	641	551	533	472
Number of staff entering the formal disciplinary process	55	57	56	4	4	2	1	1	0
Likelihood of staff entering the formal capability process	0.009	0.01	0.01	0.003	0.007	0.006	0.003	0.0009	0.O04
Relative likelihood of BME staff entering the formal Disciplinary process compared to White staff				0.38	0.72	0.65			

Table 6 - Non-Mandatory training

	White			BME		Unknown
	2019	**2020**	**2021**	**2020**	**2021**	**2021**
Number of staff in workforce	5809	5873	5923	641	664	331
Number of staff accessing non-mandatory training CPD	5529	5704	55643	574	606	149
Relative likelihood of white staff accessing non-mandatory training CPD	0.95	1.08	1.04			

Appendix 2 – WDES Data 2021

WRES/WDES & Gender Pay Gap Report Author: **Jayne Collingwood & Qurban Hussain** Report Date: **September 2021**

Table 1

Staff Group (Clusters)	Total Number of staff non-disabled staff 2021	Total Number of Disabled staff 2021	% Disabled staff 2021	Number of staff without declared status 2021	% staff without declared status 2021
Cluster Bands 1 -4 non-clinical	1337	54	3.4%	184	11.7%
Cluster Bands 5 -7 non-clinical	168	8	4.2%	13	6.9%
Cluster 8a – 8b Nonclinical	56	2	3.1%	6	9.4%
Cluster 8c – 9 VSM non clinical	33	1	2.6%	4	10.5%
Cluster Bands 1 -4 clinical	1369	53	3.2%	223	13.6%
Cluster Bands 5 -7 clinical	2012	76	3.1%	382	15.5%
Cluster 8a – 8b clinical	93	1	1.0%	11	10.50%
Cluster 8c – 9 VSM clinical	16	1	5.30%	2	10.50%
Cluster 5 Med and Dental, Cons	212	5	1.10%	255	54.0%
Cluster 6 Medical and Dental Non-consultants career grade	62	2	2.30%	22	25.60%
Cluster 7 Medical and Dental trainee grades	196	3	1.10%	64	24.3%

Recruitment and Selection

Table 2 and 3

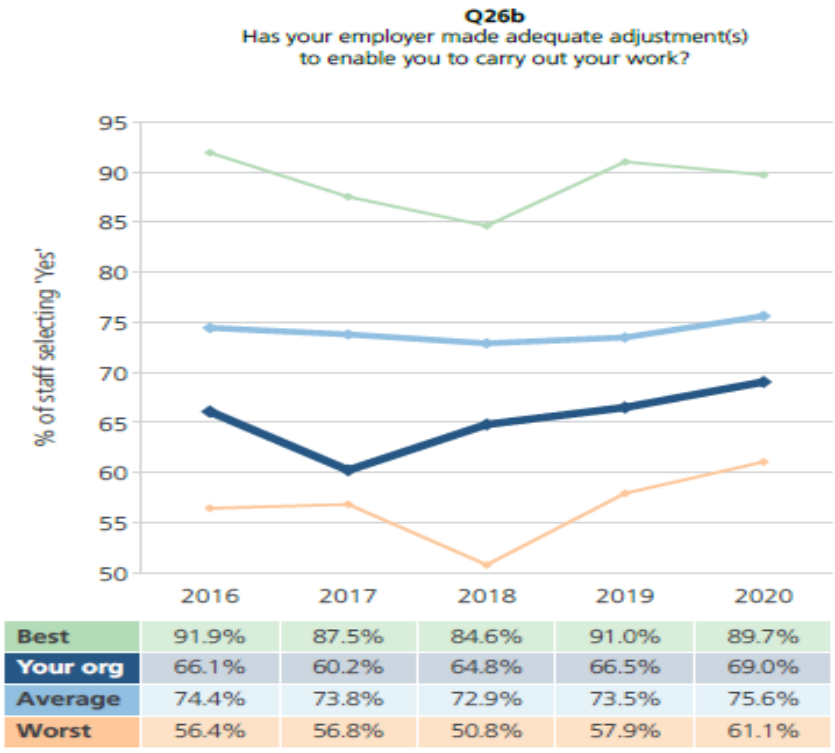
Criteria	Headcount Number of Disabled 2020	Total number of applicants Shortlisted 2020	Headcount Number of disabled 2021	Total number of applicants Shortlisted 2021
Number of shortlisted applicants	51	1337	79	1537
Number appointed from shortlisting	17	472	26	560

Criteria	2020	2021
Relative likelihood of disabled staff shortlisted and appointed	0.33 (33%)	0.33 (33%)
Relative likelihood of nondisabled staff being appointed compared to disabled	1.08	1.08

Table 4- Formal Capability

Capability	Non-Disabled 2020	Non-Disabled 2021	Disability 2020	Disability 2021	Unknown 2020	Unknown 2021
Number in workforce	5732	5838	575	641	533	472
Number of staff entering the formal capability process	12	6	0	0	1	0
Likelihood of staff entering the formal capability process	90%	100%	0.%	0.%	10%	0%

Staff Survey data 2020



	2016	2017	2018	2019	2020
Best	91.9%	87.5%	84.6%	91.0%	89.7%
Your org	66.1%	60.2%	64.8%	66.5%	69.0%
Average	74.4%	73.8%	72.9%	73.5%	75.6%
Worst	56.4%	56.8%	50.8%	57.9%	61.1%

Appendix 3 – Gender Pay Gap Data 2021

Proportion of FTE Males and Females in each pay quartile

Quartile	Female	Male	Female %	Male %
1	1391.00	200.00	87.43%	12.57%
2	1378.00	218.00	86.34%	13.66%
3	1394.00	151.00	90.23%	9.77%
4	873.00	183.00	82.67%	17.33%
Total	5036	752	87%	13%

Medical and Dental Employees including Consultants

Quartile	Female	Male	Female %	Male %
1	0	2.00	0	100.00%
2	4.00	2.00	66.67%	33.33%
3	25.00	29.00	46.30%	53.70%
4	183.00	359.00	33.76%	66.24%
Total	212	392	30.35%	63.31%

Consultants

The table below reflects that as of 31st March 2020 the Trust employs 262 consultants of which 26% (69) are female and 74% (193) are male.

Quartile	Female	Male	Female %	Male %
1	-	1.00	-	100.00%
2	-	-	-	-
3	-	-	-	-
4	69.00	192.00	26.44%	73.56%
Total	69	193	26.44%	86.78%

From the above data it is evident that the percentage of males employed in Medical, Dental (including consultant) roles is 86% which is much greater than the proportion of males employed in the AFC workforce which is 13%.

About the Clinical Excellence Award (CEA) Scheme

It is important to note that not all Consultants are eligible for CEA'S and the eligibility criteria is set by NHSE/British Medical Association as per below:

- at least one years' service as a substantively appointed consultant on the specialist register of the GMC or specialist list of the GDC at the 1st April of the award round and not hold an existing Level 9 local award, an existing National award, or a distinction award.
- Participated satisfactorily in the appraisal process
- Engaged in job planning
- Fulfilled their contractual obligations
- No disciplinary sanctions outstanding on the closing date for applications
- Advise if they are aware of any actual or potential disciplinary or professional proceedings inside or outside the Trust.

The following consultants are not eligible to apply:

- Locum consultants
- Consultants employed in full-time general management positions and who do not undertake clinical work as a consultant under a separate clinical contract

- Substantive consultants with less than 1 years' service by the 1st April of the award round.

Part-time consultants are eligible for Clinical Excellence Awards and will be scored in line with the criteria set out for all consultants. Arrangements are in place for part time consultants to receive the award based on a pro rata basis

Another relevant point to note is that before 2018 CEA awards were pensionable and recurrent until retirement. From 2018 onwards the new awards are non-pensionable and only recurrent for 3 years. So those that were successful during 2018 will receive £3,016 per year for 3 years (2018, 2019, 2020). This was received as a lump sum, one-off payment which was paid in 2020.
The table below reflects that data captured over time regarding the Clinical Excellence Award scheme payments.

Year	Number Eligible to apply	Number Awarded	Number of females	Males	Part time staff	Single Award Value
2018	192	46	13	33	4	£3016
2019	204	120	24	96		£924.57
2020	203	104	18	86		£2239.03

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	18.00	5668.00	0.32
Male	86.00	1433.00	6.00

Although there is a lower proportion of males in the total workforce than females, nearly half of the males employed (47.38%) are paid in the top earnings quartile. This is unsurprising, as males are the majority of recipients of Clinical Excellence Awards (86 of 104 awarded).

There continues to be ongoing national strategic work clarifying the position regarding Clinical Excellence Awards and the classification of them as a bonus payment. These bonuses received by 6% (86) of all males employed will inflate the average salaries. From the above table it is evident that 18 females were in receipt of the CEA which equates to 0.32% of total relevant employees. All the figures are based on net salaries which for females may have been previously depressed by salary sacrifice schemes in relation to childcare. However, this is no longer the case as it is administered differently.
The bonus gender split indicated above is broadly consistent with most NHS Acute Trusts in England and Wales. The data is based upon an NHS-wide gender pay reporting dashboard, developed by ESR, which allows the inclusion of any relevant bonus payments in the calculations

Gender Pay Gap AFC
The data in the following tables reflects the gender pay gap reports for DBTH.
The tables below show how the trust has moved as of the 31st March 2020 across all groups of staff.

Average & Median Hourly Rates

Mar-19

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	22.8791	17.2181
Female	14.5924	12.6261
Difference	8.2867	4.5920
Pay Gap %	36.2197	26.6694

Number of employees | Q1 = Low, Q4 = High

Quartile	Female	Male	Female %	Male %
1	1360.00	212.00	86.51	13.49
2	1368.00	207.00	86.86	13.14
3	1392.00	183.00	88.38	11.62
4	1057.00	517.00	67.15	32.85

WRES/WDES & Gender Pay Gap Report Author: **Jayne Collingwood & Qurban Hussain** Report Date: **September 2021**

Mar-20

Gender	Avg. Hourly Rate	Median Hourly Rate		Quartile	Female	Male	Female %	Male %
Male	23.4124	18.1892		1	1398.00	206.00	87.16	12.84
Female	14.9564	12.7690		2	1384.00	220.00	86.28	13.72
Difference	8.4560	5.4202		3	1422.00	182.00	88.65	11.35
Pay Gap %	36.1177	29.7992		4	1059.00	546.00	65.98	34.02

19/20 comparison

Gender	Avg. Hourly Rate	Median Hourly Rate		Quartile	Female	Male	Female %	Male %
Male	0.5333	0.9711		1	38.00	-6.00	0.64	-0.64
Female	0.3640	0.1428		2	16.00	13.00	-0.57	0.57
Difference	0.1693	0.8283		3	30.00	-1.00	0.27	-0.27
*Pay Gap %	-0.1020	3.1298		4	2.00	29.00	-1.17	1.17

*Please note from the above table a -ve values indicates a closing of the gap.

From the above table it is evident that there has been a slight closing of the AFC gender pay gap comparing 2019 to 2020 average hourly rate and the median hourly rate has increased**.**

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	15.3800	12.5400
Female	14.2000	12.3800
Difference	1.1800	0.1600
Pay Gap %	7.67	1.27

The above table reflects the % gender pay gap between male and female employees based upon average hourly rates of pay. Currently it reflects a 7.67% pay gap which equates to £1.18 per hour in favour of male employees. There is less of a gap when comparing the median hourly rate of males and females of 1.27% which equates to £0.16 per hour.

Gender Pay Gap Medical and Dental including Consultants

The table below reflects the 15.2% gender pay gap in Medical and Dental including consultants average hourly rates which equates to £5.92. The median hourly rates reflect a 22.0% gender pay gap which equates to £8.68.

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	38.9400	39.4400
Female	33.0200	30.7600
Difference	5.9200	8.6800
Pay Gap %	15.20%	22.00%

Gender Pay Gap Consultants only

The table below reflects the gender pay gap 7.19% for Consultants when comparing average hourly rates which equates to £3.70 per hour in favour of males. The gender pay gap for consultants based upon the median hourly rate is 9.46% which is equivalent to £4.73.

WRES/WDES & Gender Pay Gap Report Author: **Jayne Collingwood & Qurban Hussain** Report Date: **September 2021**

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	51.4000	49.9700
Female	47.7000	45.2400
Difference	3.7000	4.7300
Pay Gap %	7.19	9.46

Proportion of Males and Females receiving a Clinical Excellence Award bonus payment

Whilst technically all our staff including those on AFC terms and conditions are relevant to receive bonuses the Clinical Excellence Award (CES) is applied to Consultants only.

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	18.00	5668.00	0.32
Male	86.00	1433.00	6.00

* *Note the data for the bonus period is captured over 12 months and the total relevant employees is captured at a point in time March 31st, 2020.*

From the above table it is evident that 18 (0.32%) females were in receipt of a bonus payment in terms of the Clinical Excellence Award as compared to 86 (6.0%) males which was less than previous year of 24.

Average and Median bonus gender pay gap

Gender	Avg. Pay	Median Pay
Male	11,009.61	7,540.02
Female	10,207.45	6,032.04
Difference	802.16	1,507.98
Pay Gap %	7.29	20.00

The bonus average pay gap is much closer between male and female at 7.29% equivalent to £802.16. than the median bonus pay gap is much greater at 20% equivalent to £1507.98.

Previous year comparisons Proportion of males and females receiving a bonus payment comparison

The tables below reflects the period 2018 – 2020 in terms of bonus payment comparisons.

Mar 18 Bonus

Gender	Avg. Pay	Median Pay
Male	11,744.65	7,999.10
Female	12,660.04	9,793.84
Difference	-915.39	-1,794.74
Pay Gap %	-7.79	-22.44

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	22.00	5502.00	0.40
Male	80.00	1394.00	5.74

Mar 19 bonus

Gender	Avg. Pay	Median Pay
Male	10,966.15	7,791.35
Female	10,675.35	5,529.36
Difference	290.80	2,261.99
Pay Gap %	2.65	29.03

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	24.00	5434.00	0.44
Male	96.00	1195.00	8.03

WRES/WDES & Gender Pay Gap Report Author: **Jayne Collingwood & Qurban Hussain** Report Date: **September 2021**

18/19 bonus comparison

Gender	Avg. Pay	Median Pay
Male	-778.50	-207.75
Female	-1,984.69	-4,264.48
Difference	1,206.19	4,056.73
Pay Gap %	10.45	51.47

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	2.00	-68.00	0.04
Male	16.00	-199.00	2.29

Mar 19 Bonus

Gender	Avg. Pay	Median Pay
Male	10,966.15	7,791.35
Female	10,675.35	5,529.36
Difference	290.80	2,261.99
Pay Gap %	2.65%	29.03

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	24.00	5434.00	0.44
Male	96.00	1195.00	8.03

Mar 20 bonus

Gender	Avg. Pay	Median Pay
Male	11,009.61	7,540.02
Female	10,207.45	6,032.04
Difference	802.16	1,507.98
Pay Gap %	7.29%	20.00

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	18.00	5668.00	0.32
Male	86.00	1433.00	6.00

19/20 Bonus Comparison

Gender	Avg. Pay	Median Pay
Male	43.47	-251.33
Female	-467.90	502.68
Difference	511.36	-754.01
Pay Gap %	4.63%	-9.03

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	-6.00	234	0.12
Male	-10…	238.00	2.03

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: Jon Sargeant **Committee: F&P**	**People, Partners, Performance, Patients**	**Date last reviewed :Sept 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 within baseline resource and funding. • Significant theatre staffing issues were not foreseen by the Division within the workforce plan, leading to expensive agency spend and presents a risk to the delivery of activity plans. • Some areas of delivery falling behind plans whilst the overall income is holding up, suggests that the Trust could be earning higher levels of income. • Significant issues surround CSS division maybe need considerable investment to rectify in the short-term. Lack of clarity of plans and reasons for changes in level of delivery require further investigation. • 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). - 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. - The change of the funding regime around the ERF means that the additional work to deliver the target will not be funded as previously was the case. This potentially incurs a £6m loss for the Trust, unless support comes from the ICS. • Lack of clarity in terms of the Trust's bed plan and therefore costs of workforce plans, against a background of increasing temporary staffing spending suggesting a lack of control with some areas of the Trust. This is impacting on staffing numbers on wards. • H2 – partial guidance provided for H2 now states that CIP will be required and that Covid Support will be tapered out. Final rules and absolute targets will not be available until potentially September 2021 leaving little time for implementation. • Impact of major incident at W&C on delivery of 21/22 capital and revenue plan. o The capital budget cost of £12.5m needs to be resolved with the ICS or NHSE/I. o The incident highlights significant risks concerning the funding route for and delivery of backlog maintenance costs. Specialist reports are being commissioned and will be discussed with the Trust Board.	**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 and maintain a sustainable site as its asset base ages further. • 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. • The CDEL issue with the money for the W&C block (£12.4m) is largely resolved within the ICS at the 16 September 2021. • The Executive Team have agreed to continue funding ERF activity in the private sector for October in absence of central financial guidance, however this is at risk.	**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. • Change in financial regimes in relation to ICS and Place budgets • Return to control totals and trajectories in future years • Increasing costs relating to old and poorly maintained buildings requiring increasing interventions to main the utility of the site **Risk references:** • **F&P1, 2 and 3** • **F&P2** • **F&P3** **Opportunities:** • Change in practices, new ways of working • The Director of Finance is working with other colleagues in Doncaster to look at opportunities for additional funding to close the gap created with ERF rule changes.	
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 • Accelerator Board review.	**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.	**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	

• Improved IQPRS and information governance process via the Finance, Information and Digital Committee • Working with the ICS through CEO's and DoFs regarding the rules on ERF and funding arrangements. Reporting back through F&P and Board.	• 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.	**Gaps in controls / assurance (actions to achieve target risk score):** • Uncertainty regarding future financial regime

Report Cover Page			
Meeting Title:	**Trust Board**		
Meeting Date:	**21st September**	**Agenda Reference:**	**E2**
Report Title:	**Financial Performance – Month 5 (August) 2021**		
Sponsor:	**Jon Sargeant - Director of Finance**		
Author:	**Alex Crickmar – Deputy Director of Finance** **Jon Sargeant - Director of Finance**		
Appendices:	N/A		
Executive Summary			
Purpose of report:	To report the Month 5 financial position to the Trust Board including any risks to the delivery of the Trust's financial plan.		
Summary of key issues:	The Trust's deficit for month 5 (August 2021) was £191k, which is £97k adverse to plan. The Trust's Year to Date (YTD) surplus is £358k, which is £332k favourable to plan. Overall, whilst the year-to-date financial position to month 5 is still in surplus the financial position is worsening as evidenced by the month 4 and 5 deficit positions and there remains a number of financial risks to the position, including: • The increase in the ERF thresholds to 95% is now having a significant impact as seen in Month 5, with costs being incurred to deliver additional activity in line with the accelerator plan, but no additional funding. Across the ICS no Providers earnt any ERF in Month 5, and the system does not expect to deliver sufficient activity for the rest of Q2 to qualify for any further ERF. This is the second month in a row the Trust has reported an in-month deficit position since the ERF rules were revised. • H2 financial arrangements are still yet to be confirmed (planning guidance expected in September) however it is expected there will be less funding that in H1, with an increased efficiency ask of c 3%. • Pay spend has increased by £742k since April. The increase in spend over the previous months is due to bank and agency spend increasing, especially in Nursing. Bed plans for H2/winter are yet to be agreed and agreeing nursing budgets has also been difficult as previously raised, providing uncertainty over future pay expenditure levels. • The impact of the major incident at W&C on delivery of the 21/22 capital and revenue plans and on the cash position of the Trust. Capital expenditure spend in month 5 is £1.7m. YTD capital expenditure is £9.1m against the plan of £5.7m. YTD capital expenditure is £3.4m ahead of the plan, driven by the Women's & Children's modular costs (£5.6m) and offset with underspends in Estates (£0.7m), Medical Equipment (£1.2m) and IT (£0.4m). The ICS DoFs have reached an agreement for Month 5 reporting regarding the £12.4m capital pressure from the W&C costs. Each trust has agreed to reduce its capital programme to enable the system to absorb the cost pressure, with a £3m impact for DBTH. This means the Trust is forecasting to overspend against its original capital allocation by c£10m.		

	The cash balance at the end of August was £41.1m (July: £39.1m). Cash has increased by c £1.1m as a result of receiving Q1 accelerator funding from the ICS and receiving cash from local NHS Trusts for invoiced staff recharges. Cash flow forecasting has taken place for the rest of 21/22 and it is highly likely that cash will fall during the rest of the year, mainly as a result of capital spend, as well as PDC/loan payments. The extent of the fall is dependent on the I&E performance for the rest of the year and capital spend, but cash is expected to finish in the £12-£15m range, with a worst-case scenario of £2m.
Recommendation:	The Board is asked to note: • The Trust's deficit for month 5 (August 2021) was £191k, which is adverse to plan by £97k. (£358k surplus YTD and £332k favourable to plan YTD) • The financial risks reported within the paper.

Action Require:	Approval	Information X	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:	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 5 – August 2021

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

P5 August 2021

1. Income and Expenditure vs. Plan

Performance Indicator	Monthly Performance		YTD Performance		
	Actual £'000	Variance to budget £'000	Actual £'000	Variance to budget £'000	H1 Budget £'000
I&E Perf Exc Impairments & top up	229	101 A	(326)	(314) F	0
Income	(40,581)	40 A	(199,805)	47 A	(240,333)
Operating Expenditure	39,341	75 A	192,074	(390) F	231,541
Pay	25,044	(289) F	123,889	(1,169) F	150,311
Non Pay & Reserves	14,297	364 A	68,186	779 A	81,230
Financing costs	1,445	(17) F	7,373	11 A	8,840
I&E Performance excluding Donated Asset adjustment	**229**	**101 A**	**(326)**	**(314) F**	**49**
Donated Asset adjustment	(39)	(4) F	(32)	(18) F	(50)
I&E Performance including Donated Asset Adjustment	**191**	**97 A**	**(358)**	**(332) 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	451	104 A	1,486	596 A	2,705
Procurement & Commercial	26	7 A	67	32 A	137
Nursing and AHP workforce	8	(5) F	8	(2) F	20
Outstanding Outpatients	0	(0) F	2	(2) F	0
Total	**486**	**105 A**	1,563	**625 A**	**2,862**

3. Statement of Financial Position

All figures £m	Opening Balance	Closing balance	Movement in year
Non Current Assets	**235,884**	**238,050**	**2,166**
Current Assets	74,793	72,069	**-2,724**
Current Liabilities	-72,376	-69,380	**2,996**
Non Current liabilities	-14,787	-13,738	**1,049**
Total Assets Employed	**223,514**	**227,001**	**3,487**
Total Tax Payers Equity	**-223,514**	**-227,001**	**-3,487**

4. Other

Performance Indicator	Monthly Performance		YTD Performance		Annual
	Plan £'000	Actual £'000	Plan £'000	Actual £'000	Plan £'000
Cash Balance		41,058		41,058	21,259
Capital Expenditure	1,546	1,687	5,671	9,147	18,900

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 5 Financial Position Highlights

Summary Income and Expenditure – Month 5

	Mth 5			YTD	
	Plan	Actual	Variance	Actual	Variance
	£000	£000	£000	£000	£000
Income	**-40,620**	**-40,581**	**40**	**-199,805**	**47**
Pay					
Substantive Pay	23,318	22,155	-1,163	111,105	-4,015
Bank	578	1,219	642	5,019	2,013
Agency	712	944	232	4,619	743
Recharges	725	725	0	3,147	91
Total pay	**25,333**	**25,044**	**-289**	**123,889**	**-1,169**
Non-Pay					
Drugs	917	900	-18	4,492	141
Non-PbR Drugs	1,649	1,715	66	8,819	672
Clinical Supplies & Services	2,825	3,189	363	14,289	348
Other Costs (including reserves)	7,228	7,181	-48	32,869	-888
Recharges	1,313	1,313	0	7,717	506
Total Non-pay	**13,933**	**14,297**	**364**	**68,186**	**779**
Financing costs & donated assets	**1,447**	**1,430**	-17	**7,373**	**11**
(Surplus) / Deficit Position as at month 5	**93**	**191**	**97**	**-358**	**-332**

The Trust's deficit for month 5 (August 2021) was £191k, which is £97k adverse to plan. The Trust's Year to Date (YTD) surplus is £358k, which is £332k favourable to plan.

The vast majority of month 5 clinical income continues to be funded on block basis as per the national agreements for H1 and therefore there are no significant variances to plan. In month clinical income is £35.0m which is an increase of £0.7m compared to previous month of £34.3m primarily due to the trust recognising part of the accelerator income received from the ICS. In month the Trust has an overall adverse clinical income position against plan of c£1m mainly due to not achieving the revised ERF national target of 95% (82% achievement). Across the ICS no Providers achieved ERF in Month 5, and the system does not expect to deliver sufficient activity for the rest of Q2 to qualify for any further ERF.

Month 5 Only	Plan	Actual	Movement
Revised Baseline	**£9,446**	**£9,446**	**£0**
Revised Capacity Plans	**£9,435**	**£7,734**	**-£978**
% Achievement - Inc. ISP	100%	82%	-18%
Target Achievement	85%	95%	10%
Tariff Funding - Excluding ISP	**£272**	**-£1,476**	**-£1,748**
Tariff Funding - Including ISP	**£1,406**	**-£1,240**	**-£2,646**

Non-Clinical income was c£950k favourable to budget in month (excluding recharges and donated assets) which was mainly due to an increase in month relating to the BOS (bowl scoping) contract with STH (this is a cumulative catch from April) and a refresh of the RTA data also resulting in a cumulative catch up.

Pay in month was £289k favourable to plan, however it continues to increase on previous months with pay expenditure having increased by £724k since April (£80k from July to August). The increase in month is mainly driven by bank spend over and above the workforce plans, particularly in Medicine. The favourable variance to budget continues to be due to underspends in corporate due to admin vacancies (c. £510k YTD) and CSS due to therapy vacancies (c. £527k YTD).

Non-pay (excluding reserves and recharges) was £68k adverse to plan in month and was an increase in spend on last month of £271k. The main reason for the increase in spend on month 4 was due to the increases in clinical supplies, mainly in Medicine (c. £117k) on blood products and consumables, C&F (c. £40k) on insulin pumps and blood products and on Medical technical services within Corporate (c. £93k) on repairs and maintenance.

Year to date non-pay is overspent against budget by c. £1.2m. This was driven by:

- £812k on drugs which was mainly in the Medical Division, due to biologics/immunosuppressives that decreased during COVID but are now increasing. (some of which is offset in income for the high cost drugs)
- £348k on clinical supplies mainly in CSS who are £593k above budget YTD. This is mainly due to overspends across the theatres (c. £188k in main theatres, c. £125k in Orthopaedic theatres and c. £208k in Bassetlaw theatres).

Within reserves the Trust has included £1m of costs relating to the Women's and Children's incident and provides for an allowance for the temporary supply of facilities/buildings for lost capacity.

The Trust has delivered £486k of savings in month 5 versus the plan submitted to NHSI of £591k, an under-delivery of £105k. Year to date the Trust has delivered £1.6m versus the NHSI plan of £2.2m, an under-delivery of £625k. Delivery in month 5 was lower than plan and increases the YTD gap to target. The main reasons behind this are the reflection of the business rates rebate scheme earlier in the year than planned (as the money was received) and a residual gap of unidentified schemes to target which hasn't been filled.

Capital expenditure spend in month 5 is £1.7m. YTD capital expenditure is £9.1m against the plan of £5.7m. YTD capital expenditure is £3.4m ahead of the plan, driven by the Women's & Children's modular costs (£5.6m) and offset with underspends in Estates (£0.7m), Medical Equipment (£1.2m) and IT (£0.4m). The ICS DoFs have reached an agreement for Month 5 reporting regarding the £12.4m capital pressure from the W&C costs. Each trust has agreed to reduce its capital programme to enable the system to absorb the cost pressure, with a £3m impact for DBTH. This means the Trust is forecasting to overspend against its original capital allocation by c£10m.

The cash balance at the end of August was £41.1m (July: £39.1m). Cash has increased by c £1.1m as a result of receiving Q1 accelerator funding from the ICS and receiving cash from local NHS Trusts for invoiced staff recharges. Cash flow forecasting has taken place for the rest of 21/22 and it is highly likely that cash will fall during the rest of the year, mainly as a result of capital spend, as well as PDC/loan payments. The extent of the fall is dependent on the I&E performance for the rest of the year and capital spend, but cash is expected to be c£12-£15m at year end, with a worst-case scenario suggesting a cash balance as low as £2m.

2. Recommendations

The Board is asked to note:

- The Trust's deficit for month 5 (August 2021) was £191k, which is adverse to plan by £97k. (£358k surplus YTD and £332k favourable to plan YTD)
- The financial risks reported within the paper.

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E3

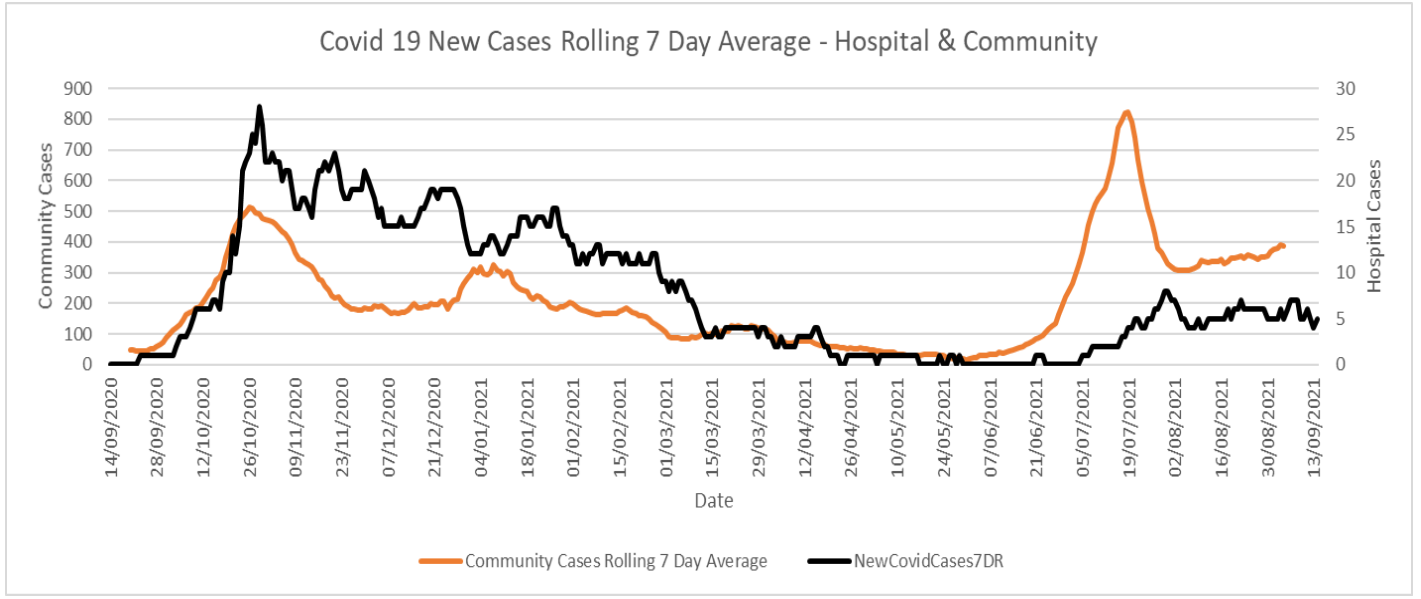
Board Sept 2021 - Operational Update

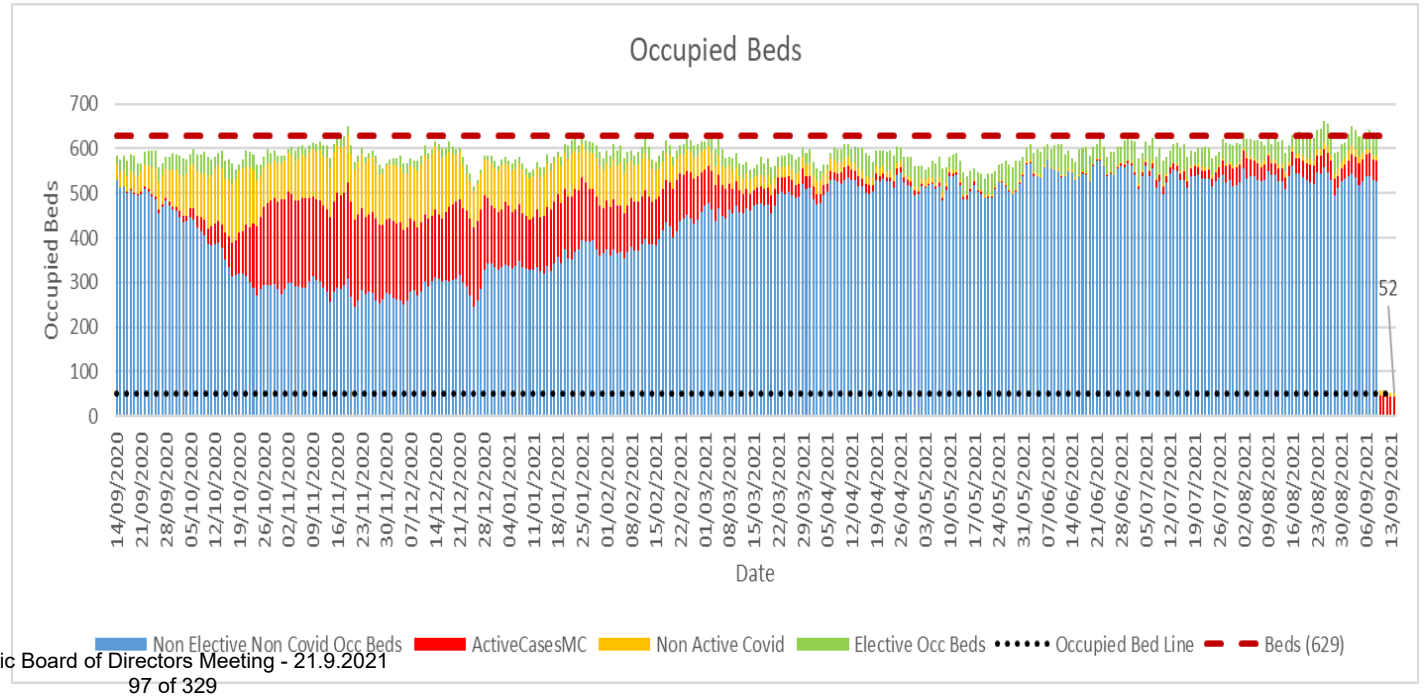
Today

- Operational trends – where are we now
- Planning for Winter
- Elective Delivery
- Summary & Next Steps

C19 Infection & Admission

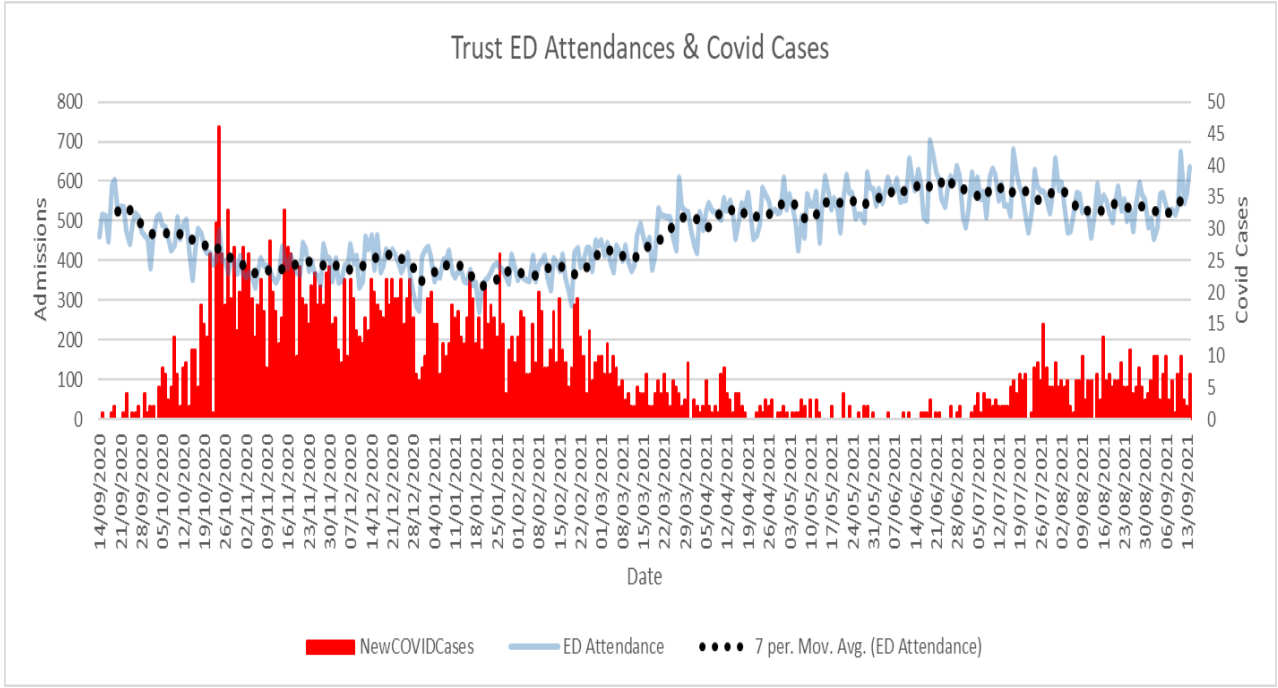
- Covid 19 infections levels steadily increasing and in over 60 age group but admissions steady at 45 - 50.
- Doncaster 422.0 per 100,000 population (7 Sept). Higher than Y&H average and national average (309).
- Total COVID occupancy = 8.2%. Active case occupancy = 6.7%.
- Significant C19 pressures across SYB. Rotherham highest COVID occupancy in country
- Seeing projections of impact on critical care as reported at Board in July

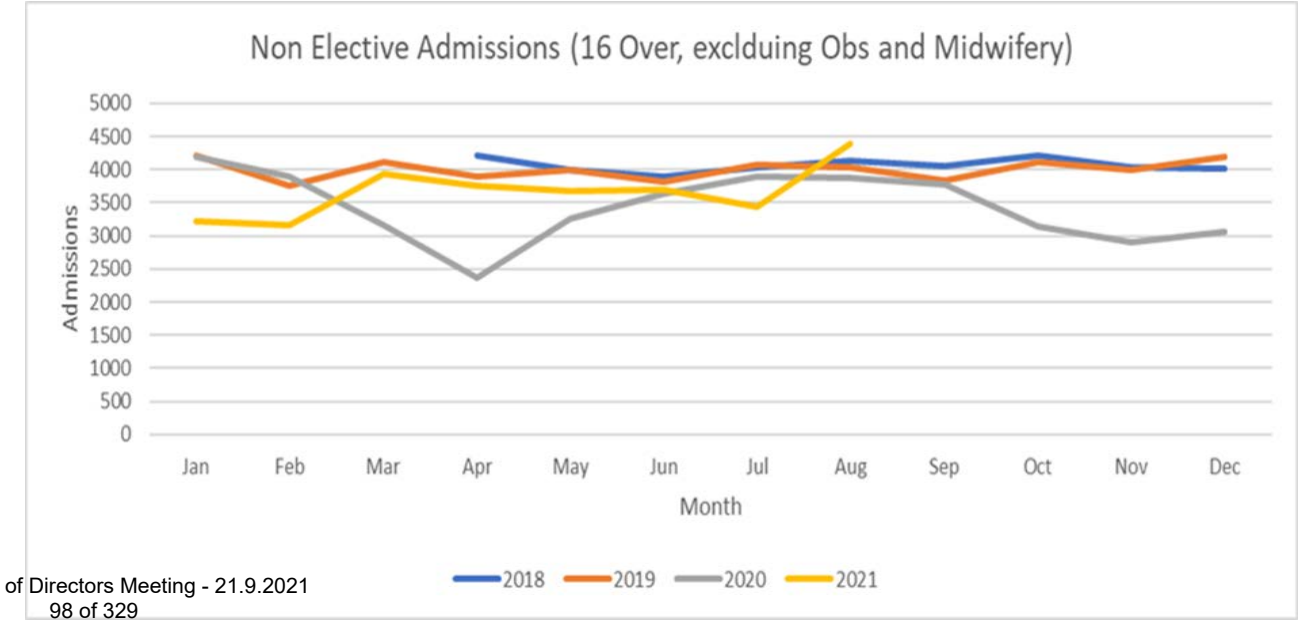




Emergency Flow

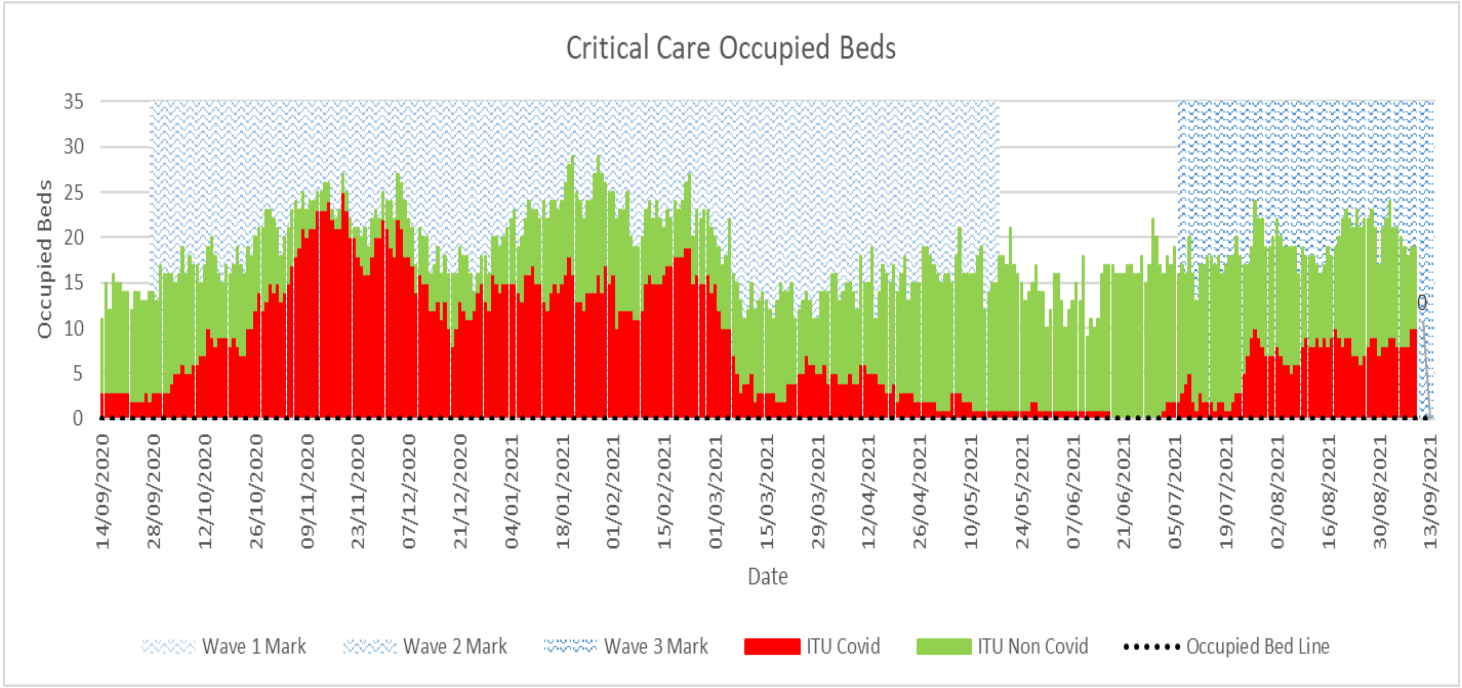
- Continued high levels of ED attendance (esp minors/ paeds) although dropped off a little since summer months
- Actions taken to mitigate pressures in department (space, staff etc) – wider partnership discussions to consider root causes & actions
- Further partnership discussions to reduce attendance
- Non-elective admissions exceeding pre pandemic levels in August – helps inform planning scenarios for winter. Consistently above > 95% occupancy
- Significant capacity constraints due to Major Incident
- 19 surgical adult emergency beds down through moves & 23 paediatric beds down
- Significant numbers of children transferred as per partnership agreement





Critical Care

- C19 numbers significant again – 8 – 10 patients. Surge required
- Network under pressure
- Challenged workforce position
- Full action plan & request for mutual aid



Winter – Our Projections

- **For adults:** A doubling of C19 demand through autumn / winter - roughly 100 -120 beds to be occupied by COVID-19 patients (15-16% occupancy).
- 20 critical care C19 patients projected (double current number).
- We can expect higher than “pre-COVID-19 normal” year for winter. Already non elective admissions surging beyond previous years – July and August
- Regional clinical intelligence indicates we can anticipate a significant flu season. PHE modelling indicates an increase of 50% on 2019/2020 which will impact early.
- Some elective demand converting to emergency – especially urology and general surgery
- Significant staffing challenges related to pandemic
- **For children:** RSV surge predicted to increase demand by 25- 50% on “normal” pre COVID levels. To commence August, peak in November
- Regional mutual aid and solutions will be an essential part of the winter plan, alongside considering any alternatives to admission.
- Modular ward for paeds arrives 8 December

Winter Plan – Next Steps

Internal Plan

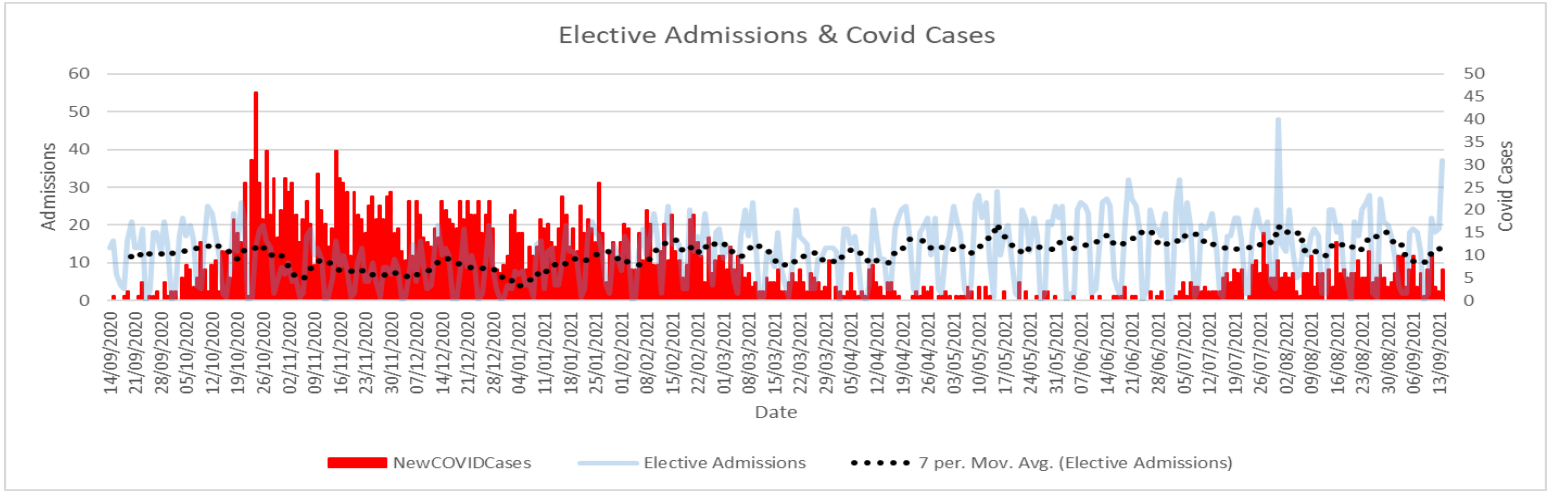
- Make a decision on capacity recommendations (by end of September) (includes Short Stay Emergency Care, additional IP capacity and relocation of discharge lounge)
- Make a decision on divisional bottom up schemes to support flow
- Develop the integrated urgent and emergency care improvement plan (length of stay, discharge etc)
- Get the basics right – optimise site management, escalation processes etc
- Individual divisions to take “next steps” actions specific to their department – ie surgery / paediatrics

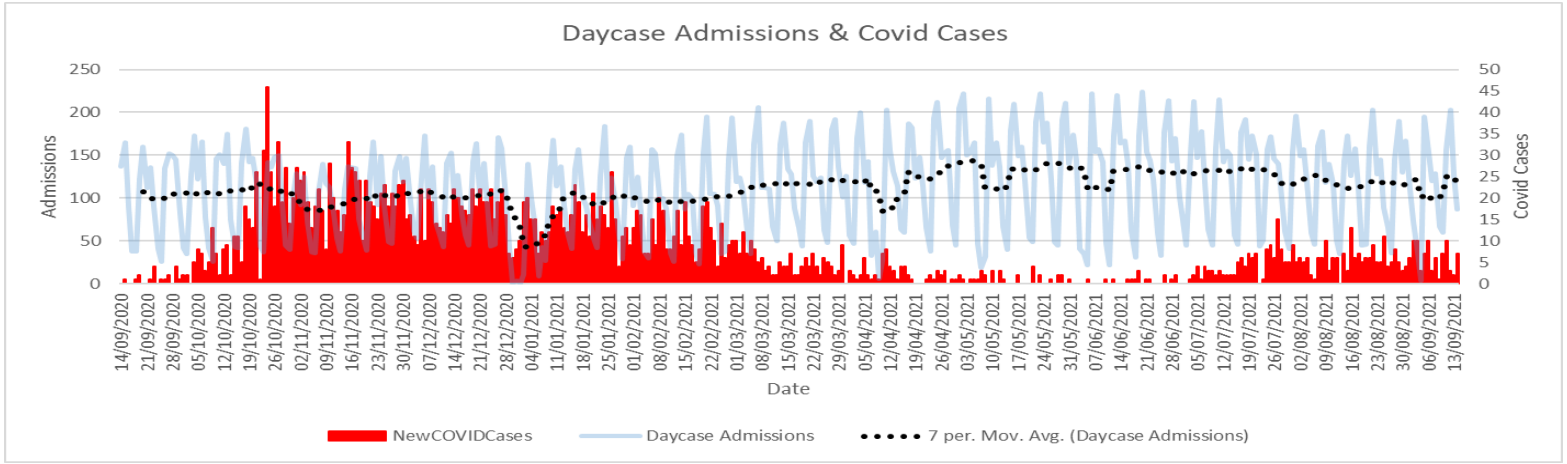
Partnership Plans

- Formalise “grippy” plans with partners – will need clear, identified capacity & further support with discharge and admission avoidance
- Be clear about additional escalation actions ie for C19 (rotas, redeployment etc)

Elective

- Bed capacity & staffing challenges linked to lockdown release key challenge
- Elective activity therefore impacted in common with Trusts across South Yorkshire and Bassetlaw (incl Accelerator)
- Focus on P2, Cancer and long waiters.
- Ongoing support of insourcing work in eyes, oral and endoscopy.
- Diagnostic position particularly challenged – focus on Radiology
- Slight increase in 52 week wait patients – around 1255 (mid Sept)
- Benchmarking data indicates many NEY Trusts challenged

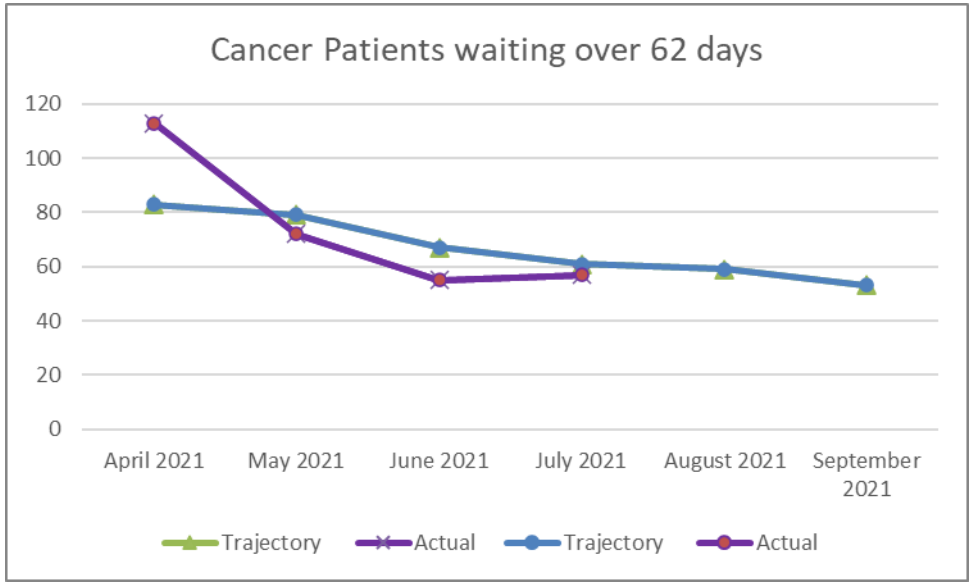




	Apr-21		May-21		Jun-21		Jul-21		Aug-21	
	Target	Achievement	Target	Achievement	Target	Achievement	Target	Achievement	Target	Achievement
OP New	77%	83%	88%	87%	84%	87%	95%	87%	95%	88%
OP Follow Up	77%	85%	88%	88%	84%	87%	95%	91%	95%	88%
Elective	77%	65%	88%	85%	84%	86%	95%	63%	95%	66%
Daycase	77%	92%	88%	94%	84%	91%	95%	96%	95%	86%
Trust	77%	82%	88%	89%	84%	87%	95%	85%	95%	82%

Cancer

- Cancer Performance – continue to make good progress- reducing > 62 day waiters in line with Trust plan submission
- Breast 2 ww position now at 93.9% in July – improved again & excellent recovery
- Faster Diagnosis Standard 73.6% (July) against 75% standard - improving
- 62 day position, improving in line with trajectory – now > 80%. Expected recovery to over 85% by September
- Cancer >104 day waiters – handful – managed at patient level – in line with trajectory
- Cancer indicators “green” on NEY benchmarking



Summary

1. Demand growing nationally & locally – C19, emergency, ED attendance & referrals. DBTH and system under significant pressure. Focus on quality & sustainability.
2. Covid causing significant workforce absence issues, major risk for service delivery.
3. Respiratory Syncytial Virus (RSV) is impacting for paeds – as anticipated, mutual aid arrangement essential. Will continue to grow to November.
4. Capacity constraints caused by major incident a significant issue in managing flow.
5. Flu, Covid and broader non elective admission patterns indicate a tough winter ahead.
6. Plan for winter developed with teams. 2nd workshop in September - focus on redesign, improving length of stay, discharge practice etc.
7. Formalising and extending partnership plans for winter critical to build on internal plans & meet projected demand
8. Pressures have had impact on elective delivery. For July 85% of 1920 value & 82% in August against plan of 95%. Benchmark " in the pack" but challenging & below plan.
9. Progress in many areas of elective activity. Further work for Radiology and Collaborative solutions across region on challenged areas. Good progress on Pre-Operative Assessment.
10. Good progress on reducing cancer waits – excellent work from cancer teams
11. Significant progress on 52 week waits thus far but now under pressure – collaborative solutions essential
12. Prepare for winter & look to spring – be ready for when we can commence recovery more fully

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Report Cover Page			
Meeting Title:	*Board of Directors*		
Meeting Date:	*21st September 2021*	**Agenda Reference:**	**E4**
Report Title:	**INTEGRATED QUALITY & PERFORMANCE REPORT (IQPR) / Performance Exception Report (June 2021)**		
Sponsor:	*Rebecca Joyce – Chief Operating Officer*		
Author:	*Julie Thornton – Head of Performance*		
Appendices:	Appendix 1 – Capacity Plan Achievement Appendix 2 – ERF Achievement		
Executive Summary			
Purpose of report:	To provide assurance to the Committee that the appropriate actions are being taken to support operational performance across the Trust in terms of recovery and moving towards business as usual.		
Summary of key issues:	The Integrated Quality & Performance Report (IQPR) is split into three parts: 1. At A Glance Charts - showing performance against the set of indicators 2. Performance Exception Report - this analysis is provided by operational teams to outline performance against the three main areas of focus; elective, emergency and cancer performance. 3. Summary to show speciality level activity against % value of 2019/2020 in line with the Elective Recovery Fund Requirements. The report has now been refreshed in light of the 21/22 National Planning Guidance. Headlines from June 2021 report include: **Elective** • For 2021/2021, activity will be monitored against: - Performance against agreed Trust capacity plan (appendix 1) - Performance against Elective Recovery Fund (ERF) - % value 2019/20 (appendix 2) - Performance against % activity of 2019/20 – Accelerator Programme • **Elective Recovery Fund** – in June 2021 the Trust achieved 87% of the 2019/20 activity value against a target of 84% • **52 Week Breaches** – in June 2021 the Trust reported 1210 breaches due to Covid 19 delays, down from 1433 at the end of May 2021. Regional benchmarking indicates that DBTH have 3% of the PTL waiting over 52 weeks, and a falling trend, which is benchmarked as "green" in the range across the region. • **RTT** - in June 2021 the Trust delivered 71.6% performance within 18 weeks, below the 92% standard. This is an improvement from last month and ahead of the most recent peer and national benchmarking position.		

	• **Diagnostics** – in June 2021 the Trust achieved 54.31% against a target of 99%. This is a reduction from last month and continues to be below the national and peer benchmark. There is a specific focus on recovering the Radiology position. **Emergency** • **Emergency Care Bundle –** The Trust are currently shadow monitoring the new standards and awaiting the performance thresholds to be issued from NHS England • **4 Hour Access** – in June 2021 the Trust delivered 78.1% achievement against national target of 95%. The attendance for June was the highest ever, and 25% higher than June 2019. Performance for the month is below the national benchmark and slightly below the peer benchmark. A wide ranging action plan is in place. • The Trust are reporting 3 x 12 hour trolley breaches in June 2021 (1 x June / 2 x May 2021) due to patient volume and bed pressures and symptomatic of the overall pressure the urgent and emergency care system is under. • **Ambulance Delays -** There are continued challenges related to COVID 19 pressures and a continued increase of ambulance conveyances. This is similar to challenges in other North East and Yorkshire Trusts. A joint action plan for DBTH and YAS is in place and a set of agreed actions between EMAS and DBTH. • **Length of Stay** for non-elective patients has increased slightly in during June 2021. Focused work with partners is ongoing to improve complex discharge pathways. • **Stroke –** for April 2021 reporting, all standards were delivered with the exception of direct admission within 4 hours to the Stroke Unit (47.9% against a standard of 75%). **Cancer** • **Faster Diagnosis Standard –** In May 2021 the Trust achieved 70.7% against the performance target of 75% • **31 Day Standard – i**n May 2021 the Trust achieved 3 out of 3 nationally reported measures, exceeding peer and national benchmarks. • **62 Day Standard -** in May 2021 the Trust achieved 1 out of 2 nationally reported measures. • The Trust is **on track with its improvement trajectories** to reach the required reduction in over 62 day open pathways improvement on cancer pathways. • **Open Pathways over 104 Days –** in May 2021 the number of open pathways increased from 5 to 12, and the data is indicating this will increase further for June 2021 due to complex pathways. **Conclusions and Next Steps** For elective and cancer performance, the key next steps of the restoration strategy are:

	• The progress since April should be noted – there has been a significant step up of activity, delivery of the elective plan, and improvement in particular on cancer performance and reduction of over 52 week waiters. • The ongoing focus on "getting the basics right" remains the right strategy • The key focus is improving access to Radiology and other key enablers to the elective pathways. From an emergency perspective, the key next steps are: • Developing the bed and capacity plan for September onwards. This will focus on both additional capacity & improving systems and processes, working internally and with place partners. • Working to improve key metrics such as ambulance handover and planning for the Emergency Care Bundle standards and supporting monitoring arrangements • Communicating with the public to promote appropriate use of care facilities and support health promotion messaging around vaccination & responsible behaviour to mitigate against growing Covid demand and the potential impact for patients requiring emergency and elective care.
	The Committee is asked to note and comment as appropriate on the attached.

Action Require:	Approval	Information	Discussion	Assurance	Review
				X	

Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**
	To provide outstanding care for our patients *X*	*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 made – risks regarding elective restoration which this report reflects are outlined on the BAF*
Corporate risk register:	*Report regards Risks ID 6 and 2349 on the Risk Register - F&P 6 and F&P 8.* • *Failure to achieve compliance with performance and delivery aspects of the SOF, CQC and other regulatory standards* • *Failure to specifically achieve RTT 92% standard* *Report outlines actions plan to make progress, no change to risks on CRR*
Regulation:	*Report links to national quality and access standards. Performance against the standards contributes to the CQC regulatory framework.*
Legal:	*Report outlines performance against standards, published annually by NHS England, some of which are outlined in the NHS Constitution.*
Resources:	*Impact on resources of delivering activity taken account of in Trust plans*

Assurance Route			
Previously considered by:	Finance & Performance Committee		
Date:	26.7.2021	**Decision:**	
Next Steps:	Continued monitoring of recovery & associated action plans at Finance & Performance Committee		
Previously circulated reports to supplement this paper:			

Report Cover Page			
Meeting Title:	Board of Directors		
Meeting Date:	21st September 2021	**Agenda Reference:**	**F1**
Report Title:	Target Operating Model, South Yorkshire and Bassetlaw Pathology Service Outline Business Case		
Sponsor:	Marie Purdue, Director of Strategy & Improvement		
Author:	South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) Pathology Transformation Programme Team		
Appendices:	Appendices are available on request		

Report Summary	
Purpose of report:	This Outline Business Case (OBC) describes the recommendations to transform pathology services across South Yorkshire and Bassetlaw (SYB) and seeks approval to proceed and develop a Full Business Case (FBC) that will further assess and finalise proposals for the proposed configuration of pathology services (the Target Operating Model) as described in the attached paper.
Summary of key issues/positive highlights:	• Recommendations in this OBC are made following an inclusive and comprehensive process involving many stakeholders • The proposed operating model will reduce variation across acute hospitals, resulting in more sustainable, high quality and innovative laboratory medicine solutions to patients, clinicians and partners to improve health, add value to patient care, safeguard best clinical outcomes and support the transformation of healthcare across SYB and beyond • The model will deliver efficiency savings (estimated to be circa £5.155m per annum). The model will therefore deliver against the objectives and strategy described in Lord Carter's Review on productivity in NHS hospitals, NHS Improvement's (NHSI) Model Hospital Programme and the NHS Long Term Plan. • It is envisaged that following further detailed work in developing the FBC and continued dialogue between NHS partners, further clarity will be obtained providing non-recurrent transitional costs and greater certainty of the savings which can be achieved through service reconfiguration.
Recommendation:	A request is made to the Board to approve the Outline Business Case and the move to Full Business Case that includes the • The formation of the pathology network is configured as described in this economic case as the recommended Target Operating Model • The SYB Pathology Service is established between the five partner Trusts as a Hosted Network, operating as a single service, with STHFT as the Host Organisation. • A Pathology Partnership Board and Operational Team should be appointed to lead delivery of the substantial reconfiguration of services as described in the recommended target operating model of this OBC •

Action Require:	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:	None
Corporate risk register:	Positive impact
Regulation:	Positive impact
Legal:	No impact
Resources:	Financial analysis in case

Assurance Route			
Previously considered by:		Trust Executive Group	
Date:	9th August	**Decision:**	For information and discussion
Next Steps:		N/A	
Previously circulated reports to supplement this paper:		N/A	

South Yorkshire and Bassetlaw Integrated Care

Target Operating Model
South Yorkshire and Bassetlaw Pathology Service

Outline Business Case
V 2.0




August 2021

Document Control

Version History

Version No	Date	Description of Most Significant Amendments	Editor
V1.0 Draft	Oct 2020	Initial draft shared with all NHS FTs	N/A
V1.1 Draft	12/11/2020	OBC document restructured to improve flow and ensure all necessary content included	Andy Turner
V1.2 Draft	27/11/2020	Economic Case - Output from Reference Groups covering Blood Sciences, Microbiology and Histopathology (11 pages) included in Appendices. Commercial Section - further developed which now includes content describing SYB Pathology Partnership Board. Finance Section - restructured to improve flow and overall structure. Management Case - Workforce and Organisational Development Strategy copied out into Appendices	Andy Turner
V1.3 Draft	08/12/2020	Strategic Case – Future development of ICS added and additional enablers added.	Andy Turner
V1.4 Draft	26/03/2021	Links provided to relevant documentation in 'description of further proposed changes table'. Strategic case – updated information added in key enablers section. Optimal configuration updated with latest information	Sarah Bayliss
V1.5 Draft	20/04/2021 04/05/2021	Strategic Case – added in Independent Review of Diagnostic Services. Governance structure illustrations updated on Page 19 and Page 43. Enablers – Wording added referring to the proposed work on standardisation. Most significant risks updated from latest Risk Register. Financial Case – Gain and Risk Share Proposals section updated following approval at DoFs meeting in April 2021.	Andy Turner
V 1.6 Draft	20/06/2021	Strategic case – MSC section updated and QMS section added Economic case – model and site recommendations updated with evaluation criteria and scoring (subject to ESB agreement 23 June). Financial case – costs updated to reflect latest workforce plans recommended by reference groups and detailed wording as agreed by Finance Group Management case – updated with proposed management and programme posts and KPIs	Sarah Bayliss
V 1.7 Draft	27/6/21	Updated following discussion of TOM at ESB 23/6/21 and AfCE 05/7/21	Sarah Bayliss
V1.8 Draft	05/07/21	Finance section updated	Julie Broscomb
V1.9 Draft	26/07/21	Figures and Tables numbered, updates made following ESB feedback	Jean Wardell
V1.10 Draft	28/7/21	Minor updates following discussion at ESB and AF CEO meetings and to reflect latest information on LIMS and Digital Pathology funding	Sarah Bayliss

Review Control

Reviewer	Date	Comments	Actions Agreed
ESB	23/06/21	Draft Outline Business Case v1.6 shared for comment whilst recognising work continues to finalise the business case.	
ESB	06/07/21	Draft Outline Business Case v1.7, with updates following the ESB meeting held 23/6/21 and AF CEO meeting held 05/7/21. ESB members asked to share with appropriate senior colleagues for comment whilst recognising work continues to finalise the business case	Take updated draft to CIC before submission to September Trust Boards
ESB	04/08/21	Draft Outline Business Case v1.10 with updates following the ESB and AF CEO and Committees in Common meetings held 2/8/21	ESB to discuss Draft OBC with Trust Executive Teams and provide final comments by 16/8/21
ESB	25/08	Final OBC V1.11 for submission to Trust Boards	Taken to ESB 25/08/21

Contents

1. LIST OF ABBREVIATIONS

Abbreviation	Full Description
AfC	Agenda for Change
AF CEOs	Acute Federation Chief Executive Officers
AHCS	Academy for Healthcare Science
AI	Artificial Intelligence
BH	Bassetlaw Hospital
BHFT	Barnsley Hospital NHS Foundation Trust
BMS	Biomedical Scientists
BRILS	Barnsley and Rotherham Integrated Laboratory Service
BSRG	Blood Sciences Reference Group
CCG	Clinical Commissioning Group
CDH	Community Diagnostic Hub
COSD	Cancer Outcomes Services Dataset
CRHFT	Chesterfield Royal Hospital NHS Foundation Trust
CSL	Central Service Laboratory
DBTHFT	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
DHSC	Dept. of Health and Social Care
DRI	Doncaster Royal Infirmary
ESL	Essential Service Laboratory
EESL	Extended ESL – an ESL with wider repertoire
ESB	Executive Steering Board
ETS	Extension to Scope
FBC	Full Business Case
FYFV	Five Year Forward View
GIRFT	Get It Right First Time
GLH	Genomic Laboratory Hub
GMC	General Medical Council
HCPC	Heath and Care Professional Council
HEE	Health Education England
HODS	Haemato-oncology Diagnostic Service
HRG	Histology Reference Group
HSST	Higher Specialist Scientific Training
IBMS	Institute of Biomedical Scientists
ICP	Integrated Care Partnership
ICS	Integrated Care System
LIMS	Laboratory Information Management System
LoA	Letter of Agreement
LTP	Long Term Plan
Mini-CSL	Blood Sciences EESL plus Microbiology secondary laboratory
MoU	Memorandum of Understanding
MRG	Microbiology Reference Group
MSC	Managed Service Contract
MSCa	Modernising Scientific Careers
MDTM	Multi-disciplinary Team Meeting
NEPSEC	North of England Pathology and Screening Education Centre
NEY	North East & Yorkshire

Abbreviation	Full Description
NGH	Northern General Hospital
NHSE/I	NHS England / Improvement
NMC	Nursing & Midwifery Council
NSHCS	National School for Healthcare Science
OB	Operational Board
OBC	Outline Business Case
OOH	Out of Hours
OT	Operational Team
PACS	Picture Archive and Communications System
PCN	Primary Care Network
PDT	Programme Delivery Team
POCT	Point of Care Testing
PPB	Pathology Partnership Board
PQAD	Pathology Quality Assurance Dashboard
PRU	Protein Reference Unit
PTPB	Pathology Transformation Programme Board
PTP	Pathology Transformation Programme
PracTP	Practitioner Training Programme
QMS	Quality Management System
RCPath	Royal College of Pathologists
RDS	Rapid Diagnostic Service
RHH	Royal Hallamshire Hospital
SCFT	Sheffield Children's NHS Foundation Trust
SCH	Sheffield Children's Hospital
SOF	Single Oversight Framework
STHFT	Sheffield Teaching Hospitals NHS Foundation Trust
STP	Scientist Training Programme
SYB	South Yorkshire & Bassetlaw
SYBND	South Yorkshire, Bassetlaw and North Derbyshire
TOM	Target Operating Model
TRFT	The Rotherham NHS Foundation Trust
UKAS	UK Accreditation Service
WSI	Whole Slide Images

2. EXECUTIVE SUMMARY

This Outline Business Case (OBC) describes the recommendations to transform pathology services across South Yorkshire and Bassetlaw (SYB) and seeks approval to proceed and develop a Full Business Case (FBC) that will further assess and finalise proposals for the proposed configuration of pathology services (the Target Operating Model) as described in this paper.

Recommendations in this OBC are made following an inclusive and comprehensive process involving key staff from all SYB providers, commissioners, service users, and other stakeholders with the aim of improving lives and safeguarding best clinical outcomes by delivering high quality, innovative laboratory medicine solutions.

The proposed operating model will reduce variation across acute hospitals, resulting in more sustainable, high quality and innovative laboratory medicine solutions to patients, clinicians and partners to improve health, add value to patient care, safeguard best clinical outcomes and support the transformation of healthcare across SYB and beyond. The model will deliver efficiency savings (estimated to be circa £5.155m per annum). The model will therefore deliver against the objectives and strategy described in Lord Carter's Review on productivity in NHS hospitals[1], NHS Improvement's (NHSI) Model Hospital Programme[2] and the NHS Long Term Plan[3]. It is envisaged that following further detailed work in developing the FBC and continued dialogue between NHS partners, further clarity will be obtained providing non-recurrent transitional costs and greater certainty of the savings which can be achieved through service reconfiguration.

The OBC follows the NHSI guidelines using the stepwise, systematic Five Case Model[4].

Strategic Case Summary

Pathology is a fundamental diagnostic and prognostic service that supports every aspect of patient care[5]. Pathology services across SYB provide a wide range of both routine and specialist services and offer an extensive nationally and internationally recognised portfolio of services and expertise.

The NHS Five Year Forward View[6] and the NHS Long Term Plan[3] have both identified a need to improve efficiency and productivity across the NHS. In recent years there have also been numerous national reports on pathology services, the most significant of which are Lord Carters Independent Review of NHS Pathology Services in England (2008)[7] and Review of Unwarranted Variation in Operational Performance and Productivity in English Acute Trusts (2016)[8]. These reports advocate the consolidation of pathology services across England as a means of improving both service quality and cost effectiveness.

Following these reports NHSI recommended the formation of 29 pathology networks across England with pathology services delivered within each network on a 'hub and spoke' basis and estimated that £200m savings could be achieved by implementation of this model. NHSI proposed that a 'North 6' network should be established corresponding to the footprint of the SYB ICS, and named STHFT as the hub for the network. There is an expectation that all 29 networks are established and starting to release benefits during the 2021/22 financial year.

In April 2018 the constituent Trusts of the SYB ICS signed a Memorandum of Understanding to agree to implement a common strategy to network pathology service and to work together to provide a single pathology service for SYB with the aim of improving sustainability and ensuring services are as cost effective as possible while maintaining high quality patient care. Boards and expert reference groups were established to consider the NHSE recommended model and other possible options for service delivery across SYB. A shared vision and mission was agreed as well as guiding principles against which to evaluate reconfiguration options, and a number of key enablers identified which are critical dependencies for reconfiguration.

Economic Case Summary

A number of options were considered for the organisational form of the SYB network. In Jan 2020, after legal advice, it was recommended that the network should be formed as a single service partnership with a Hosted Network organisational form, with STHFT acting as the Host Trust. This form was perceived to be the most cost efficient model from a tax perspective and importantly, would allow staff to remain within the NHS.

A range of operating model options was also considered:

1. Do nothing
2. Collaborative working with no change to organisational form and operational model
3. NHSI model – a single central service (hub) laboratory with essential service laboratories at all other acute hospital sites
4. Modified NHSI model, with up to two central service laboratories per discipline

The general principles for appraisal of the options were developed by the Transformation Board with the recommended target operating model needing to:

a) Meet the guiding principles
b) Align to the goals of the SYB ICS
c) Meet the requirements set by the NHSI, being aligned with the NHSI concept as well as the operational realities of Pathology in SYB
d) Adhere to the principle of the primacy of clinical quality, safeguarding and future-proofing the standard of clinical care/clinical quality across SYB
e) Deliver maximum consolidation, and projected cumulative financial efficiency as well as resilience, sustainability, ability to adapt to future workload and workforce changes and assured business continuity

After an initial review of these options Option 1 and 2 were discounted. Each expert reference group was then asked to review their discipline and specialties, starting with Option 3 and only considering Option 4 if the NHSI proposed model did not meet the agreed guiding principles and/or clinical requirements. Services were grouped into three clinical disciplines: Blood Sciences, Microbiology and Histology and the groups asked to recommend their target operating and associated workforce models.

The output from the expert groups is a recommendation of the following Target Operating Model:

Hospital Site	Type of Lab	Range of Services
NGH	CSL for Blood Sciences and Microbiology Sp	Main automated lab for Blood Sciences Specialist centre for Blood Sciences All Immunology Main 24/7 lab for Microbiology Specialist centre for Microbiology All Virology Frozen sections Andrology POCT
RHH	ESL Sp CSL for Histopathology	ESL for Blood Sciences Specialist centre for Haematology and Coagulation Specialist centre for Gestational Trophoblastic Disease Frozen sections POCT Main Histology lab processing site and all Histopathologists
SCH	ESL Sp Paediatric PM	ESL for Blood Sciences Specialist centre for Paediatric Biochemistry Paediatric PM Frozen sections Brain smears POCT

Hospital Site	Type of Lab	Range of Services
Rotherham	ESL	ESL for Blood Sciences Frozen sections Andrology POCT
Doncaster	Mini CSL	Extended ESL for Blood Sciences Secondary lab for Microbiology (not 24/7) Frozen sections Andrology POCT
Barnsley	ESL	ESL for Blood Sciences POCT
Bassetlaw	ESL	ESL for Blood Sciences POCT
Chesterfield		Frozen sections

Key:

CSL	Central Service Laboratory
ESL	Essential Service Laboratory
EESL	Extended Essential Service Laboratory undertaking a wider repertoire of automated tests than an ESL (but on ESL equipment) and/or a proportion of primary care work
Mini CSL	EESL for Blood Sciences plus a secondary Microbiology Laboratory
Sp	Specialist Centre

Commercial Case Summary

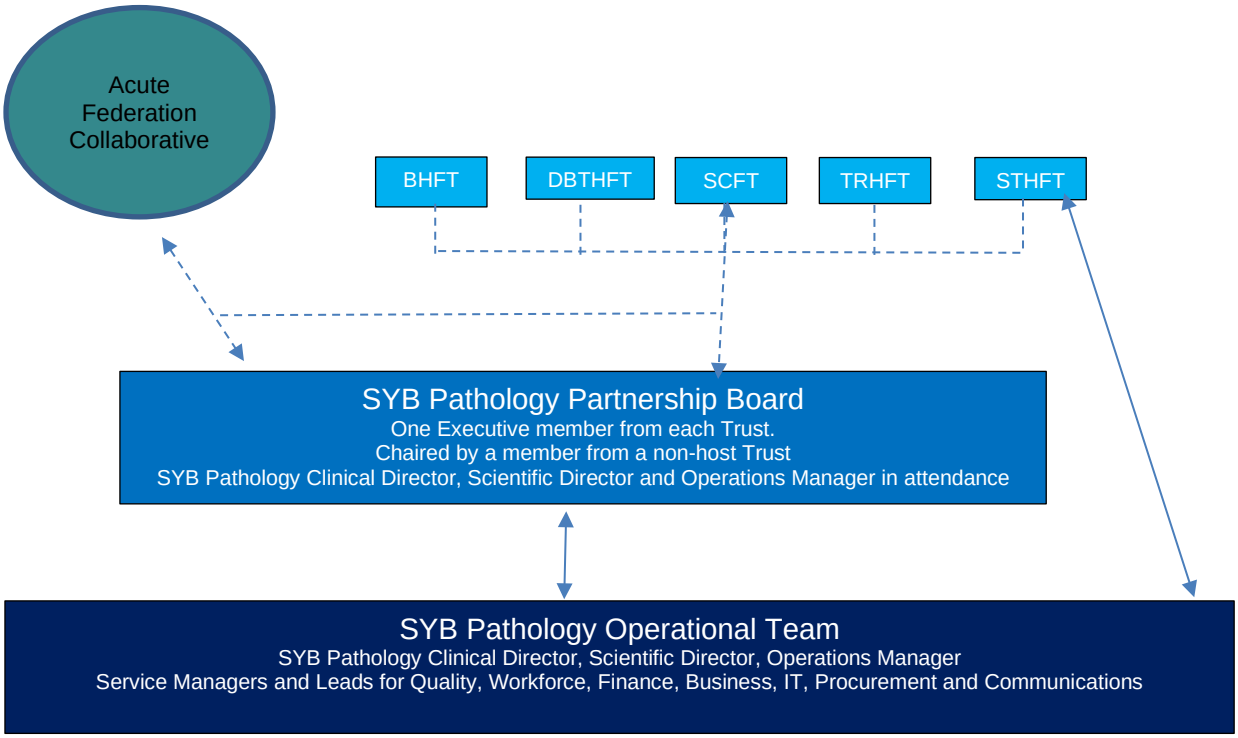
The commercial model provides a framework that will allow all partner Trusts to move towards the recommended TOM, implement agreed priorities and benefit fairly from the qualitative and financial benefits generated through the formation of the partnership. Key to the partnership is a formal Partnership Agreement which is being developed by a legal team and will be signed by all partners.

As a hosted network strategic influence will be retained by all partner Trusts through an SYB Pathology Partnership Board with each partner having executive representation and decision making rights. An Operational Team will operate in accordance with a well-defined, and regularly reviewed, scheme of delegation which will form part of the Partnership Agreement. Each Trust will retain clinical control through the agreed clinical governance structure.

The Partnership Agreement will detail how STHFT will act as the Host, taking the lead on pathology services across the network and will include:

- the resources and services that will be transferred from non-host Trusts to STHFT
- transfers of pathology staff from non-host Trusts to STHFT at the point in time when there is a change to service provision under the terms of the 'Transfer of Undertakings (Protection of Employment) Regulations' (TUPE)
- the transfer of pathology assets from non-host Trusts to STHFT (including contracts, IT systems and liabilities)
- the commissioning contracts that are to be transferred to STHFT (depending on status)
- an approved Scheme of Delegation to allow the network to operate with a degree of autonomy and governance arrangements in accordance with the standing orders and scheme of delegation of the Host Trust

The recommended Governance and Management arrangements for the network are:



Financial Case Summary

The recommended TOM and associated workforce models are expected to take between 2 to 4 years to fully implement due to a need to implement the key enablers identified in the strategic summary. It is anticipated that the target workforce model will be achieved by managing turnover and vacancies with no compulsory redundancies.

The estimated pay and non-pay savings on completion of the transition are £5.155m per year.

The costs associated with the identified key enablers have not been included within the current financial modelling. Bids for LIMS and Digital Pathology have been submitted to NHSE&I against capital funding that has recently been made available; the submitted bid for LIMS for 21/22 has been successful subject to an approved Letter of Agreement. The cost implications of all key enablers will be included as part of the financial modelling in a Full Business Case.

Risk & Gain Share principles for the network have been agreed, based on cost information following agreed adjustments (baseline costs). The agreed percentages in the Risk & Gain share will be used to distribute savings / surplus income within SYB Pathology Services as a consequence of implementing the Full Business Case.

	BRILS	DBTH	SCH	STH
Baseline cost for OBC (£m)	**£17,052**	**£12,997**	**£4,912**	**£37,476**
% Share	**24.0**	**17.8**	**6.7**	**51.4**

It is anticipated that there will be non-recurrent / short term costs relating to the transition from current state to the proposed TOM and from the current workforce to the proposed model. As far as possible these costs will be identified in the Full Business Case, and shared in accordance with the Risk and Gain Share principles as appropriate.

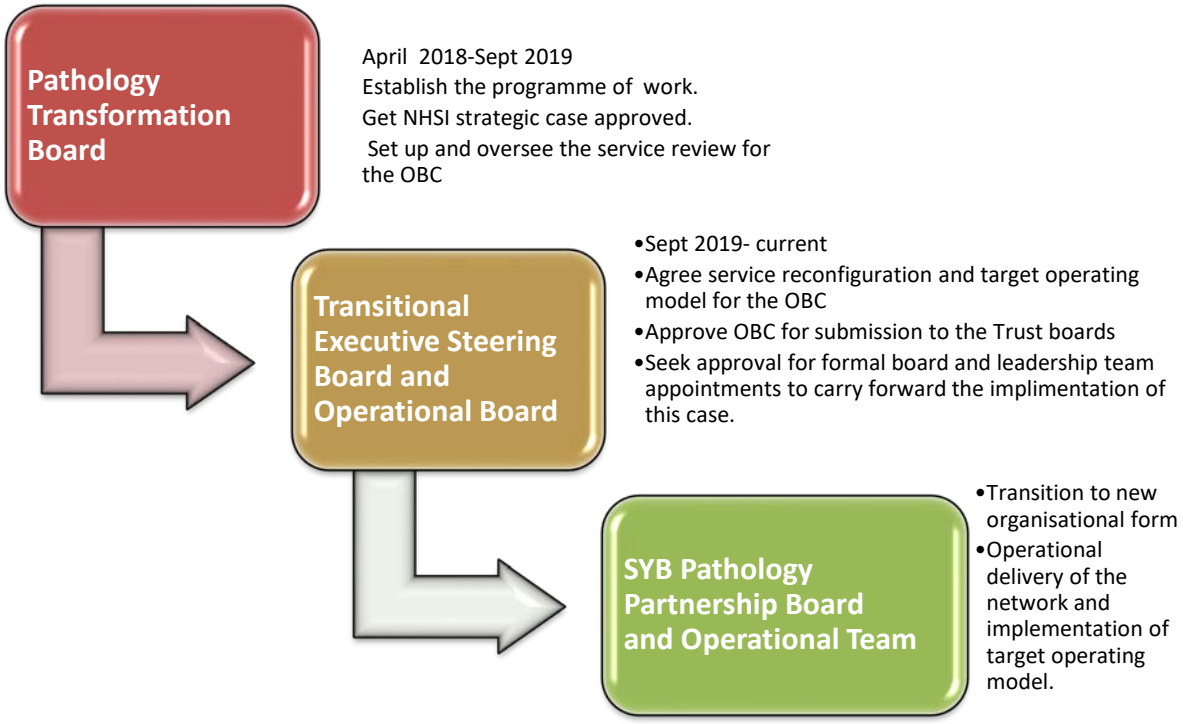
The SYB Pathology network will be treated as a separate trading entity by the Host Trust who will adopt and develop a trading account built around the principle of a trading entity, both for planning and in-year actual trading. It is recommended that the trading entity collects all fully absorbed costs of operating the SYB Pathology Service and

charge users, including the Host Trust, for services received. The trading account will be the main vehicle for reporting financial performance through to the SYB Pathology Partnership Board, and onward to each respective partner Trust Board of Directors

Management Case Summary

Expert reference groups and Boards have recommended the target operating model for pathology services, as a single managed service, across SYB. If the OBC is approved, a Full Business Case will be developed and the groups asked to describe the steps needed to move from the current position to the final recommended TOM. Each Trust will need to share with staff how the business case will be implemented and there will be a need for an integrated staff consultation exercise. A key priority is to ensure a sustainable and stable workforce in SYB; retention of the expertise and dedication from current staff in providing high quality Pathology Services is a priority for the new Service. There will be equal opportunities for all staff to apply for future roles, careful consideration will be given to any proposal which would lead to movement of staff across the SYB Service and there will be no compulsory redundancies.

The development of the network is moving into the finals stages of development, subject to approval of this OBC:



The recommended Governance and Management arrangements for the network are shown in the commercial summary. The proposed structure allows for a responsive service that is well-defined and where the operational team has full control of operations at all sites. This means it will have greater leverage to execute the agreed priorities and objectives to grow as a sustainable pathology service, to meet the clinical needs of the SYB partners and to optimise the effectiveness and efficiency of the service and implement change.

Conclusions and Recommendations

The SYB ICS Pathology Programme team makes the following recommendations for approval by the Trust Boards, these being; BHFT, DBTHFT, TRHFT, SCFT and STHFT:

Title	Description
1. Proposed Target Operating Model	The formation of the pathology network is configured as described in this economic case as the recommended Target Operating Model.
2. STH Hosted Network	The SYB Pathology Service is established between the five partner Trusts as a Hosted Network, operating as a single service, with STHFT as the Host Organisation. This will involve STHFT, as the host organisation, contracting for all the relevant services comprising the pathology network on behalf of the partner trusts. A contractual Partnership Agreement will be in place to assure all five partners and to document how each will be held to account.
3. Pathology Partnership Board and Operational Team	A Pathology Partnership Board and Operational Team should be appointed to lead delivery of the substantial reconfiguration of services as described in the recommended target operating model of this OBC. In order to deliver the scale of change at pace it is recommended that the three senior network appointments are advertised as soon as possible. These appointments should be employed by STH as the network Host with authority to lead the new network on behalf of the partner trusts

3. STRATEGIC CASE

3.1 Introduction

Pathology is a fundamental diagnostic and prognostic service that supports every aspect of patient care. It is the link between science and medicine. The NHS pathology laboratories in the UK[5]:

- handle over 150 million samples per year
- undertake 500 million individual biochemistry and 130 million haematology tests per year
- perform 300,000 tests every working day
- are involved in over 70% of all diagnoses
- are involved in 95% of clinical pathways

In addition, pathology laboratory services support infection control and disease prevention through many links with other departments, clinical specialties and public health programmes. Pathology services support diagnoses and clinical decision making in all care settings including primary care, outpatient consultations, unplanned and planned inpatient care.

Pathology is divided into a number of disciplines and specialties. Some are delivered in every pathology laboratory, others are more specialist and are only provided in a small number of centres. Below is a brief summary of the pathology services currently delivered within SYB.

Table 1 : Current Provision of Pathology Services across South Yorkshire and Bassetlaw

Discipline and Specialties	
Haematology • Routine Haematology • Specialist Haematology • Routine Coagulation • Specialist Coagulation • Haemophilia Reference Centre • Haemato-oncology Diagnostic Service (HODS) • Blood Transfusion • Phlebotomy • Anticoagulant dosing	**Clinical Biochemistry** • Routine Biochemistry • Specialist Biochemistry • Gestational Trophoblastic Disease Services • Toxicology • Lipid and Familial Hypercholesterolemia Service • Paediatric Inherited Metabolic Disease • Adult Inherited Metabolic Disease • New-born screening • Metabolic Bone clinics
Microbiology • Routine Bacteriology • Molecular Bacteriology • Infection Prevention and Control • Antimicrobial Stewardship	**Virology** • Routine Virology (serology) • Molecular Virology • Specialist Virology • Chlamydia Screening
Immunology • Routine Immunology • Specialist Immunology • Protein Reference Unit	**Point of Care Testing (POCT** • All relevant disciplines
Cellular Pathology • Generalist reported Histopathology • Specialist reported Histopathology (including integrated reporting of Genetic and Molecular tests) • Electron Microscopy • Diagnostic Cytology • Frozen sections • Genomic sampling • Semen analysis • Bowel and Breast Cancer Screening Histology • Mortuary Services • Bone Banking	**Genomics (not currently within the scope of this project)** • Molecular Genetics • Genome Sequencing • Bioinformatics • Genetic analysis • Cytogenetics

In addition to the above, there is significant research and development activity across the region. Our pathology teams offer an extensive, internationally recognised breadth of knowledge and expertise in research and

development. Research and development is driven by our expert clinicians and healthcare scientists who continue to publish a large number of research articles each year. We support clinical trials across the UK by providing high quality specialised testing for our research partners. We also support local universities in carrying out clinical quality assessments on their study samples.

Approximately 43% of the workload (by number of tests) of SYB Pathology laboratories is currently generated by GPs or other out-of-hospital services, although the proportion is as high as 57% in Barnsley and Rotherham. However, this varies significantly between Pathology disciplines, with less than 5% of cellular pathology workload generated by Primary Care. Logistics to transport samples from GP practices and other sample collection points to laboratories, and also moving samples between laboratories, is crucial to ensure sample integrity and support timely analysis and reporting. In addition, each pathology service relies heavily on its current Laboratory Information Management System (LIMS) and other pathology specific IT systems.

Pathology tests also vary in frequency of usage from very widely used tests such as full blood counts and liver function tests, through to very specialist and esoteric tests which are generally undertaken only in specialist reference labs. Some pathology results are required very urgently to support diagnoses in A&E; whereas for others 8 hours, 24 hours or even up to 6 weeks is acceptable. The frequency of usage and the required turnaround time are key factors which influence the optimal configuration of laboratories.

3.2 National Context

NHS Five Year Forward View and the NHS Long Term Plan

The NHS Five Year Forward View 2014[6] set out an ambition to address growing demand for health care and reduce the variation in quality of care delivered by NHS services. At the same time, it recognised the need to improve efficiency and productivity in order to address an estimated funding gap of £30billion by 2020/21.

The NHS Five Year Forward View (FYFV) describes how, in order to sustain a comprehensive, high quality NHS, it will be necessary to develop new models of care with greater levels of integration between health and social care, requiring new partnerships with local communities, local authorities and service providers. The FYFV set out an aim of accelerating innovation in new ways of delivering care, as well as a greater emphasis on prevention and earlier diagnosis. This was reiterated in Next Steps on the NHS Five Year Forward View 2017[7] where specific reference was made to the need to ensure pathology services across England deliver the fastest and highest quality possible support to Trusts. The NHS Long Term Plan (LTP) echoes this view and states that by 2021, pathology networks will mean quicker test turnaround times, improved access to more complex tests and better career opportunities for healthcare scientists at less overall cost.

The context of health, care and support is changing, with people living longer, many with multiple and complex needs and higher expectations of what the NHS can and should deliver. The combination of growing demand and continuing financial restraint mean that the NHS is under sustained pressure to realise efficiency savings to address a potential funding gap, estimated at £30 billion by 2020/21. The ongoing COVID pandemic has further highlighted this issue.

Lord Carter Review of Operational Productivity and Performance

There have been numerous reports on pathology in the last 20 years including Lord Carter's Independent Review of NHS Pathology Services in England (2008)[8] and Lord Carter's Review of Unwarranted Variation in the Operational Performance and Productivity in English Acute Trusts (2016)[9]. Lord Carter advocates the consolidation of pathology services as a means of improving both service quality and cost effectiveness. The 2016 Review recommended that all Trusts should achieve the acute pathology model hospital benchmarks by April 2017, or have agreed plans for consolidation with, or outsourcing to, other pathology providers by January 2017. It identified efficiency

opportunities of £5bn across the NHS, a potential contribution of at least 9% on the £55.6bn spent by acute hospitals at that time. In Pathology, it was estimated that the total cost of NHS pathology services was between £2.5bn and £3.0bn per annum and as a broad high-level measure pathology costs as a proportion of trust operating expenditure ranged from less than 1.5% to over 3%.

Development of Pathology Networks

NHS Improvement wrote to all acute Trusts in June 2016 requesting plans for the consolidation of pathology across STP footprints. In September 2017 the National Pathology Implementation and Optimisation Delivery Group signalled to all acute hospital trusts in England that they would need to change how they work and collaborate to drive out unwarranted variation in pathology services. NHSI also published a document 'NHSI Operational Productivity – Proposed Pathology Consolidation Networks'[10] which recommended the formation of 29 pathology networks across England with all Trusts (excluding specialist) allocated to one of the networks, allowing for the transformation of pathology services into a series of networks across the country. Specialist Trusts were subsequently allocated to their geographical networks in December 2017. The recommended network for SYB was initially named as 'North Mid 1' and later as 'North 6'. NHSI set a requirement for Trusts to respond by the end of January 2018 with plans for taking forward local reviews

The NHSI model conceptualised pathology networks as 'hub and spoke' models (later termed central service laboratory - CSL, and essential service laboratory – ESL), and estimated £200m of annual savings could be achieved by the formation of networks and the central service laboratory delivering the high volume and more complex tests, whilst preserving essential laboratory services relevant to the clinical services delivered on each hospital site.

NHSI proposed that the 'North 6' Pathology network be made up of the following Trusts and Pathology services, corresponding with the footprint of SYB ICS, and named Sheffield Teaching Hospitals FT (STHFT) as the hub or central service laboratory for the SYB network:

- Barnsley Hospital NHS Foundation Trust (BHFT) part of the Barnsley and Rotherham Integrated Laboratory Service (BRILS)
- Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTHFT)
- The Rotherham NHS Foundation Trust (TRFT) part of the Barnsley and Rotherham Integrated Laboratory Service (BRILS)
- Sheffield Children's NHS Foundation Trust (SCFT)
- Sheffield Teaching Hospitals NHS Foundation Trust (STHFT)

In April 2018 the five Trusts formally signed a Memorandum of Understanding (MoU) to agree to implement a common strategy to network pathology services with the aim of improving sustainability and ensuring services are as cost-effective as possible whilst maintaining high quality patient care.

The MoU recognised that, in order to align the regional cancer services with the South Yorkshire, Bassetlaw and North Derbyshire Cancer Alliance, and with typical patient flows, Chesterfield Royal Hospital NHS FT (CRHFT) would have an interest in the network arrangements. The CRHFT Histopathology Service merged with STHFT Histopathology in October 2018.

NHSI have subsequently published two updates to this report – NHSI Pathology Networking in England 2018: the State of the Nation[11] and NHSI Pathology Networking in England 2019 : the State of the Nation[12], which give an update on where each of the proposed networks are in their implementation as of 2018 and 2019 respectively.

The first tranche of pathology networks is now fully operational and the expectation set out in the NHS LTP is that the rest will be established and starting to release benefits during the 2021/22 financial year.

Independent Review of Diagnostic Services for NHS England

In October 2020 a Report of the Independent Review of Diagnostic Services for NHS England[13] led by Sir Mike Richards was published calling for significant investment and reform of diagnostic services. The report refers to how the Covid-19 pandemic has further amplified the need for radical change in the provision of diagnostics, whilst recognising the opportunities for change in how these services are delivered. Recommendations include a major drive to expand the pathology workforce, specifically Consultant Histopathologists, Advanced Practitioners and other Healthcare Scientists, with an emphasis on skill mix. The report also calls to improve connectivity and digitisation across all aspects of diagnostics to drive efficiency, deliver seamless care across traditional boundaries and to facilitate remote reporting. NHS Digitals work on developing and implementing a standardised universal test list across all diagnostic disciplines (pathology, imaging, endoscopy and cardiorespiratory services) should also be accelerated. The SYB Pathology Programme Delivery Team aims to access any national funding made available to support these proposals and has submitted bids for revenue and capital funding for:

- CliniSys ICE electronic requesting at Sheffield Children's Hospital and interfacing to STH LIMS – capital awarded and project progressing to plan
- Upgrade of existing CliniSys ICE systems to v8.2 with ICE Enterprise SYB – capital awarded but project not progressing due to concerns over deliverability of the product and benefits realisation
- Network Leadership roles – fixed term revenue awarded
- Single SYB Laboratory Information System (LIMS) – capital awarded for 20/21 subject to approved LoA
- Digital Pathology – awaiting outcome

3.3 Local Context

South Yorkshire and Bassetlaw Integrated Care System (SYB ICS)

The South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) formally launched as an "ICS" in October 2018. It has been working as a partnership for well over two years, first as a Sustainability and Transformation Partnership, then as a first wave Accountable Care System and now, as one of the leading ICSs in the country.

The SYB ICS is a partnership of 23 organisations responsible for looking after the health and care of the 1.5 million people living in Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield. It is made up of NHS organisations local authorities and key voluntary sector and independent partners in the SYB region.

Figure 1 : Size and scale of the South Yorkshire and Bassetlaw Integrated Care System

NHS partners (*Appendix A*), with support from other statutory bodies in the region, join forces where it makes sense to do so and where it makes a positive difference to patients, staff and the public. The SYB ICS aim is to break down organisational barriers in order to wrap support, care and services around people as individuals and positively change lives. The Chief Executives from each of the partner Trusts work in collaboration as the Acute Federation of Chief Executives.

The SYB ICS Five Year Plan[14] focuses around four key ambitions:

- Developing a population health system
- Strengthening our foundations
- Building a sustainable health and care system
- Broadening and strengthening our partnerships to increase our opportunity

It also identifies five areas of particular focus to improve population health and reduce inequalities:

- Best start in life
- Reduce harm from smoking, alcohol and obesity
- Improve cardiorespiratory health
- Improve mental health and wellbeing
- Early diagnosis and increased survival from cancer

Cancer

An ageing population and a rise in lifestyle related risk factors mean that the number of people being affected by cancer is increasing. There are currently 14,000 people being treated for cancer each year in SYB and this is expected to increase to 18,000 by 2030[14]. The vision of the ICS is to work together to reduce the risk of people developing cancer, quickly diagnose and treat those who do, and develop services based around the whole person, not just their cancer. To do this, teams will work together as the South Yorkshire, Bassetlaw and North Derbyshire Cancer Alliance as well as continuing the partnership with Macmillan's Living With and Beyond Cancer team to support the overall vision of the ICS and better care for and support people with cancer and their families across the SYB region.

Urgent and Emergency Care

The ICS vision for urgent and emergency care in SYB is to ensure there is high quality primary and community urgent care services (for treating non-life threatening injuries or conditions) and for the urgent and emergency care services within SYB hospitals to be the best, with world-class facilities and the specialist expertise to treat and care for those with serious or life threatening emergency needs. To achieve this a holistic approach to services is being taken, looking at them as a whole and not just in individual Places, to make sure services are fit for purpose, sustainable and are meeting the needs of the SYB population.

Integrated Care Partnerships

Partners in each of the 5 Places (Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield) are working together to improve health and care and have developed Integrated Care Partnerships to do this. Each Integrated Care Partnership (ICP) has a Local Plan that sets out how partners will play their part in helping everyone to have the best start and a healthier life and details their priorities for the coming years in relation to integration and improving the health and wellbeing of people in their local area. Each Plan has been developed by local doctors, hospital chief executives, clinical commissioners, council officers and patient and voluntary sector groups. The development of Place based plans will have a direct impact on the provision of Pathology Services across the SYB region.

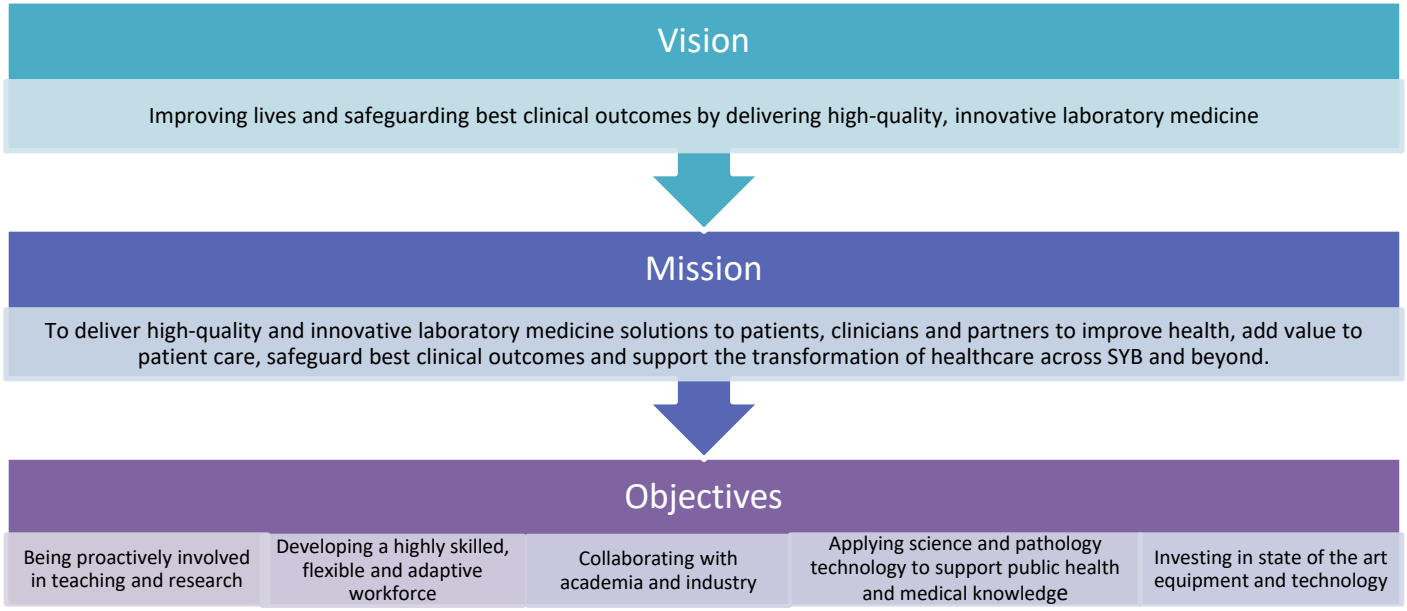
Further development of the ICS

NHS England has confirmed that 11 more parts of the country will be formally designated integrated care systems from 1 April 2021 serving a combined population of 14.5 million people. This brings the total number of ICSs to 29, out of an original 42 STPs, and means more than 60 per cent of England's population is covered by an ICS. The NHS aims for ICSs to cover essentially the whole of England by April 2021, with 13 remaining parts of the country working to achieve designation. Legislative proposals[15], if accepted, will put ICSs on a statutory footing by as early as April 2022.

SYB Pathology Network

The development of the SYB Pathology network will support delivery of the ICS vision and objectives.

Figure 2 : SYB Pathology – A Shared Vision and Mission



The following guiding principles were then agreed for the SYB Pathology Service:

Figure 3 : Guiding Principles

Quality

- Have patients at heart of all services with equity of access for all patients
- Provider of choice to service users by developing and safeguarding a unified, standardised, harmonised, comprehensive, clinically-led, user-centred, quality service, responsive to the needs of users and patients with the highest standards of professionalism and maximum use of specialist knowledge
- Provide flexible 7-day services relevant to service, user and patient requirements
- Safeguard all compliance, accreditation standards and adherence to RCPath and other appropriate guidelines
- Develop a culture of continuous improvement of quality, governance, risk management and performance at all levels of service
- Actively seek users' feedback on the current service provision and their strategic requirements, and respond appropriately and proactively
- Right First Time
- Ensure highest quality estates, equipment, IT and logistics that ensure service resilience and keep pace with time and new developments

Workforce

- Be the employer of choice providing exciting opportunities with equity of access to flexible career pathways and development opportunities for all staff
- Positively and proactively involve all members of our service in the transformation process and empower and support individuals and teams committed to the goals to make the change happen
- Develop all tiers of our workforce to be professionally competent, productive, cost-effective, flexible and compatible with future developments, service resilience and current and future needs of the service ensuring 'right job right grade' at all levels
- Remain active in undergraduate and postgraduate education ensuring that it is delivered to high standards and all trainee posts are fully utilised
- Develop new medical, scientific, academic and support roles to enable innovative practice and service models
- Strive for wellbeing, job satisfaction, career and personal development and job stability and security for all members of our team, with special attention to the needs of those at the beginning of their careers and approaching retirement

Innovation

- Remain receptive and enhance our adaptability to changes in the health care system and society ensuring the ability to accelerate implementation of relevant national strategic initiatives and provide proactive and dedicated support for the transformation of the healthcare sector within SYB ICS
- Ensure an agile service model that proactively leverages a cutting-edge clinical and scientific approach to optimise and integrate services into new care models and develop innovative patient pathways to add value to clinical operations across the organisational boundaries and boundaries of care
- Develop pre-analytical, scientific and clinical processes with emphasis on quality, innovation, productivity, flexibility and compatibility with the future developments working with other NHS and commercial partners where appropriate
- Ensure equity of innovation across whole organisation ensuring the best use of resources
- Empower patients to self- manage long-term conditions
- Proactively lead and manage Point of Care Testing services and governance
- Maintain close links with any developing e.g. genomics

Science and Technology

- Remain future-proof by being open and receptive to new scientific and technological developments which can add value to clinical operations and improve job satisfaction
- Organisation-wide laboratory IT system
- Use IT, business intelligence and data analytics used to enhance clinical pathways ensuring adherence to Information Governance
- Ensure that all patient results, including POCT, are easily electronically available to all clinicians across primary and secondary care within SYB ICS and beyond
- Proactively develop and introduce innovative IT and data analytical solutions across all specialisms to enable more effective patients management and support new models of care ensuring involvement of all key stakeholders in new developments
- Ensure good working relationships and partnerships with technology providers

Research and Innovation

- Develop and support research opportunities with constituent organisations of SYB ICS, Universities, Cancer Alliance, AHSN and other appropriate bodies and commercial partners
- Develop innovative methodologies where appropriate
- Ensure all R&D undertaken is appropriately coordinated and organised such that delivery of R&D across the organisation is not impeded
- Support staff to become active participants in the R&D across the organisation ensuring all R&D activity is appropriately accounted for in job descriptions and job plans and adequately resourced and accredited
- Proactively bid and collaborate in the local, regional and national research initiatives, programmes, projects and trails where appropriate
- Remain represented in relevant professional bodies, organisations and other forums in order to increase our profile and positive influence and facilitate collection and transfer of information, ideas and skills

Value for Money

- Make the best use of taxpayers money
- Deliver locally validated and agreed on NHSI-assigned savings target and proactively support the financial effectiveness of SYB ICS to agreed timelines
- Work smarter to deliver efficiencies from economies of scale and scope
- Horizon scan for potential funding and income opportunities
- Develop service to safeguard the existing, and establish new, commercial ventures within the healthcare, R&D and in-vitro diagnostic markets in SYB, nationwide and internationally
- Refine our business model and develop appropriate skills and business connections to acquire and maintain a competitive edge in the market
- Define our relationships with other laboratories, professional bodies and organisations outside of the SYB ICS based on mutual interests, shared values and a culture of support and collaboration.
- Actively participate in benchmarking to ensure consistent competitiveness and continuously improve clinical, operational and financial effectiveness across all services, including reducing unwarranted variations in service provision and costs

Overview of Trust, Primary Care and Community Clinical Services

The SYB clinical portfolio is comprehensive, covering the major medical and surgical specialties, routine and specialist diagnostic services and other clinical support services. The clinical specialties provide general, specialist and tertiary services primarily to a catchment population of approximately 1.5 million.

The five acute Trusts host extensive pathology services, providing over 40 million tests per annum. The services employ over 1,000 staff (WTE) with a combined annual budget of circa £102m* distributed across 8 hospital sites:

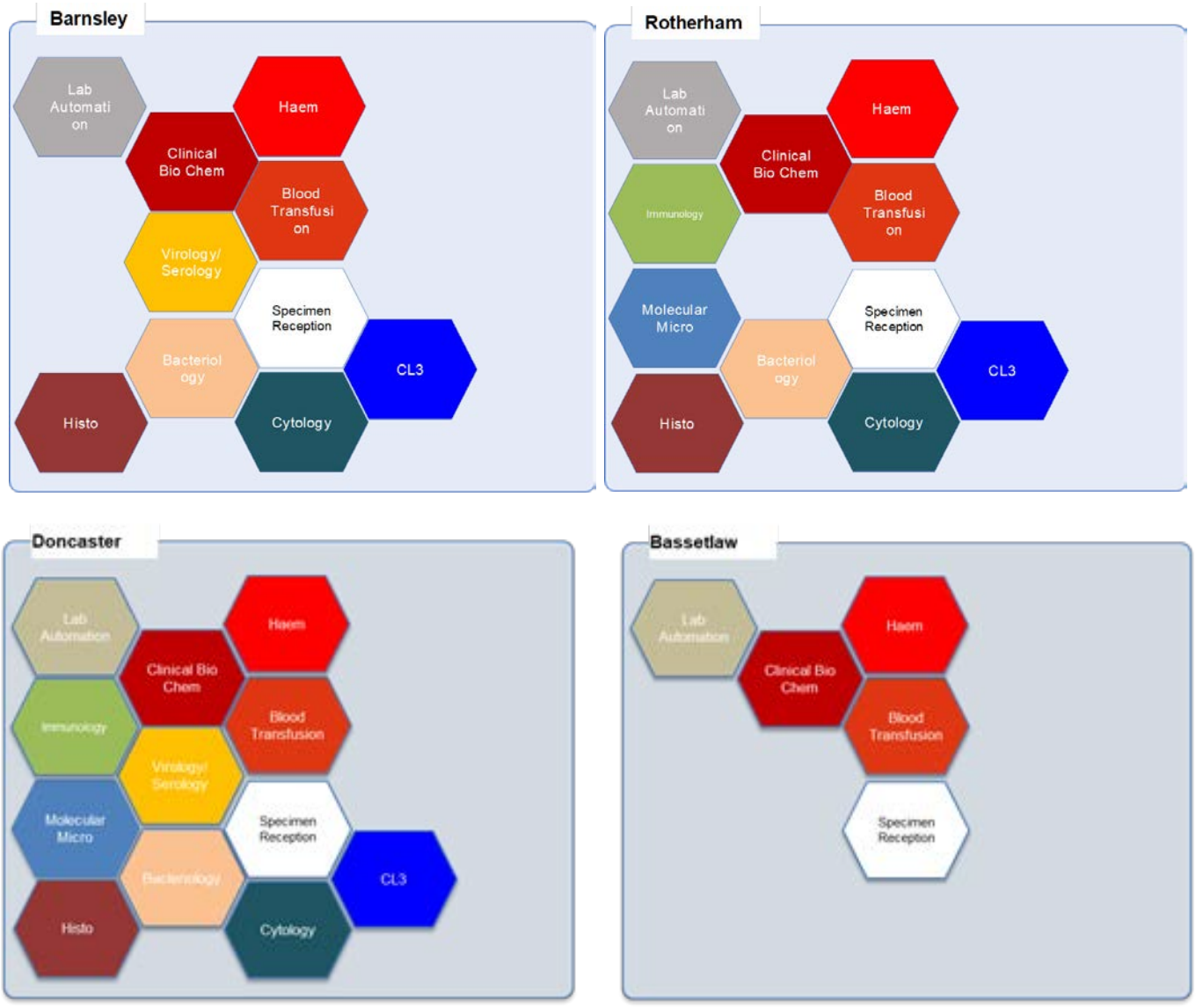
- Barnsley Hospital (BH)
- Bassetlaw Hospital (BDGH)

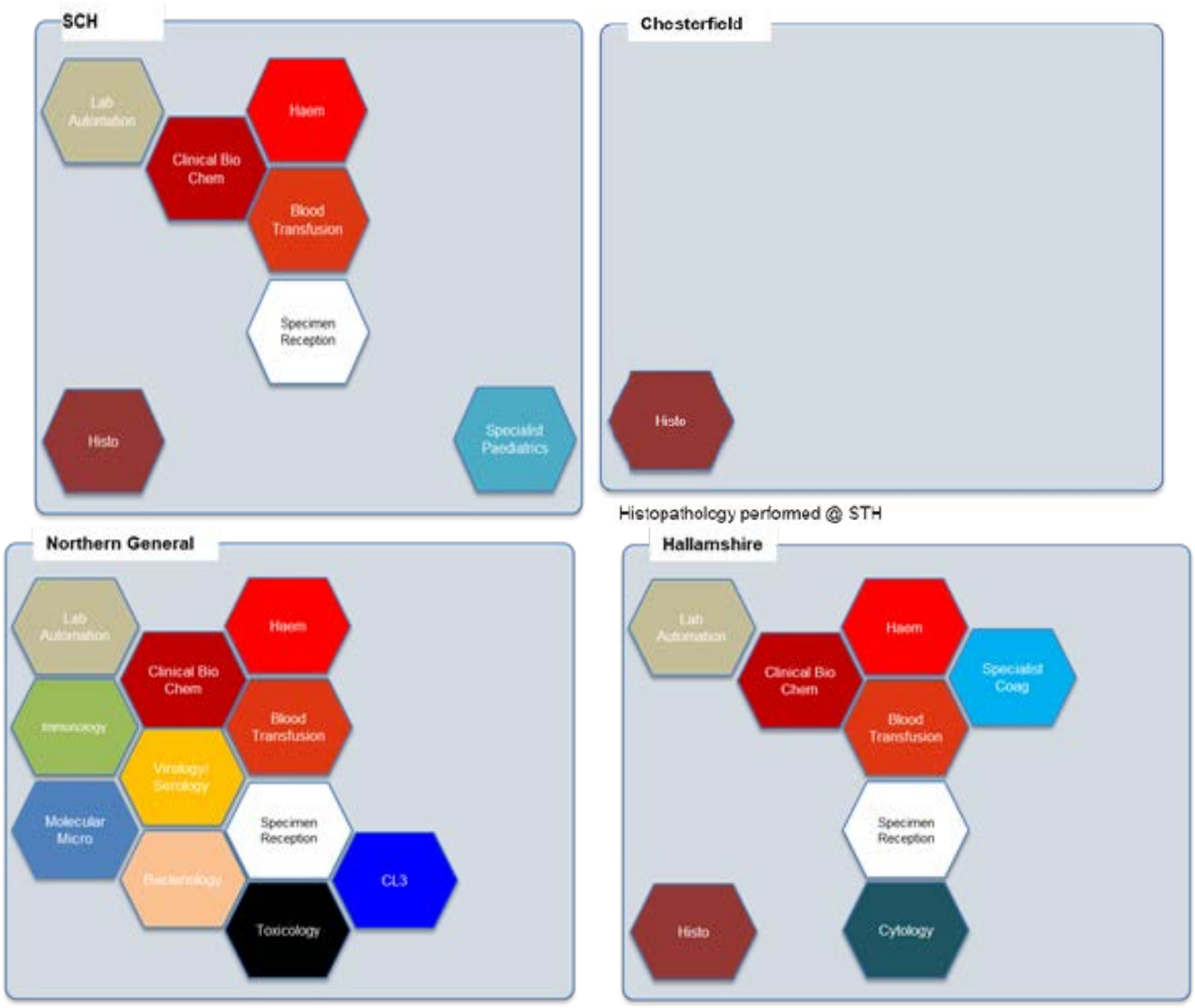
- Chesterfield Royal Hospital (CRH)
- Doncaster Royal Infirmary (DRI)
- Northern General Hospital, Sheffield (NGH)
- Royal Hallamshire Hospital, Sheffield (RHH)
- Sheffield Childrens Hospital (SCH)
- The Rotherham Hospital (TRH)

* 2019/20 NHSI data and investments recurrently funded in 2020/21

The scope of services currently provided on each site is illustrated below:

Figure 4 : Current Configuration of Pathology Services





3.4 The Case for Change

NHSI Pathology Network Review

As identified in the 'Development of Pathology Networks' in section 3.2 above, SYB pathology providers have been identified as the North 6 Pathology network. With a requirement for all networks to be in place by end 2021, there is a need for the Pathology Services in SYB to work together to develop a partnership model which meets the needs of the local population and delivers improvements in clinical quality and patient experience. In April 2018 the SYB ICS agreed to the creation of a transformation programme of work to bring about the required system change.

Growing Demand and Increased Test Complexity

As with other healthcare services, demand for pathology is growing both in the number of patients and test requests as well as the complexity of tests requested. This is driven by:

- Increasing demographic population
- An ageing population with increased prevalence of long term conditions
- Clinicians undertaking more diagnoses prior to making decisions regarding treatment
- The availability of new tests, for example: companion diagnostics, which enable better targeting of drugs, or personalised medicine

Pathology demand in SYB is projected to grow across all specialties and sources (hospital, GP and community). Workload increases vary by discipline but an overall increase of circa 5% year on year is anticipated, with increased complexity in many areas. Demand is outstripping supply in many specialist areas and the national difficulties in recruiting consultant staff in areas such as Histopathology and Immunology are impacting on SYB. In addition to this are unexpected and sudden workload increases related to health events such as the on-going COVID pandemic.

The implied financial impact of this increased demand has not been calculated if services remain configured as they are currently; however, increased pay costs and non-pay costs will be inevitable. In addition, longer turnaround times for some test results are likely with an associated adverse impact on patient care.

NHSI are encouraging the formation of laboratory networks to address these challenges through consolidation of specialist and routine testing on fewer, more sustainable sites (and to deliver increased capacity for e.g. training, research and innovation in service delivery including through point-of-care testing).

Increasing Cost of New Technology

Technology is moving rapidly in several areas of pathology, driven by competition between suppliers to develop products which enable faster and more accurate results with greater efficiency. Some of the key trends are:

- Developments in genetic and molecular diagnostics
- Improved automation across all laboratory disciplines
- Digital technologies – rapidly developing and rollout of effective digital reporting. These are essential to harness the additional quality and efficiency benefits that computational pathology/ artificial Intelligence will offer
- Improved point of care testing (POCT) and expanded available repertoire

These developing technologies will require a workforce that is adaptable and flexible to meet the technical challenges as well as clinical expertise to utilize these emerging diagnostics.

Atlas of Variation

Across our region there is wide ranging variation in the use of the pathology diagnostics being provided. The 2013 Atlas of Variation[16] showed that unwarranted variation is ubiquitous in England across a wide range of conditions and highlighted differences in the relative activity of a number of pathology tests across the country, notably thyroid hormones, cancer markers, therapeutic drugs, allergy, lipid and cardiac markers. Some of this variation was also reflected in the recent GIRFT data collection exercise and SYB deep dive report (*Appendix B*).

Workforce Challenges – Sustainability of Services

Nationally there are difficulties in the recruitment and retention of highly specialised and skilled staff, in particular Consultant Histopathologists, but also Consultants, Clinical Scientists and Biomedical Scientists across other sub-specialties. Consultants in pathology have an older than average age profile and some vacant posts have been unfilled for several years. Vacancy rates for Consultant Histopathologists are currently in the order of 40% nationally[17]. This ongoing situation can lead to delays in diagnostic results, high locum and agency costs and charges for referring work out to private providers.

The current COVID pandemic has significantly increased demand for molecular testing and required the rapid development and introduction of new testing platforms and assays. Operational processes, validation and verification procedures, the need for clinical advice and ongoing submission of data to research programmes, NHS Test and Trace and to meet NHSE&I reporting requirements have added significant pressure on the existing workforce. Recruitment of staff was essential to meet demand during the pandemic and was particularly challenging

as NHS laboratories and the national COVID Lighthouse Laboratories all required additional resources; it was not possible to fill all vacancies.

3.5 Responding to the Challenges

In order to address these challenges, the Boards of BHFT, DBTHFT, TRFT, SCFT and STHFT asked their respective pathology services to consider how they could work together to provide a single pathology service for SYB. A Pathology Transformation Programme (PTP) was agreed and a SYB Pathology Transformation Programme Board (PTPB) established in April 2018, chaired by the CEO of DBTH (nominated as Senior Responsible Officer for the PTP), with a Medical Director as deputy chair and including the clinical director and managerial lead from each SYB Pathology service. A programme delivery team (PDT) of Clinical Director, Associate Clinical Director, Programme Manager and Finance Lead were later appointed and added as members of the Programme Board.

A number of expert reference groups were established, with representation from across all Trusts, to undertake a high level assessment of the service options suggested by NHSI for the formation of a network and to give expert advice to the PDT and PTPB. The reference group structure has included representatives from all clinical disciplines in pathology, plus IT, finance, procurement and logistic colleagues from all trusts. The established reference groups are:

- Blood Sciences
- Microbiology
- Histopathology
- Workforce
- IT
- Quality
- Logistics
- Procurement
- Finance

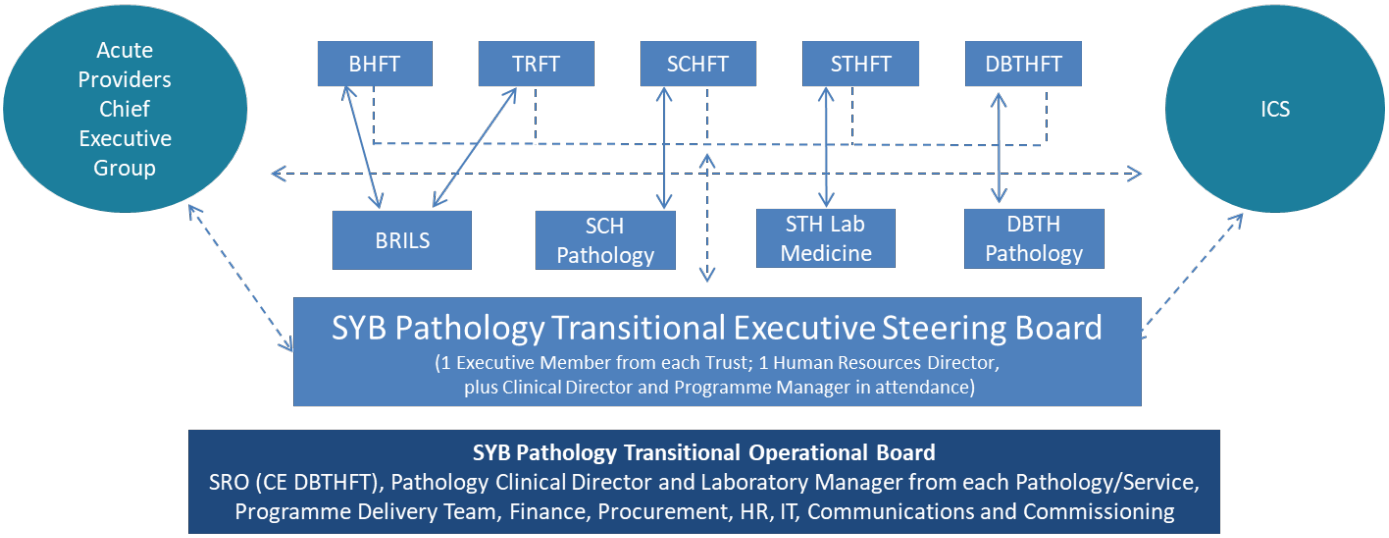
A task and finish Specialised Services Reference Group was also established and tasked with identifying issues of particular relevance to specialised services across all disciplines. Once completed, work on specialised services was incorporated into the respective discipline reference groups.

In September 2019, the Chief Executives of all Trusts (the Acute Provider Chief Executive Group) agreed amendments to the governance of the SYB PTP. The Programme Board was spilt into a Transitional Executive Steering Board (ESB) and a Transitional Operational Board (OB) with the aim of facilitating better and quicker decision making, with the Executive Steering Board directing and overseeing the work of the Operational Board to offer more scrutiny over the detail of the proposals being made. The Executive Steering Board is made up of an Executive Director from each Trust, supported by one of the SYB Human Resources Directors, and is attended by the Clinical Director and Programme Manager from the PDT. The Operational Board has been expanded to include representation from HR, Finance, Procurement, IT, Commissioning, Communication and Workforce.

Board Remit

The aim of the SYB PTP is to develop a network that will ensure that the highest quality, sustainable and affordable pathology services are delivered across the SYB healthcare system. The ESB will position the SYB Pathology Service to support the redesign of patient pathways through progressive and transformational change, ensuring that services are able to respond to the challenges of the evolving health care environment.

Figure 5 : Agreed Transitional Arrangements (until OBC/FBC approved)



Both the OB and ESB continue to be informed by reference group members who have undertaken detailed work to identify the most effective and efficient operational options and have received feedback on operational considerations from the potential suppliers of a Managed Service Contract. The reference groups have tested the operational options against the SYB Guiding Principles for transformation to inform the recommended option included in this OBC.

If the OBC and recommended TOM is approved, a Full Business Case (FBC) will follow and the reference groups will describe the steps needed to move from the current position to the final recommended TOM. Each Trust will need to share with staff how the business case and TOM will be implemented and there will be a need for an integrated staff consultation exercise. A key priority is to ensure a sustainable and stable workforce in SYB; retention of the expertise and dedication from current staff in providing high quality Pathology Services is a priority for the new SYB Pathology Service.

In the new service model there will be equal opportunities for all staff to apply for future roles and careful consideration will be given to any proposal which would lead to movement of staff across the SYB Service. Trusts are already exploring network recruitment where they believe this will attract candidates to work in the SYB Pathology Service; the first approach taken was to support local recruitment by recruiting Consultant Histopathologists to work in specific sub-specialities of Histopathology, where the candidates report work for more than one hospital across SYB. This is the first step in our proposed network recruitment approach, and one that will allow us to pursue a more sustainable subspecialist histopathology service to all our patients. The recommended TOM and workforce plan is expected to take two to four years to implement and it is anticipated that the target staffing model will be achieved by managing turnover and vacancies. There will be no compulsory redundancies. The Pathology Workforce and Education Lead (centrally funded for one year) is undertaking a workforce planning exercise that will include an analysis of turnover and vacancy rates; this will be included in the FBC.

3.6 Scope of the Collaboration and Service Review

The PTP Board established a number of expert reference groups and agreed a plan of work to undertake a high level assessment of the type of service options suggested by NHSI. All laboratory and ancillary areas were included in the scope of the collaboration with the following exceptions:

- Clinical services including Medical Haematology and Immunology

- Mortuary & bereavement services and Phlebotomy services
- Genomics Services, as Sheffield Diagnostic Genetic Centre has become a part of North East and Yorkshire Genomic Laboratory Hub/Genomic Medicine Service.

The Memorandum Of Understanding (MoU) signed by all Trusts in April 2018 provided Trust approval to share data, and the PTPB, PDT and reference groups were given access to all activity, finance, estates, supplies and workforce data relating to the four pathology services (BRILS, DBHFT, SCFT, STHFT). The NHSI GIRFT reports have also been shared. Activity from primary and secondary care, any activity from out of area sources and private sector activity was also included.

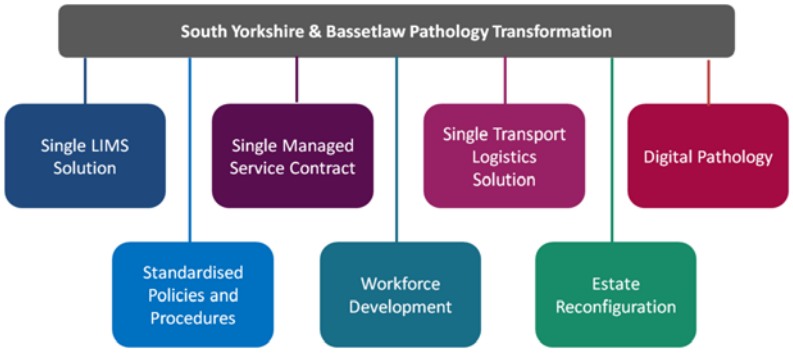
Known national, regional and local clinical drivers that will impact on pathology services have been considered.

The PTPB agreed the guiding principles against which to evaluate the various reconfiguration options. Specific criteria were also developed in consultation with stakeholders to evaluate the proposed reconfiguration and recommended location of a mini-CSL (*Appendix C*) and a single CSL for Histopathology (*Appendix D*) that underpin the target operating model.

3.7 Key Enablers

In order to deliver the vision and the proposed Target Operating Model a number of key enablers are identified (*Figure 6*), all of which are critical dependencies for the transformation programme.

Figure 6 : Key Enablers



Single Laboratory Information Management System (LIMS)

The implementation of a single LIMS for SYB has been recognised by all SYB reference groups, as well as nationally by other emerging networks and by NHSE/I, as a key requirement to enable successful consolidation of laboratory services across the network and delivery of the associated quality and financial benefits.

The significant limitations of working with multiple LIMS across the network has been highlighted during the ongoing COVID pandemic. Multiple NHSE/I requests for information, often at short notice, has meant that for SYB the information has had to be gathered separately from 4 different LIMS systems and then collated by the Pathology Incident Director or other network representative before submission.

If a single LIMS had been in place this would have been a single request each time and many hours of various staff members time would have been saved. Of even greater significance has been the duplication of data entry into different LIMS systems as samples have had to be moved round SYB and beyond to access available capacity. This puts additional pressure on an already stretched workforce, adversely impacted on patient care and staff absence

rates with longer turnaround times and increased costs. The National Pathology Exchange system (NPEx) has been implemented to provide a link between LIMS for COVID tests, but even this carries an administrative burden.

The key benefits to SYB of a single LIMS, aligned to an electronic ordering system such as ICE, are:

- Master index of requests maintained for all patients, including receipt, preparation, analysis, reports and retrievals
- Common IT processes across the network
- Standardised order/requesting format for all SYB clinicians
- Standardised test names and testing profiles
- Standardised reporting formats
- Reduced variability
- All staff able to see the content and status of all orders/requests, irrespective of where the order has been generated, where the sample is collected and where the staff member is physically located
- Any SYB citizen can have an order raised from anywhere
- Irrespective of where an order is generated, sample collection from the patient can occur anywhere across SYB, or can be sent out of SYB as required
- Results reporting can be completed at any location, against any order, for samples analysed at any location
- Results can be viewed within pathology at any hospital site irrespective of where the order was created, sample collected or analysis undertaken
- Fast access to confirmatory and specialist testing without the need for a separate referral system
- Reduction in traditional paperwork or electronic referral and result receipt processes
- Reduced overall turnaround time for tests sent from one site to another for analysis
- Facilitates the movement of staff around the network as IT processes are identical, improving the resilience of services with workforce shortages
- Single repository for data mining
- Single repository for activity, finance and business information across SYB
- Economies of scale through consolidation of equipment and shared IT support

It is essential that informatics solutions providing seamless electronic access to requests and results across the SYB footprint are in place to underpin the vision for the future. The transfer of requests and results between laboratories and hospital sites, GP surgeries, external laboratories, locality hubs and patient records is key to the quality and deliverability of the SYB Pathology Service. Therefore, procurement and implementation of a single LIMS is believed to be an essential enabler. In addition, integration of order communications (order comms) systems for test requests is essential.

The Strategic Outline Case for a single SYB LIMS was endorsed by the ICS Digital Delivery Board in March 2021 and by each Trust Executive Group during March - May 2021. Stakeholders are currently reviewing the content of the LIMS Outline Business Case before it is submitted for consideration and approval by Trust Boards. Procurement via the QE II framework is proposed and all LIMS suppliers on this framework were invited to a pre-procurement engagement event to be held on 'Teams' on 29 June 2021. This event advised suppliers what the SYB Pathology network will look like, what we are trying to achieve, shared an outline of the proposed LIMS procurement, design and implementation process and invited all suppliers to bid to provide a single LIMS for SYB.

<u>Capital Investment</u>

In December 2020 the SYB Pathology Programme Team submitted proposals to access a share of £60m capital in support of 'COVID 19 LIMS investment'. Following regional and national moderation against the funding specification, SYB was awarded £121k in 20/21 for the introduction of CliniSys ICE electronic requesting at Sheffield Children's Hospital and interfacing of this to STH LIMS and this project is progressing to plan.
SYB was also awarded £929.5k in 21/22 for an upgrade of existing CliniSys ICE systems to v8.2 with ICE Enterprise ('Hub & Spoke / Publisher') Network Solution; however, a decision was taken in June 2021 not to proceed with this

initiative in 21/22 as there is no confidence that it will deliver benefits across Places in SYB with the current lack of standardisation and current ICE V8 product. The national team have indicated that they are likely to approve use of the capital funding to support SYB to standardise sample label printers as this is an essential preparatory step for a single SYB LIMS and ICE V8 Enterprise; advice has been requested regarding what Providers will account for as capital.

NHSE has announced that £100m capital funding will be made available in 2021/22 for LIMS replacement with the objective of providing interoperability to enable network service provision. Networks were invited in May 2021 to set out their 2021-2024 roadmap for Diagnostic Digital Development of LIMS and to bid for capital to support this. The SYB bid was supported by the NEY Regional Diagnostic Board on 27 May 2021 and has been submitted to the national team. Feedback, received 12/8/21, indicates that the bid has been notional approved supported with a full allocation of the £510K requested for 2021/22, subject to approved Letters of Agreement. Letters of Agreement will be reviewed nationally for value for money, viability and appropriateness and will form the basis for final financial allocations. The funding is intended to be used to appoint a LIMS Project Manager and team to progress the LIMS specification and move to tender as soon as possible, subject to an approved LIMS OBC and FBC. The full LIMS bid submission is available as Appendix E

Figure 7 : SYB Pathology – LIMS roadmap and indicative costs submitted for capital funding

LIMS: Proposed Scope/Area of Work	21/22		22/23	23/24	Anticipated Total Costs £k (In VAT)		Future indicative costs £k (In VAT)			
					2021/22		2022/23		2023/24	
	H1	H2			Capital	Revenue	Capital	Revenue	Capital	Revenue
LIMS specification, pre-engagement activity, OBC approval, issue mini-comp tender via framework					510.3					
Evauation, moderation, contract negotiation and award										
Design, build and testing; go live at first Trust							8,484.1	240.0		
Testing and go live at other four Trusts									5,868.9	1,566.4

Single Managed Service Contract (MSC)

Common equipment platforms and middleware will allow standardisation to be effected across all laboratories, providing equitable access to tests and removing the complexity and risk currently associated with different methodologies and reference ranges. It also facilitates the movement of staff around the network as operational processes are identical, improving the resilience of services with workforce shortages. Integration of equipment and platforms with common suppliers will increase purchasing power and deliver economies of scale benefits for the SYB Pathology network.

The procurement process commenced with the release of a Prior Information Notice to the market on 18 June 2021. STHFT is the contracting authority and Akeso & Co are supporting this procurement as a procurement partner acting on behalf of all Acute Trusts in SYB. This procurement will be for a replacement pan pathology managed equipment and consumable service which all Trusts in SYB currently have in place. As part of this notification we intend to undertake market testing to decide the scope of service to be considered for this procurement but at this stage it is envisioned that it will include all blood sciences, microbiology, immunology, virology, cellular pathology and point of care testing. The procurement will also include any IT hardware, software and middleware required to integrate to the Trust's Laboratory Information Management Systems (LIMS) to be able to provide consolidated reporting from any analytical platform. The procurement is not intended to be an outsourcing of the services to another provider,

simply the management of the equipment, technology, reagents and other consumables. A multi-supplier engagement event took place on 15th July 2021. It is anticipated that the initial term for contract will be 10 years with options to extend (including a refresh option). However, SYB reserves the right to change the lotting structure, scope, term of contract and procurement procedure as a result of the market engagement or any further engagement. The supplier engagement was held in accordance with Regulation 40 & 41 of the Public Contract Regulations 2015.

Single Transport Logistics Solution

Given the proposed increase in specimen movement across the network, it is essential that effective and efficient transport systems are in place.

Intra-Hospital Transfer

Current transport routes and times between sites have been collated. Increased frequency of intra-site transport between the 8 acute hospital sites will be required to enable consolidated testing laboratories to meet the turnaround times required for high quality clinical care. The frequency of the transport runs has been modelled as:

- every 1.5 hours during 08:00 to 22:00 Monday to Friday plus 2 overnight runs
- every 1.5 hours during 08:00 to 16:00 Sat, Sun and Bank Holidays plus 4 runs outside these hours

There will also be an ad hoc requirement for additional transport between hospital sites for those samples that need very urgent analysis and reporting in between the scheduled transport times. The proposed scheduled transport timetable will be regularly reviewed to balance its cost/benefit versus the ad hoc arrangements.

Primary Care

Transport across primary care has also been looked at in detail and collated in terms of:

- the number of requests sent from each GP practice on an annual basis
- the current number of weekday and weekend collections
- the scheduled time of the current transport collections from each practice
- other items that are currently transported along with pathology specimens e.g. post, pharmacy items/scripts and pathology consumables
- any separate transport that occurs to the same practice for reasons other than sample collection

SYB Pathology Transport Logistics

In order to ensure best value, it is recommended that a procurement is approved for the delivery of transport services across SYB that will support delivery of a high quality SYB Pathology Service and comply with current legislation/standards whilst minimising transport costs and impact on the environment.

Transport for a range of specimens will be required, including:

- blood, urine, faeces and other sample types
- surgical specimens (if samples are stored in formalin these must not be transported in vehicles carrying passengers)
- potentially infectious samples (potentially post-culture, increasing infection risk)
- frozen samples for analyte stability
- potentially mid-incubation microbiology samples in order to minimise delays to turnaround time

GP practices currently receive between one and three transport collections per day and typically have arranged practice phlebotomy and other sample collections to meet the scheduled timetable. The starting point will be to

replicate the existing timetable as closely as possible in order to minimise disruption for primary care services. However, drive through phlebotomy services and services at Primary Care Hubs that have been established during the COVID pandemic has changed the flow of samples into pathology laboratories. Minimising the time from 'vein to analyser' improves quality, and a more even flow of samples into a laboratory tends to improve turnaround time further. Places are currently reviewing the design of their phlebotomy services, and transport services may need to change accordingly.

The quality of current pathology services could be improved upon with the addition of sample tracking and temperature control during transportation. Controlled temperatures are important for the stability of certain analytes, otherwise erroneous results may be issued causing inappropriate treatment and/or further investigation for patients. Indicative costs for these service improvements are being sought in order to assess the value of such investment and the anticipated cost of a newly procured logistics service will be included as part of the FBC.

Digital Pathology

A business case for the full implementation of digital technology and end to end processes across SYB is in progress. NHSE has announced that £40m capital funding will be made available nationally in 2021/22 for Digital Pathology with the aim of ensuring that all Histopathology departments are digitised with NHS-wide connectivity. Networks were invited in May 2021 to set out their 2021-2024 roadmap for Diagnostic Digital Development of Digital Pathology and to bid for capital to support this. The SYB bid was supported by the NEY Regional Diagnostic Board on 27 May 2021 and has been submitted to the national team. Verbal feedback, received 3/8/21, indicates that the bid has been supported by the national team but funding requests are in excess of the national funding pot so further moderation is required. Further feedback is expected in early September 2021 and any allocation must be spent in year. SYB requested £219k for Digital Pathology for 2021/22. The 2021/22 proposed scope of work, anticipated costs and indicative costs for 2022-2024 are summarised in Figure 8. The full Digital Pathology bid submission is available as Appendix F.

Figure 8 : SYB Pathology – Digital Pathology roadmap and indicative costs submitted for capital funding

Digital Pathology: Proposed Scope/Area of Work	21/22		22/23	23/24	Anticipated Total Costs £k (In VAT)		Future indicative costs £k (In VAT)			
					2021/22		2022/23		2023/24	
	H1	H2			Capital	Revenue	Capital	Revenue	Capital	Revenue
Digital Pathology specification, pre-engagement activity, OBC approval, issue mini-comp tender via framework					218.6	35.2				
Evauation, moderation, contract negotiation and award										
Design, build and testing; go live at first Trust (STH)							4,082.2	367.9		320.1
Testing and go live at second site										

Standard Policies and Procedures

Standardisation is key to the successful delivery of a sustainable Pathology service across SYB of consistent high quality, providing equitable access for all patients and clinicians. Procurement and implementation of a single MSC, a single LIMS and Digital Pathology will support risk reduction and will deliver quality and efficiency improvements through workforce optimisation, reduction of unwarranted variation and removal of duplication. However, these

must be underpinned by common methodologies, policies and processes. Discussions about ICE v8 Enterprise highlighted the significant variation that currently exists in sample labelling, printing and numbering systems. GIRFT analysis, comparison of the national NHSI data returns and transformation planning in reference groups has highlighted significant variation across SYB in blood sample tubes, test names and codes, content of test profiles, use of syndromic requesting, reference ranges, and collection of clinical information and content of reports.

A small group of IT, scientific, clinical and operational staff have identified the key elements that require standardisation and recommended a priority order based on the benefits they will offer, ease of implementation and dependency on other initiatives e.g. single LIMS with specific functionality. Reference groups are commencing work to recommend the most appropriate standard for implementation; these will be approved via the agreed governance arrangements. Some changes are internal to Pathology but many will affect and require the input of the clinical community across SYB, including acute, primary and community services. Some standardisation will be effected in 21/22 with other aspects planned in over three or more years.

There is agreement across SYB Pathology that standardisation is essential to maximise benefits from a truly unified target operating model delivering consistent high quality for patients, staff and service users

Quality Management System

UKAS accreditation is an essential quality marker for UK Pathology services. As SYB Pathology introduces a single MSC with standardised analytical platforms, a single LIMS, equitable staff training programmes, standard operating procedures etc. there will be a significant quality management workload involving multiple 'Extension to Scope' (ETS) applications and UKAS assessors visiting each laboratory respectively over time.

To enable a phased approach to a single accreditation number and schedule, to facilitate standardisation, staff rotation and remove duplication, a single Quality Management System (QMS) for SYB Pathology will be required. Each laboratory currently has a separate Trust hosted Q-Pulse database for their QMS. To enable a single Network accreditation and a single QMS, a network wide Q-Pulse database will be required. The quality reference group have undertaken market research with the incumbent supplier of QMS software at each laboratory, Q-Pulse (Ideagen). Estimated initial costs of approximately £170,000 were provided by Ideagen for an Enterprise edition of their software. This will enable each Trust to maintain its own QMS system but also move to a shared QMS system with merged documentation over time. As services are merged standard operating procedures, training and competency documentation etc. can be merged and uploaded to a single system. This is ultimately where efficiencies can be realised from. UKAS costs are based on the number of days of effort for assessment, any reduction in assessment time will therefore reduce accreditation costs; the number of assessment days will depend on the final Target Operating Model.

Workforce Development

A common workforce that has the same standard processes and a common management team will allow for greater integration and improved service resilience across all sites. A single management team will reduce management costs and increase opportunity for reinvestment. Changes in skill mix and economies of skills and scale, together with cross skilling of staff across disciplines will deliver significant benefits.

Funding has been secured in 2021/22 enabling the fixed term appointment of a SYB Strategic Workforce and Education Lead to undertake a pathology wide workforce planning exercise and training needs analysis, assess future skills demand in key areas, diagnose the current supply and propose initiatives to fill the gaps.

Creation of a SYB Pathology network should enable improvements for staff and service delivery by:

- Enabling a common career structure (job profiles and grading) for staff across the network to ensure equity and enable transferability

- Development of a more flexible workforce, exploring opportunities for innovative employments - network wide roles or 'blurring the boundaries' between medics, scientists and operational roles such as I.T.
- Development of training and career development pathways for all staff within the Pathology workforce including use of apprenticeship programmes at all levels to 'grow our own'
- Supporting work with our national bodies, universities and industry to create new roles and attract, recruit and retain the most talented individuals into the pathology workforce
- Making most effective use of our resources, including all staff groups and working as a single healthcare science service to maximise capacity across the network

Estate Reconfiguration

Adaptation, redevelopment and rationalisation of the Pathology estate will be service led and professionally informed. The reconfiguration of services will take into account the requirements of each acute hospital site, including the requirement for a full emergency and inpatient service. In order to support the reconfiguration of pathology services in line with the recommended target operating model, capital investment and considerable support from Estates Teams across SYB will be required.

Estates Directors led assessments at Barnsley and Doncaster have informed the evaluation process for the location of the mini CSL (for Blood Sciences and Microbiology); they concluded that either site could accommodate the space required and neither identified the need for significant investment. Minor works were identified at both sites e.g.to create a larger staff room and kitchen, to expand the Category 3 testing facilities (if required). The re-use of space at either site would be possible but would need investment.

A similar estates exercise has been undertaken at the Royal Hallamshire Hospital and Sheffield Children's Hospital for Histopathology following the Executive Steering Board's acceptance (23 June 2021) and AF CEOs support (5th July 2021) of the recommendations and evaluation criteria for agreeing the target operating model and preferred location(s). Estates Directors from RHH and SCH were asked to undertake a site assessment against the requirements for a single Histopathology CSL. SCH have fed back that they could not accommodate the full CSL without major expansion and do not currently have the estate to do this. The preference of SCH would be to retain the paediatric element of the histopathology service for SYB. RHH believe that the site could accommodate the full CSL but further work is required to understand the cost implications. Further assessment will be included within the FBC.

A single Managed Service Contract (MSC) across SYB will result in the replacement of laboratory analysers, pre and post analytical equipment and associated IT middleware. Detailed work will be required as part of this process to understand the cost of any required works to meet the estates requirements in Blood Sciences, Microbiology and Cellular Pathology; this will vary depending on the outcome of the MSC procurement process and will form part of the MSC full business case. Estates work across SYB will also require careful phasing to provide the relevant capacity for the planned consolidation of work in line with implementation of the equipment platforms and LIMS.

Space within some hospitals will be released following reconfiguration delivering additional benefits.

4. ECONOMIC CASE

The Economic Case now describes the process which was adopted to determine the recommended target operating model and configuration of pathology services across South Yorkshire and Bassetlaw.

4.1 Introduction

The following section provides a review of the work that has been undertaken to determine the recommended option for the Target Operating Model (TOM) and will outline the proposed way forward following a review of all the potential laboratory configuration options which were considered following direction by the Executive Steering Board.

4.2 Organisational Form Options

The options for organisational form were discussed at Acute Provider Chief Executives meetings during 2019 which are listed below:

(i) Collaboration (Status Quo formalised)
(ii) Alliance Contracting (Staff employed by different Trusts, lead for certain aspects)
(iii) Outsourcing
(iv) Host Trust
(v) Joint Venture (LLP)
(vi) Joint Venture (Limited by Shares)
(vii) Community Interest Company

In November 2019 Executive Directors from all Trusts and the PDT met together with a legal representative to consider the options. The unanimous recommendation from all attendees was for the formation of a SYB Pathology Network, operating as a single service, with one of the Trusts acting as host. A hosted network would be the most efficient from a tax perspective and, importantly, allow staff to stay within the NHS framework.

4.3 Target Operating Model Options

In 2018, the SYB Pathology Transformation Programme Board discussed a range of operating model options for the delivery of services in the NHSI North 6 Region. Guiding principles for the overall programme were agreed, and four options were assessed in terms of their alignment, these were:

1. Do nothing
2. Collaborative working with no change to organisational form and operational model
3. NHSI model – a single CSL with ESLs at all other acute hospital sites
4. Modified NHSI model - with up to two CSLs per discipline

The Programme Board (later restructured as the Transitional Executive Steering Board and Transitional Operational Board) recommended that the future configuration of SYB Pathology Services should be as a single Pathology Service, aligned with the guiding principles, providing high-quality, clinically relevant, equitable, affordable and future-proof services for all partners in the SYB ICS and external users of the service. The first two options above were discounted as not meeting this recommendation.

Each reference group was then asked to review their discipline and specialties, starting with Option 3 - the NHSI proposed model (the most consolidated option), and to explore the alignment of this model with the guiding principles and the impact it would have on other disciplines. They were asked to only consider Option 4 if the NHSI proposed model did not meet the guiding principles and clinical requirements. During 2020, reference groups have also been asked to review their recommendations in light of any learning from the COVID pandemic.

4.4 Scope

The PTP Board (later restructured as the Transitional Executive Steering Board and Transitional Operational Transition Board) considered the scope of the laboratory disciplines and specialties to be included in the development of the SYB Pathology Service. All laboratory disciplines and specialties, aspects and activities were included in the scope of the review with the following exceptions:

- Clinical services including Medical Haematology and Immunology
- Mortuary & bereavement services and Phlebotomy services
- Genomics Services, as Sheffield Diagnostic Genetic Centre has become a part of North East and Yorkshire Genomic Laboratory Hub/Genomic Medicine Service

4.5 Identifying and Assessing the Options

The general principles for appraisal of options were developed by the PTP Board in keeping with; a) the guiding principles of the programme, b) the goals of the SYB Integrated Care System and c) requirements set by the NHS England/Improvement. Further considerations stemmed from this work as follows:

- To be aligned with the NHS England/Improvement (NHSE/I) concept and the operational realities of Pathology in SYB, the services in the scope of the PTP should be grouped into three clinical disciplines: Blood Sciences, Microbiology and Histopathology
- The principle of the primacy of clinical quality. To be considered viable, an option must safeguard and future-proof the standard of clinical care/clinical quality
- The recommended option would be the one that delivers maximum consolidation, and projected cumulative financial efficiency as well as resilience, sustainability, ability to adapt to future workload and workforce changes and assured business continuity

The task of reviewing the options was delegated to expert reference groups, set up for each clinical / laboratory discipline as follows:

- Blood Sciences Reference Group (BSRG): routine and specialised Biochemistry, Haematology and Immunology
- Microbiology Reference Group (MRG): Microbiology and Virology
- Histopathology Reference Group (HRG): Cellular Pathology/Histopathology

These discipline specific reference groups were asked to look at the TOM options and the required associated workforce models for their discipline. Reports from these groups are shown in Appendices G, H and I resp.

In addition several cross-cutting reference groups were established and tasked with considering and harmonising approaches across all disciplines and specialties within the SYB Pathology Service. These included:

- Workforce
- IT
- Quality
- Logistics
- Procurement
- Finance

Reports from the first 4 of these groups are available as Appendices L to M. A Specialised Services Reference Group was also established and tasked with identifying issues of particular relevance to specialised services across all disciplines. Once completed, work on specialised services was incorporated into the respective discipline reference groups.

Table 2 below shows the advantages and disadvantages of each option and those taken forward for further detailed assessment.

Table 2 : Shortlisted Operating Model Options

Option	Description	Advantages	Disadvantages	Scheme objectives
1. Do nothing	• Keep the existing service configuration and continue to operate as individual Pathology services	• Staff familiarity	• Variation would continue with inequitable access to services • Workforce shortages in key staff groups could not be resolved on a Network basis • Inability to invest in the latest technology and optimum methodologies on all sites • Services would be unable to deliver the scale of expected savings • Would not meet the NHSI mandate to develop a Pathology Network	• Does not meet the Guiding Principles **Discounted**
2. Collaborative working with no change to organisational form and operational model	• Keep the existing service configuration and continue to operate as individual Pathology services. • Harmonise methodologies, reference ranges, terminology etc.	• Staff familiarity and a degree of standardisation across SYB	• Variation would continue with inequitable access to services • Workforce shortages in key staff groups could not be resolved on a Network basis • Inability to invest in the latest technology and optimum methodologies on all sites • Services would be unable to deliver the scale of expected savings • Would not meet the NHSI mandate to develop a Pathology Network	• Does not meet the Guiding Principles **Discounted**
3. Develop the NHSI hub and spoke model	• Centralise all laboratory services into an existing single site CSL and maintain ESL's only at each spoke (acute hospital)	• Would allow standardisation across all disciplines, consolidation of equipment assets and delivery of staff and non-pay efficiencies • Supports a more sustainable staffing model • Facilitates investment in the latest technology and optimum methodologies for the benefit of all in SYB	• Would require substantial alteration to the estate to accommodate the volume of work on a single site • Sustainability and business continuity at greater risk than Option 4 • Maximum impact on staff; less likely to retain required expertise than option 4 • Uncertainty during implementation may affect retention of staff	• Should meet the Guiding Principles. However, there are worries about deliverability, impact on staff and business continuity risk. **Taken forward for assessment**
4. Modified NHSI model with up to two CSLs per discipline	• Centralise all specialist services onto a single site (not necessarily all on the same site) • Operate up to 2 CSLs per discipline	• Would allow standardisation across all disciplines, consolidation of equipment assets and delivery of staff and non-pay efficiencies • Supports a more sustainable staffing model • Facilitates investment in the latest technology and optimum methodologies for the benefit of all in SYB • Improved resilience and business continuity compared to option 3 • Easier to accommodate in existing estate than Option 3 • Less impact on staff than Option 3; more likely to retain required expertise	• Less consolidation than Option 3 • Uncertainty during implementation may affect retention of staff	• Meets the Guiding Principles • Provides the best opportunity to meet the guiding principles **Taken forward for assessment**

4.6 Blood Sciences

Reviewing the Optimal Configuration

Blood Sciences encompasses the clinical disciplines of clinical biochemistry (including toxicology, newborn screening and inherited metabolic diseases), haematology (including haemato-oncology diagnostic service (HODS), coagulation and blood transfusion) and immunology which includes many specialist services. Blood Science services support clinical pathways of all acute Trusts and primary care. The services also provide commercial work for NHS organisations outside SYB, independent healthcare providers, academia and industry.

Blood Science laboratories and facilities are currently located on all hospital sites. However, large aspects of specialist biochemistry, haematology and immunology have for many years been consolidated within Sheffield at STHFT and SCFT. In addition, a small element of specialist biochemistry is currently consolidated at TRFT.

The recommendation of the BSRG is to:

1. Consolidate all specialist testing within Sheffield. This includes:
   a) Specialist paediatric biochemistry at SCFT
   b) HODS, specialist coagulation and haemoglobinopathies at RHH
   c) Specialist (adult) biochemistry, toxicology and immunology at NGH

   It has been recognised that the theoretically most optimal scenario for all specialist services to be physically co-located at a single site within a Central Services Laboratory (CSL) is not possible due to the estate available, but also because of the relevant clinical proximities. It was concluded that the above model in Point 1 is the most appropriate.

2. Establish a viable and flexible system comprising a single CSL based at NGH, one Extended ESL (EESL) and five Essential Services Laboratories (ESL), so that there is one co-located with each acute hospital site. The CSL will perform the ESL function for its hospital site. This is in line with NHSI recommendations and sound clinical practice.

   ESLs will offer a limited repertoire of assays (tests); these have been defined with the input of clinical services across SYB and are those required to support the time-critical, clinical pathways and scenarios relevant for each hospital site (*Appendix N*). Therefore, a Blood Sciences ESL is defined by the scope of its work (limited repertoire of tests) and to those samples taken on the site of the acute hospital that it supports.

   An Extended ESL (EESL) will deliver the ESL test list of tests (*Appendix N)* plus other high volume tests that are available on the ESL instrumentation and where the samples are taken on-site and/or may undertake a proportion of the network's primary care work that can be delivered on the ESL instrumentation. Compared to the ESLs, the EESL is likely to have enhanced pre and post analytical capability to enable them to handle the higher volume of testing efficiently; this will also provide greater service resilience should a business continuity event occur at the CSL. An EESL for 24/7 services will not affect the proposed model for specialist services; tests that are not part of the ESL or EESL repertoire will only be performed at the CSL.

   Technological and economic drivers for the effectiveness of this model are standardised processes on unified analytical platforms with a single SYB LIMS.

3. Provide specimen reception and support for the operations of Histopathology and Microbiology that are not present on those sites in addition to Blood Sciences workflows (see the relevant sections).

4. Provide sufficient floor space at each site to allow for the appropriate instrumentation with additional floor space to future proof against growth in demand and to allow for undefined additional requirements such as a COVID pandemic.

The options considered in detail by the BSRG were therefore:

1. A single CSL and six ESLs.
2. One CSL, one EESL and five ESLs.

Due to the geographical proximity of RHH and SCH, potential MSC suppliers have suggested that it should be possible to meet the clinical need for time critical testing at RHH and SCH with one ESL and that a reduction of one ESL should deliver some additional financial efficiencies. SCH initially advised the PTP ESB that they would not support an OBC that did not include an ESL at SCH; however, in December 2020 ESB agreed that the costs of one versus two ESLs should be determined. A paper presented to ESB in March 2021 showed a potential annual difference of a little over £1M excluding the costs of sample transport between sites. As a consequence of this financial estimate being deemed as 'material' by ESB members, ESB asked that a Quality Impact Assessment (QIA) be undertaken of the establishment of a single ESL serving both RHH and SCH. Representatives from RHH and SCH have identified the risks associated with a single ESL and are in the process of scoring the likelihood and consequence of the risk likely to remain after any mitigating action has been identified.

A key consideration is the Paediatric Major Trauma Centre designation at SCH. The NHS England guidance associated with this designation states that Pathology must be a 'co-located' service. Similar queries have arisen as to whether a single ESL laboratory would adversely impact on the status of the Level 4 Obstetrics service at Jessops and the Thrombotic Thrombocytopenic Purpura (TTP), national blood apheresis and haemoglobinopathy services at RHH. The issue of whether the two sites of RHH and SCH can be considered to be co-located is a key decision that is needed to enable completion of the QIA as several of the identified risks are associated with accreditation/status and the need to have services 'co-located on site'. The NHSE&I Pathology National Lead and a representative of the RCPath Council for the North of England have indicated that the determination of co-location is a matter for the network medical directors and Boards to decide informed by risk assessments. Following discussion on 23 June 2021, ESB concluded that they believe that, for the purposes of the programme, RHH and SCH should be assumed to be co-located and that the key requirement is for any future Pathology service model to maintain or improve service quality including the delivery of required turnaround times. This was supported by AF CEOs on 5 July 2021. It is proposed that the AF CEO Chair and Pathology SRO should write to regulators confirming this position and seeking assurance that this does not adversely affect Paediatric or other trauma/ service status. A recommendation on one or two ESLs at central Sheffield would thereafter be dependent on the outcome of the QIA and consideration of costs after any required investment to mitigate risk. It was noted at the AF CEO meeting on 2 August 2021 that the SCH Board have indicated their agreement with this approach. This recommendation will form part of the Full Business Case.

In considering the target operating model options the following was discussed and agreed by the BSRG as recommendations for inclusion in the Outline Business Case:

- Blood Sciences are the most complex of all three laboratory disciplines. This complexity reflects not only the volume of work and the user base but the scope of pathology specialties, assays, technologies and equipment, the interplay of routine and specialist services and workflows and IT, estate and logistics required.
- It is assumed that whenever clinically, scientifically and technologically possible, assays will be performed on unified, automated and the economically most advantageous analytical platforms and the test results forwarded/accessible for interpretation and reporting by relevant discipline experts.
- It is recognised that the current services in the SYB region host several clinically relevant, commercially successful or high-profile specialist laboratory services with a nationwide user base. Since most of these services are a part of the Blood Science specialties they (and relevant issues) are listed here:
    - Specialist Paediatric Biochemistry, comprising Neonatal Screening and the highly-specialised Inherited Metabolic Disease service will remain co-located with the clinical operations at the SCFT. These services may pursue a different consolidation pathway (e.g. a National Paediatric Pathology Network) following an on-going national work programme.
    - HODS is a multidisciplinary regional SYBND haemato-oncology diagnostic service based at RHH. Several Haematologists from other Trusts participate in the service. Given the consolidation of Genomics at the North

East and Yorkshire Genomic Laboratory Hub (GLH), there is a possibility that haemato-oncology diagnostics will be consolidated at a Haematological Malignancies Diagnostic Service in Leeds as a part of the future NHSE-driven consolidation programmes.
    - A Protein Reference Unit (PRU), part of the current Immunology service based at NGH, is a commercially successful laboratory with a national footprint. Consultant Immunologists currently provide support for all laboratory services in the SYB Region.
    - A Toxicology service, based at NGH, is a distinct unit concentrated around equipment, technologies (High Performance Liquid Chromatography and Mass Spectrometry) and clinical forensic expertise.
    - A Specialist Coagulation service, based at RHH, is relatively small, but one of a very few nationally recognised services in the discipline.
    - The Specialist Services and arrangements that sit outside of Blood Sciences Reference Group have been considered by the Histopathology Reference Group (Electron Microscopy South and East Yorkshire Neuropathology Network, National Ophthalmic Pathology Network, National Gestational Trophoblastic Disease Network) and the Microbiology Reference Group (Specialist Bacteriology and Virology). All were also considered by a task and finish Specialist Laboratory Services Reference Group before being handed back to the BRSG, HRG and MRG.
    - Three NEQAs schemes (Immunophenotyping, Immunology and Coagulation) are hosted by STHFT, but these are organisations separate to STHFT.
    - The definition of Specialist Biochemistry is prone to interpretation. Some assays performed on specific equipment purchased over time by individual organisations may not necessarily fit under the umbrella of Specialist Services. In principle, these applications should benefit from standardisation of analytical platforms and consolidation of resources, whenever clinically applicable. Many specialist assays become commoditised and available for migration to the mainstream, automated platforms over time. It is economically and operationally desirable to facilitate migration when possible and keep a development pipeline active.
    - Some specialist assays are outsourced. There are three main reasons: (i) SYB services have not developed these assays thus far, mainly due to low volume of demand (ii) historical and reciprocity arrangements; some of these may have bypassed pathology services (iii) nationally driven consolidation (e.g. genomics). SYB Pathology Services will develop guidelines for future repatriation and outsourcing.
- The OBC assumes that the Blood Sciences Consultant workforce (medics and scientists) will stay as-is but with a shared responsibility for clinical services across the network. Suitable Consultant accommodation will be available at all sites. Nevertheless, the PTP is aware that there are additional opportunities via comprehensive regional standardisation and development of new models of work. In keeping with Modernising Scientific Careers[18] and the NHS People Plan[19], SYB Pathology is committed to the further development of a Consultant-level scientific workforce.
- Blood typing assays are defined as part of the ESL repertoire (Appendix N), as relevant for the acute operations of individual acute hospital sites. However, complexities of transfusion pathways, including procurement of blood products, have not been addressed by the PTP thus far. The costs of blood products have been excluded from the baseline and predicted costs in this OBC as the budget and expenditure sits outside Pathology with clinical divisions/directorates.
- There are a range of historical arrangements in regards to the implementation and governance of point-of-care testing (POCT) across SYB. There will be future drivers to optimise and standardise procurement, integration and governance of POCT, as well as to develop the strategy for its further expansion. This is not in the scope of this document although staffing of the POCT team within the SYB Pathology Service has been included. It is strongly recommended that in the future model SYB Pathology should 'manage' POCT delivery and guide clinical staff in its procurement, deployment, IT connectivity and quality assurance, but that the budget for equipment and consumables should sit with clinical divisions/directorates.
- Healthcare providers in SYB have a range of phlebotomy arrangements in place; only a relatively small proportion of it is managed and governed by laboratory services. At SCH some staff undertake phlebotomy as well as laboratory duties; only these staff have been included in the staffing review. However, some solutions developed during the on-going pandemic (e.g. drive-through phlebotomy) highlight the clinical and operational benefits of vertical integration of pre-analytics. The PTP initiated discussions about a coordinated SYB approach to phlebotomy and a decision was taken by the Health Care Management Team that phlebotomy planning will occur at Place level.

The perceived advantages and disadvantages of the two operating model options are shown in Table 3 below

Table 3 : Blood Sciences Reconfiguration Options

Option	Description	Advantages	Disadvantages	Scheme objectives
1. NHSI Model (One CSL and six ESLs)	• Single CSL undertaking full range of automated tests • All primary care and non-acute work where samples are collected away from the hospital site analysed at the CSL • Specialised services consolidated within Sheffield • ESLs at each of the other six acute hospital sites undertaking a defined list of time critical tests	• Most consolidated model • Standardised equipment platforms, methodologies, test names, reference ranges etc. • Time critical services retained on all acute sites	• Low resilience if major failure at CSL • Risk to turnaround time if CSL processes and staffing fail to cope with volume of samples arriving at peak times	• Meets the Guiding Principles • Risk of failure due to low resilience **Discounted**
2. Modified NHSI Model (One CSL, one EESL and five ESLs)	• Single CSL undertaking full range of automated tests • Single EESL with same instrumentation as ESL but undertaking a wider range of automated tests and/or undertaking some primary care and non-acute work • Specialised services consolidated within Sheffield • ESLs at each of the other five acute hospital sites undertaking a defined list of time critical tests	• Large degree of consolidation • Standardised equipment platforms, methodologies, test names, reference ranges etc. • Time critical services retained on all acute sites • Increased resilience • Improved business continuity	• Delivery of primary care samples to two sites (CSL & EESL)	• Meets the Guiding Principles • Improved resilience **Recommended Option**

Site Evaluation

In Feb. 2021 the Pathology Executive Steering Board (ESB) agreed the evaluation criteria to assess the most appropriate site for the location of a mini-CSL (EESL for Blood Sciences and a second Microbiology laboratory) and, after consideration of advice received from prospective Managed Service providers, agreed that the sites to be evaluated were Barnsley and Doncaster. A decision was taken to co-locate the EESL and second Microbiology laboratory to ensure logistics efficiencies.

Following an estates assessment and collection of the relevant quantitative data, the members of the PDT and chairs of the reference groups individually completed the scoring exercise. To avoid bias, a BRILS representative was also asked to complete the scoring exercise as the co-chair of the BSRG is a DBTHFT employee. The Evaluation Criteria table, all relevant data, scores and comments from individuals are available at Appendix O.
A summary of the weighted scores are provided in Table 4.

Table 4 : Weighted Scores for location of mini CSL

SCORER	A	B	C	D	E	F	G	H	A	B	C	D	E	F	G	H
LOCATION	BH	BH	BH	BH	BH	BH	BH	BH	DRI	DRI	DRI	DRI	DRI	DRI	DRI	DRI
WEIGHTED SCORE	4.73	4.73	4.73	5.08	5.98	3.7	4.48	5.61	7.61	7.61	7.86	7.86	7.70	7.08	7.36	7.21
TOTAL SCORE	39.04								60.29							

Doncaster was scored by all individuals as the most appropriate site for the mini-CSL using the data gathered against the agreed evaluation criteria.

A paper detailing all the scores and comments was considered by ESB at their meeting on 23 June 2021 (*Appendix O*). Variation in scores between individual scorers and all comments were noted; however, the outcome of the scoring was consistent in all cases. A document listing queries and concerns from staff about the evaluation criteria, data and scoring highlighted the need for a communication and engagement process with staff and Trust Directors of Communication are assisting with this. Having considered the concerns raised by staff, ESB members agreed that the process appeared open, fair, transparent and robust and supported the outcome of the evaluation, concluding that Doncaster should be recommended to the AF CEOs and for inclusion in the OBC as the location for the mini CSL. AF CEOs supported this recommendation at their meeting on 5 July 2021.

4.7 Microbiology

Reviewing the Optimal Configuration

Currently, three providers (BRILS, DBTHFT and STHFT) operate a Microbiology service at four laboratory sites (BH, DRI, NGH and TRH) with consultant accommodation at seven trust sites (BH, BDGH, DRI, NGH, RHH, SCH, and TRH). The majority of molecular virology testing has been consolidated at the NGH site for some time. Microbiology and Virology services support clinical pathways of all acute Trusts and primary care. The services also provide commercial work for NHS organisations outside SYB, independent healthcare providers, academia and industry.

In addition to reporting and post-analytical support for laboratory testing, Microbiology Consultants take part in a range of Trust-based clinical or supervisory activities such as infection control and antibiotic stewardship. Virology Consultants, employed by STH, provide support for all Trusts in the Region and service users outside SYB.

During the COVID-19 pandemic, all three services have provided PCR testing for SARS-COV-2 and rapid testing has been implemented at all acute hospital sites in line with nationally published use cases and technological developments. Point of care testing for influenza is in place at relevant gateways of all Trusts.
The options considered by the MRG were:

1. Consolidation of all laboratory processing onto a single CSL site
2. Consolidation of laboratory processing at two sites with a main CSL and a smaller secondary laboratory

In considering the target operating model options the following was discussed and agreed by the MRG as recommendations for inclusion in the Outline Business Case:

- Specialist Microbiology and Virology will be consolidated at a CSL, and co-located with the Blood Sciences CSL at NGH.
- The CSL will operate a 24/7/365 service. The secondary laboratory will operate an extended day but not 24/7.
- The secondary laboratory should be co-located with a Blood Sciences EESL and could be sited at Barnsley or Doncaster, pending a detailed review including estates and logistics. A decision was taken to co-locate the EESL and second Microbiology laboratory to ensure logistics efficiencies.

- The CSL and secondary laboratory will both be able to perform a full range of routine Bacteriology, including use of MALDI ToF technology.
- The secondary laboratory may also undertake some non-urgent, high-volume work.
- Each acute hospital site that does not host the CSL or secondary laboratory will have access to on-site blood culture incubation incorporated into the Blood Sciences ESL to enable real-time processing of blood cultures. The positive cultures will be transported to one of the Microbiology laboratories (dependent on location and time of day) for further analysis and reporting.
- Each Blood Sciences ESL located on a site that does not host the CSL or secondary laboratory will provide specimen reception and support for the Microbiology work from that site
- The current assumption is that there is a pending technological change in mainstream Bacteriology. It will comprise automation, a shift to molecular technologies with pathway-specific pathogen panels as well as an increase in the use of point-of-care and rapid diagnostic/screening methods. This OBC does not attempt to predict these future developments; however, the MRG believes that the proposed options will best enable SYB to be ready to harness their potential. MRG reviewed the automation currently available and concluded that whilst it offers quality benefits, it requires substantial investment and does not offer value for money.
- A strategy for regional standardisation of the Consultant Workforce has not been detailed as the part of the OBC but is an expectation as the SYB Pathology Service becomes established. Suitable Consultant accommodation will be available at all sites. In keeping with Modernising Scientific Careers[18] and the NHS People Plan[19] , SYB Pathology is committed to the further development of a Consultant-level scientific workforce.
- There is an assumption that all acute hospital sites will have suitable infection prevention POCT at relevant gateways, which will expand beyond the current scope.
- The design of COVID testing capabilities has not been discussed in this document. Nevertheless, in the context of this and the risk of similar events of this type in the future, it is assumed that the service must have dynamic capabilities to support health and care in SYB. Some of these considerations will, for example, reflect in the planning for Blood Science ESLs and in the design of pre-analytical pathways.

The perceived advantages and disadvantages of the two operating model options for Microbiology and Virology are shown in Table 5 below.

Table 5 : Microbiology and Virology Reconfiguration Options

Option	Description	Advantages	Disadvantages	Scheme objectives
1. Single CSL	• Consolidate all laboratory services in a single CSL • Consultants at all sites • Flexible approach to POCT	• Most consolidated model • Standardised equipment platforms, methodologies, test names, report comments etc.	• Most disruption for staff • Low resilience if major failure at CSL • Insufficient floor space identified at the CSL (NGH)	• Theoretically meets Guiding Principles, but low deliverability: does not ensure high quality estate that can ensure service resilience • Risk of failure due to low resilience **Discounted**
2. CSL and Secondary Laboratory	• Two laboratories – a main CSL and a smaller secondary facility • Specialist bacteriology and all virology testing consolidated at the CSL • Blood culture incubators at every acute site • Consultant service at all sites. • Flexible approach to POCT	• Standardised equipment platforms, methodologies, test names, report comments etc. • Less disruption for staff • Increased resilience • Improved business continuity • Gives greater flexibility for operational capacity in undefined situations highlighted by the on-going COVID pandemic	• Less consolidated option	• Meets the Guiding Principles • Improved resilience • Improved deliverability **Recommended Option**

Site Evaluation

The recommendation of BSRG and MRG is that the Microbiology secondary laboratory should be co-located with the Blood Sciences EESL (to gain efficiencies in staffing and sample logistic reasons) and that this mini CSL could be sited at Barnsley or Doncaster (flowing advice from prospective MSC providers). The site evaluation has been covered in section 4.6 for Blood Sciences. The Evaluation Criteria table, all relevant data, scores and comments from individuals are available at Appendix O. Doncaster has been scored by all individuals as the most appropriate site for the mini-CSL using the data gathered against the agreed evaluation criteria.
Variation in scores between individual scorers and all comments were noted; however, the outcome of the scoring was consistent in all cases. A document listing queries and concerns from staff about the evaluation criteria, data and scoring highlighted the need for a communication and engagement process with staff and Trust Directors of Communication are assisting with this. Having considered the concerns raised by staff, ESB members agreed that the process appeared open, fair, transparent and robust and supported the outcome of the evaluation, concluding that Doncaster should be recommended to the AF CEOs and for inclusion in the OBC as the location for the mini CSL. This recommendation was supported by the AF CEOs at their meeting on 5 July 2021. ESB suggested that the next steps should include the offer of the PDT to meet with the BRILS Executive team.

4.8 Histopathology

Reviewing the Optimal Configuration

Histopathology is currently delivered by four services (BRILS, DBTHFT, SCFT and STHFT) with laboratory and consultant facilities at six acute trust sites (BH, CRH, DRI, RHH, SCH, and TRH). There is an intraoperative frozen section satellite lab at the NGH. The services support clinical pathways in the acute trusts, with a limited amount of primary care work and some commercial work for independent healthcare providers, academia and industry. The technical aspect of histopathology work does not lend itself to automation at scale. Consultant reporting is affected by the growing gap between demand and capacity, due to increases in volume and complexity of workload, staff shortages, underdevelopment of the workforce, and historical fragmentation of services. Career development for scientific staff to enable BMS cut up has only progressed significantly at STH; other services have had insufficient sub-speciality workload and difficulties in providing training and supervision, although more recently a network solution to this has commenced. Development of BMS reporting and Clinical Scientists roles has been very limited but SYB Pathology is committed to the further development of a Consultant-level scientific workforce.

Advances in digital and computational pathology provide a pivotal opportunity to redesign the SYB histopathology service and address challenges with capacity. Digital technology has been used for diagnostic intraoperative frozen sections at STHFT since 2010 and a rollout of digital histopathology for high-volume work is currently in progress at STHFT; however, the current technical solution is sub-optimal with adverse impact on delivery of the potential benefits. As described in the draft Digital Pathology Outline Business Case (*Appendix P*), proposals for the full implementation of digital technology and end to end processes across SYB are in progress. The outcome of a bid for capital funding to support the implementation on Digital Pathology in SYB is eagerly awaited (expected by early August 2021).

The two operating model options being considered by the HRG are:

1. Consolidation of laboratory processing and consultant reporting offices onto a single CSL site with digital pathology.
2. Consolidation of laboratory processing at two sites with digital pathology: a main CSL and a smaller secondary laboratory with all Consultant Histopathologists located together on a single site at the main CSL that will process the SYB specimens most likely to require 'specialist input' e.g. consultant cut-up, specialist processing, specialist immunohistochemistry (IHC), special stains, cytogenetics and other molecular testing. The second processing laboratory (mini-CSL) will handle tissues/pathways suitable for Biomedical Scientists (BMS) cut-up and requiring only a limited range of IHC. The mini-CSL will have hot desk/offices for consultants attending on an as and when required basis. BMS staff will rotate between the two sites.

In considering the target operating model options the following was discussed and agreed by the HRG as recommendations for inclusion in the Outline Business Case:

- A single processing laboratory (CSL) will provide equitable access to all routine and specialist histopathology and non-gynae cytology for all in SYB, will enable career development for scientific staff, thereby improving service resilience and will deliver efficiency savings. The majority of sample dissection will be undertaken by BMS staff.
- Satellite (ESL) sites will provide intraoperative procedures and andrology services to meet clinical requirements if no on-site CSL is present. To meet current requirements this will be as follows:
    - TRHFT - Andrology, Frozen section
    - RHH - Frozen section, OSNA, MOHS, BAL
    - SCH - Frozen sections and brain smears
    - NGH - Frozen section
    - DRI - Andrology, Frozen section
    - CRH - Frozen section
- Histopathologists will be co-located with each other on a single site providing peer support and ease of interaction with senior and experienced Histopathologists and providing the greatest opportunities for interaction with complex cases. Histopathologists should practice as sub-specialists in circa 1 to 3 areas; this will provide exposure and experience to the full case mix in sub-speciality area(s) and makes it more manageable for individuals to keep up to date with the latest guidance, continuing professional development and external quality assurance in sub-speciality areas. These are believed to be very significant factors in supporting the recruitment and retention of Histopathologists that is essential for SYB service resilience.
- Histopathologists will be co-located with the single central processing laboratory (CSL) to provide in-person clinical leadership of the service, consultant cut-up (where this is needed) and direct supervision and training of BMS and histopathology trainees (for cut-up and reporting).
- There will be a named lead Histopathologist for each subspecialty for each Trust site; leads will act as the key point of contact for service users from that site. For small sub specialties there may be a single named lead for SYB; for the larger sub-disciplines there may be multiple named leads, all working collectively to ensure equity of service across SYB.
- Co-location of cellular and relevant molecular pathology to provide lean workflow and support personalised medicine & tumour classification.
- Close collaboration and effective working between cellular pathology, Sheffield Diagnostic Genetics Service and Genomic Laboratory Hubs
- Paediatric Histopathologists to be in close proximity to the Paediatric mortuary to minimise consultant travel time during the day and ensure availability to liaise with bereaved families
- Histopathologists to be in close proximity to the University of Sheffield (UoS) campus to facilitate efficiency of Clinical Academics' teaching and research activity minimise consultant travel time during the day and attract new recruits; all STH Consultants have honorary senior lecturer status
- Location of processing laboratory to support governance and chain of custody of material including paediatric and adult post mortem material
- Digital Pathology is an essential enabler of the target operating model and proposed workforce plan to support efficient workflow and speed of diagnosis, enabling the laboratory to cope with higher activity levels and providing efficiencies before and during multi-disciplinary team meetings. It will also support rapid image sharing for second opinions including ease and speed of access to specialists outside SYB and facilitate the sharing of cases for learning and development, thereby supporting training. It reduces manual handling, delivers a more ergonomic reporting process for Histopathologists and enables some home reporting without the need to transport glass slides. It will also offer faster recall of 'old' cases to benefit review and research. Importantly digital pathology is an essential step to enable the use of AI; in the future AI should offer significant decision support benefits for Histopathologists.

The perceived advantages and disadvantages of the two operating model options are shown in Table 6 below:

Table 6 : Histopathology Reconfiguration Options

Option	Description	Advantages	Disadvantages	Scheme objectives
1. Consolidation of laboratory processing and consultant reporting offices onto a single CSL site with digital pathology.	• A single histopathology processing laboratory for all acute Trusts • Intraoperative frozen section and dissection facilities available at other sites, as required • All Consultants co-located	• Most consolidated model • Standardisation of pre-analytics and processing • Standardisation of staff development, training and pooling of scientific expertise; greater service resilience • Close proximity of all Consultants: peer support and development of sub-specialty reporting in circa 1 to 3 areas • Optimal solution for recruitment of Histopathologists • Minimises need for equipment • Most efficient in terms of running costs	• Will need significant estates alterations • Biggest impact on scientific staff • Business continuity risk if incident affects CSL	• Meets Guiding Principles • Estates costs may be prohibitive (but yet to be identified) **Recommended Option (subject to estates assessment)**
2. Consolidation of laboratory processing at two sites with digital pathology: a main CSL and a smaller secondary laboratory with BMS cut-up and limited IHC.	• A single CSL processing 'specialist' work from all acute Trusts with all consultants co-located • A mini Histopathology CSL processing tissues/pathways suitable for BMS cut-up and requiring only a limited range of IHC. The mini-CSL will have hot desk/offices for consultants attending on an as and when required basis • BMS staff will rotate between the two sites • Intraoperative frozen section and dissection facilities available at other sites, as required	• Less significant estates alterations/costs (TBC) • Standardisation of pre-analytics and processing • Standardisation of staff development, training and pooling of scientific expertise • Less disruption for scientific staff • Increased resilience if incident affects CSL site	• Requires specimen sorting and transportation to two sites • Adverse impact on turnaround time if sample initially processed at mini CSL has to be sent on to CSL for specialist work • Mini CSL lacks day to day in-person clinical leadership • Lower workforce resilience • Some duplication of costs but this is expected to be minimal	• Meets Guiding Principles • Risk of adverse impact on turnaround time for some samples initially processed at mini CSL that then need to go to CSL for specialist work • Estates costs may be high (but yet to be identified) **Discounted (subject to estates assessment)**

Site Evaluation

ESB accepted the HRG recommendations for the most appropriate target operating model for Histopathology and suggested evaluation criteria to determine the optimal location(s) at their ESB meeting on 23 June 2021.
ESB members agreed that, based on the HRG recommendations, only RHH and SCH are suitable locations for a single Histopathology CSL. This is due to the fact that the vast majority of the SYB Consultant Histopathologist workforce is currently located within central Sheffield, mainly on the RHH site. Location at either RHH or SCH is minimally disruptive for this essential and highly sought after workforce for which there are many vacancies across SYB. Also, both RHH and SCH are within close (walking) proximity of both the paediatric mortuary and UoS. ESB members agreed that a target operating model for Histopathology of a single CSL should be recommended to the AF CEOs, with the RHH and SCH sites being subject to an evaluation process. This recommendation was supported by the AF CEOs at their meeting on 5 July 2021.

Estates Directors from RHH and SCH were asked to undertake a site assessment against the requirements for a single Histopathology CSL. SCH have fed back that they could not accommodate the full CSL without major expansion and do not currently have the estate to do this. The preference of SCH would be to retain the paediatric element of the histopathology service for SYB. RHH believe that the site could accommodate the full CSL but further work is required to understand the cost implications. Further assessment will be included within the FBC.

Combined Summary of Options

The following table provides a combined summary of the options across all laboratory specialties and workstreams. Each option has been colour coded in order to demonstrate which options have been

- Discounted (Red)
- Considered alternative (Amber)
- The recommended way forward (Green)

Table 7 : Operating Model Options by Speciality

Options	Blood Sciences	Microbiology	Histopathology
1. Do nothing	Discounted	Discounted	Discounted
2. Collaborative working with no change to organisational form and operational model	Discounted	Discounted	Discounted
3. Single CSL with ESLs at all other acute hospital sites	• One CSL located at NGH undertaking full range of automated tests. All primary care and non-acute work where samples are collected away from the hospital site analysed at the CSL • All specialised services consolidated within Sheffield • ESLs at each of the other six acute hospital sites undertaking a defined list of time critical tests	• One CSL for all Microbiology and Virology located at NGH • Blood Culture incubators at each acute site	• One CSL for histopathology processing with all consultants co-located based at either RHH or SCH • Intraoperative frozen sections facilities at acute hospital sites as required by clinical services. • Digital Pathology
4. Up to 2 CSLs per discipline with ESLs at other acute sites	• Single CSL located at NGH undertaking full range of automated tests including primary care and non-acute work from across SYB • Single EESL located at DRI with same instrumentation as ESL but undertaking a wider range of automated tests and/or undertaking some primary care and non-acute work • All specialised services consolidated within Sheffield • ESLs at each of the other five acute hospital sites undertaking a defined list of time critical tests	• Main CSL located at NGH • Consolidated Specialist Testing at the Main CSL • Secondary lab located at DRI • Blood culture incubators at each acute hospital site	• Single CSL processing 'specialist' work from all acute Trusts with all consultants co-located • A mini Histopathology CSL processing tissues/pathways suitable for BMS cut-up and requiring only a limited range of IHC. The mini-CSL will have hot desk/offices for consultants attending on an as and when required basis. • BMS staff will rotate between the two sites. • Intraoperative frozen section and dissection facilities available at other sites, as required • Digital Pathology

4.9 Recommended Combined Service Option

Pathology Services constitute multiple departments. These departments function in the main independently of each other but are often co-located. The PTP and reference groups have assessed the combination of options to determine if the combined option meets the guiding principles and if the adoption of one option impacts on other departmental options. Essentially the assessment looked at whether the adoption of any laboratory option impacted or prevented the adoption of another laboratory option.

Table 8 : Combined Options vs Guiding Principles

Guiding Principles	1. Do nothing	2. Collaboration (no change to org form)	3. NHSI Model	4. Modified NHSI model
Quality	X	Y	At risk	Y
Workforce	X	X	At risk	Y
Innovation	X	X	At risk	Y
Science and Technology	X	X	Y	Y
Research and Development	X	X	Y	Y
Value for money	x	x	y	y
Assessment	**Discounted**	**Discounted**	**Discounted**	**Recommended**

The recommended option for the future combined configuration is Option 4 with:

- A single CSL for Histopathology
- One CSL and one mini CSL for Microbiology
- One CSL, one EESL and five ESLs for Blood Sciences

The final configuration will be subject to a detailed review following the outcome of the MSC procurement and including estates and logistics and their influence on the financial forecast that follows the review. The number of ESLs is also subject to the outcome of the QIA and consideration of 'co-location' between RHH and SCH.

In principle, Option 3 may deliver against the guiding principles but it has maximum impact on staff and there were concerns expressed with regard to deliverability and resilience for Blood Sciences and Microbiology. No location was deemed to have sufficient space for this model for Microbiology.

The conclusion drawn was that Option 4 should enable provision of a resilient service with the flexibility to deliver on the guiding principles and future-proof the continuity and standard of care for all stakeholders and clinical pathways across the SYB ICS, whilst improving sustainability and financial efficiencies compared to current services.

As previously stated, it is widely recognised that the clinical, operational and financial viability of this option requires the following organisational, operational and technological infrastructure:

1. A unified governance structure
2. A unified approach to procurement, with a modern single SYB Managed Service Contract to enable standardisation and flexibility of analytical platforms
3. A single LIMS
4. End-to-end digital histopathology platform/processes
5. Suitable logistics
6. Adequate estates

4.10 Risk Assessment

Inevitably, in proposing a change to the configuration of pathology services, a number of overarching risks have been identified as shown below:

Table 9 : Principle Risks Relating to the Preferred Option

Risk	Impact	Likelihood	Risk	Mitigating Actions	Residual Risk
Workforce A proactive workforce strategy is in place but there is a risk that transition to the proposed operating model may temporarily affect staff retention. (Most Pathology networks have reported significant staff turnover during implementation of their TOM). In the recommended TOM Barnsley and Rotherham are the most likely sites to see increased staff turnover due to the changes in service configuration at those sites. The proposed reconfiguration of services should have little adverse impact on existing clinical staff and it is hoped that the Histopathology proposal will in fact improve recruitment to consultant vacancies.	Major	Possible	**Medium**	Active HR approach to the organisational changes in place. Network approach to staffing gaps as they arise to support service continuity.	**Medium**
Logistics There is a risk to delivery of the TOM if an efficient and effective transport service is not implemented across SYB Pathology. Planning for the future logistics model has been delayed whilst the TOM, including locations, is specified. There is a need to engage with the market to select a logistics partner to provide a SYB service.	Major Inadequate sample transportation Delays in implementing transport will delay delivery of TOM	Unlikely	**Medium**	Procurement and implementation of SYB transport solution should be possible in the timescale needed to procure and implement MSC and LIMS.	**Low**
Information Technology A single Laboratory Information Management System (LIMS), integrated OrderComms and Digital Pathology solutions are essential to deliver the TOM but are not yet agreed. Bids have been submitted to NHSE/I for capital funding. OBCs in development There is a risk that the timeline for implementation of the LIMS and Digital Pathology projects may delay SYB's ability to deliver the TOM	Major Integrated IT platforms are essential to services	Possible	**Medium**	LIMS and Digital projects with robust project management and business cases. Secure funding.	**Medium**
Laboratory Estate Service reconfiguration is dependent on the adjustments of existing laboratory estate. Estates assessments indicate that Blood Sciences and Microbiology can be accommodated without major investment but this will need detailed review once the outcome of the MSC procurement is known. The estates assessment for Histopathology has not yet been undertaken. There is a risk that this may identify need for significant reconfiguration and cost.	Major Failure to provide suitable laboratory accommodation will impact on the effectiveness of the TOM	Medium	**High**	The recommended options have been selected with the aim of making best use of available estate and to minimise the investment . Detailed reviews are planned as part of the MSC business case and investment cases will be developed for the necessary estate changes.	**Medium**

4.11 The Proposed Target Operating Model – South Yorkshire and Bassetlaw

The Target Operating Model (TOM) detailed below will address the case for change, whilst ensuring continued service resilience across the network. It is acknowledged that a detailed implementation plan is required to transition from the current configuration of services across SYB. The transformation programme will be detailed in the Full Business Case.

To conclude the Economic Case within this OBC, the proposed target operating model is as follows.

Blood Sciences

The recommended configuration for Blood Sciences is for a CSL at the NGH site of STH, plus an Extended Essential Service Laboratory (EESL) at Doncaster Royal Infirmary and Essential Service Laboratories (ESLs) at Bassetlaw Hospital, Barnsley Hospital, Royal Hallamshire Hospital, Sheffield Children's Hospital and The Rotherham Hospital (subject to the outcome of the QIA of a single ESL serving RHH and SCH). The proposed model includes the consolidation of all specialist work within Sheffield (each delivered from only one location, co-located with clinical services at NGH, RHH and SCH).

Work is on-going on a Quality Impact Assessment considering whether there should be one or two ESLs at central Sheffield (RHH and SCH). A decision on this will be included in the Full Business Case and is dependent on the outcome of the QIA and consideration of costs after any required investment to mitigate risk.

Microbiology

For Microbiology the recommended configuration is for a Central Service Laboratory (CSL) at the NGH site of STH, plus a secondary laboratory at Doncaster Royal Infirmary. In this configuration virology and specialist microbiology (e.g. molecular microbiology) is consolidated on the NGH site. The proposed model will deliver laboratory consolidation and allow SYB to harmonise analytical processes; however, medical microbiology care will continue to be delivered for every SYB hospital and local community.

It is recommended that the EESL for Blood Sciences and the secondary Microbiology laboratory are co-located at Doncaster Royal Infirmary in order to gain efficiencies of both staffing and logistics.

Histopathology

The recommended option for cellular pathology is to consolidate the processing laboratory and all consultants onto a single site including specialist work at RHH.

It is the recommendation of reference groups and PTP that in order to optimise patient safety and achieve maximal efficiencies in this model there are some critical enabling activities that need to be completed first, including the full implementation and roll out of a :

- Single LIMS
- Single MSC
- Digital Pathology and 'end-to-end' digital processes in Histopathology including: digital Whole Slide Images (WSI) – scanning and storage, Image Management Software (IMS), LIMS integration, electronic requesting, video conferencing to multi-disciplinary team meetings (MDTMs), remote support for specimen dissection and intraoperative frozen sections, electronic proformas, voice recognition and automated cancer services dataset (COSD) returns
- SYB logistics solution

These critical activities need to be completed in order to achieve implementation of the Target Operating Model.

The recommended overall TOM for SYB is as below.

Table 10 : Recommended SYB Pathology TOM

Hospital Site	Type of Lab	Range of Services
NGH	CSL for Blood Sciences and Microbiology Sp	Main automated lab for Blood Sciences Specialist centre for Blood Sciences All Immunology Main 24/7 lab for Microbiology Specialist centre for Microbiology All Virology Frozen sections Andrology POCT
RHH	ESL Sp CSL for Histopathology	ESL for Blood Sciences Specialist centre for Haematology and Coagulation Specialist centre or Gestational Trophoblastic Disease Frozen sections POCT Main histology lab processing site and all Histopathologists
SCH	ESL Sp Paediatric PM	ESL for Blood Sciences Specialist centre for paediatric biochemistry Paediatric PM Frozen sections Brain smears POCT
Rotherham	ESL	ESL for Blood Sciences Frozen sections Andrology POCT
Doncaster	Mini CSL	Extended ESL for Blood Sciences Secondary lab for Microbiology (not 24/7) Frozen sections Andrology POCT
Barnsley	ESL	ESL for blood sciences POCT
Bassetlaw	ESL	ESL for Blood Sciences POCT
Chesterfield		Frozen sections

Key:

CSL	Central Service Laboratory
ESL	Essential Service Laboratory
EESL	Extended Essential Service Laboratory undertaking a wider repertoire of automated tests than an ESL (but on ESL equipment) and/or a proportion of primary care work
Mini CSL	EESL for Blood Sciences plus a secondary Microbiology Laboratory
Sp	Specialist Centre

Further details setting out the configuration and operational strategies which are to be deployed to transition to the new operating model will be included in the FBC.

Recommendation 1: The formation of the pathology network is configured as described in this economic case as the recommended Target Operating Model.

5. COMMERCIAL CASE

This section provides context and background on the commercial considerations for the formation of a SYB pathology collaboration network. It sets out the key considerations and recommends an immediate way forward to ensure that SYB Pathology can be formed upon acceptance by Trusts of the OBC and so that work can progress at pace to deliver the anticipated benefits.

The aim of the commercial principles developed in this section is to establish an initial Partnership Agreement that could support the next phase and that would allow further development of a full commercial model in the FBC. It should be noted that the aim of the commercial model is to provide a framework that would allow all collaborating trusts to best move towards the target operating model, implement agreed priorities and benefit fairly from the qualitative and financial benefits generated through collaboration at scale.

5.1 Organisational Form and Hosting

As part of developing this OBC, the PTP sought advice on the possible organisational forms that the network might take. The ESB, OB and PDT examined information and guidance provided by legal teams, NHSI and from other established pathology networks on the criteria on which to evaluate the most favourable organisational form.

As described in the previous section, Executive representatives from all Trusts and the PDT met together with a legal representative in November 2019 to consider the options. The unanimous recommendation from all attendees was for the formation of a SYB Pathology Network, operating as a single service, with one of the Trusts acting as host. A hosted network would be most efficient from a tax perspective and, importantly, allow staff to stay within the NHS framework.

In a 'hosted network' there is not a separate entity into which the pathology services are transferred and so anything that the joint venture or partnership does would be through the host Trust (for example, contracting and decision making). The arrangement between the Host and all other partners can be controlled contractually via a Partnership Agreement covering both clinical and operational governance requirements.

Each Trust Board was invited to submit an expression of interest if they wished to host the network, and ESB agreed that the NHSI guidance around Transactions would be used to select between Trusts should more than one wish to be considered.

STHFT subsequently submitted an expression of interest to host the SYB Pathology Network and all of the four partners, namely BHFT, DBTH, SCFT and TRFT, expressed the view that STHFT is best placed to act as the Host Organisation and deliver a robust, high quality Pathology Service for SYB. All confirmed that key considerations in the development of the network relate to governance and decision making processes and the need to ensure that the network operates in an open, transparent and fair way.

Members of the ESB, following discussion in January 2020, agreed to develop the following within the Outline Business Case (OBC):

- Formation of a SYB Pathology Network, operating as a single service
- Hosted Network Organisational form, with STHFT as the Host Organisation

This was believed to offer the best opportunity to create a sustainable Pathology Service for the benefit of all in SYB, and one that will best support delivery of the objectives in the NHS Long Term Plan.

Strategic influence will be retained by all Trusts through the SYB Pathology Partnership Board (PPB) with each having executive representation and decision making rights. The Operational Team (OT) will operate in accordance with a well-defined scheme of delegation forming part of the contractual Partnership Agreement between the partner trusts. The proposed structure allows for a responsive service that is well-defined and where the operational team

has full control of operations at all sites. This means it will have greater leverage to execute the agreed priorities and objectives to grow as a sustainable pathology service, to meet the clinical needs of the SYB partners and to optimise the effectiveness and efficiency of the service and implement change.

A formal Partnership Agreement has been developed and is proposed as part of this OBC; the understanding had been that this agreement would not be finalised until the OBC is complete, but the Senior Responsible Officer has asked that this is reviewed, particularly in light of the White Paper and the statutory duty on providers to collaborate. This will be the contractual agreement to assure all five partners, setting out how each Trust will be held accountable to maximise delivery of all benefits within the business case and in keeping with the Mission, Vision and Guiding Principles of the SYB Pathology Transformation Programme. The latest draft of the Partnership Agreement is included as Appendix Q; ESB members were asked in May 2021 to provide feedback including any queries and suggested changes and a further meeting was held on 9 August 2021 to discuss and recommend content for agreement with the legal team.

Each Trust will retain clinical control through the clinical governance structure. The Partnership Agreement details how STHFT will act as the 'Host' taking the lead on pathology services across the network and includes the following arrangements/information:

- the resources and services that will be transferred from non-host Trusts to STHFT
- transfers of pathology staff from non-host Trusts to STHFT at the point in time when there is a change to service provision under the terms of the 'Transfer of Undertakings (Protection of Employment) Regulations' (TUPE)
- the transfer of pathology assets from non-host Trusts to STHFT (including contracts, IT systems and liabilities)
- the commissioning contracts that are to be transferred to STHFT (depending on status) or retendered by STHFT

As host for the proposed SYB Pathology Service, STHFT will contract for all the relevant services comprising the pathology network on behalf of all partner Trusts and will procure the single Managed Service Contract (MSC), LIMS, Digital Pathology and Logistics.

The SYB Pathology Network will be required to operate with a degree of autonomy and governance arrangements in accordance with the standing orders and scheme of delegation of the host trust. An approved Scheme of Delegation will be part of the contractual Partnership Agreement between the parties.

5.2 The Proposed Host Organisation

As the largest of the NHS Foundation Trusts within the area, STH as Host offers resilience and depth when it comes to any form of major service change. In addition, STH Laboratory Medicine already hosts the majority of specialist work and workforce within the Network. This mitigates the potential impact on operational service delivery during any transition and provides a stable platform on which to make ongoing improvements.

An initial view has been taken on elements of the relevant NHSI guidance around Transactions. STH's assumption is that in their proposed capacity as Host, their Regulator would classify the transaction as small based on the assets, income and capital criteria not being greater than 10%. Also, when considering the risk factors within the guidance, the Trust's position is as follows.

Table 11 : STHFT as Host

Risk Factor	Risk Y/N	STHFT Position
Use of Resources Rating	N	Good
Quality	N	CQC rating Good (with many Outstanding) / UKAS fully accredited
Leverage	N	Capital servicing capacity is >2.5 times
Experience of service provision	N	Services are a core part of the Trust's business as above
SOF Rating	N	Segment 2

On the current assumptions, the transaction would not be reportable to NHSI due to the envisaged relative size of the transaction and would not create any issues with the Trust's Single Oversight Framework (SOF) rating. However, due to the potential for large scale transfer of staffing involving a number of NHS Foundation Trusts, the process that is proposed to be followed locally is that aligned to a material transaction. This would ensure that individual Boards are sighted in full of the detail of the transaction at each stage, in order to provide the greatest assurance. This approach would follow best practice as outlined in the relevant guidance and ensure that relevant Board certification is completed alongside the necessary legal documentation outlining the Partnership.

Table 12 : Hosting Decision Matrix

Essential Criteria		Assessed by	Recommendation
1	The financial impact of hosting will not disadvantage the host	Finance Team	The financial team will ensure processes are in place such that STHFT will not be advantaged or disadvantaged by the hosting arrangement. All trusts will be contracted and treated as service users. Financial and strategic accountability will be through the Partnership Board. Work is on-going to understand the impact of IFRS 16 but it does not influence the recommendation for the host.
2	The choice of host offers the best opportunity to deliver financial savings for the wider system	Finance Team Legal Advice	The legal assessment of these criteria is that all trusts will be able to access the SYB Pathology service and this offers the opportunity for saving through VAT reclamation. The cost/benefits of accessing this service are the same regardless of the host.
3	The choice of host does not negatively impact on the ability of the new network to deliver its current and future service (as per the TOM)	ESB	The legal advisors have provided assurances that the contractual arrangements of the Partnership Agreement for the new network will bind the trusts equally to supporting the new network.
4	The prospective host and partner trusts agree to put appropriate contractual and governance processes in place as per the management case outlined below	ESB	
5	The host trust and partner trusts recognise the autonomy of the new network and the network is supported to develop its own brand	ESB	At this point there are no objections raised to the proposed oversight structure in this OBC i.e. Partnership Board and Operational Team. The legal advisers have provided assurances that appropriate binding contracts can be put in place to assure the autonomy of the new service and also appropriate accountability to the host, partner trust sand ICS. Ultimately this decision is one for the respective trust boards.
6	The new network is fully supported in the development of its own brand identity	ESB	At this point there are no objections raised to this ethos.

5.3 SYB Pathology Partnership Board

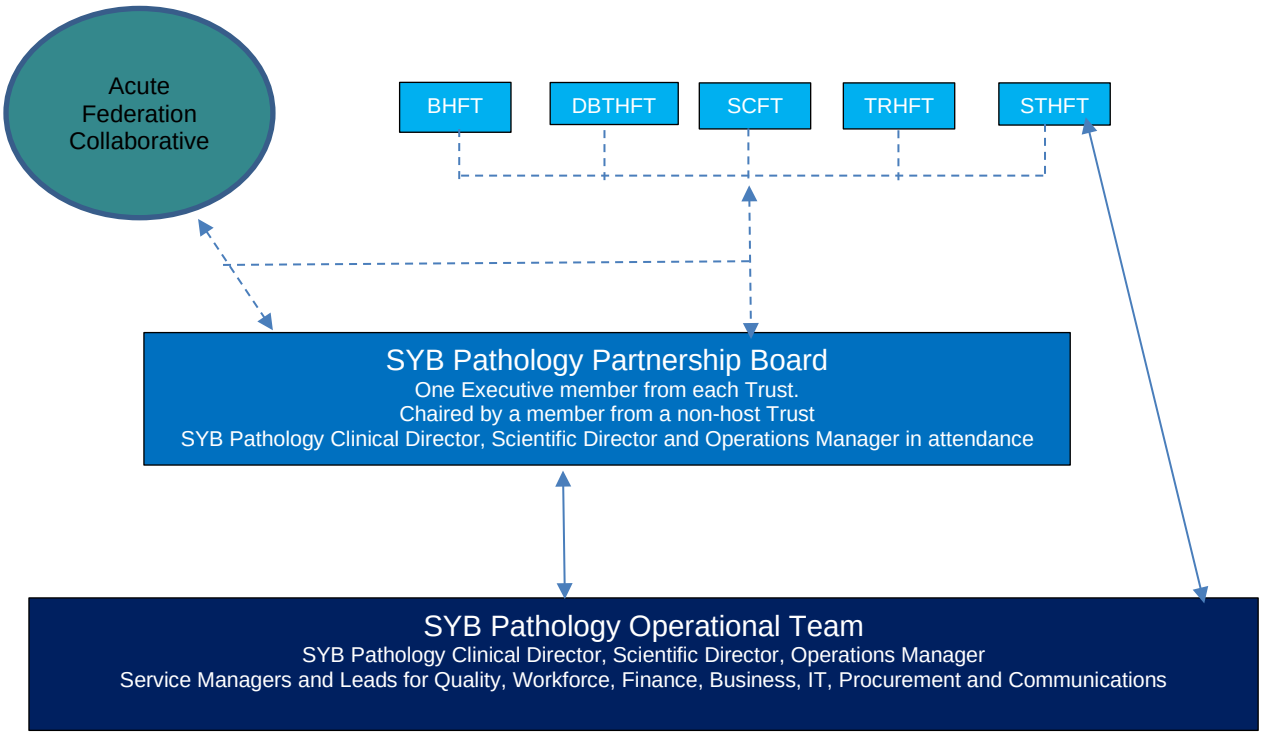
Key to the governance process will be the creation of a SYB Pathology Partnership Board (PPB) with equal representation of the partner trusts with one executive member each; the PPB Terms of Reference will be described in the Partnership Agreement; this will specify whether decisions (within the agreed scheme of delegation from Trusts) will be based on majority voting or whether unanimous agreement is required and what actions will be taken if this cannot be achieved. It is proposed that the PPB is chaired by an executive member from a non-Host Trust.

The PPB will set up a formally appointed SYB Pathology Service Operational Team (OT) led by the appointed posts of Clinical Director, Scientific Director and Operations Manager. These leaders will attend and inform the PPB meetings but will not have decision making rights at the PPB.

The Clinical Director, Scientific Director and Operations Manager will have delegated management responsibilities agreed by the PPB and reviewed on a regular basis.

Strategic influence is retained by all trusts through the SYB PPB where all trusts have executive representation and decision making rights. The OT will operate in accordance with a well-defined scheme of delegation which will form part of the contractual Partnership Agreement between the partner trusts. The proposed structure allows for a responsive service that is well-defined and where the operational team has full control of operations at all sites. This means it will have greater leverage to execute the agreed priorities and objectives to grow as a sustainable pathology service, to meet the clinical needs of the SYB partners and to optimise the effectiveness and efficiency of the service and implement change.

Figure 9 : Proposed SYB Pathology Governance and Management Arrangements



The OT and management teams will develop the long term plan for the service and provide assurances to the PPB on the progress and effectiveness of the new network. The OT will also include representation from quality, workforce, business management, IT, finance, procurement and communications.

Recommendation 2: The SYB Pathology Service is established between the five partner Trusts as a Hosted Network, operating as a single service, with STHFT as the Host Organisation. This will involve STHFT, as the host organisation, contracting for all the relevant services comprising the pathology network on behalf of the partner trusts. A contractual Partnership Agreement will be in place to assure all five partners and to document how each will be held to account.

6. FINANCIAL CASE

The financial model is a cost model for the evaluation of savings of the proposed configuration of pathology services (the Target Operating Model) compared against the current financial investment in Pathology Services within SYB as declared in the 19/20 NHSI budgeted cost base submission, adjusted to reflect additional recurrent investments made by Organisations in the 20/21 baseline. The indicative projected savings are anticipated once the TOM is fully implemented.

6.1 Financial Assessment

Following detailed discussions each expert reference group has recommended the level of staffing required across the pathology disciplines and specialities to deliver the recommended TOM.

It is assumed that there will be a single SYB Pathology workforce employed by STHFT as the Host Organisation; where and when relevant, TUPE will apply. The recommended TOM and workforce plan is expected to take three to to five years to implement and it is anticipated that the target staffing model will be achieved by managing turnover and vacancies. There will be no compulsory redundancies. The Pathology Workforce and Education Lead (centrally funded for one year) is undertaking a workforce planning exercise that will include an analysis of turnover and vacancy rates; this will be included in the FBC.

Estimated non-pay savings are calculated based on the full implementation of a single managed service contract (MSC) informed by scoping work undertaken by Akeso & Co on behalf of the SYB Pathology Transformation Project.

Furthermore, a single LIMS, Digital Pathology, appropriate logistics and estates are key enablers and deemed essential to deliver a safe service and efficiency savings. Estimated costs for LIMS and Digital Pathology have been submitted as part of the capital bids to NHSE; these are listed separately below and have not been reflected in the pay/non-pay costs for the proposed target operating model. Costs for logistics and estates have not been included in this OBC. Work is on-going with both Pathology and Estates colleagues to understand the Estates requirements for the TOM configuration; exact requirements will depend on the outcome of the MSC procurement and detailed costs will be included in the FBC. If, following a procurement exercise, additional logistics investment is required to deliver the TOM this will also be detailed in the FBC.

Table 13 : Financial Assessment of Recommended SYB Pathology TOM

PAY	Total Basleine (NHSI 19/20 Value +recurrently funded developments 19/20-20/21)			Proposed Workforce / establishment for SYB Pathology as per Reference groups.			Difference Baseline vs Proposed Establishment (-ve- = savings)			*For Information: NHSI Estimated Saving for North 6*
Speciality	Funded AFE	Staff Budget £'000's		Funded AFE	Staff Budget £'000's		Funded AFE	Staff Budget £'000's		*Staff Budget £'000's*
Blood Sciences	536.3	£22,999		474.9	£20,540		-61.43	-£2,459		*-£1,700*
Histology	218.9	£12,933		202.5	£12,149		-16.32	-£784		*-£905*
Microbiology / Virology	214.6	£10,780		213.3	£10,606		-1.28	-£174		*-£784*
IT/ Quality / Business / Management *	40.8	£1,795		39.5	£2,062		-1.29	£266		*-£350*
Total Pay	**1,010.6**	**£48,508**		**930.2**	**£45,357**		**-80.32**	**-£3,150**		***-£3,739***

Non Pay	Total Baseline (NHSI 19/20 value + recurrently funded developments 19/20- 20/21)				Estimated Non PaySavings	*For information:: NHSI Estimated Saving for North 6*
Expenditure Heading		Budget '000's			Budget '000's	*Non Pay £'000's*
Equipment/Reagents/ Consumables.		£25,064	Estimated MSC potential saving (Min) 8%		-£2,005	*-£1,580*
Total Non Pay		£25,064		£23,059	-£2,005	*-£1,580*
Grand Total	**1,010.6**	**£73,572**	**930.2**	**£68,416**	**-£5,155**	***-£5,319***

Notes.

Staffing / Pay

Proposed establishment costed at 19/20 Standard staffing costs (payscale points reflect current Pathology Staffing as at Payroll date March 2021

The above pay values assume NO Medical staffing pay savings.
Blood Science establishment derived using staffing requirements hour by hour matched against workload data. To be reviewed once 'workable' rota parameters are agreed (for FBC)

Speciality baseline values include a number of Management posts >AfC 8b, so no direct comparative to NHSI baseline.

Non Pay MSC scope of potential benefits (8% - 11%) as per scoping work by Akeso & Co on behalf of SYB Pathology Transformation Project.

As shown above, the proposed target operating model across SYB Pathology is expected to deliver:

- 80.32 WTE reduction in the staffing establishment and pay savings of £3.150m against the baseline.
- Non-pay savings of £2.005m against the baseline
- Total annual (pay and non-pay) savings of £5.155m against the baseline

A more detailed breakdown of the financial assessment, together with supporting information including the WTE and pay cost savings per discipline is provided in Appendix R.
A Workforce Summary Report for each Reference Group/Work Group is also provided (Appendices E to M).

6.2 Financial Modelling Assumptions

The following assumptions have been made in the financial modelling for the OBC, all of which will be reviewed in preparation of the FBC.

Baseline

The baseline / 'as is' values are taken from the 2019/20 Pathology NHSI data returns adjusted to reflect additional recurrent investments made by Organisations in the 20/21 baseline. Pathology have been required to submit NHSI returns since 2015/16 and for the last two years work has been on-going to improve consistency of completion of these returns between all Organisations within SYB.

The 19/20 funding as declared in the 19/20 NHSI returns should reflect all existing contracts held by each Trust. Mortuary Services & Phlebotomy staffing are not currently included in the SYB Pathology Transformation programme and so these costs are excluded from both the baseline values and the proposed cost model.

Staffing

Reference Groups have produced workforce models detailing the staffing requirements for the configuration of Pathology Services as proposed in the Target Operating Model (*Appendices E to M*).

Medical Staffing (Consultants and other Medical Staff) and Clinical Scientist staffing (Consultants and other Clinical Scientists) currently remain unchanged from the 19/20 NHSI submission. A separate process is underway to make recommendations in respect of these staffing groups within the future SYB Pathology Service and this will be included in the FBC.

The proposed workforce models have been costed using the Agenda for Change 2019/20 Standard Staffing Costs (inclusive of Employers NI & Superannuation) using the following points of the scales:-

AfC Band	19/20 SSC per WTE	Details
Band 8c	£90,000	Actual weighted average
Band 8b	£75,508	Actual weighted average
Band 8a	£62,866	Actual weighted average
Band 7	£53,830	Actual weighted average
Band 6	£42,022	Mean
Band 5	£32,417	Point 2
Band 4	£27,485	Mean
Band 3	£24,078	Mean
Band 2	£22,161	Mean

Where appropriate, the Reference Group workforce reports include Agenda for Change compliant staffing rotas; these proposed rotas have been costed using the appropriate Agenda for Change unsocial hour % payment uplifts.

22.6 % uplift has been applied to all posts which require cover arrangements i.e. 24/7 services. The Finance Reference Group recommended using this bespoke % uplift for Pathology staffing within SYB based on the average of the values currently used across SYB Organisations, adjusted using weighted average actual values for annual leave and sickness as per the current SYB pathology workforce. This was agreed by the Directors of Finance on the 22nd April 2021 (*Appendix S*).

The Reference Groups have agreed that not all posts require absence cover. Absence cover has NOT been applied to the following staff groups: senior clinical staff, management posts, business management posts, secretariat, general administration posts, pathology IT Staff, and quality & governance staff.

Trainee BMS Staffing for Blood Sciences

Trainee BMS staff are recruited to AfC Band 6 posts, but are remunerated at AfC Band 5 whilst training (2 years). In recognition of the number of Trainees in post at any one time across the network, the BSRG has agreed that 20 WTE BMS posts at Band 5. (Although the average number of trainees is higher than 20 per annum additional funding is required to pay overtime to Band 6 BMS staff where trainees are unable to take part in rota slots).

Non Pay

Discussions with suppliers indicate an expectation that the purchasing power of a SYB Pathology network will likely result in savings. It is assumed that a single SYB MSC contract will be procured, and that VAT will be recoverable. Based on the work undertaken with other networks, and using the profile of the current MSC contracts, Akeso & Co estimate non pay savings within SYB pathology would be between 8% and 11%. It should be noted that this saving is dependent on the TOM and on the formation of the network that will allow greater negotiating power. As recommended by the Finance Group, the estimated savings value in the OBC is calculated using 8**%** saving.

Overheads

The model does not include any anticipated savings on overheads. Values will be dependent on releasable values at each site. Overheads are excluded from the Risk and Gain Share values.

Logistics

Baseline values are a combination of costing the current service provision, and apportionments of the Pathology elements of current commercial provider contracts and community providers. If additional logistics investment is required to deliver the TOM following a procurement exercise, this will be detailed in the FBC.

Estates Costs

Work is on-going with both Pathology and Estates colleagues to understand the Estates requirements for the TOM configuration. Exact requirements will depend on the outcome of the MSC procurement and detailed costs will be included in the FBC.

Volume Increases

The financial model assumes no volume growth. This is assumed for financial modelling purposes to facilitate comparability against the baseline. The future workforce profile is based on current workloads, although it should be noted that any equipment configuration in automated blood sciences will allow an increased capacity of circa 40%.

Inflation

All revenue and costs are at 19/20 prices to make the comparison to allow comparability to the baseline values.

Income

The costing model is a cost saving model, and assumes no changes in contract income from GP Direct Access or other third-party sources.

Savings

It is anticipated that all savings will be distributed to SYB member Organisations in the proportions agreed in the Risk and Gain Share document.

IT – LIMS, Digital Pathology and Quality Management System

Both LIMS and Digital Pathology are deemed to be enabling projects. Reference Group workforce assumptions are based on a single LIMS and Digital Pathology implementation across SYB Pathology. Bids have been made for central funding for both projects with written confirmation of funding expected early September 2021. A single Quality Management system is also recommended.

Timeline for Savings & Non Recurrent Enabling Costs

To be considered following approval of OBC and for inclusion in the FBC.

6.3 Transitional Costs

It is anticipated that there will be non-recurrent / short term costs relating to the transition arrangements from the current staffing and business models to the proposed structures, which ideally will be identified upfront, built into the Full Business Case, and shared in accordance with the Risk and Gain Share agreement within the Partnership Agreement (Appendix Q) by the Partner Trusts; an example of this is a single Quality Management System. Where transition costs arise in year and are not recognised in the FBC, it is suggested that these are split between the Partner Trusts in accordance with the Partnership Agreement unless the origin and nature of the costs suggests otherwise. It is proposed that all additional expenditure outside of the FBC/ Annual Financial Plan is agreed through the SYB Pathology Partnership Board prior to being incurred, in accordance with delegated authority.
A SYB bid for NHSE&I revenue funding to pump prime the establishment of Pathology and Imaging Networks resulted in an allocation of £598k (for July 21-March 22) and £518k for the 22/23 financial year. The Acute Provider Chief Executives agreed the proposed allocation of revenue funding between the two networks at their meeting on 5 July 2021. The funding will be used within Pathology to put the SYB network senior management team in place.

6.4 Financial Monitoring and Financial Management Accounting

SYB Pathology will be treated as a separate trading entity by STHFT and the Host Trust will adopt and develop a trading account built around the principle of a trading entity, both for planning and in-year actual trading. A principle will be that the trading entity will collect all fully absorbed costs of operating the SYB Pathology Service and then charge users, including the host Trust, for services received. The trading account will be the main vehicle for reporting financial performance through to the SYB Pathology Partnership Board, and onward to each respective partner Trust Board of Directors.

6.5 Annual Planning, Scheme of Delegation and Accounting Principles

An annual plan will be established based on planned activity for all customers (each Trust, GPs, others) from which the fully absorbed cost of operating the Partnership as a trading entity will be assessed. Use of laboratory facilities on all sites will be recharged to SYB Pathology on a fully absorbed cost basis.

The annual planning process employed by the host Trust will be aligned with the timetable for clinical activity and other planning processes within the partner Trusts. Pay and non-pay budgets will be set to take account of inflationary predictions, and relevant activity and other information available at the time. These will form the basis from which prices are established in support of the annual plan and agreed by the Partnership Board prior to the start of the financial year.

The SYB Pathology Service will operate in line with the Partnership Agreement and the host Trust's Scheme of Delegation, as amended where necessary to reflect the unique nature of the partnership. The SYB Pathology Clinical Director, Scientific Director and Operations Manager will be identified as the prime budget holders for the purposes of the scheme of delegation, but with authority to delegate authority to other officers within the SYB Pathology management structure.

Monthly financial reports will be produced by the host Trust's management accounts team and made available to the SYB Pathology Partnership Board and Operational Team.

Efficiency Targets

The planned income and expenditure for the trading entity will include an efficiency requirement agreed by the SYB Pathology Partnership Board that reflects the planned savings to be delivered by the Transformation Programme. Any actual profit/loss at the year-end will be apportioned between Trusts as per the Risk and Gain Share agreement within the Partnership Agreement. Progress against plan will be monitored throughout the year.

Allocations of any additional efficiency requirements above those savings outlined in the FBC should be negotiated via the SYB Pathology Partnership Board.

6.6 Contract Monitoring

Trading accounts will form the prime basis through which the SYB Pathology Partnership Board will monitor the performance of the Partnership. They will facilitate contract monitoring meetings between the Trusts and with other customers allowing the monitoring of activity levels and emerging cost pressures. Corrective action may then be agreed, and where necessary the management and burden of residual risks agreed between the partner Trusts.

Regular contract management meetings will occur between the host and all partners to ensure no unforeseen charges are received by each Trust and also that demand management is monitored to ensure income is being received at expected levels for all non-NHS and other providers.

It is proposed that the partnership arrangements are established in a way that ensures no financial penalty for each Organisation in respect of Direct Access contracts.

Direct Access Contracts will continue to be negotiated by each Partner Organisation as part of the annual commissioner contract negotiation; delivery of these contracts will be managed by SYB Pathology on their behalf. Any over performance (or underperformance) of Direct Access contracts will be shared by the Partnership on a pooled basis as per the Risk & Gain share agreement.

It is anticipated that all contracts with existing external customers will transfer to SYB Pathology at the point of renewal, unless agreed earlier by mutual consent. All new contracts will only be held by the SYB Pathology Service.

6.7 Pricing and Costs

Once established the SYB Pathology Service will agree a common pricing strategy and harmonise test prices between Partner Trusts. The key mechanism to support this will be the installation of a new LIMS system which is essential to provide the activity data required to produce a standard pricing structure across all sites for every test. (Without a unified LIMS system, achieving this will be very difficult and interim arrangements will need to be devised).

Recharges using an agreed pricing methodology to all service users (including partner Trusts) will be based on a fully absorbed cost per test basis linked to actual activity, although there may be a differential pricing strategy for external customers.

The principal of harmonisation of prices within the network is for each organisation to have the same price per test (irrespective of cost). The timing of unified pricing will be dependent on the implementation process and the costs per test are likely to change in a phased way as changes to equipment platforms, training, workforce, and implementation of digital systems are introduced.

The price per test will need to be sensitive to changes in activity volumes, recognising tracked high volume tests will have a different trigger to a lower volume specialist test

The pricing strategy will also need to determine the uplifts to be applied for Commissioner Contracts, and external contracts (both NHS & Commercial).

Please Note: Each Organisation will need to understand the impact of current Income targets on the baseline Pathology Budgets.

Corporate Services

The SYB Pathology Service will require access to corporate services including; Financial Management, Human Resources, Payroll and Procurement as agreed by the Partnership Board. The cost of providing these services will be included in the annual plan and charged to the SYB Pathology Service by the providing organisations and recovered through the pricing mechanism to all users for services received (overheads).

The Partnership Board will determine the required contribution for a number of Corporate Services e.g. HR, Finance, Procurement, for which there will be a full cost recharge, from the appropriate Organisation. Costs of 'other' corporate services used by Pathology Services on each site will be chargeable using an agreed methodology.

Estates and Facilities

The full cost of facilities will be recharged by each site on an agreed basis.

6.8 Transfer of Assets / Asset Management

Current Assets (primarily stocks)

Non-host stocks to be sold to the host Trust at cost.

Fixed Assets

Non-host Trust laboratory buildings, plant, and non-clinical equipment that are still to be used as part of the SYB Pathology Service operational model will be retained by the non-host Trusts and a charge made to the host Trust. Clinical equipment acquired through existing Managed Service Contracts (MSC) will be novated into the single SYB MSC where appropriate.

It is anticipated that Pathology clinical equipment assets will transfer to the balance sheet of the Host Organisation as they will be deemed to be in control of these assets. Donated Assets will be subject to individual agreement. New/replacement assets will be subject to an agreed business case process as defined by the Partnership Agreement; this will be aligned with the host Trust's policies and processes.

6.9 Risk and Gain Share Proposals

In February 2020 the Risk and Gain Share financial principles were agreed by the Finance Work Group for inclusion in the OBC and Partnership Agreement in support of a 'Fair Share Partnership' arrangement for SYB Pathology. The Finance Work Group considered options using both the costs and activity of the current Pathology services within SYB based on the NHSI returns collated by the Programme Team. Consensus was reached that cost information, following agreed adjustments (baseline costs), should be used to accurately reflect the current level of Investment by each Trust in Pathology services and this was approved by DoFs at their meeting on 22nd April 2021 (*Appendix T*). In debating the Risk and Gain Share proposals it was noted that using the current cost methodology could penalise organisations that that have been the most effective in implementing efficiency initiatives as the cost base would be lower, however this is negated by the opportunity to share in any future savings by joining a consolidated pathology network. Agreed percentages (Table 14) will be used to distribute savings / surplus income within SYB Pathology Services as a consequence of implementing the Full Business Case.

Table 14 : Risk and Gain Share Proposals for inclusion in OBC which reflect the existing investment in Pathology Services (19/20)

	BRILS	DBTH	SCH	STH
Baseline cost for OBC (£m)	**£17,052**	**£12,997**	**£4,912**	**£37,476**
% Share	**24.0**	**17.8**	**6.8**	**51.4**

- Note the above percentage values have been rounded.
- The current BRILS agreement between BHFT and TRHFT is a 50:50 split

All future investments / service improvements following the establishment of SYB Pathology will be considered on an 'individual basis' based on the merits of the proposal.

It is widely acknowledged that there is risk to existing external contracts; as the 29 Pathology networks across England become more established, some will wish to repatriate specialist tests currently referred to the SYB network. SYB Pathology will need to take a proactive approach to mitigate risks to current activity and income.

6.10 Capital Investment

The SYB Pathology Partnership Board will have responsibility for ensuring that there is a robust rolling equipment replacement and investment programme in place and will do so via the SYB Managed Service Contract, rather than via capital purchase, whenever this is deemed to be more advantageous.

Where funding by capital investment is required, this will be done in accordance with the host Trust's standing financial instructions. The SYB Pathology Partnership Board will also have responsibility to seek other sources of capital investment e.g. NHSE&I and Cancer Alliance funding.

Common equipment will be used across different sites wherever possible to maximise procurement efficiency opportunities, whilst mitigating risk of supply chain issues and ensuring business continuity. Replacement and investment plans will be agreed with the SYB Pathology Partnership Board, and incorporated within the annual plan.

6.11 Programme Funding

The SYB ICS budget includes £331k for the 2.4WTE in the Pathology Transformation Delivery Team for 21/22.
The SYB bid for NHSE&I revenue funding to pump prime the establishment of Pathology and Imaging Networks resulted in an allocation of £598k (for July 21-March 22) and £518k for the 22/23 financial year. The Acute Provider Chief Executives agreed the proposed allocation of revenue funding between the two networks at their meeting on 5 July 2021.
The Programme Clinical Director post has been vacant since Jan. 2021 and the existing Programme Manager moved to an alternative post on 1 Aug. 2021. The recommendation is to appoint substantively to the SYB Pathology senior leadership team (Clinical Director, Scientific Director and Operations Manager) as soon as possible. It is recommended that the posts are advertised within limited internal competition in the first instance and externally if this is unsuccessful. The Programme Manager role has already been advertised.
STH has drafted job descriptions that have been agreed with partners and the A4C banding will be confirmed. These posts are critical for delivery of the FBC and for leadership of the transformation to a single service, to lead the development and design of complex concurrent change projects and progress establishment of the network at pace. Without the pump priming funding, the existing management teams in each Pathology service do not have the capacity to progress these major projects at speed. From January 2023 onwards we expect the roles to become operational; responsibilities of the appointed individuals will then be to lead an established SYB Pathology Network and they will be funded via changes to existing workforce models.

6.12 Future Benchmarking

Benchmarking cost per test and cost per WTE will continue as networks continue to transition. Trusts are mandated to submit data to NHSE&I on a quarterly and annual basis and outputs are published in Model Hospital. However, despite efforts to reduce variability, there is national recognition that accurate benchmarking remains difficult due to the lack of standardisation e.g. due to the lack of a national Pathology test list.

7. MANAGEMENT CASE

A Pathology Transformation Programme (PTP) was established in April 2018 at the request of the five Trust Boards. The SYB Pathology Transformation Programme Board (PTPB) was established and a programme delivery team (PDT) of Clinical Director, Associate Clinical Director, Programme Manager and Finance Lead were appointed and added as members of the Programme Board. A number of expert reference groups were established, with representation from across all Trusts and have been working to assess the service options suggested by NHSI for the formation of a network and to give expert advice to the PDT and PTPB:

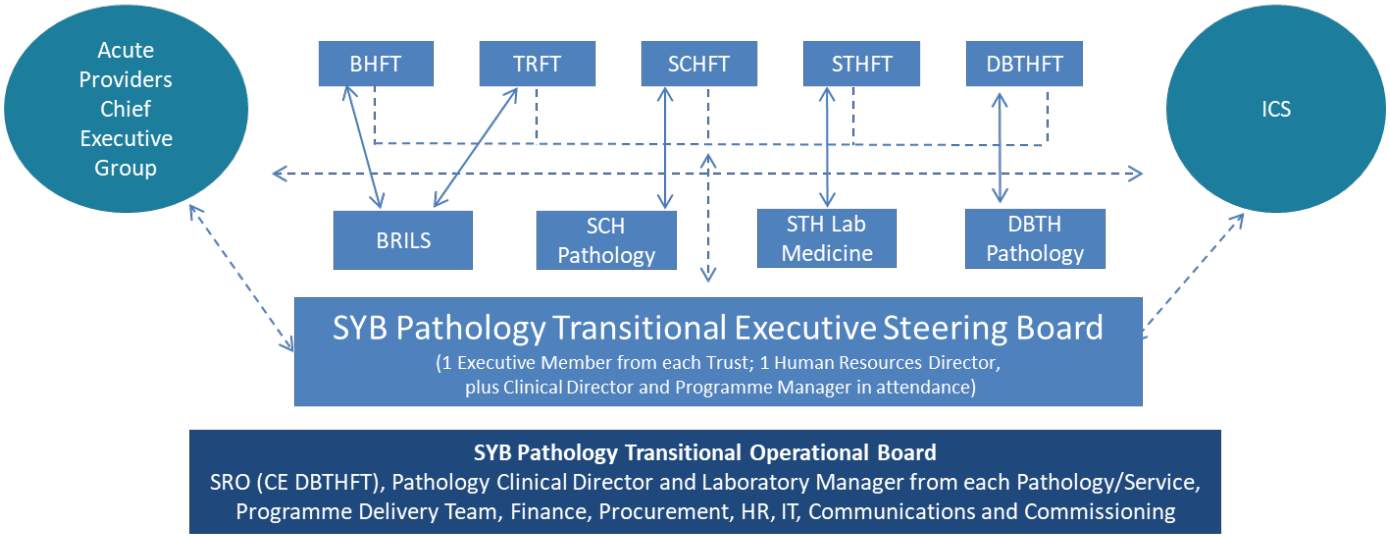
- Blood Sciences
- Microbiology
- Histopathology
- IT
- Quality
- Logistics
- Procurement
- Finance

A task and finish Specialised Services Reference Group was also established and tasked with identifying issues of particular relevance to specialised services across all disciplines. Once completed, work on specialised services was incorporated into the respective discipline reference groups.

Operational pressures on Pathology staff from 2018 to the present time have resulted in delays in progressing the transformation agenda and completion of the OBC; during the COVID pandemic this was intensified and all transformation meetings were halted for a period of time. However, NHSE's expectations of Pathology services to respond as networks during the pandemic, the requirement for the rapid development and introduction of new testing platforms and COVID assays and the need to manage COVID testing supplies, testing capacity and demand at network and regional level only highlighted the need to progress with transformation in SYB.

In September 2019, the Chief Executives of all Trusts (the Acute Provider Chief Executive Group) agreed amendments to the governance of the SYB PTP; the Programme Board was spilt into a Transitional Executive Steering Board (ESB) and a Transitional Operational Board (OB) with the aim of facilitating better and quicker decision making, with the Executive Steering Board directing and overseeing the work of the Operational Board to offer more scrutiny over the detail of the proposals being made. The Executive Steering Board is made up of an Executive Director from each Trust, supported by one of the SYB Human Resources Directors and is attended by the Clinical Director and Programme Manager from the PDT. The Operational Board has been expanded to include representation from HR, Finance, Procurement, IT, Commissioning, Communication and Workforce.

Figure 5 : Agreed Transitional Arrangements (until OBC/FBC approved)



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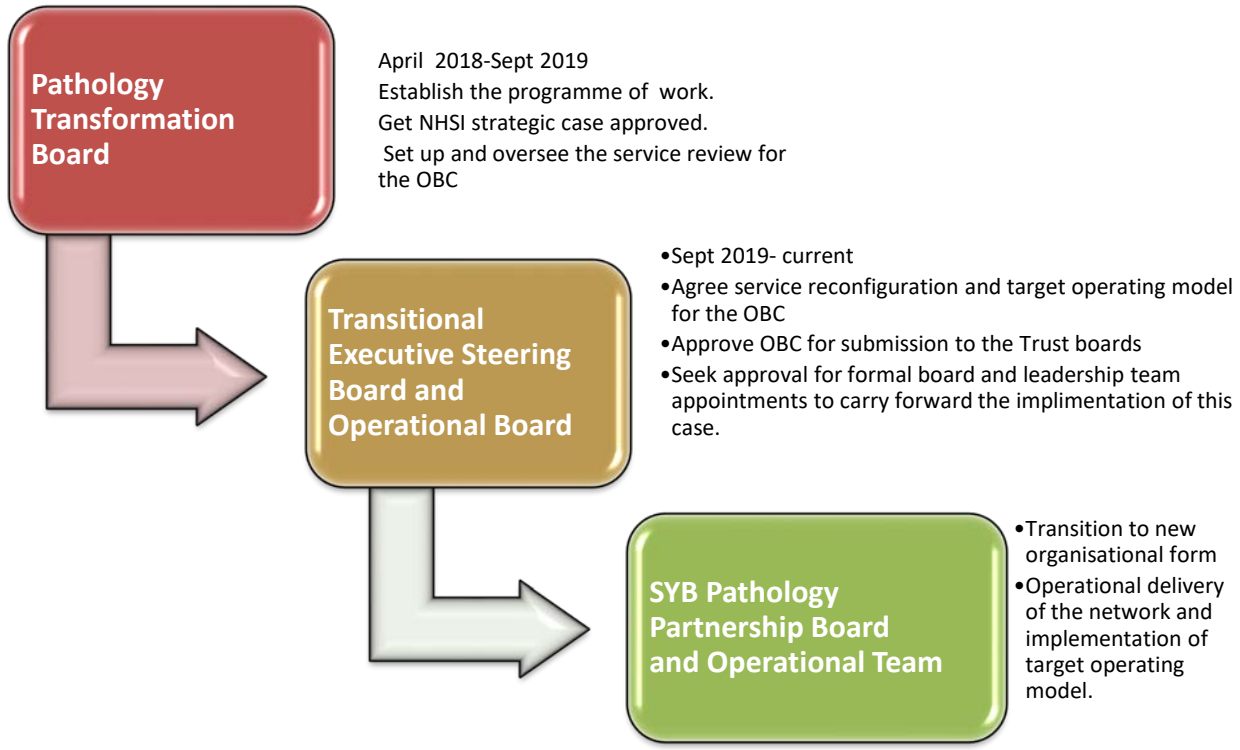
Both Boards continue to be informed by reference group members who have undertaken detailed work to identify the most effective and efficient operational options and the partnership has received feedback on operational considerations from the potential suppliers of a Managed Service Contract. The groups have tested the operational options against the SYB Guiding Principles for transformation to inform the recommended option included in this OBC.

If the OBC is approved, a Full Business Case will follow and the groups will describe the steps needed to move from the current position to the final recommended TOM. Each Trust will need to share with staff how the business case will be implemented and there will be a need for an integrated staff consultation exercise. A key priority is to ensure a sustainable and stable workforce in SYB; retention of the expertise and dedication from current staff in providing high quality Pathology Services is a priority for the new Service.

In the new service model there will be equal opportunities for all staff to apply for future roles and careful consideration will be given to any proposal which would lead to movement of staff across the SYB Service. Trusts are already exploring network recruitment where they believe this will attract candidates to work in the SYB Pathology Service; the first approach taken was to support local recruitment by recruiting Consultant Histopathologists to work in specific sub-specialities of Histopathology, where the candidates report work for more than one hospital across SYB. This is the first step in our proposed network recruitment approach, and one that will allow us to pursue a more sustainable subspecialist histopathology service to all our patients. The recommended TOM and workforce plan is expected to take two to four years to implement and it is anticipated that the target staffing model will be achieved by managing turnover and vacancies. There will be no compulsory redundancies. The Pathology Workforce and Education Lead (centrally funded for one year) is undertaking a workforce planning exercise that will include an analysis of turnover and vacancy rates; this will be included in the FBC.

Figure 10: Development of Programme Management Arrangements



The purpose of this section of the business case is to outline the high level actions and governance arrangements that are needed to establish the proposed pathology network in the configuration described. The management case describes the control frameworks to be used to implement the recommendations in the business case including:

- Proposed SYB management structure.
- Programme management and governance for the transition to the new network including:
  - Clinical and corporate governance structures
  - Programme management arrangements and plans
  - Risk Management arrangements
  - Objective realisation management
  - Post project evaluation arrangements

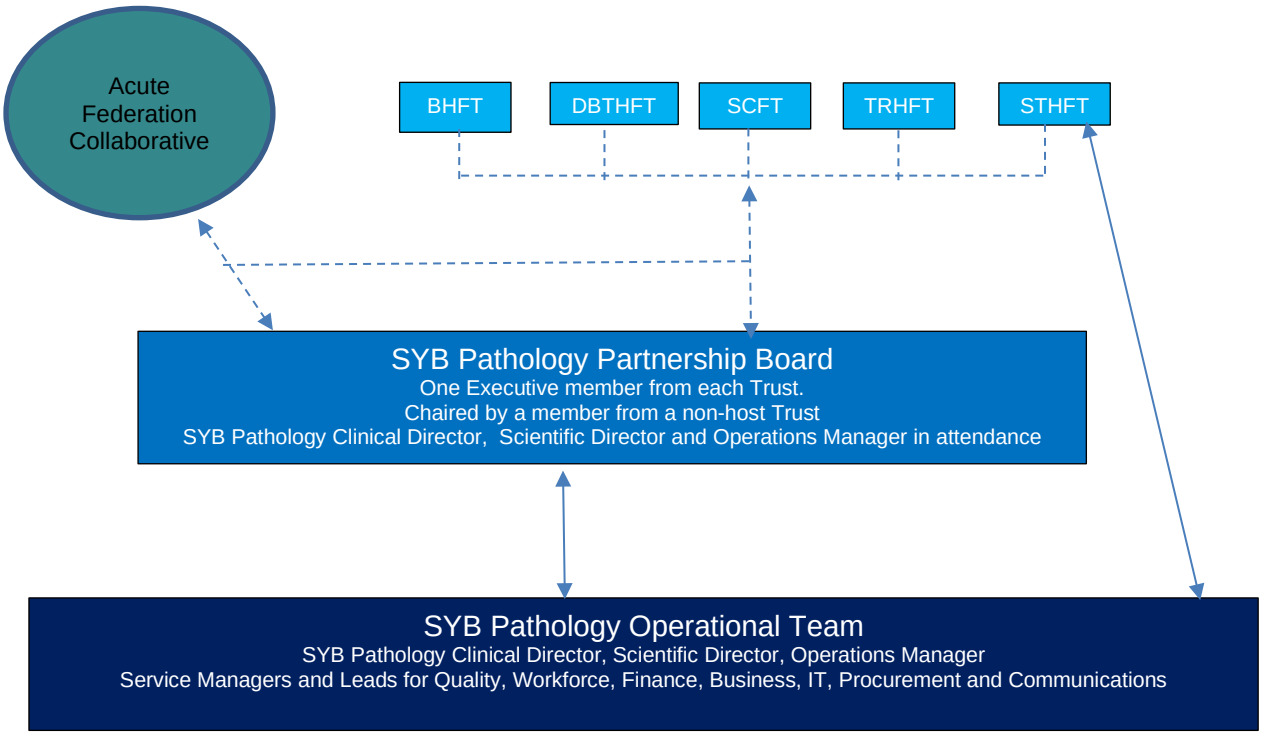
7.1 SYB Pathology Service Boards

Key to the governance process will be the creation of a SYB Pathology Partnership Board (PPB) with equal representation of the partner trusts with one executive member each; the PPB Terms of Reference will be described in the Partnership Agreement; this will specify whether decisions (within the agreed scheme of delegation from Trusts) will be based on majority voting or whether unanimous agreement is required and what actions will be taken if this cannot be achieved. It is proposed that the PPB is chaired by an executive member from a non-Host Trust.

The PPB will set up a formally appointed SYB Pathology Service Operational Team (OT) led by the appointed posts of Clinical Director, Scientific Director and Operations Manager. These leaders will attend and inform the PPB meetings but will not have decision making rights at the PPB. The Clinical Director, Scientific Director and Operations Manager will have delegated management responsibilities agreed by the PPB and reviewed on a regular basis. The PPB, formally appointed Operational Team and management team will manage the transition to the new organisational form and manage the SYB Pathology Service beyond the anticipated go live date.

Strategic influence is retained by all trusts through the SYB PPB where all trusts have executive representation and decision making rights. The OB will operate in accordance with a well-defined scheme of delegation which will form part of the contractual Partnership Agreement between the partner trusts. The proposed structure allows for a responsive service that is well-defined and where the operational team has full control of operations at all sites. This means it will have greater leverage to execute the agreed priorities and objectives to grow as a sustainable pathology service, to meet the clinical needs of the SYB partners and to optimise the effectiveness and efficiency of the service and implement change.

Figure 9 : Proposed SYB Pathology Governance and Management Arrangements

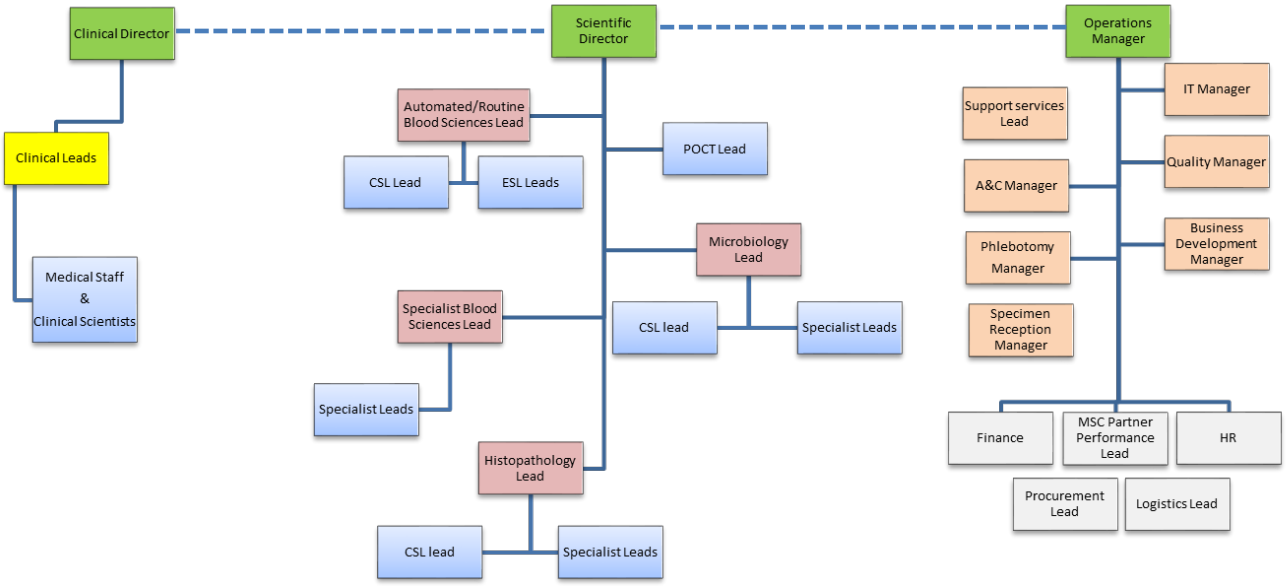


The OT and management teams will develop the long term plan for the service and provide assurances to the PPB on the progress and effectiveness of the new network. The OB will include representation from quality, workforce, business management, IT, finance, procurement and communications.

Recommendation 3: A Pathology Partnership Board and Operational Team should be appointed to lead delivery of the substantial reconfiguration of services as described in the recommended target operating model of this OBC. In order to deliver the scale of changes at pace it is recommended that the three senior network level appointments are advertised as soon as possible. These appointments should be employed by STH as the network Host with authority to lead the new network on behalf of the partner trusts.

The Operational Team will be responsible for the planning, implementation and delivery of the network whilst maintaining effective operational services. The Board will set up a senior management team led by the Clinical Director, Scientific Director and Operations Manager that will provide the organisational structure for the transformation of the pathology laboratory services across SYB.

Figure 11 : Proposed Organisational Structure



7.2 Programme of Activities and Support

If this OBC is approved by all Trust Boards, STH as Host Trust should be resourced appropriately to complete the FBC at pace. The FBC will include a detailed transitional plan that ensures that the supporting workstreams are coordinated and delivered on time, including:

- Blood Sciences Reference Group
- Microbiology Reference Group
- Histopathology Reference Group
- Procurement and contracts
- LIMS
- Digital histopathology
- IT connectivity
- Managed Service Contract
- Workforce and Organisational development
- Finance
- Logistics
- Quality Management
- POCT
- Standardisation
- Estates

The FBC will include:

- Detailed plans for the recommended future service configuration
- A detailed transitional plan
- A full financial assessment including transitional costs
- A detailed benefits realisation plan

7.3 Communication Strategy/Stakeholder Engagement

All minutes from Reference Group meetings have been shared through NHS trusts. Periodic updates at key stages in the transformation programme have been provided to relevant stakeholder groups e.g. Digital Delivery Board, SYB Staff Partnership Board, Health Executive Group.

The formally appointed SYB Pathology Operational Team will undertake a proactive approach to communication with staff, service users and stakeholders from the outset. Engagement with stakeholders will be through formal and informal processes as shown in Appendix U.

7.4 Risk Management

A risk register is well established for the Pathology Transformation Programme. The register will continue to be updated to reflect the specific risks relating to individual projects and the wider programme associated with implementation of the proposed operating model. Risk mitigation and management actions have been identified with responsibilities and timelines assigned for their implementation. The high level risks to delivery of the programme are shown below with more detail provided in Appendix V.

Figure 12 : SYB Pathology Transformation Programme - Most Significant Risks

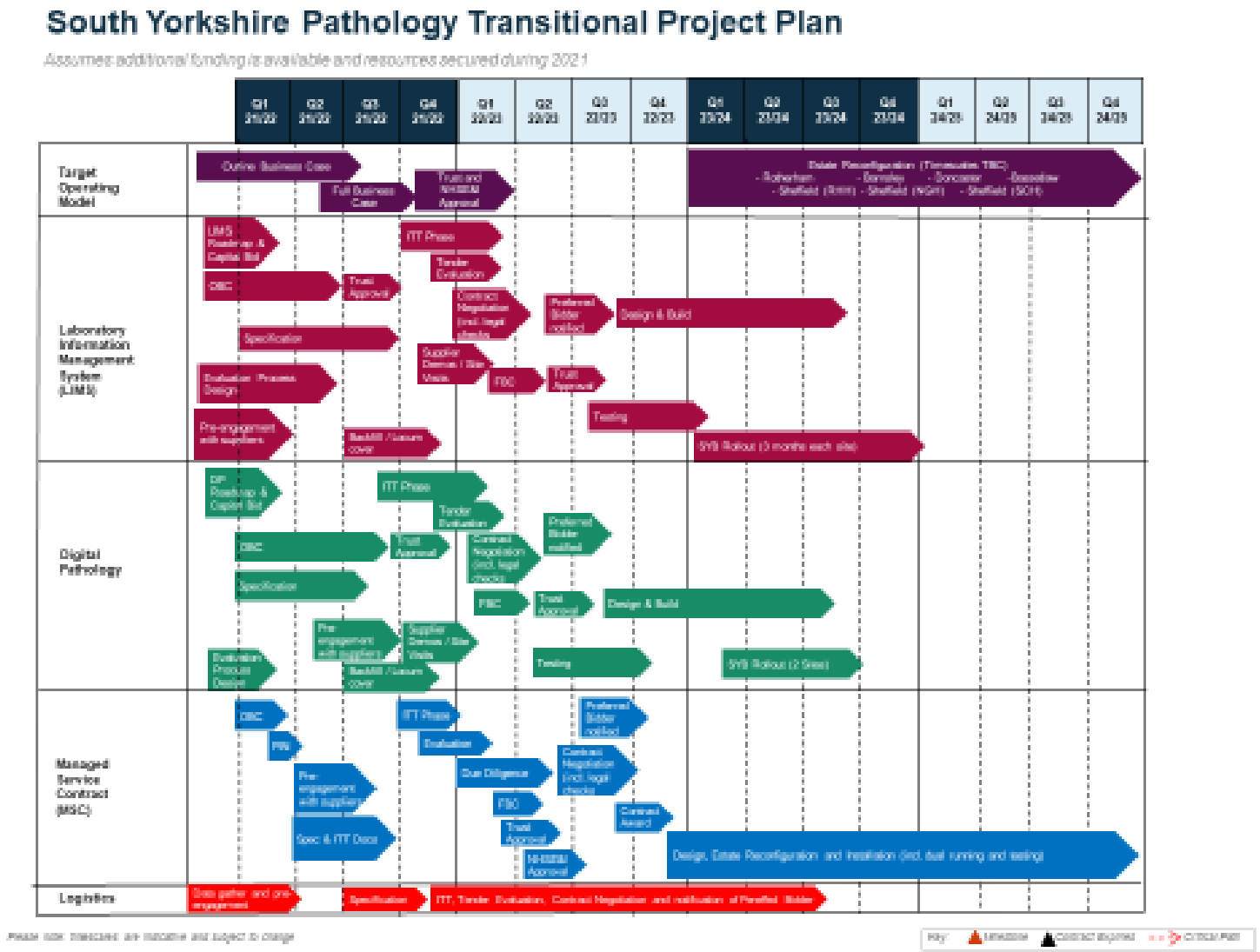
Description of Risk	Risk Score			Existing Controls in place	Action	Date to be completed	Responsible Person	Re-score after			Status
	Likelihood	Con'qce	Total					Likelihood	Con'qce	Total	
Timeline for procurement and implementation of a single LIMS (and hence benefits from Pathology transformation) may be delayed due to STH EPR timeline. (If STH EPR LIMS option used for network, rollout to other Trusts will occur some time after STH EPR completion. Or if standalone LIMS is chosen, STH unlikely to implement until after EPR project completion.)	4	5	20	Programme Manager communicates regularly with STH EPR Team to seek updates. STH reps participate in Pathology IT Group.	Prepare LIMS business case in parallel with EPR case to ensure it is ready should an EPR without integrated LIMS be selected.	30 June 2021	IT Group	4	5	20	STH EPR procurement stopped and appraisal process underway to determine next steps for STH. Risk to LIMS be updated as STH EPR proposals become better understood and as Pathology undertake evaluation of inbuilt and standalone LIMS. LIMS SOC endorsed by DDB and all Trust TEGs March-May 2021; OBC in draft form.
Insufficient Pathology and Procurement staff time to complete overlapping tenders for MSC,LIMS and Digital	4	4	16	Business case preparation underway.	Business cases and implementation plans for MSC, LIMS and Digital Pathology will need to reflect required and available resources.	As per individual business cases	Programme Delivery Team, Procurement and IT Group members	4	4	16	Digital Delivery Board (March 2021) highlighted the complexity of implementing IT projects across multiple Trusts; significant resource and time to deliver will be required
Trust IT staff time to support and inform Transformation Programme is limited by need to manage other IT priorities	4	4	16	IT workgroup meets monthly and is well attended by Pathology IT Leads, with some input from Trust IT Leads. Regular comms with ICS Digital Lead.	IT Project Management support to be included in LIMS, Digital Pathology, ICE v8 and MSC business case and bids.	As per individual business cases and implementation plans	IT workgroup	4	4	16	Digital Delivery Board (March 2021) highlighted the complexity of implementing IT projects across multiple Trusts; significant resource and time to deliver will be required
Gap in programme resources. Programme Delivery Team contracts cease 31 July 2021 but the leadership model to develop the FBC and progress the network has not yet been agreed, nor recruitment commenced. Risk of loss of detailed knowledge and of hiatus in progress of network.	5	4	20	ESB requested that Paul Buckley develop proposal for future leadership team and is awaiting further detail. Bid for revenue funding has been prepared for submission to regional team 28 April 2021	Seek approval for revenue bid submission and await outcome from Regional Diagnostic Board (expected late May?). STH (?) to prepare JDs for leadership team so recruitment can commence ASAP. All Trusts to engage with current senior leaders.	31/05/2021	Richard Parker & Paul Buckley	4	4	16	Even if revenue funding is approved at end of May, recruitment timeline will mean there is a gap from end of July in programme resources. Alternative plan required if revenue funding not provided by NHSE.
Investment requirements are not met / supported	4	5	20	Capital bid submitted as part of ICS wave 4 national bid in summer 2018 for a single LIMS, digital pathology and estates work; this was not supported from national funding allocation (Dec.2018). £922k capital funding awarded for use in 21/22 for ICE v8 Enterprise. No funding yet secured for LIMS, Digital Pathology, Estates reconfiguration or Logistics - but year 1 digital diagnostics capital bid for LIMS and Digital Pathology suppported by regional team 27/5/21; awaiting national decision re funding.	Await capital funding decision from national team June/July 202	2021/22 in line with national digital funding being available. June 2021 for Estates and Logistics costs	Sarah Bayliss	3	5	15	Single LIMS and digital pathology are key enablers for delivery of Pathology Transformation. £100M LIMS and $40M Digital Pathology available in 21/22. Capital funding awarded Dec 2020 from COVID 'LIMS enhancement' for ICE v8 ICE nterprise (details being considered by Trusts Jan 2021). Capital bids submitted for LIMS and Digital Pathology and supported by Regional Diagnostic Board 27/5/21; awaiting national decision June/July 2021.

Programme Management

The SYB Pathology Transformation Programme will be managed by the senior leadership team of Clinical Director, Scientific Director and Operations Manager. A Programme Manager will be appointed for a fixed term (Sept. 2021 to March 2023) to provide them with additional support in managing the multiple projects essential for transition to the TOM. Appointment to these posts is being taken forward by STH as the Host as a supporting step of moving the SYB Network forward. The Pathology Transformation Associate Clinical Director and Finance Lead will provide continuity for the programme from 1 Aug. 2021 to 31st March 2022 and oversee planning for the FBC with Reference Groups and Work Groups alongside the senior leadership team when in place.

A high level programme plan is shown in Figure 13.

Figure 13 : SYB Transformation Programme Overview



An evaluation will be carried out after each individual project has been completed and/or the programme has achieved a significant milestone, as shown in the programme plan. The evaluation process will include consultation with appropriate stakeholders on performance, timescales and key deliverables for each project/workstream.

7.5 Financial Impact

The full financial impact, including transition costs will be developed as part of the FBC.

7.6 Benefits Realisation Planning

The project plan for implementation of the proposed operating model will include workstreams and tasks that enable optimum performance against the programme objectives; a benefits realisation plan will be detailed in the FBC.

Key Performance Indicators (KPIs) will be agreed and monitored. The SYB Pathology Quality Group's recommendation is that the nationally prescribed Pathology Quality Assurance Dashboard (PQAD) along with NHSE screening programme assay target turnaround times are immediately adopted as network KPI's; each Pathology service already submits PQAD KPI data (Appendix W) to its Board and to NHSE quarterly. Other Quality Management System (QMS) KPIs relevant to service users will be established as part of the development and implementation of the joint QMS; this may require a period of time to allow monitoring of the metrics during the initial implementation phase to set up KPIs that are both appropriate and achievable and to ensure it is feasible to collect the relevant data. Specific transport related and service specific turnaround time KPIs will be established as samples are moved around the network and work force metric KPIs will be used to monitor the impact of the SYB Pathology TOM on our people.

8. Recommendations

The SYB ICS Pathology Programme team makes the following recommendations for approval by the Executive Steering Board and subsequently Trust Boards, these being; BHFT, DBTHFT, TRHFT, SCFT and STHFT:

Table 15 : Recommendations for Approval

Title	Description
1. Proposed Target Operating Model	The formation of the pathology network is configured as described in this economic case as the recommended Target Operating Model.
2. STH Hosted Network	The SYB Pathology Service is established between the five partner Trusts as a Hosted Network, operating as a single service, with STHFT as the Host Organisation. This will involve STHFT, as the host organisation, contracting for all the relevant services comprising the pathology network on behalf of the partner trusts. A contractual Partnership Agreement will be in place to assure all five partners and to document how each will be held to account.
3. Pathology Partnership Board and Operational Team	A Pathology Partnership Board and Operational Team should be appointed to lead delivery of the substantial reconfiguration of services as described in the recommended target operating model of this OBC. In order to deliver the scale of changes at pace it is recommended that the three senior network appointments are advertised as soon as possible. These appointments should be employed by STH as the network Host with authority to lead the new network on behalf of the partner trusts

9. Appendices

9.1	Appendix A:	SYB ICS NHS Partners
9.2	Appendix B:	GIRFT SYB Pathology Data Pack and Report
9.3	Appendix C:	Evaluation Criteria for mini-CSL
9.4	Appendix D:	Recommendations and Evaluation Criteria for a single Histopathology CSL
9.5	Appendix E:	LIMS Capital Bid Submission
9.6	Appendix F :	Digital Pathology Capital Bid Submission
9.7	Appendix G :	Blood Sciences Reference Group Report
9.8	Appendix H:	Microbiology Reference Group Report
9.9	Appendix I:	Histology Reference Group Report
9.10	Appendix J:	SYB Workforce Strategy
9.11	Appendix K :	IT Reference Group Report
9.12	Appendix L:	Quality Reference Group Report
9.13	Appendix M:	Logistics Reference Group Report
9.14	Appendix N:	SYB ESL Test List
9.15	Appendix O:	Mini-CSL Evaluation & Scoring ESB June 2021
9.16	Appendix P :	Draft Digital Pathology OBC
9.17	Appendix Q :	Draft Partnership Agreement
9.18	Appendix R :	Financial Assessments - AFE and Pay Budget Savings per Discipline
9.19	Appendix S :	Agreed SYB Percentage Uplift for Absence Cover
9.20	Appendix T :	Risk & Gain Share
9.21	Appendix U :	SYB Pathology Communication Strategy
9.22	Appendix V:	SYB Pathology Transformation Programme Risk Register
9.23	Appendix W:	Pathology Quality Assurance Dashboard

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Report Cover Page			
Meeting Title:	Board of Directors		
Meeting Date:	21st September 2021	**Agenda Reference:**	**F2**
Report Title:	Update on Developing Closer Working Arrangements Between Rotherham Doncaster and South Humber NHS Foundation Trust (RDASH) and Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH)		
Sponsor:	Richard Parker		
Author:	Marie Purdue, Director of Strategy, DBTH and Jo McDonough, Director of strategy, RDASH		
Appendices:	N/A		

Report Summary	
Purpose of report:	This report provides an update on progress in developing closer working arrangements between RDASH and DBTH
Summary of key issues/positive highlights:	• RDASH and DBTH already collaborate in different ways to provide services, mutual aid and joint roles. • The joint working described in this paper will build on the ongoing work and allow both Trusts to consider opportunities for greater efficiencies, arising from the removal of underused or duplicated capacity. • There are also opportunities from facilitating service process redesign and efficiency savings as well as shared workforce models. • It is not intended to change the statutory responsibilities of either organisation in undertaking this work; rather it is about utilising the opportunities already available that do not affect organisational form.
Recommendation:	The Board of Directors are asked to note the progress to date and support: • The Design Group working to agree plans to engage an external partner to support our scoping work; and • The development of plans for engagement across our two organisations including general communication plans for partners and our staff.

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

Link to True North Objectives: Provides opportunities in all 4 areas	**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:	N/A
Corporate risk register:	N/A
Regulation:	N/A
Legal:	N/A
Resources:	Resources required to scope opportunities

Assurance Route			
Previously considered by:	None		
Date:		**Decision:**	
Next Steps:	Continued review at Design Group with report to both Boards		
Previously circulated reports to supplement this paper:	N/A.		

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST (RDASH) / DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST (DBTH)

UPDATE REPORT ON DEVELOPING CLOSER WORKING ARRANGEMENTS BETWEEN

RDASH AND DBTH

1. BACKGROUND

This paper has been prepared on behalf of the Chief Executive Officers of Rotherham Doncaster and South Humber NHS Foundation Trust (RDASH) and Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) to provide an update on discussions on the development of more formal joint working between the two Trusts in areas where there may be opportunity to improve patient care and treatment, staff health and well -being or efficiency which could include some clinical services, some back office services, education, training and research and use of Estate. This list is indicative only and joint working will only be pursued where there appears to be a benefit for patients, staff or efficiency and effectiveness and an approach which is consistent with the developing legislation and guidance.

In July 2021, the Health and Care Bill was published, setting out key legislative proposals to reform how health services in England are delivered and organised. Many of the proposals have been informed by the NHS's recommendations and the Bill will establish a legislative framework that supports collaboration rather than competition and leads to more joined-up services.

RDASH and DBTH already collaborate in different ways to provide services, mutual aid and joint roles. The joint working described in this paper will build on the ongoing work and allow both Trusts to consider opportunities for greater efficiencies, arising from the removal of underused or duplicated capacity. There are also opportunities from facilitating service process redesign and efficiency savings as well as shared workforce models. It is not intended to change the statutory responsibilities of either organisation in undertaking this work; rather it is about utilising the opportunities already available that do not affect organisational form.

2. PROGRESS TO DATE

Following the approval from both organisations' Board of Directors to proceed with exploring opportunities for joint working, a Design Group has been established with representation from both organisations including Chairs, Chief Executives, Non-Executive Directors and Directors of Strategy. The group met in August and has begun work on the scoping of potential areas for and forms of joint working.

In addition, during August the "*Thriving places guidance on the development of place-based partnerships as part of statutory ICSs*", which NHSE/I co-produced with the Local Government Association, was published. The guidance aims to support partner organisations working in Integrated Care Systems to collectively define and evolve their place-level working arrangements. It sets out the activities that place-based partnerships

may lead and suggests several potential governance arrangements following the passage of the Health and Care Bill through parliament. It also clarifies that place-based partnerships will have a role in developing the integrated care board's and the integrated care partnership's strategic plans.

Both RDaSH and DBTH are partners in the Doncaster Place with the Clinical Commissioning Group, Doncaster Council, Primary Care Doncaster and others. This partnership will form a wider Integrated Care Partnership for Doncaster as described in the guidance mentioned above. The two Trusts are also members of the Doncaster Provider Alliance.

The scope of the joint working that RDaSH and DBTH are exploring will be more specific to our two statutory healthcare organisations and the design group defined that any joint working should:

a) Work within current guidance and structure to enable DBTH and RDaSH achieve their strategic ambitions;
b) Provide real benefits to patients and their families and drive quality improvement;
c) Maximise resource - for example by attracting and retaining skills to the two organisations and shared use of estate;
d) Create efficiency – reduce duplication and capitalise on potential economies of scale;
e) Be supported by a robust and resilient governance and decision making structure.

The Design Group agreed that detailed scoping work should be undertaken to analyse the current position of each organisation and identify the areas where joint working and collaboration would most meet the principles outlined above. It was also agreed that both organisations did not currently have the capacity or capability to undertake this work at pace and therefore we would jointly procure external support.

The Design Group has also begun to consider the possible organisational and/or governance framework that could be implemented to support future joint working, with legal support. Whilst a range of options are available, at this early stage the group were clear that this should be formulated once we have decided where and how we want to collaborate.

Finally, the group considered the communications and engagement required to ensure that key parties are included in and understand the work that has commenced. It is proposed that both organisation's full Boards of Directors should come together to discuss this further in the Autumn. The group also felt it was important to bring together both Councils of Governors at the appropriate point in time. Communication and engagement with the teams in each organisation will be co-ordinated and inclusive.

3, NEXT STEPS

The Board of Directors are asked to note the progress to date and support:

1. the Design Group working to agree plans to engage an external partner to support our scoping work; and
2. the development of plans for engagement across our two organisations including general communication plans for partners and our staff.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	21.09.2021	**Agenda Reference:**	**F3**		
Report Title:	**Teaching Hospital Board Update**				
Sponsor:	David Purdue, Chief Nurse/Deputy CEO				
Author:	David Purdue				
Appendices:	N/A				
Report Summary					
Purpose of report:	Update the Board on the progress of the Teaching Hospital Board				
Summary of key issues/positive highlights:	• Board has met twice • Full engagement with partners from both places, including public health, Higher Education Institutes, Schools, and place-based partners • Workplan agreed with key areas of focus 1. University guidance for research and education 2. Widening participation 3. Anchor institution				
Recommendation:					
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 new changes
Corporate risk register:	No change
Regulation:	N/A
Legal:	N/A
Resources:	

Assurance Route			
Previously considered by:	N/A		
Date:		**Decision:**	
Next Steps:	*Quarterly meetings set up with work-plan*		
Previously circulated reports to supplement this paper:	.		

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Trust Board of Directors**				
Meeting Date:	21 September 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 SEP 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 122 risk logged rated 15+ across the Trust and were tabled at the September 13th Trust Executive Group (TEG) for review. • 13 of these risks are currently monitored via Corporate Risk register (CRR) 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.				
Recommendation:	The Committee 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 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 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:		F&P , ARC, TEG Executive Team – (15+ risks)	
Date:	TEG 13 Sept 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:		Risks rated 15+ Detail & Overview papers discussed at TEG 13/9/2021	

Corporate Risk Register Summary September 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	31/08/2021	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	Apr-21	⟺
2664	PEO3	01/07/2021	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. Mutual from Sheffield commenced (covers approx. 5 shifts per week during the day -DRI site.). planned for 2 existing consultants to join rota following changes across site. Wider high impact recruitment planned alongside other action in the plan. CIG IT case has been agreed to improve attractiveness of the department.(RJ)	Extreme Risk	20	High Risk	May-21	⟺
2472	COVID1	30/08/2021	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	**14/7/21** existing controls in place and recovery plans monitored via COO and delivered to F&P & Board17/5/21: Operational Update / Delivery of Elective Restoration Update (Presentation)given to F&P Committee on monthly basis. Covers risk areas of Theatre staffing, Be Plan, Risk to patients & Oversight & Governance. Mitigation via high level actions from COO led Performance & Access Board. High level actions from Performance and Access Board -Strengthening governance of "getting the basics right" (642, POA etc)	Extreme Risk	25	High Risk	Jul-21	⟺
11	F&P1	13/08/2021	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	13/5/21:New controls : Budget process linked to capacity planning; Additional Training Programmes for managers; Perf Assurance Framework; Close working with ICS and Provider DoF's	Extreme Risk	16	High Risk	May-21	⟺
7	F&P6	17/07/2021	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	May-21	⟺
19	PEO1 (Q&E1)	31/08/2021	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	Jul-21	⟺

Appendix 4 (Level 4 detail) **Corporate Risk Register Summary September 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	Apr-21	⟺
1410	F&P11	16/07/2021	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	[17/05/2021 10:10:16 David Linacre] The server patching work has been subject to delays, with divisional system administration contacts not responding to requests from IT to arrange regular monthly maintenance windows. A decision was taken in April to enforce a recurring maintenance slot where no response had been received to multiple requests from IT. As a result, all supported systems should be patched up-to-date by end May. The backup software and hardware was installed to plan, but configuration and implementation has been delayed by other priorities in IT during January - March (final quarter / year end pressures). The work is now underway again and will be completed by end May. A small number of Windows 10 devices remain active on the network, with security concerns mitigated by a combination of ESU from Microsoft and network segmentation to restrict access to high-risk activities (eMail and web sites). The cyber-security dashboard is implemented and configuration is on-going, although valuable asset and vulnerability tracking information is already available. Work on security logging and retention is underway, with the initial systems expected to be integrated by end May. Network Access Control and Micro-segmentation have been delayed due to other work pressures, and delays on completed of the pre-requisite telephony system upgrade. New completion dates for these projects are under discussion at present.	Extreme Risk	15	Moderate Risk	May-21	⟺
16	PEO2 (F&P8)	31/08/2021	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	Jul-21	⟺
2426	F&P	30/07/2021	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. (linked with 2703)	Extreme Risk	15	High Risk	May-21	⟺
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	[8/4821] Works carried out to install edge protection to various areas including OPD1 at DRI and MI Block at BDGH. Further review to be carried out for potential inclusion within 21/22.	Extreme Risk	15	Moderate Risk	Apr-21	⟺
1807	F&P20 / Q&E12	08/11/2021	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	Jul-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	⟺

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	Board of Directors				
Meeting Date:	21st September 2021	**Agenda Reference:**	G2		
Report Title:	**Trust Board Annual Declaration of Interests.**				
Sponsor:	David Purdue, Deputy Chief Executive Officer				
Author:	Fiona Dunn, Deputy Director Corporate Governance/Company Secretary				
Appendices:	Register of Interests.				
Report Summary					
Purpose of report:	To provide assurance to the Board on its statutory and regulatory requirements in requirement for declaration of Director interests.				
Summary of key issues/positive highlights:	The NHS Code of Accountability and NHS England's guidance on managing conflicts of interest in the NHS requires Board Directors to declare any interests which are relevant and material to the Board. This includes any interest that could conflict with the impartial discharge of their duties and which could cause conflict between their private interests and their NHS duties. The Register for the Board was updated as of 1st August 2021 and is attached. This information will be made publicly available on the Trust website following the meeting. All Board members comply with the "fit and proper persons" declaration as required by Trust policy. In addition to this annual declaration, at each meeting of the Board of Directors and its Committees, members are asked to declare any further interests since the date of the last declaration and to notify the Chair of any conflicts of interest in relation to the agenda items for discussion (for which they may need to abstain). Any such declaration is recorded in the minutes Summary : No conflicts of interest have been identified •				
Recommendation:	The Board is asked to receive and approve the Register of Interests.				
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 changes				

Corporate risk register:	F&P6 – no changes (Failure to achieve compliance with performance and delivery, CQC and other regulatory standards Leading to: (i) Negative patient and public reaction towards the Trust (ii) Impact on reputation
Regulation:	• Financial Reporting Council's publications (UK corporate governance code and guidance on board effectiveness) • Monitor's code of governance for NHS foundation trusts
Legal:	Compliance with regulated activities and requirements in Health and Social Care Act 2008.
Resources:	N/A

Assurance Route			
Previously considered by:			Board - Outcome report 2021
Date:	*15/09/2020*	**Decision:**	Approved & acknowledged register of Interest.
Next Steps:			Continue monitoring prior to each Board and sub-committee meeting.
Previously circulated reports to supplement this paper:			Previous meeting minutes

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
Register of Directors' Interests and 'Fit and 'Proper Person' Declarations

Register of Interests

Suzy Brain England OBE, Chair of the Board
Chair at DBTH
Chair at Keep Britain Tidy
Lead Examiner for Chartered Director by the Institute of Directors
Founder and Chair of Cloud Talking, Aspirational Mentoring
Co-opted Board member Doncaster Chamber of Commerce
Trustee of NHS Providers

Kath Smart, Non-Executive Director
Independent Audit Committee Member – Doncaster Metropolitan Borough Council
Non-Executive Director & Audit Committee Chair – ACIS Group, Gainsborough (Housing provider)
Court Secretary – Foresters Friendly Society, Sheffield
Trust Associate Manager (TAM – or 'Hospital Manager' under the Mental Health Act) – Rotherham, Doncaster & South Humber NHS FT

Neil Rhodes, Non-Executive Director
Chair, Doncaster and Bassetlaw Healthcare Services
Non-Executive Director at the Disclosure and Barring Service
NED with Youth Justice Board, Ministry of Justice.
Director, Kendal Green Associates, professional standards, and senior personnel appointment consultancy

Patricia Drake, Non-Executive Director
Governor of Calderdale FE College
Magistrate (Supplemental)
Member of Local Community Partnerships
Member of Yorkshire Ambulance Service

Sheena McDonnell, Non-Executive Director
Director of Sheena McDonnell Consultancy
Non-Executive Director of Oldham Community Leisure
Associate of Do-Well Company Limited

Jon Sargeant, Director of Finance
Directorship, Doncaster and Bassetlaw Healthcare Services

Mark Bailey, Non-Executive Director
Visiting Fellow at Cranfield University
Executive Leadership Coach – provider of freelance services

The following have no relevant interests to declare:

Karen Barnard	Director of People & Organisational Development
Rebecca Joyce	Chief Operating Officer
Tim Noble	Executive Medical Director
Richard Parker OBE	Chief Executive
David Purdue	Deputy Chief Executive / Chief Nurse

Fit and Proper Person Declarations

The Trust can confirm that every director currently in post has declared that the following within their current role:

(i) am not an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.

(ii) am not the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.

(iii) **am not** a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986.

(iv) have not made a composition or arrangement with, or granted a trust deed for, my creditors and not been discharged in respect of it.

(v) have not within the preceding five years been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on me.

(vi) am not subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986.

(vii) have the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which I am employed.

(viii) am able by reason of my health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which I am appointed or to the work for which I am employed.

(ix) have not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

(x) am not included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland; and

(xi) am not prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

Directors are requested to note the above and to declare any changes to their position as appropriate in order to keep their declaration up to date.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Use of Trust Seal**		
Report to:	**Board of Directors**	Date:	**21st September 2021**
Author:	**Fiona Dunn – Deputy Director Corporate Governance/Company Secretary**		
For:	**For approval**		

Purpose of Paper: Executive Summary containing key messages and issues

The purpose of this report is to advise of use of the Trust Seal in accordance with section 14: Custody of Seal and Sealing of Documents of the Standing Orders of the Board of Directors:

Seal No.	Description	Signed	Date of sealing
125	WH Smith Hospital Limited, WH Smith Hospitals Holding Limited and Doncaster and Bassetlaw Teaching Hospitals renewal lease by reference to an existing lease.	Richard Parker OBE Chief Executive	8th September 2021
		Jon Sargeant Director of Finance	

Recommendation

The Board is requested to approve the use of the Trust Seal.

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	21 September 2021	**Agenda Reference:**	**H1**		
Report Title:	**Chair & NEDs Report to Board**				
Sponsor:	Suzy Brain England OBE				
Author:	Suzy Brain England OBE				
Appendices:	None				
Executive Summary					
Purpose of report:	To update the Board of Directors on the Chair and NED activities since July 2021's 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

NHS Providers

At the beginning of this month I attended NHS Providers Board meeting, board trustees received the Chief Executive and Director update, management accounts for the period ending 30 April 2021 and details of the imminent board election process. We were briefed on provisional plans for NHS Providers to contribute and support members in relation to the Covid-19 public enquiry and heard about progress with this year's Annual Conference, which is due to take place on 16 & 17 November at the ACC, Liverpool.

NHS Providers Governor Advisory Committee (GAC) took place on 7 September, a new committee was elected in April 2021 and on an interim basis I have been supporting the newly elected members by taking on the responsibility of Committee Chair. However, in accordance with the committee's terms of reference an election process will commence next month with a view to electing both a Chair and Deputy Chair by the end of this year. At this month's meeting the Committee received, for approval, its Terms of Reference and Code of Conduct and a progress update on Q1 activity which highlighted the great work that goes into the support and education of governors. The election process for the Chair and Deputy Chair was shared and as always members received a policy update from Miriam Deakin, Director of Policy & Strategy and had the opportunity to share local intelligence.

Finally, I supported the first of four NHS Providers virtual governor workshops, which run between 20 September and 5 October 2021. The workshops include an update on current NHS policy and hot topics, they also share good practice, explore key governor duties, and provide the opportunity for governors to share their experiences and ask questions of colleagues and the NHS Providers team.

Governor Meetings

Since my last board report Governors have had the opportunity to join three development and training sessions:

- Infection Prevention & Control, hosted by Miriam Boyack, Infection Control Lead Nurse and Abigail Trainer, Director of Nursing

- Charitable Funds, hosted by Sarah Dunning, Corporate Fundraiser and Emma Shaheen, Head of Communications & Engagement

- Skin Integrity, hosted by Kelly Moore, Skin Integrity Lead Nurse

I would like to extend my thanks to those colleagues who provide such a valuable insight into their work, governors who embrace these learning opportunities and our colleagues in the Trust Board Office for making the necessary arrangements.

1:1s and Introductory Meetings

In addition to my regular meetings with the Chief Executive, Non-executive Directors, Lead and Deputy Lead Governor and Company Secretary I have also met on a 1:1 basis with Becky Joyce and David Purdue.

I met with Richard Canetti, who recently joined the Trust as Deputy Director of Strategy & Improvement and we were able to share future ambitions and reflect on our past experiences.

Along with Pat Drake, Clinical Non-executive Director, it has also been my pleasure to welcome the first two cohorts of international nurses to DBTH. Whilst the nurses are self-isolating on arrival in the country, we make good use of their time and have linked in remotely to welcome them to Doncaster and the Trust. Welcoming them to the DBTH family is hugely important at what must be an incredibly daunting time for them. Estelle Burton, International Nurse Recruitment, is doing an amazing job making all the necessary plans to ensure an efficient and effective induction and entry to the UK and Pat and I look forward to greeting the remaining cohorts as they come on board.

Finally, I also had the opportunity to meet for a pre-interview discussion with Dr Joseph John, who was subsequently appointed as Medical Director for Operational Stability & Optimisation. I look forward to meeting him again when he formally takes up post.

Education Opportunities

Last week I joined a virtual learning event organised by South Yorkshire and Bassetlaw ICS Health and Wellbeing Hub, which was hosted by Professor Michael West. The session addressed the question of how we can develop a culture of high quality, continual improvement and compassionate care in the challenging circumstances we face across health, care and other public services and, at the same time, ensure the wellbeing and growth of our staff who provide that care.

Following a pause last year, due to the pandemic, I am pleased to announce the return of the popular Sharing How We Care Conference. The virtual event took place on 16 September, and as usual attendance levels were high with an agenda full of opportunities to learn and share best practice. The conference was opened by our Chief Executive, Richard Parker, who then introduced our keynote speaker, Suzette Woodward, who shared her thoughts on patient safety and just culture. A series of breakout sessions were organised, allowing colleagues the opportunity to maximise their own personal learning and as I formally closed the conference, I was able to reflect on the tremendous efforts over the last 18 month in ensuring delivery of high standards of patient care, which the Trust will continue to develop into the future.

Other meetings

A board workshop, facilitated by Marie Purdue, took place this month to consider the implications of the recent boundary changes, which results in a move for the district of Bassetlaw from South Yorkshire & Bassetlaw ICS to Nottingham and Nottinghamshire ICS. The team worked together to anticipate strengths, weaknesses, opportunities, and threats arising from the change, considering any impact upon the Trust and its business.

The Board continues to raise awareness of the estate's pressures faced by Doncaster Royal Infirmary, which were further challenged by the recent internal incident in the Women's & Children's Hospital. As DRI were not named in wave one of the Health Infrastructure Plans for new hospitals we have again submitted an expression of interest for wave 2. The increasing risks on the site have been escalated to NHSE/I and a recent risk summit called to ensure an understanding of the challenges we face, the mitigating action taken and the overall service impact. We continue to work closely with Doncaster MBC and our local Doncaster MPs on the critical situation; and earlier this month Richard Barker, Regional Director, Sir Andrew Cash, ICS Lead and the newly appointed Independent Chair of SY&B ICS, Pearse Butler, visited the site to see firsthand the issues we face.

Finally, as co-opted director at Doncaster Chamber I have recently supported the initial shortlisting for 2021's Doncaster Chamber Business Awards and along with other members of Team Doncaster have been invited to join the newly formed City Status Steering Group. My involvement at the Chamber provides an excellent opportunity to raise the profile of Doncaster and in turn that of the Trust as an anchor organisation and employer of choice.

NED Reports

Mark Bailey

Since the last Board, Mark has participated in the Board Committees for People and Quality & Effectiveness and chaired the Trust's Charitable Funds Committee.

Mark has also participated in a further Board workshop exploring ICS System working arrangements post legislative change. He has attended the NHS Provider's Digital Boards event looking at collaboration at system level to deliver digital transformation and the NHS Chair's reset meeting which shared best practice in board level support of digital innovation.

In early September, Mark chaired a second meeting of the new Teaching Hospital Board. This Board is charged with the strategic development of our educational and research ambitions working in collaboration with external stakeholders which include the Doncaster College and University Centre, Doncaster Public Health, Hall Cross Academy, University of Sheffield, Sheffield Hallam University and Nottinghamshire Healthcare.

Mark has supported the Medicine and Clinical Specialties Divisions in their respective appointments into the Consultant Haematology and Consultant Radiologist positions and the Executive Medical Director in the appointment to the Medical Director position

Regular catch-up calls with Executive and Non-Executive colleagues have been held including specific assurance discussions on Health & Wellbeing, digital programme development and securing learning opportunities on healthcare innovation. In addition, individual 'buddy' calls with Governors continue and Mark hosted the recent Governor briefing and development session on the Trust's Charity.

Finally, in recognition and appreciation of our colleagues continued care and commitment, Mark was pleased to be on-site at DRI supporting our 'random acts of kindness' day.

Kath Smart

Since the last report Kath has had 1:1s with David Purdue and Fiona Dunn, Wendy Baird (Governor), Gill Marsden (Deputy Chief Operating Officer - Elective), Harriet Fisher (KPMG), Ruth Vernon (360 Assurance) and fellow NED, Sheena McDonnell. She has also attended two Governor briefing sessions on Charitable Funds and Skin Integrity.

Kath has represented DBTH at the ICS Integrated Assurance Committee, which has been set up to assist with developing governance arrangements for the forthcoming changes with the ICS.

Alongside other NEDs, she has also had opportunity to be involved in the upcoming Strategic Outline Case (SOC) for the DRI New Build Project, attending the NED briefing session, plus the stakeholder sessions and workshop designed to feed into the SOC.

She has attended the People Committee, Charitable Funds Committee, the Board Workshop, the Division of Medicine Management Team Meeting and chaired interviews for the Medical Examiner role.

Finally, it was a pleasure to be at the opening ceremony for the new Rainbow Garden, opened for staff and patients to enjoy using charitable funds and donations, in addition on the "Random Acts of Kindness Day" Kath distributed bags of sweets as part of the Trusts ongoing commitment to thank staff for their hard work during difficult and challenging times.

Pat Drake

At the end of July Pat visited the paediatric and maternity areas to thank staff for their resilience following the internal incident in the Women's and Children's Hospital. Pat has also visited Bassetlaw Hospital and met with the Director of Midwifery and maternity colleagues to discuss patient safety.

In her role as Maternity Safety Champion, she participated in two training sessions, one on reliability and transparency and the other on psychological safety. In order to develop relationships Pat has met separately with the Maternity Voices Partnership leads and set up monthly meetings. She also joined two staff safety champion meetings and attended the Children and Families Board.

Pat has attended the Finance & Performance, People and Charitable Funds Committees and chaired the Quality & Effectiveness Committee planning meeting in preparation for the full committee meeting, where a number of high quality clinical presentations were received, including one from the Medicine Division following the re-establishment of divisional reviews.

Along with the Chair, Pat welcomed the first two cohorts of international nurses, she also met with governors and attended two Governor briefings, one of which she chaired.

The Chair undertook Pat's appraisal during August and conducted a 1:1 in September. Pat has also joined the NED update meetings and the Board Workshop which considered the recent boundary change for Bassetlaw.

Finally, Pat observed the Equality and Diversity Committee, the Mortality Governance Committee, Patient Experience & Engagement Committee and the Clinical Governance Committee. She also took the opportunity to visit the Emergency Department and medical areas to thank the staff for all their hard work.

Neil Rhodes

Since the last board meeting Neil has had a 1:1 meeting with the Chair and attended regular update meetings with his fellow NEDs. He has also met with the Director of Finance and the Chief Operating Officer.

Neil chaired the Finance and Performance Committee in July and ahead of September's meeting has held an agenda setting meeting. He also attended a productive initial meeting with RDASH board members along with DBTH's Chair and Chief Executive to consider collaborative ways of working.

Neil has interacted with governors and dealt with queries in relation to aspects of Trust performance.

He has also attended September's Charitable Funds Committee and has met with Gill Marsden, Deputy Chief Operating Officer – Elective.

Sheena McDonnell

This month has seen Sheena preparing for and chairing a People Committee meeting.

She has attended a Governor briefing on Charitable Funds and caught up with the Freedom to Speak up Guardian in connection with recent developments to the national picture.

Along with other NEDs Sheena has participated in a briefing on the plans for a new hospital and had a catch up with all NED's to update on progress across the Trust.

Sheena has also been involved in recruitment for a Consultant in Acute and Stroke Medicine

Chief Executive's Report
September 2021

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

An update on the Trust's response to COVID-19

As we head out of the summer and into autumn, we are facing some of the most challenging times we have experienced as a Trust. Our COVID-19 inpatient numbers continue to hover around 50, and we are seeing a return to the usual seasonal illnesses expected at this time of year which is resulting in high levels of attendance at our emergency departments.

These activity levels have put increased demand on staff and staffing levels as colleagues take well-earned annual leave. We are also continuing to see the impact of increased COVID-19 infections in our communities with illness and contact isolation in staff and their families. My thanks go to colleagues who are working hard to deal with and reduce the current shortfalls.

To support in this regard, we have increased incentives via NHS Professionals, as well as re-prioritising work to try to ensure that we have the capacity to deal with those with the most urgent need. With daily meetings, regular calls between neighbouring organisations and thrice-weekly Enhanced Operations discussions, colleagues continue to manage the position closely and I want to thank everyone for the dedication they have shown, particularly throughout these past few days.

Undoubtedly, we have further challenges as we move into the colder part of the year, however I know that Team DBTH more than measure up to the task.

In memory of Susan Bishop

It was with the greatest sadness that I shared the news that, following complications related to COVID-19, our beloved friend and colleague, Susan Bishop, passed away peacefully on Sunday 15 August.

A skilled, compassionate, and diligent Midwife of almost 30 years' experience, Susan joined Team DBTH in 1978. Described by colleagues as a great listener with a fantastic sense of humour, Susan was attentive, nurturing and a loyal friend who never had a bad word to say about others – all the characteristics required of a wonderful midwife, and a cherished member of the NHS.

Within our Trust, Susan meant so much to so many, but above all else she will remain forever within the hearts of the countless parents to whom she attended with boundless care, empathy, and commitment. Susan helped to bring so many little ones into this world, and, while we grieve for her passing, we must celebrate a life which was spent in such a profound and positive manner.

Bassetlaw moves to Nottingham and Nottinghamshire Integrated Care System

In July it was announced that the Bassetlaw district will join the Nottinghamshire Integrated Health System on the 1 April 2022.

While this will change financial and commissioning arrangements within the area, we want to assure our communities it does not affect the daily operations of Bassetlaw Hospital – Bassetlaw Hospital remains a key site within our Trust and you are unlikely to see any changes on a day-to-day basis.

The decision does not change existing patient pathways, and individuals will continue to be seen and treated by their local GP practice, as well as at Bassetlaw Hospital, and they will also carry on receiving other health and care services in the same way. It also does not affect any future developments and investments planned for this site.

The key difference will be the development of stronger connections between Nottinghamshire ICS and the Trust in the planning of health and Social care services to improve the health and wellbeing of Bassetlaw people.

Our Trust is first within the NHS to achieve RACE accreditation

I am pleased to announce that Doncaster and Bassetlaw Teaching Hospitals has become the first NHS organisation to qualify to use the RACE (Reporting Action Composition Education) Equality Code Quality Mark, following assessment.

The new code has been developed to help organisations take action to improve race equality within the workplace. The Race Equality Code draws learning and recommendations outlined in reports, charters, and pledges, with the aim of supporting organisations who are actively tackling diversity and inclusion challenges. It was launched in October last year as part of Black History Month 2020 by Dr Karl George MBE and a national steering group of experts in governance and racial inequalities.

To qualify to display the mark, the Trust had to go through an in-depth assessment and develop an action plan to demonstrate that it encourages racial equality amongst its workforce and is actively improving internal measures.

As part of the assessment process and before they are granted use of the mark, organisations must show that they meet the standards for each of the RACE principles and have an action plan to tackle areas of improvement. A RACE action plan will include measures for publicly reporting on progress, improving HR practices, increasing diversity at senior levels, and educating staff on racial inequality.

We are so pleased to have been awarded the use of the RACE Code Quality Mark. As an organisation which employees over 6,600 members of staff drawn from a variety of backgrounds, it is vital that we place equality and diversity at the heart of our plans to better reflect the needs of our communities in Doncaster, Bassetlaw and beyond.

As a Trust, we are committed to promoting inclusion across all our varied specialities and specialisms, taking steps to raise awareness of any disparities within our own organisation, to create a better workplace for all.

Gaining the use of this Quality Mark is just one step upon our journey, and as we recover from the pandemic, we will continue to deliver on our RACE action plan which we believe will aid us in our overall vision of providing the safest care in England, and to be outstanding in all that we do.

In the past year, the Trust has strengthened its commitment to fairness within the organisation, appointing Kirby Hussain as Equality, Diversity, and Inclusion Lead, whilst a Black, Asian, and Minority Ethnic (BAME) Staff Network has been established.

Celebrating our inaugural ‘Pride Week’

As a Trust we celebrated our very own version of LGBTQ+ Pride, with a range of speakers hosting virtual events throughout the week commencing 2 August.

LGBTQ+ stands for lesbian, gay, bisexual, transgender, queer (or sometimes questioning), and others, while the 'plus' represents other sexual identities. The first four letters of the acronym have been used since the 1990s, but in recent years there has been an increased awareness of the need to be inclusive of other sexual and gender identities to offer better representation.

DBTH's Pride Week was organised by the Trust's LGBTQ+ Staff Network, with co-chairs Christine White and Adam Evans, curating a programme of guest speakers to host presentations and discussions throughout the seven days of the event.

The first session was delivered by Heather Paterson of SAYiT, an organisation which supports young people between 11 and 25 years old, focused upon LGBTQ+ history. The second was presented by Phil Hill, a writer and vlogger who specialises in mental health and gender, centring on the concept of 'allyship' towards the trans and non-binary community. Finally, the third hour-long seminar was provided by Eva Echo, blogger, and activist, who led a discussion about being transgender, sharing her experiences of gender transition and her journey to self-acceptance.

The purpose of the week, as well as the LGBTQ+ Staff Network, forms part of our wider commitment as a Trust to help create a safe, inclusive, and diverse working environment that encourages respect and equality for all, whoever you are and whoever you love.

I want to say a huge 'thank you' to our guest speakers, as well our colleagues who attended these virtual sessions. The presentations were informative, insightful, and moving, and led to fantastic discussions. Based on the success of this week, we hope to add DBTH Pride to our annual calendar of events, and we can't wait to celebrate it once again next year.

The Trust's LGBTQ+ Staff Network was formed in 2020, and works in partnership with the Equality, Diversity, and Inclusion Committee to ensure that, as an employer, DBTH values and recognises the differences between sexual orientation and gender identity, fostering an environment of respect and inclusivity.

Range of 'pop-up' eateries introduced throughout September and October

We have begun to work with local caterers and businesses to increase the variety of nourishment on offer to staff, patients and visitors.

Ranging from fresh fruit and vegetables to handmade crepes, several pop-up stalls are available each day on a rotating basis, in addition to the various restaurants and outlets which are available at Doncaster Royal Infirmary, Bassetlaw Hospital and Montagu Hospital.

From now until the end of October, the following is available at the local hospitals:

Doncaster Royal Infirmary (within the Gate 4 entrance):

- Smith's Fish and Chips every Monday between 11am and 2pm.
- Spudbuddies (jacket potatoes, Greek dishes and more) every Wednesday between 11am to 3pm.
- Fresh 'n' Local (fruit and vegetables) every Thursday and Friday between 8am and 1pm.
- Madame Crepe (sweet and savoury crepes) Friday (24 September and 8 October) between 11am and 4pm.
- Yellow Bus Catering (gourmet American foods), every Friday 5pm to 9pm, Saturday 8am to 8pm and Sunday 11am to 4pm until Mid-October.

Bassetlaw Hospital:

- Spudbuddies every Monday, outside Clinical Therapy entrance from 11am to 3pm.
- Fresh ‘n’ Local every Tuesday, outside of the main entrance of the hospital between 8am and 1pm.
- Smith’s Fish and Chips every Wednesday near to the Clinical Therapy entrance between 11am and 2pm.
- Madame Crepe every Thursday near to the Clinical Therapy entrance between 11am to 4pm.

Montagu Hospital:

- Fresh ‘n’ Local every Monday, outside the Fred an Ann Green Rehab Centre between 8am to 3pm.
- Madame Crepe Wednesday (22 September and 6 October) adjacent to the Aurora building between 11am and 4pm.
- Smith’s Fish and Chips every Thursday adjacent to the Aurora building between 11am to 2pm.
- Spudbuddies every Friday adjacent to the Aurora Building between 11am to 3pm.

Doncaster Cancer Detection Trust donation improves care for urology patients

The Doncaster Cancer Detection Trust has fundraised to purchase a life-changing piece of equipment for Doncaster Royal Infirmary’s Urology clinic.

The BK3000 ultrasound machine is already benefitting patients under the care of Doncaster and Bassetlaw’s Urology team. Principally, the machine will allow the team in Urology to perform precision-point prostate biopsies in an outpatient setting under local anaesthetic, reducing the need for day-case surgery.

Previously, patients requiring a prostate biopsy as part of their diagnosis would have attended Montagu hospital for a pre-operative assessment with an anaesthetist and would have needed to stay for further monitoring following the procedure. This old method also undoubtedly carries more risk, as there are potential reactions to the general anaesthetic drugs. Traditional prostate biopsies can be less accurate and come with an additional risk of infection due to the nature of the procedure.

The new procedure, using the BK3000, is much less invasive than this method. With the introduction of the new equipment, patients can attend a one-stop shop at the hospital, receive their MRI scan and undergo the biopsy procedure in one visit.

Patients are given a local anaesthetic and the biopsy is carried out in a 15-minute procedure, following which the patient can return to the comfort of their own home.

Being able to perform prostate biopsies in an outpatient setting is not just beneficial for Urology patients, thanks to the new equipment, demand on the Trust’s anaesthetists and post-surgery services has also been greatly reduced and whole theatre lists have been freed up for patients needing other surgical procedures.

On behalf of all at DBTH, I would like to extend my sincere gratitude to the Doncaster Cancer Detection Trust for their efforts in fundraising for this equipment which is not only providing clinical benefits for our patients but making the pathways of their care more convenient for them.

Doncaster Cancer Detection Trust raised funds to the total of £142,000 to purchase the equipment for the hospital. If you'd like to support them in their future fundraisers, you can visit their website at dcdt.co.uk.

Drive-through ECG service helps to reduce hospital wait times

Earlier this year, our Cardiology team introduced a new drive-through service for patients requiring an ambulatory ECG test, to help reduce waiting times and improve overall experience.

Before the COVID-19 pandemic, 100% of ECG patients were seen in clinic and fitted with a monitor, which is roughly the size of a credit card, hooked up to three electrodes and set to record the activity of the heart for anywhere from 24 to 72 hours.

With the infection prevention and control challenges presented by coronavirus, and the resulting delays in getting people in and out safely, inspired by a similar service within phlebotomy, the department decided to roll-out the drive-through.

Patients now arrive at Doncaster Royal Infirmary, or Montagu Hospital, and park in a reserved parking spot. They then call a dedicated mobile phone number letting the service know they have arrived, and a member of staff will greet them and present the device after asking a few important questions. The patient also receives an instruction pack which contains very clear instructions and a link to a YouTube video showing how to properly hook up the electrodes.

Ultimately, the new drive-through service means more ECG tests can be carried out each day, with around 100 conducted each week, and the clinical spaces can be used primarily for those essential tests which must be carried out face-to-face, ultimately helping to reduce waiting lists which have been generated as a result of COVID-19 challenges.

150,000 COVID-19 tests completed at DBTH

Last month, the Microbiology team at Doncaster and Bassetlaw Teaching Hospitals (DBTH) completed their 150,000th Polymerase Chain Reaction (PCR) test, one of the most common screening tools for COVID-19.

Early on within the pandemic, the Trust had relied on its partners at Sheffield Teaching Hospitals to undertake testing for patients, however with limited capacity, this meant that around only 50 swabs per day could be sent from DBTH for analysis.

Thanks to some quick thinking and planning by our Microbiology team, we were able to take delivery of new equipment, providing DBTH with in-house testing. This was up and running by April 2020, with patients and staff alike benefitting from the innovative technology.

The PCR test is able to detect the virus by analysing samples obtained on extra-long cotton buds that are inserted in the nasal passages and into the back of the throat. Specialists, like those from DBTH's resident Microbiology laboratory team, can then process the result using real-time PCR techniques – a scientific method which creates a large number of copies of a specific target, amplifies it and analyses it in detail. In all, the process takes a few hours to confirm whether the swab is positive or negative.

A key tool in the Trust's fight against COVID-19, this in-house test has been measured as having a sensitivity (chance of producing true negatives) of 98% and a specificity (chance of producing true positives) of 96%. Due to improvements in efficiency and hard work, the average turnaround time

from patient to completed test is now on average, 11 hours, with hundreds carried out each and every day.

In addition to PCR testing, the Trust now has access to a range of rapid testing options, including molecular tests which offer an alternative fast and portable way to detect SARS-CoV-2 infection. This is also complemented by the requirement for all front-line staff to undertake twice weekly lateral flow testing, which is primarily used to detect any asymptomatic cases of COVID-19.

A huge well done to all involved.

Drop-in COVID-19 vaccination clinic success at Doncaster Royal Infirmary

On Monday 23 August, 20 local pregnant women received the COVID-19 vaccination at Doncaster Royal Infirmary's Antenatal Clinic following a special drop-in event.

The Joint Committee on Vaccination and Immunisation (JCVI) has advised that pregnant women should be offered COVID-19 vaccines at the same time as people of the same age or risk group. In the USA, around 90,000 pregnant women have been vaccinated mainly with Pfizer and Moderna vaccines and no safety concerns have been identified at this time.

The vaccination efforts were arranged by NHS Doncaster Clinical Commissioning Group (CCG) in partnership with Midwives and Maternity colleagues at the Trust, as well as Doncaster's Primary Care Network.

Christmas stars to return to our hospitals

A variety of stars, of all shapes and sizes are now available to sponsor in time for the festive period. The illuminations will be safely secured to the buildings which make up local hospitals within the area, each bearing a special message from their respective sponsor. At night, they will begin to shine, the filling the immediate area with seasonal starlight.

Last year over 60 local businesses, organisations and families got involved, each donating anywhere from £300 to £1,500 to sponsor a star, and in the process raising over £30,000 which has been directly reinvested into patient care, treatment, and facilities at the Trust.

The kindness shown to the Trust, and the wider NHS, throughout the past few months has been humbling. So please, if you wish to go above and beyond for your local hospitals, think about sponsoring a star this December. Your donation, big, small, or somewhere in between is hugely appreciated.

If you wish to sponsor a star, please contact dbth.charity@nhs.net for more information click here.

If you have any questions about how you can support DBTH, you can contact the Fundraising and Communications Team on 01302 644244 / dbth.charity@nhs.net

Hospital staff to enjoy a wild day out as a thank you

Finally, as a 'thank you' for the tremendous effort its staff have made throughout the challenges presented by Covid-19, we have teamed up with Yorkshire Wildlife Park (YWP) to host an exclusive 'thank you' event for local NHS heroes, their families, and friends.

Over the past 18 months, every single member of Team DBTH has worked tirelessly to adapt to new ways of working which has allowed us to continue to care for patients throughout the Covid-19 pandemic. Many them have also spent a lot of time away from their families and they themselves

have had to deal courageously with additional worries and anxieties of having a loved one fighting this disease on the frontline.

“We want to recognise these truly heroic contributions during the pandemic, and we thought the Yorkshire Wildlife Park provided the perfect opportunity for this. The park is set over hundreds of acres of land which will allows us all to adhere to social distancing guidance, whilst also coming together to celebrate our recent achievements, during what has been the most challenge period the Trust has ever encountered. It is a small gesture, but the least we could do for our amazing team.”

Taking place on Saturday 25 September, staff at Bassetlaw Hospital, Doncaster Royal Infirmary, Montagu Hospital and Retford Hospital will gain exclusive access to the park, with family and loved ones also invited to come along to share in the fun. The Trust’s Board of Directors will personally greet guests, as well as present a special ‘thank you’ badge to all the staff at DBTH.

Research suggests that bringing colleagues together, alongside their families and loved ones is a good way to reflect upon and move forward from times of high stress and anxiety.

Throughout the Covid-19 pandemic, the Trust received an overwhelming amount of support from local residents in Doncaster and Bassetlaw, and many donors who provided funds made specific requests that their donations be used for the benefit of staff. Amongst these donations, DBTH Charity received a number of large sums from local businesses and individuals including Premier League footballer Danny Rose whose contribution will fund a large proportion of the events.

Another large proportion of the funding for the event is attributed to a donation made to the Trust through NHS Charities together after Captain Sir Tom Moore raised £32.8million for NHS. YWP also provided half of the allocation of tickets. Several local celebrities will be at the park on the day to say thank you to their health heroes including Olympic Taekwondo athlete Bradly Sinden who brought home silver for Great Britain at Tokyo 2020. European Championship gold-medallist sprinter Lee Thomson and current Scottish record holder for the 200m sprint, Beth Dobbin will also be at the park on the day to celebrate their health heroes.

Finally, I would like to take this opportunity to thank my Trust colleagues again for the inspiring effort and bravery you have displayed over the last few months and extend this thank you to your families for their resilience and patience. I hope you enjoy your day at the Yorkshire Wildlife Park and I look forward to thanking you all in person.

South Yorkshire and Bassetlaw Integrated Care System

Chief Executive Report

Health Executive Group

14th September 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

Where has the paper already been discussed?	
Sub groups reporting to the HEG:	**System governance groups:**
☐ **Quality Group**	☐ **Joint Committee CCGs**
☐ **Strategic Workforce Group**	☐ **Acute Federation**
☐ **Performance Group**	☐ **Mental Health Alliance**
	☐ **Place Partnership**
☐ **Finance and Activity Group**	
☐ **Transformation and Delivery Group**	

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 August 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

14th September 2021

1. Purpose

This paper from the South Yorkshire and Bassetlaw (SYB) Integrated Care System (ICS) System Lead provides an update on the work of the South Yorkshire and Bassetlaw health and care partners for the month of August 2021.

2. Summary update for activity during August

2.1 Coronavirus (COVID-19): The South Yorkshire and Bassetlaw position

Covid case rates in SYB remain at around 300-400 (per 100,000) which is due to increased levels of social mixing and large public events. There are also higher-than-expected rates among our vulnerable groups where case rates for the over-60's are at 250 per 100,000. This could translate into an increase in hospitalisations.

One of the main causes for concern among public health teams is that this appears to be a low figure and likely to rise in the coming weeks, especially now that schools have returned and subsequent Covid testing frequency will start to increase.

There also appears to be a natural slowing-down of vaccine uptake among our more vulnerable unvaccinated populations (over-50's) and the ongoing reluctance among those who remain unvaccinated, despite repeated offers, signalling uptake will not gather any further pace.

Our hospitals currently have 226 patients admitted for Covid-related illnesses (28 of those in intensive care beds) continue to find that the majority of their Covid patients are unvaccinated or have only had one vaccine dose (instead of two).

There are also preparations for a reassessment of workforce priorities if the Joint Committee on Vaccination and Immunisation (JCVI) changes its advice on eligible groups, especially in regards to 12-17 year-olds (currently only vaccinated in exceptional circumstances) and the proposed Covid vaccine booster campaign likely aimed at eligible cohorts identified as Clinically Extremely Vulnerable (not necessarily all).

These new vaccination commitments will have a knock-on effect on workforce demand, especially across our Primary Care Networks (PCNs), and so plans are being discussed on realigning workforce skills based on priority areas with the highest clinical need/capacity.

2.2 Regional update

2.2.1 Leaders meeting

The North East and Yorkshire (NEY) Regional ICS Leaders meet weekly with the NHS England and Improvement Regional Director. During August, discussions focused on urgent and emergency care and winter resilience, planning and recovery, the ongoing Covid response and

vaccination programme and ICS development (including feedback from the NEY transition oversight group).

2.3 National update

2.3.1 Social Care reform

A new health and social care tax will be introduced across the UK to pay for reforms to the care sector and NHS funding in England.

This new funding aims to generate £36bn for frontline services over the next three years and support the NHS' commitments to address the waiting list backlog exacerbated by the Covid-19 pandemic.

The tax will begin as a 1.25% rise in National Insurance (NI) from April 2022 and is paid by both employers and workers.

It will become a separate tax on earned income from 2023 (calculated in the same way as NI and appearing on an employee's payslip), paid by all working adults, including older workers.

You can find out more on the Government website.

2.3.2 Pride in the NHS Week and NHS Virtual Pride 2021 (#UnderTheRainbow)

The first ever national Pride in the NHS Week and NHS Virtual Pride finale will take place as an 'always-on' virtual festival.

Spanning 6th-10th September, this year's theme for 2021 is 'Elevate, Educate, Celebrate' to promote rest, relaxation and recovery for NHS colleagues from our LGBT+ communities.

The grand finale to Pride in the NHS Week will be the 'NHS Virtual Pride' returning for a second year on 10th September (4-6pm).

2.4 Integrated Care System update

2.4.1 System Development Plans

The new HR Framework to support the transition to Integrated Care Boards (ICBs) has now been published alongside a range of other guidance which can be found on the NHS England and NHS Improvement (NHS E/I) website:

(1) Interim guidance on the functions and governance of the integrated care board
(2) HR Framework for developing Integrated Care Boards
(3) Building strong integrated care systems everywhere: guidance on the ICS people function

The guidance documents are intended to help NHS system leaders and their partners support the aforementioned 'one workforce' approach by delivering key outcome-based people functions from April 2022.

The HR Framework document provides a clear outline of the proposed changes relating to the Employer Commitment for colleagues within CCGs (and other NHS employers hosting ICS staff) that will move across during this transition to the SY ICB.

2.5 National award nominations for South Yorkshire and Bassetlaw

SYB has been successful in receiving nominations for two national awards.

A number of services were shortlisted for the 2021 Health Service Journal (HSJ) Awards with special recognition for the SYB ICS in the category of '*Integrated Care System of the Year'* based on our work in the transformation of the hyper acute stroke unit (HASU) pathway which has been firmly established by our Integrated Stroke Delivery Network.

The following teams/services were also shortlisted:

- Primary Care Innovation of the Year: The South Yorkshire and Bassetlaw ICS Cancer Alliance: Nudge the Odds - Adopting behavioural science to increase early diagnosis of cancer
- Provider Collaboration of the Year: Sheffield Clinical Commissioning Group, Primary Care Sheffield, Sheffield Health and Social Care NHS Foundation Trust, Sheffield Mind, Sheffield City Council and Sheffield Primary Care Networks, Sheffield Mental Health Collaboration (Primary & Community Mental Health Transformation Programme)
- Environmental Sustainability Award: Sheffield Children's NHS Foundation Trust
- Primary Care Networks, GP or Community Provider of the Year: Barnsley Healthcare Federation, Covid-19 Response - Blue Clinic, Out of Hours, Extended Hours and PCN Vaccination Programme
- Digitising Patient Services Award: The Rotherham NHS Foundation Trust, Expanding Speech Therapy Services through synchronous and asynchronous digital care using Microsoft Teams
- Services and Information Award: Barnsley Hospital NHS Foundation Trust, Oxygen supply management during Covid-19 pandemic

SYB was also successful in the nomination process for this year's Nursing Times Workforce Summit and Awards (2021).

In the category of '*Preceptorship of the Year - Under 1,500 Nursing Staff*', SYB's Primary Care Workforce and Training Hub have been recognised for their work towards the primary care nurse pipeline project (nurse vocational training scheme).

NHS Professionals, International recruitment for South Yorkshire and Bassetlaw ICS also made the shortlist for the '*Best International Recruitment Experience'* category.

2.6 A new digital accelerator programme by Yorkshire & Humber AHSN

The Propel@YH scheme led by the Yorkshire & Humber Academic Health Science Network (AHSN) aims to find digital health solutions to strengthen our system priorities in the areas of reducing health inequalities, supporting our workforce and enabling patients to manage their long-term conditions.

With access to a six-month structured course of support and advice from experts in the field, this unique accelerator programme connects researchers, academia, local businesses and digital innovators to work together to implement new ideas to support SYB's five-year transformation plans (2019 - 2024). Applications close on 1st October 2021 (see brochure).

2.7 Media interest for SYB's green social prescribing schemes

Our green social prescribing initiatives were featured in WIRED magazine as an exemplary case study thanks to a direct approach to the SYB ICS from one of their journalists.

The article also includes patient perspectives and one of our GPs, Dr Ollie Hart (Clinical Director at Heeley Plus Primary Care Network and GP at Sloan Medical Centre, Sheffield).

In addition, BBC Radio Sheffield also hosted a live phone interview (8th September) with two project officers from the Sheffield and Rotherham Wildlife Trust to learn about our pre-work developments, the benefits of these social inclusion programmes to reduce non-medical interventions and an insight into a local walk – including an interview with a group participant.

Thank you to Karen Smith (Prevention Programme Manager at SYB ICS) for coordinating this and to Jenny King and Kieran Boden from the Wildlife Trust.

2.8 Better Health Sheff campaign helps smokers quit

Sheffield City Council has launched the 'Better Health Sheff' campaign to help raise awareness of the importance of quitting smoking, eating well and moving more.

The campaign is particularly focused on Black, Asian and Ethnic Minority communities aged over 40 who are likely to be at increased risk of Covid-19 due to poorer diet, lack of exercise and higher smoking rates. The campaign is inclusive and has been developed locally with the support of the BAME PH inequalities group.

This campaign aligns closely with SYB's recently launched QUIT programme, which provides patients (and those recently discharged) with specialist support from the relevant Trusts' own smoking cessation team, alongside as-needed clinical interventions such as nicotine replacement therapy.

Further information is available on the Sheffield Council website.

2.9 Developments for SYB's Health and Wellbeing 'emotional resilience' Hub

There have been further additions to raise the internal profile of staff support services which includes Vivup, the 24/7 helpline providing a potential gateway for staff counselling. SYB's wellbeing support also includes wellbeing webinars and self-help resources (videos/podcasts).

Developments include:

- A new wrap-around website
- 90-second promotional video filmed across multiple locations within SYB
    - Alternate formats include a British Sign Language version of the video and four additional non-English languages)
- A webinar 'launch' event with over 135 guests with talks by Professor Michael West, CBE (The King's Fund), Tracey Paxton (Vivup) and Dean Royles.You can now also watch a recording of the event

2.10 RDaSH Bee Gardens featured on BBC Radio 2

BBC Radio 2 broadcast their entire breakfast show (20th August) from the Doncaster site of Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH). The new Walled Garden and The Bee Garden, unveiled by Radio 2 DJ Zoe Ball and a host of other celebrities, is situated outside their new Children's and Young People's Mental Health unit. The interview also included a short interview with RDaSH's Christina Harrison (Children's Care Group Director) and a patient.

RDaSH were chosen to host the garden after a national children's competition to design it. The design was taken by Gardner's World presenter Adam Frost and turned into reality.

You can watch a video to see how the garden was transformed.

2.11 New Britain Thinks report – patient and public satisfaction of NHS services measured across the Covid pandemic

A new report 'Attitudes towards and experiences of the NHS during Covid-19: views from patients, professionals and the public' by Britain Thinks and The Richmond Group of Charities provides an insight and useful benchmark to consider in our response to planning how health and care services will be delivered in the future.

3. Finance

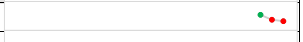
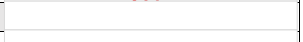
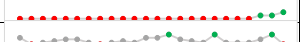
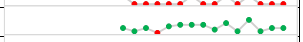
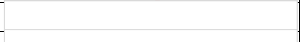
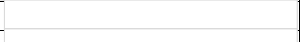
At Month 4 the ICS has a surplus of £23.4m which is £20.8m better than plan. The forecast has improved from a surplus of £3.4m to a surplus of £20m as a result of a further review of forecast positions at Month 4. The key movements were an improved forecast position at STH of £16.8m and at SHSC £0.5m. These changes better align the year to date and forecast positions.

The forecast capital position is for an overspend of £13.2m which is made up of the £12.4m of additional costs that will be incurred at Doncaster Royal Infirmary as a result of the critical incident in the Women & Children's block an underspend at RDASH of £0.6m and an allowable overspend on accelerator capital of £1.4m. Work is ongoing to agree slippage of £12.4m to ensure that the ICS remains within its capital envelope for 21/22. This requires to be concluded by Month 5 reporting. A separate paper, on this issue, will be considered by HEG once agreed by provider Directors of Finance.

Andrew Cash
System Lead, South Yorkshire and Bassetlaw Integrated Care System

Date: 8th September 2021

Category	Indicator	Benchmarking Month Reported	Peer Benchmark	National Benchmark	Latest Month Reported	CURRENT MONTH			YEAR-TO-DATE			Trend Graph (Jul-19 - stated month) This is calculated based on rolling 24 month data with performance below expected control limits highlighted in red and above expected control limits in green
						Local Target	Actual	Variance	Local Target	Actual	Variance	
Performance (NHSI Compliance Framework -	A&E: Max wait four hours from arrival/admission/transfer/discharge (Type 1 benchmarking only)	May-21	81.8%	83.7%	Jun-21	86%	78.2%	-7.8%	86%	80.4%	-5.6%	
	ED Attendances (For Monitoring Only)				Jun-21	-	17533	-	-	50189	-	
4 Hour Access - Trust Boarding Times	Average Wait Time (from clinically ready to proceed to admission) - Medicine	-	-	-	Jun-21	<1 Hour	-	-	<1 Hour	-	-	
	Average Wait Time (from clinically ready to proceed to admission) - Surgery	-	-	-	Jun-21	<1 Hour	-	-	<1 Hour	-	-	
	Average Wait Time (from clinically ready to proceed to admission) - Gynaecology	-	-	-	Jun-21	<1 Hour	-	-	<1 Hour	-	-	
	Average Wait Time (from clinically ready to proceed to admission) - Paediatrics	-	-	-	Jun-21	<1 Hour	-	-	<1 Hour	-	-	
Performance (NHSI Compliance Framework - Elective Care)	Max time of 18 weeks from point of referral to treatment- incomplete pathway	Apr-21	61.0%	64.6%	Jun-21	TBC	71.6%	-	TBC	70.1%	-	
	RTT 52 Week Breaches to date	-	-	-	Jun-21	1233	1210	23	1233	1210	23	
	Waiting list size - 18 Weeks referral to treatment -Incomplete Pathways	-	-	-	Jun-21	-	39728	-	-	39728	-	
	% waiting less than 6 weeks from referral for a diagnostics test	Apr-21	77.3%	76.0%	Jun-21	TBC	54.3%	-	TBC	57.4%	-	
Performance (Cancer)	Maximum 2 week wait to see a specialist for all patients referred with suspected cancer symptoms	-	-	-	Apr-21	-	-	-	-	-	-	
	Maximum 2 week wait to see a specialist for breast symptoms, even if cancer not suspected	-	-	-	Apr-21	-	-	-	-	-	-	
	Day 28 Standard (patients received diagnosis or exclusion of cancer within 28 days)	-	-	-	Apr-21	-	-	-	-	-	-	
	Maximum 31 day wait from decision to treat to first definitive treatment for all cancers	-	-	-	Apr-21	-	90.9%	-	-	90.9%	-	
	Maximum 31 day wait for subsequent treatment - Surgery	-	-	-	Apr-21	-	100.0%	-	-	100.0%	-	
	Maximum 31 day wait for subsequent treatment - Drugs	-	-	-	Apr-21	-	100.0%	-	-	100.0%	-	
	Maximum 62 day wait for patients on 2ww pathway to first definitive treatment	-	-	-	Apr-21	-	84.4%	-	-	84.4%	-	
	Maximum 62 wait from referral from NHS cancer screening service to first definitive treatment	-	-	-	Apr-21	-	31.3%	-	-	31.3%	-	
	Cancer Waiting Times Open Suspected Cancer Pathways 63 - 104 Days - reduction of 10% month on month (trajectory at trust level - tracking only at specialty)	-	-	-	Apr-21	-	-	-	-	-	-	
	Cancer Waiting Times Open Suspected Cancer Pathways 104 Days +	-	-	-	Apr-21	-	5	-	-	5	-	
Activity Against Plan	Non Elective Activity - Discharges	-	-	-	Jun-21	-	4850	-	-	14568	-	
	TOTAL Activity (against plan - numbers)	-	-	-	Jun-21	51197	48227	-2970	1721369	135535	-1585834	
	Day Case Theatre Activity (against plan - numbers)	-	-	-	Jun-21	5073	4199	-874	12944	11886	-1058	
	In Patient Elective Theatre Activity (against plan - numbers)	-	-	-	Jun-21	336	413	77	618	1046	428	
	Endoscopy Activity (against plan - numbers)	-	-	-	Jun-21	1543	1206	-337	4330.6	3483	-848	
	Non-Theatre Elective Activity -excluding Endoscopy (against plan - numbers)	-	-	-	Jun-21	214	245	31	999	755	-244	
	Elective Patient Activity - Independent Sector	-	-	-	Jun-21		40	-		114	-	
	Outpatient New Activity - face to face (Including Procedures against plan - numbers)	-	-	-	Jun-21	9782	10157	375	27146	27436	290	
	Outpatient New Activity - telephone (against plan - numbers)	-	-	-	Jun-21	2883	3065	182	7966	9164	1198	
	Outpatient New Activity - video (against plan - numbers)	-	-	-	Jun-21	113	69	-44	314	171	-143	
	Outpatient Follow Up Activity - face to face (Including Procedures against plan - numbers)	-	-	-	Jun-21	15893	18909	3016	44149	51847	7698	
	Outpatient Follow Up Activity - telephone (against plan - numbers)	-	-	-	Jun-21	7681	6193	-1488	21278	18151	-3127	
	Outpatient Follow Up Activity - video (against plan - numbers)	-	-	-	Jun-21	531	111	-420	1471	430	-1041	
	Outpatient Procedures (For Monitoring Only)	-	-	-	Jun-21	-	6060	-	-	17531	-	
	Outpatient Activity - Independent Sector	-	-	-	Jun-21	0	232	232	0	623	623	
Activity Against Value (19/20) - Elective Recovery Fund National Submission	TOTAL Activity Value (%19/20)	-	-	-	Jun-21	84%	87.0%	3.0%	84.0%	86%	2%	
	Day Case Theatre Activity Value (% 19/20)	-	-	-	Jun-21	84%	91.4%	7.4%	84.0%	91.7%	7.7%	
	In Patient Elective Theatre Activity Value (%19/20)	-	-	-	Jun-21	84%	85.7%	1.7%	84%	80.2%	-3.8%	
	Outpatient New Activity Value (%19/20)	-	-	-	Jun-21	84%	82.8%	-1.2%	84%	83.6%	-0.4%	
	Outpatient Follow Up Activity Value (%19/20)	-	-	-	Jun-21	84%	87.4%	3.4%	84%	88.1%	4.1%	
Addressing Health Inequalities	TBC	-	-	-	-	-	-	-	-	-	-	
	TBC	-	-	-	-	-	-	-	-	-	-	
	TBC	-	-	-	-	-	-	-	-	-	-	
	TBC	-	-	-	-	-	-	-	-	-	-	
	TBC	-	-	-	-	-	-	-	-	-	-	
Performance Ambulance Handover Times	Ambulance Handovers Breaches -Number waited <= 15 Minutes	-	-	-	Jun-21	79%	50%	-29%	79%	53%	-26%	
	Ambulance Handovers Breaches -Number waited >15 & <30 Minutes	-	-	-	Jun-21	21%	27%	-6%	21%	28%	-7%	
	Ambulance Handovers Breaches-Number waited >30 Minutes	-	-	-	Jun-21	0%	23%	-23%	0%	19%	-19%	
Performance Stroke	Overall SSNAP Rating	-	-	-	Mar-21	B	B	-	B	B	-	
	Proportion of patients scanned within 1 hour of clock start (Trust)	-	-	-	Apr-21	48%	60%	12%	48%	60%	12%	
	Proportion directly admitted to a stroke unit within 4 hours of clock start	-	-	-	Apr-21	75%	48%	-27%	75%	48%	-27%	
	Percentage of all patients given thrombolysis	-	-	-	Apr-21	90%	100%	10%	90%	100%	10%	
	Percentage treated by a stroke skilled Early Supported Discharge team	-	-	-	Apr-21	24%	65%	41%	24%	65%	41%	
	Percentage discharged given a named person to contact after discharge	-	-	-	Apr-21	80%	69%	-11%	80%	69%	-11%	
Performance Outpatients	New to Follow Up Ratio (DCCG) (For Monitoring Only)	-	-	-	-	-	-	-	-	-	-	
	New to Follow Up Ratio (BCCG) (For Monitoring Only)	-	-	-	-	-	-	-	-	-	-	
	New to Follow Up Ratio (TRUST) (For Monitoring Only)	-	-	-	Jun-21	-	1:1.90	-	-	1:1.92	-	
	Out Patients: DNA Rate (first appointment)	-	-	-	Jun-21	-	10.10%	-	-	10.05%	-	
	Out Patients: DNA Rate (Follow up appointment)	-	-	-	Jun-21	-	9.68%	-	-	9.77%	-	
	Out Patients: DNA Rate (Combined) (For Monitoring Only Target Set At Specialty Level)	-	-	-	Jun-21	-	9.82%	-	-	9.86%	-	
	Out Patients: Hospital Cancellation Rate (under 6 weeks)	-	-	-	Jun-21	-	12.24%	-	-	11.73%	-	
	Out Patients: Patient on the Day Cancellation Rate (For Monitoring Only)	-	-	-	Jun-21	-	-	-	-	-	-	
	Backlogs - To reflect Simple PTL Excluding Active Waiters (For Monitoring Only)	-	-	-	-	-	-	-	-	-	-	
	Typing Turnaround (Trust Contract)	-	-	-	Jun-21	7WD	21WD	14WD	7WD	40WD	33WD	

	Out Patient Clinic Utilisation - Booked 2 weeks Prior	-	-	-	Jun-21	95%	53.12%	-41.88%	95%	51.22%	-43.78%	
	Out Patient Clinic Utilisation (attended)	-	-	-	Jun-21	90%	84.34%	-5.66%	90%	83.88%	-6.12%	
	Registered Referrals not Appointed	-	-	-	Jun-21	0	643	643	0	5937	5937	
	Unreconcilled Appointments 14 days + E-Reconcillation	-	-	-	-	-	-	-	-	-	-	
	Unreconcilled Appointments 14 days + CAMIS	-	-	-	-	-	-	-	-	-	-	
	ERS Advice & Guidance Response Time	-	-	-	May-21	2WD	3WD	1WD	2WD	4WD	2WD	
	ERS Advice & Guidance Activity (Trust)	-	-	-	May-21	547	102	-445	547	61	-486	
	Number of Specialities offering PIFU (ENT / Cardiology / Dermatology) TRUST TAB ONLY	-	-	-	-	-	-	-	-	-	-	
	% of OP appointments delivered virtually (video or telephone)	-	-	-	Jun-21	25%	24.48%	-0.52%	25%	26.00%	1.00%	
Performance Theatres	Theatre Booking - 4 weeks prior -Lists Populated	-	-	-	Jun-21	50%	68.29%	18.29%	50%	67.69%	17.69%	
	Theatre Booking - 2 weeks prior -Lists Populated	-	-	-	Jun-21	75%	81.03%	6.03%	75%	80.74%	5.74%	
	Theatre Booking - 1 week prior -Lists Populated	-	-	-	Jun-21	95%	84.90%	-10.10%	95%	84.79%	-10.21%	
	Theatre Utilisation	-	-	-	Jun-21	87%	86.08%	-0.92%	87%	86.18%	-0.82%	
	Number of Prioirity 2 Patients waiting 28 days + for surgery from date of listing/P2 Categorisation	-	-	-	Jun-21	-	216	-	-	409	-	
	% Cancelled Operations on the day (non-clinical reasons)	-	-	-	Jun-21	1%	0.97%	0.03%	1%	0.85%	0.15%	
	% Cancelled Operations on the day (clinical reasons) (For Monitoring Only)	-	-	-	Jun-21	-	-	-	-		-	
Patients (National Requirements)	Infection Control Hosptial Onset C.Diff (Medicine & Surgery Only)	-	-	-	Jun-21	2	0	2	7	11	-9	
	Infection Control Community Onset C.Diff (Medicine & Surgery Only)	-	-	-	Jun-21	1	2	-1	3	4	-3	
	Infection Control Combined Onset C.Diff (Medicine & Surgery Only)	-	-	-	Jun-21	3	2	1	10	15	-12	
	MRSA Cases Reported	-	-	-	Jun-21	0	0	0	0	0	0	
	HSMR (rolling 12 Months - Combined)	-	-	-	Jun-21	100	111.2	-11.2	100	111.2	-11.2	
	HSMR : Non-Elective (rolling 12 Months)	-	-	-	Jun-21	100	110.8	-10.8	100	110.8	-10.8	
	HSMR : Elective (rolling 12 Months)	-	-	-	Jun-21	100	153.1	-53.1	100	153.1	-53.1	
	Never Events	-	-	-	Jun-21	0	0	0	0	0	0	
	Serious Incidents Reported in Month (For Monitoring Only)	-	-	-	Jun-21	-	3	-	-	7	-	
	SI Action Plans closed within 3 months of CCG closure of incident	-	-	-	Jun-21	100.00%	-	-	100%	-	-	
	All open incidents on Datix to be closed within 3 months of reporting (excluding patient experience)	-	-	-	Jun-21	100.00%	-	-	100%	-	-	
	Pressure Ulcers - Category 4	-	-	-	Jun-21	0	0	0	0	0	0	
	Pressure Ulcers - Category 3	-	-	-	Jun-21	4	0	4	13	7	6	
	Pressure Ulcers - Category 2 / UNS / DTI	-	-	-	Jun-21	61	79	-18	184	225	-41	
	Falls with Severe Harm / Lapse in Care / SI	-	-	-	Jun-21	-	1	-	-	1	-	
	Falls with Moderate or Severe Harm	-	-	-	Jun-21	1	7	-6	4	13	-9	
	Complaints Resolution Performance (% achieved closure in agreed timescales with complainant)	-	-	-	May-21	95.0%	50.0%	-45.00%	95.0%	50.0%	-45.00%	
	Complaints Upheld / Partially Upheld by Parliamentary Health Service Ombudsman	-	-	-	Jun-21	0	0	0	0	0	0	
	Claims CNST (patients)	-	-	-	Jun-21	-	4	-	-	4	-	
	Claims LTPS - staff	-	-	-	Jun-21	-	1	-	-	1	-	
	Friends & Family Response Rates (ED)	-	-	-	Jun-21	15%	0.10%	-15%	15%	0.07%	-15%	
	Friends & Family Response Rates (Inpatients)	-	-	-	Jun-21	30%	10.75%	-19%	30%	6.97%	-23%	
	% Reduction on LoS for patients remaining in hospital between 7-14 days compared to 2019-20	-	-	-	-	-	-	-	-	-	-	
	Mixed Sex Accommodation	-	-	-	Jun-21	0	0	0	0	0	0	
	Sepis Screening - % of appropriate patients screened	-	-	-	-	90%	-	-	90%	-	-	
	Sepsis Prescribing - Antibiotics within 1 Hour	-	-	-	-	90%	-	-	90%	-	-	
	Deaths Screened as part of Mortality Review Process	-	-	-	-	100%	-	-	100%	-	-	
	NICE Guidance Response Rate Compliance	-	-	-	Jun-21	95%	99%	4.44%	95%	99%	4.18%	
	NICE Guidance % Non & Partial Compliance (For Monitoring Only)	-	-	-	Jun-21	-	-	-	-	-	-	
	% Patients Asked for Smoking Status	-	-	-	-	50%	-	-	50%	-	-	
People	Staff Flu Vaccinations (1.9.21 - 28.2.22)	-	-	-	-	-	-	-	-	-	-	
	Agenda for Change Appraisals (rolling 12 months)	-	-	-	Jun-21	90%	50%	-39.58%	90%	47%	-42.52%	
	Non-Medical Appraisals - in season (April - July)	-	-	-	Jun-21	-	-	-	-	93%	-	
	Sickness (rolling 12 months)	-	-	-	Jun-21	4%	1%	2.22%	4%	4%	-0.92%	
	Job Planning (TBC)	-	-	-	Jun-21	TBC	-	-	TBC	-	-	
	SET Training	-	-	-	Jun-21	90%	85%	-4.62%	90%	86%	-3.83%	
	Vacancies	-	-	-	-	5%	-	-	5%	-	-	
	Turnover (rolling 12 months)	-	-	-	Jun-21	10%	10%	0.00%	10%	7%	3.16%	
	Casework - number of grievances opened in month	-	-	-	Jun-21	-	0	-	-	5	-	
	Casework - number of conduct cases opened in month	-	-	-	Jun-21	-	16	-	-	87	-	
	Number of Incorrect Payments (Trust Originated) (rolling 12 months)	-	-	-	May-21	-	90	-	-	114	-	
	Compliance with EWTD (on hold until 2021)	-	-	-	-	YES	-	-	YES	-	-	
	Time to Fill Vacancies (from TRAC authorisation - unconditional offer)	-	-	-	-	47WD	-	-	47WD	-	-	

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INTRODUCTION

This report provides a summary of the Trust's performance against the following national indicators:

1. Elective

a) Activity – Performance Against Trust Capacity Plan
b) Activity Value – Performance Against Elective Recovery Fund (ERF)
c) Priority 2 Elective Patients
d) 52 Weeks
e) Referral to Treatment Times
f) Diagnostic Performance
g) Cancelled Operations on the Day for Non-Clinical Reasons
h) Cancelled Operations – Not Rebooked within 28 Days
i) Integrated action plan - elective

2. Emergency

a) Emergency Care Bundle Standards
b) 4 Hour Access
c) Ambulance Handover
d) Length of Stay & Super Stranded Patients
e) Stroke Performance – April 2021

3. Cancer Performance

a) Faster Diagnosis Standard
b) Performance against 31, 62 day standards
c) Cancer Performance - Specialty – May 2021
d) Cancer Performance Exceptions – 31/ 62 days
e) 104 Day Breaches

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1. ELECTIVE

A summary of performance against the standards is provided in section a) - f). A single integrated action plan for elective is provided at the end of this section.

a) Activity - Performance Against Trust Capacity Plan – with Comparison to 19/20 Activity Levels

The following table summarises performance against the Trust Capacity Plan.

		% Achievement Against Trust Capacity Plan						
Point of Delivery	**Trust Capacity Plan**	**April 2021**	**May 2021**	**June 2021**	**July 2021**	**August 2021**	**Sept 2021**	**% 19/20 Activity (June 2021)**
Outpatient New	10956	97.9%	103 %	102.1%				
Outpatient F/U	20816	101.5%	108%	103.5%				
Elective	576	104.7%	101%	113.6%				
Day Case	4513	112.7%	85.7%	82%				
CT	5726	117%	112%	121%				122.4%
MRI	1381	102%	106%	98%				81.5%
Non-Obstetric Ultrasound	5830	96%	85%	91%				82.1%
Endoscopy	1372	72%	73%	71%				78.7%

*****Activity recorded at flex positon – achievement is subject to change up to 6 weeks after month end*

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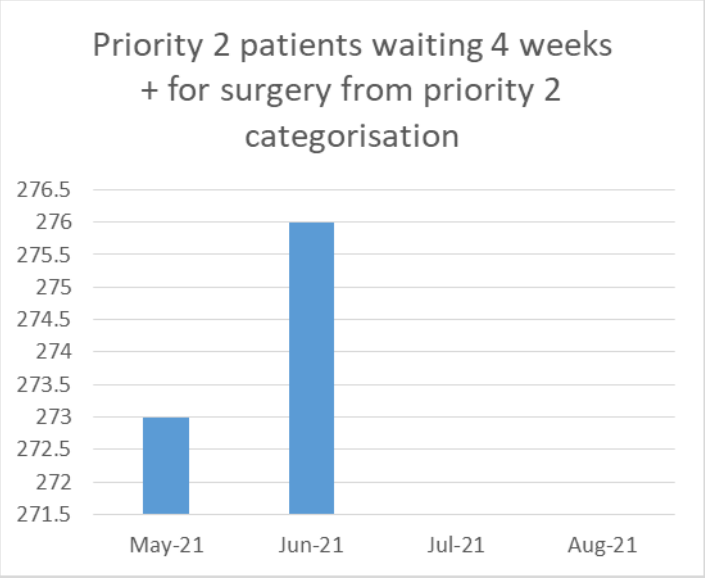
b) Activity Value – Performance Against Elective Recovery Fund (ERF)

The following table summarises performance against the Elective Recovery Fund - % activity value of 2019/20

	Elective Recovery Fund Target (% of 19/20 Activity Value)					
Point of Delivery	**April 2021**	**May 2021**	**June 2021**	**July 2021**	**August 2021**	**Sept 2021**
	77%	**88%**	**84%**	**95%**	**95%**	**95%**
Outpatient New	82.06%	87%	83%			
Outpatient F/U	83.31%	88%	87%			
Elective	65.09%	85%	86%			
Day Case	88.88%	94%	91%			
TRUST TOTAL	**80.4%**	**89%**	87%			

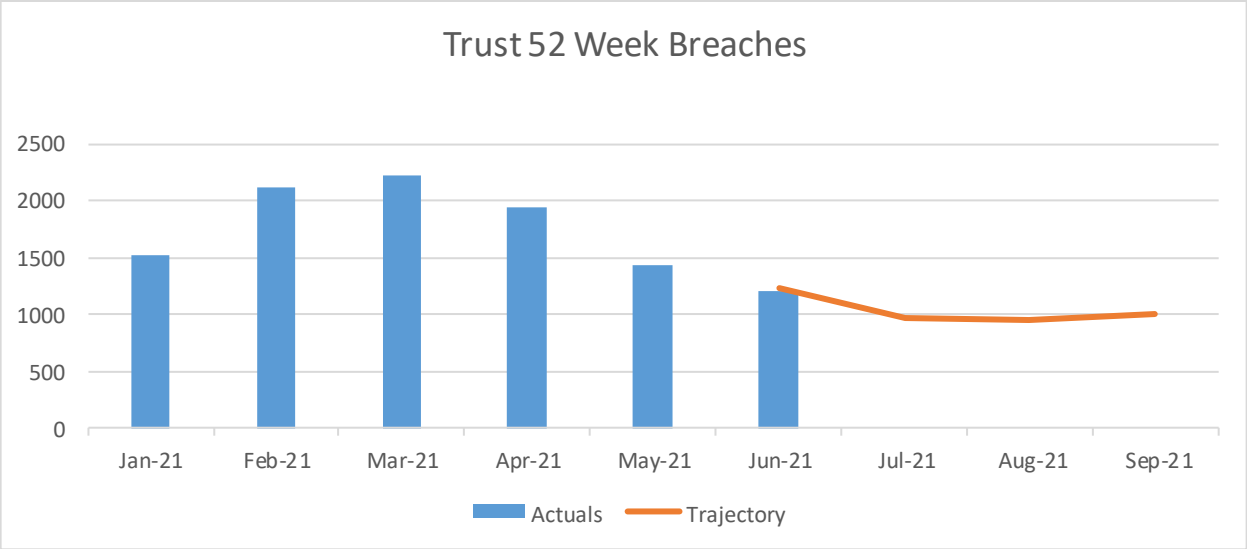
c) Priority 2 Patients – Waiting 4 Weeks + for Surgery (from P2 categorisation)

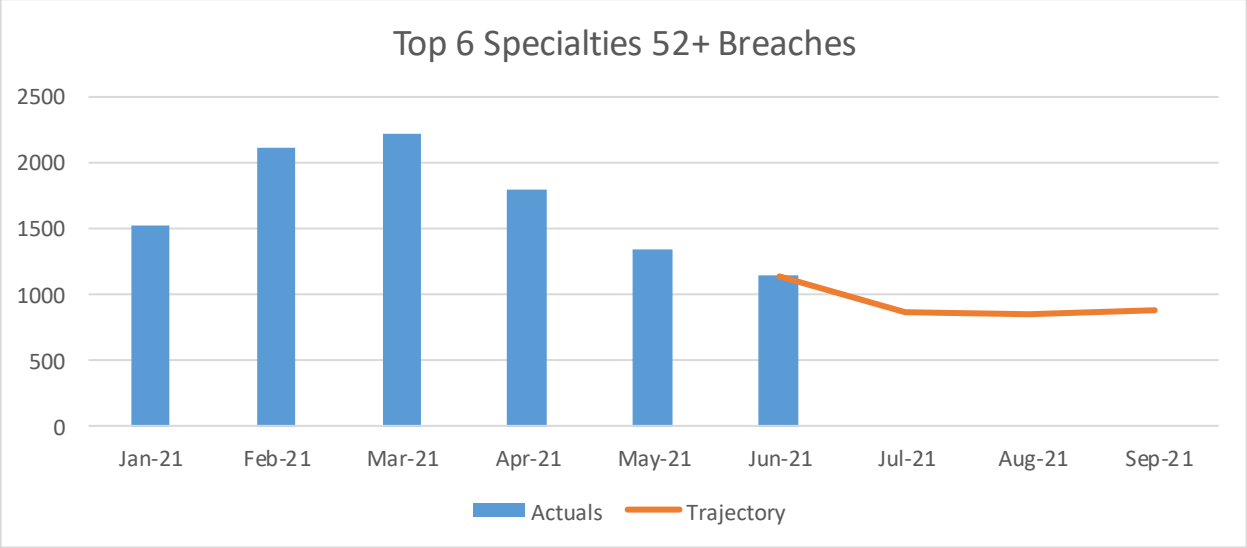
The following graph highlights the current Trust position for priority 2 patients waiting 4 weeks + for surgery from priority 2 categorisation. Reporting with this criteria only commenced for May 2021 so no historical data is available for comparison. This cohort of patients has increased by 3 during June 2021.

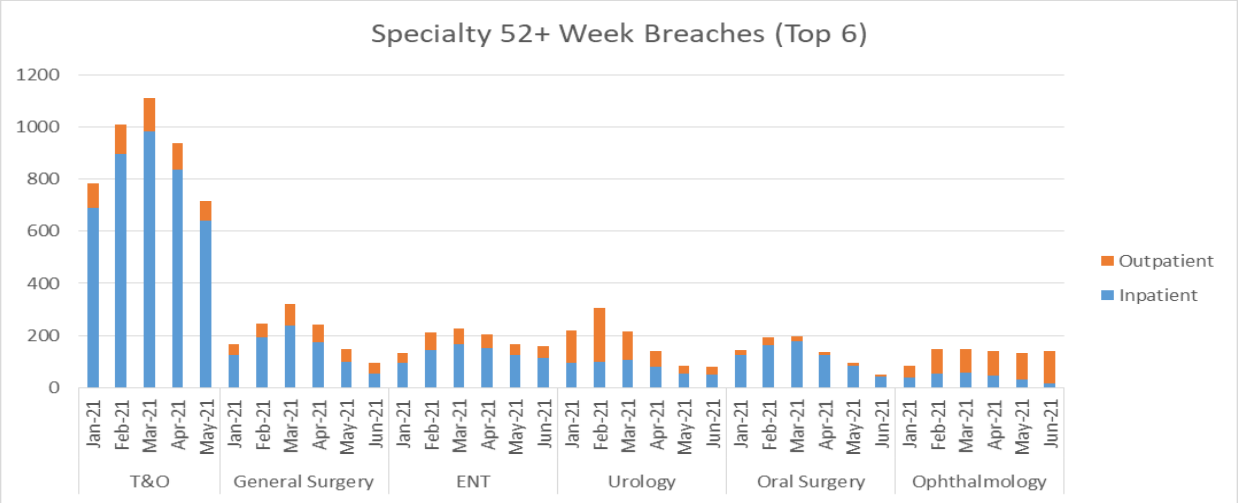


d) 52 Weeks

The following graphs highlight the current Trust and top 6 (combined) 52 week breach position. June 2021 saw a continued reduction in breach numbers with a total of 1210 breaches reported. The Trust benefitted from the reduction of referrals during the first few months of the pandemic, however, this also reflects the focus of the scheduling teams on booking long waiting patients after clinical priorities. From June 2021 onwards, Trust, speciality and top 6 trajectories were produced to reflect both the core and accelerator activity planned up to September 2021. Both Trust and top 6 specialities achieved trajectory for June 2021.

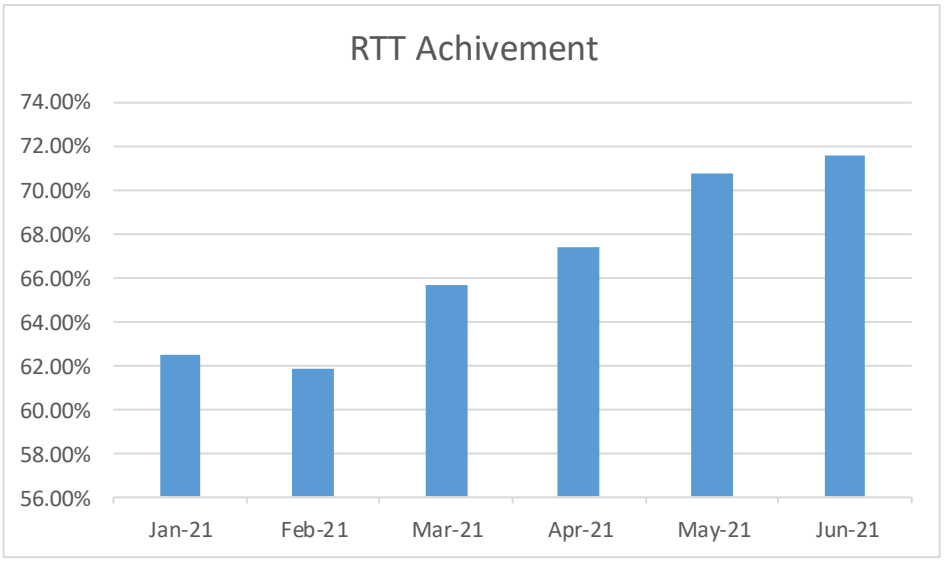






e) RTT – Performance Against National Target – 92%

An improving position on RTT is shown month on month as the Trust recovers from the pandemic. Performance has improved since May 2021 with a 0.8% increase in achievement to 71.6%.



The table below summarises 18 weeks performance. It should be noted that all but two medical specialties are achieving the RTT standard, which is excellent. Surgical specialities continue to be more challenged where services were more severely impacted by COVID.

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The total waiting list size stands at **39728,** which is an increase of 1910 since last month, with a plan in development to improve this position.

Specialty	Waiting List	RTT Percentage	Longest Wait (weeks)
Breast Surgery	416	91.1 %	73
Cardiology	1733	94.2 %	68
Clinical Haematology	203	95.6 %	28
Dermatology	1732	97.6 %	35
Diabetic Medicine	378	95.0 %	33
ENT	4571	57.3 %	95
General Medicine	2284	85.4 %	84
General Surgery	3657	66.8 %	105
Geriatric Medicine	211	85.8 %	52
Gynaecology	1934	84.9 %	75
Medical Ophthalmology	652	84.4 %	87
Nephrology	101	99.0 %	32
Ophthalmology	4065	69.9 %	106
Oral Surgery	2362	65.7 %	93
Orthodontics	56	83.9 %	48
Paediatric Cardiology	93	95.7 %	25
Paediatrics	592	97.3 %	46
Pain Management	501	92.0 %	49
Podiatry	285	79.6 %	82
Respiratory Medicine	984	93.4 %	47
Rheumatology	632	97.3 %	38
Trauma & Orthopaedics	8420	60.1 %	104
Upper GI Surgery	197	53.3 %	93
Urology	2749	53.2 %	95
Vascular Surgery	785	84.3 %	81
Grand Total	39728	71.6 %	N/A

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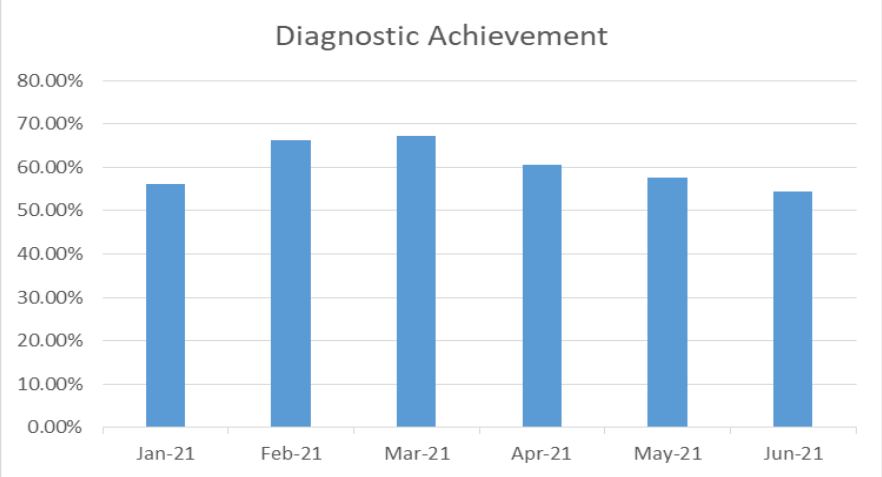
A summary of breakdown by CCG and over the last 4 months is outlined below:

Incomplete Pathways	June 2021	May 2021	April 2021	March 2021
Total (Trust)	39728	37818	35189	33018
% under 18 Weeks (Trust)	71.6%	70.8%	67.4%	65.7%
Total (Doncaster CCG)	24554	23139	21417	19973
% under 18 Weeks (Doncaster CCG)	73%	71.9%	68.3%	66.2%
Total (Bassetlaw CCG)	8640	8184	7655	7287
% under 18 Weeks (Bassetlaw CCG)	71.6%	70.9%	67.5%	66.9%

f) Diagnostics – Performance Against National Target – 99%

Performance against the 6 week target has decreased compared to last month (54.31% compared to 57.56%). Additional activity is being organised to support the reduction of the backlog.



The total number of waiters has increased by 1024 since last month with those over 6 weeks also increasing by 1035. A challenging position is shown at modality level:

Exam Type	<6W	>=6W	Total	Performance	Longest Waits
MRI	1629	1598	3227	**50.48%**	**38**
CT	2082	1073	3155	**65.99%**	**33**
Non-Obstetric Ultrasound	4121	4482	8603	**47.90%**	**50**

DEXA	419	165	584	**71.75%**	**43**
Audiology	292	153	445	**65.62%**	**73**
Echo	277	1	278	**99.64%**	**7**
Nerve Conduction	165	215	380	**43.42%**	**17**
Sleep Study	12	0	12	**100.00%**	**4**
Urodynamic	23	21	44	**52.27%**	**67**
Colonoscopy	221	186	407	**54.30%**	**29**
Flexible Sigmoidoscopy	67	107	174	**38.51%**	**29**
Cystoscopy	379	58	437	**86.73%**	**76**
Gastroscopy	331	370	701	**47.22%**	**26**
Total	**10018**	**8429**	**18447**	**54.31%**	**N/A**

Performance for the Trust, NHS Doncaster and NHS Bassetlaw is outlined below:

	Waiters <6W	Waiters >=6W	Total	Performance
Trust	10018	8429	18447	54.31%
NHS Doncaster	6612	5415	12027	54.98%
NHS Bassetlaw	2548	2267	4815	52.92%

g) Cancelled Operations on the Day for Non-Clinical Reasons

The table below summarises performance against the national standard of 1%, with a breakdown of reasons for cancellations.

CCG	Total Activity	No of Cancellations	% Achievement
Trust	4830	47	0.97%
Doncaster	3151	31	0.98%
Bassetlaw	1121	8	0.71%
Other	558	8	1.4%

Issues driving performance and the related improvement plan are summarised below:

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Issues Affecting Performance	No of Theatre Breaches	No of Non-Theatre Breaches	Improvement Plan
Missing Notes		1	
Insufficient Time/ Lack of Theatre Capacity (clinical reasons)	21	1	10/22 - previous patients more complex than planned 9/22 - late start to the list – 5/9 due to AM list over running, 1 due to over populated list and 2 unidentified sub reason
Equipment	3	2	1 x tear in theatre drapes. Third outside drape to be added to mitigate risk 1 x due to laser failure, machine currently out at repair until 19.7.21 1 x insufficient equipment to be investigated
Other Urgent Cases	2		Emergency /Trauma took priority
Staffing	8	1	4/8 surgeon isolating due to COVID 4/8 no theatre staff, 3 on day sickness, 1 due to bereavement.
No HDU / DCC Bed	1		HDU bed not booked. Patient sent home without escalation. Process reiterated to all parties
Drugs out of stock		3	
Admin Error		4	

f) Cancelled Operations – Not Rebooked within 28 Days – Performance against National Target

In June 2021 there were 3 operations cancelled that were not rebooked within 28 days:

Speciality	TCI Date:	28 Day Breach Date:	New Date:	Cancellation Reason:	Breach Reason:	CCG:
Medical Ophthalmology	6.5.21	3.6.21	8.6.21	Missing Notes	Missing Notes	BCCG
Medical Ophthalmology	6.5.21	3.6.21	8.6.21	No Theatre	Lack of Theatre time	BCCG
Trauma & Orthopaedics (Park Hill)	20.5.21	17.6.21	23.6.21	Lack of theatre time	No Earlier Date Offered	RCCG

g) Elective Action Plan

A single action plan for elective is provided below:

Point of Delivery	Issues Affecting Performance	Improvement Plan
Outpatients	• Reduced capacity for all face to face activity due to COVID Safe Working	• Trust Accelerator Delivery Cell (ADC) meeting weekly to monitor performance, chaired by Deputy Chief Operating Officer • Insourcing in place for endoscopy (Medinet), Oral Surgery and Ophthalmology (Totally Health Care). ENT activity scheduled for August 2021 • Insourcing (third party providers) confirmed target start date was 21.06.2021 • T&O outsourced contract with new provider Trent Cliff • Phase 2 programme of works to be driven through the ADC group • Recruit to A&C vacancies/additional posts to book out further in advance • Services continue to proactively look for ways to optimise capacity and scheduling to help release/create additional capacity
Elective/Day Case	• Reduced non-urgent elective activity due to reduced operating timetable • Challenge to maximise theatre capacity due to staffing	• Source additional lists at Park Hill for T&O • Maximise opportunities with Barlborough and Trent Cliff • Source additional lists where possible on all sites Consider alternative incentive scheme for Trust staff groups
Diagnostics	• Reduction in 2ww, urgent and routine referrals for MRI • Increase in general US backlog, but reduction in 2ww, urgent and routine referrals seen. • Increase in MSK US backlog but reduction in referrals for 2ww, urgent and routine scans. • Slight increase Vascular US for 2ww and routine, but significant reduction in	• Additional sessions in CT and US carried out in June 21 improving current position. • A third party U/S provider approved from July – September 21 to perform 2000 MSK scans over 3 months • Funded NHSE fixed CT scanner planned for July – September 21 • On-going steady state 8 days MRI Van monthly as part of the run rate. • More additional sessions US, CT and DEXA planned in July to help with the backlog. Clinic type (2ww/Urgent/Routine) | Modality | No. of patients

<table>
<tr>
<td></td>
<td>urgent scans.
• Reduction in planned and unplanned plain film referrals
• Reduced capacity in NOUS waiting rooms due to Covid 19 Infection Control requirements</td>
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<table>
<tr><td>Sonographers</td><td>NOUS</td><td>200</td></tr>
<tr><td>Radiologist</td><td>NOUS</td><td>168</td></tr>
<tr><td>Contrast</td><td>CT</td><td>164</td></tr>
<tr><td>Bone scans</td><td>DEXA</td><td>10</td></tr>
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<tr>
<td>Theatre Cancellations</td>
<td>• See specific issues on specific patients
• Theatre staff absences due to A/L & sickness</td>
<td>• Agency staff utilised when available to cover staffing gaps</td>
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<tr>
<td>Looking Forward</td>
<td></td>
<td>• Release of version 1 of Simple PTL due in July 2021 to support patient management.</td>
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2. EMERGENCY

a) Emergency Care Bundle – New Standards

The Trust are currently shadow monitoring the new standards and awaiting the performance thresholds to be issued from NHS England

b) 4 Hour Access

Performance against the 4 hour target dipped during June 2021, although attendances increased by 734, giving the highest monthly attendance ever, 25% higher than in 2019.

Hospital	% Achievement	Attendances	No of Breaches	% Streamed from FDASS
Doncaster	69.1%	10562	3266	19.38%
Bassetlaw	88.4%	4930	574	6.39%
Mexborough	99.9%	2059	3	0%
Trust	78.2%	17551	3843	13.46%

12 Hour Trolley Breaches
There were three 12 hour trolley breaches reported in June, with a full root cause analysis done on each individual. They are symptoms of the current level of pressure on flow and exceptional volume of patients within the Emergency Department.

Hospital	Date of Breach	Breach Reason	Clinical Harm Review
Doncaster	5.6.2021	Patient volume / Bed pressures	No harm identified
Doncaster	30.5.2021 (x2)	Bank Holiday weekend – high levels of admissions	No harm identified

Issues driving performance and the related improvement plan are summarised below:

Issues Affecting Performance	Improvement Plan
• 4 hour performance reduced further due to continued increase in attendances • Increase in Ambulance arrivals and walk ins at peak periods • Main breach reasons continue to be doctor and bed waits	• Quality improvement work • New General Manager in post increasing capacity of senior leadership team • Flow work- right care, right place • Team development and leadership work progressing well • Early Senior Assessment working well at front

• Boarding time in department increased due to bed pressures • Average time in department 192 minutes • Longer length of stay for COVID patients affecting discharges and flow impacting on bed waits • Reduced bed base impacting on bed waits • Improvement in streaming numbers to FCMS compared to May 2021 • Increased resus activity- 641 in June • Increase in overall attendances in reduced space due to social distancing	door • Work to commence with ECIST/ICS to support the flow review work • Actions taken by primary care and CCGs to encourage primary care patients to attend GP practices and public communication campaigns that GPs open to business • In reach from Community to support social prescribing in ED • Development of a Surge Unit to provide additional capacity to support social distancing in the ED waiting area

c) Ambulance Handover

The following tables summarises performance against national standards. Whilst the national standards were not met, the Trust's performance is comparable to acute providers across North East and Yorkshire. The standards are:

- Within 30 Minutes: 100%
- Less than 15 minutes: 78.4% (TBC for 2021/22)
- Between 15 – 30 minutes: 21.6% (TBC for 2021/22)

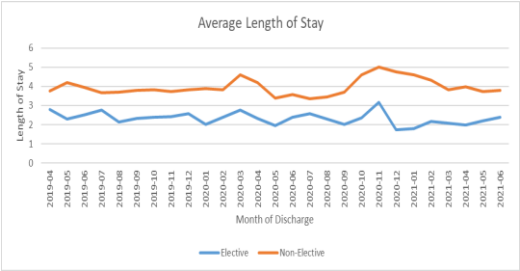
Month	Hospital	No of Arrivals	% less than 15 minutes	% between 15 & 30 minutes	% over 30 minutes	Longest Wait (hrs & minutes)
June 2021	**Doncaster**	2083	39%	29%	19%	3 hrs 15 mins
	Bassetlaw	799	38%	50%	10%	2 hrs 20 mins
	Trust	2882	39%	17%	10%	N/A

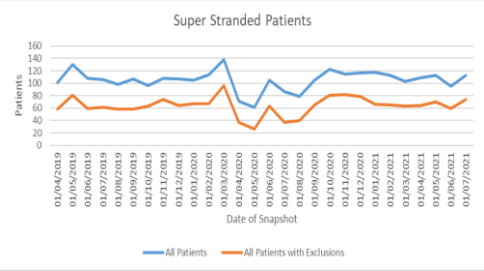
Issues driving performance and the related improvement plan is summarised below:

Issues Affecting Performance	Improvement Plan
• High levels of ambulances in the Doncaster area frequently	• Action plan in place with YAS • ECIST / ICS support for improving handover

disproportionate to the rest of Yorkshire • Exit block from ED causing challenges to flow of ambulances coming in and the receiving of handovers • Batching of ambulances • Increase in overall attendances and reduced space	process to be completed - awaiting start • Direct pathways for YAS to Acute Medicine being implemented • Same Day Emergency Care full review – advanced stages to be discussed through Length of Stay work stream – will support emergency flow

d) Length of Stay & Super Stranded Patients





*The exclusions are as follows, based the data available on each snap shot date;

- Any patient who was at Montagu Hospital
- Any patient under the care of Rehabilitation
- Any patient aged under the age of 18
- Any patient on ward PARK, BARL, EPAU, ECL, ED WARD and D

Super Stranded Patients

Super stranded patients reported in June 2021 - 117 patients in total - 100 (DRI) 17 (BDGH), the majority of whom remain not medically fit for discharge. Patient numbers remain relatively consistent month on month.

Issues Affecting Performance	Improvement Plan
• Social care – limited capacity within the community for home care for - Short Term Enablement Programme (STEPs) i.e. packages of care - up to 6 weeks free care and - commissioned packages of care – significant waits e.g. 2 weeks - No bridging services available to bridge the wait	• Escalated to social care managers • Patients with significant waits are being offered alternative accommodation to wait for their package of care

• Fast track packages of care (care for patients within the last 12 weeks of life) – Continuing Health Care report unprecedented numbers of Fast Track referrals from hospital and from the community requiring packages of care to support at home	• CCG are aware • Source alternative providers of home care if possible
• Neuro rehabilitation pathway - Magnolia Lodge- limited capacity to accept Category A patients resulting in complex, vulnerable patients being referred out of area. This significantly extends length of stay Clinical staff time used to co-ordinate specialist placements	• Escalated through the System Surge and Operations Group, Partner Flow Meeting and with CCG colleagues • Doncaster CCG escalating
• Increasing numbers of Covid positive patients being admitted – not affecting discharge currently, but concerns regarding increasing numbers	Watch and wait

e) Stroke – Performance Against National Target – (Direct Admission within 4 hours) – 75%

All SSNAP KPIs compare favourably to the national average with DRI Stroke Unit 'B' rated on SNNAP the latest being received for October - December 2020. The remaining area of focus is timeliness of direct admission to the Stroke Unit with data for **April 2021** outlined below:

Direct Admission within 4 Hours	Bassetlaw CCG	Doncaster CCG	Barnsley CCG	Rotherham CCG	Other CCG	Total
Yes	2	14	2	3	2	**23**
No	9	12	1	2	1	**25**
Total	**11**	**26**	**3**	**5**	**3**	**48**
Performance	18.2%	53.8%	66.7%	60.0%	66.7%	**47.9%**

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Issues driving performance and the related improvement plan is summarised below:

Issues	Breaches	Improvement Plan Update
Stroke Unit Bed Availability	1	Stroke Improvement Group are working on the key priority areas across the pathway which fall under 4 Themes: • Treatment/ Diagnostics • Safer Care • Patient flow and Service Organisation • Research and Quality Improvement Staff sickness, nursing vacancies and bed capacity pressures continue to cause delays in month to achieving 4 hour direct admissions. Stroke team working together to improve patient flow into rehab beds/early discharge planning to optimise bed capacity.
Stroke Staff Availability	2	
CT Scan Delay	1	
ED Delay	7	
Delay in transfer of patients from ED to HASU	7	
Delay - transport BDGH to DRI	7	
Patient Presentation: secondary / late diagnosis of stroke	0	

3. CANCER

The following sections summarise cancer performance for May 2021 against 31 and 62 day standards. Whilst the teams still face challenges related to recovering from COVID, the position shows an improving position against all standards, which benchmarks as green by NHS England.

a) Faster Diagnosis Standard

The Trust achieved 70.7% for the above standard against the performance target of 75%

b) Cancer Performance (Trust) May 2021 – 31 and 62 day Standards

Standard	Target	Performance
31 Day Classic	96%	99.2%
31 Day Sub – Surgery	94%	100%
31 Day Sub – Drugs	98%	100%
62 Day – IPT Scenario Split	85%	75.5%
62 Day – Local Performance (local measure only)	-	84.4%
62 Day – Shared Performance only 50/50 Split (local measure only)	-	34.6%
62 Day Screening	90%	69.8%
62 Day Consultant Upgrades (local measure only)	85% (local)	98.2%

c) Cancer Performance (Specialty) May 2021

	31 Day - Classic	31Day Sub - Surgery	31 Day Sub - Drugs	62 Day – Day 38 IPT split	62 Day Screening	62 Day Consultant Upgrades (no national standard)	Day 28 Faster Diagnosis Standard
Standard	**96%**	**94%**	**98%**	**85%**	**90%**	**85%** (local)	
Breast	100%	100%		88.2%	100%		83%
Gynaecology	100%			22.2%	100%	100%	72.1%
Haematology	100%			87.5%	100%	100%	36.8%
Head & Neck	100%			100%			65.5%
Lower GI	96.3%	100%		28.6%	23.5%	100%	45.5%
Lung	100%			40%		92.9%	71%
Skin	100%			93.5%			81.9%
Upper GI	100%			85.7%		100%	73%
Prostate							80%
Urological	97.3%	100%	100%	80%		100%	54.5%
Performance	99.2%	100%	100%	75.5%	69.8%	98.2%	70.7%

Cancer performance by CCG is as follows:

	31 Day Classic	31Day Sub Surgery	31 Day Sub Drugs	62 Day Classic 50/50	62 Day Screening	62 Day Consultant Upgrades
Operational Standard	96%	94%	98%	85%	90%	85% (locally agreed)
Doncaster CCG	98.8%	100%	100%	76.5%	38.5%	88.8%
Bassetlaw CCG	100%	100%	100%	77.7%	0.0%	50%

d) Cancer Performance Exceptions (31/62 days) – May 2021

Tumour Group	Breached Standard 31 Day/62 Day	No of Breaches	Summary of Breach Issues
Gynaecology	62 Day	5	4 x pathway delays 1 x patient choice
Lower GI	62 Day	13	7 x patient choice 4 x pathway delay 1 x medical reasons 1 x Covid 19 reasons
Lung	62 Day	2	2 x complex diagnostic pathway
Urology	62 Day	4	2 x complex diagnostic pathway 1 x STH OP capacity 1 x medical reasons

e) 104 Day Breaches – May 2021

The table summarises the over 104 day waiters. The Trust continues to focus at patient level, looking to drive down pathways for every patient:

Cancer Waiting Times Open Suspected Cancer Pathways 104 Days +	**Actual**										Predicted 104 Day Open Suspected Cancer Pathway Breaches		
	Aug 20	**Sept 20**	**Oct 20**	**Nov 20**	**Dec 20**	**Jan 21**	**Feb 21**	**Mar 21**	**April 21**	**May 21**	**June 21**	**July 21**	**Aug 21**
	15	5	3	3	10	6	4	6	5	12	13*	10*	12*

*Due to complex pathways

Overall lessons to improve performance are summarised below:

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Overarching Issues Affecting Performance	Summary of Trust Wide / Corporate Improvement Plan
• Improving position in Breast • Continued Histopathology delays due to staffing levels and continued need to outsource for reporting impacting on 28 and 62 day Standards • 31 day & 62 day breaches – impact of 14 day patient self-isolation prior to surgical treatment • Continued radiology delays (see breach reasons above) • SY&B local intelligence reports indicate a surge in skin referrals above 2019/20 figures	• Additional capacity in Breast services continuing – position at 52% for TWW for June 2021. • Internal and ICS meetings taking place to discuss support for diagnostic services across ICS footprint. Funding bids put into Cancer Alliance for new kit and Bio Medical Scientist staffing. • Improving position on both treatment targets • Increased theatre capacity coming for all surgical groups • Additional Dermatology Locum Consultant offering additional capacity

Cancer Improvement Trajectories

Cancer 62 day pathways waiting 63 days + after an urgent suspected cancer referral excluding non-site specific at end of reporting period	April 2021	May 2021	June 2021	July 2021	August 2021	Sept 2021
Trajectory	83	79	67	61	59	53
Actual	113	72	55			
Variance	30	7	11			

Total number of patients receiving first definitive treatment for cancer within a given period -all cancers	April 2021	May 2021	June 2021	July 2021	August 2021	Sept 2021
Trajectory	132	150	155	150	160	150
Actual	163	130				
Variance	30	20				

All patients urgently referred with suspected cancer by any source of referral excluding from a National Screening Programme who received a first outpatient appointment in the given month.	April 2021	May 2021	June 2021	July 2021	August 2021	Sept 2021
Trajectory	1450	1450	1401	1574	1434	1683
Actual	1490	1451				
Variance	40	1				

FINAL

FP21/06/A1– FP21/06/G4

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

FINANCE AND PERFORMANCE COMMITTEE

Minutes of the meeting of the Finance and Performance Committee
Held on Thursday 17th June 2021 at 12:00 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:	Alex Crickmar, Deputy Director of Finance Fiona Dunn, Deputy Director Corporate Governance/Company Secretary Claudia Gammon, Secretarial Support Officer (Minutes) Katie Shepherd, Corporate Governance Officer	
To Observe:	Bev Marshall, Public Governor Lynne Schuller, Public Governor Suzy Brain England OBE, Chair of the Board Lauren Ackroyd, General Manager (Children and Families Division) Jane Tombleson, Perform Management Deputy Chief Operating Officer	
Apologies	Marie Purdue, Director of Strategy and Transformation	
		ACTION
FP21/06/A1	**Welcome, Apologies for Absence and declarations of interest (Verbal)**	
	The Chair welcomed the members and attendees. No conflicts of interest were declared.	
FP21/06/A2	**Requests for any other business (Verbal)** The Director of Finance wished to discuss his presentation on the Women and Children's Services: Recovery Strategy as an item of any other business.	
	Action: Regular updated report from Jon and how it would be monitored	**J/S**
FP21/06/A3	**Action Notes from Previous Meeting (Enclosure A3)** Updates were provided on the below actions: Action 1 – 52 Week Wait Reprofiling – Further work had been completed by the Information Team to identify the trajectories until 30 September 2021 based on the H1 (Month 1-6 of 2020/21) activity plans. It was agreed that this would be shared with Committee members prior to the next meeting.	

	Action 2 - Corporate Risk Detail – A meeting would take prior to the next meeting. The target date was changed to July 2021. Action 6 - Estates and Facilities Oversight Board – This would be discussed as part of item FP21/06/E3. Action 10 - Integrated Performance Report – Surgical Waiters – The target date was changed to July 2021. Action 15 - Alignment of Bed Plan and Nursing Budget – Further work was required. It was noted that this had been highlighted as a key risk within item FP21/06/C1. Action 19 – Emergency Care Bundle & Type of Acute Emergencies – The Chief Operating Officer suggested that the Emergency Department Team attend the Finance and Performance Committee Meeting in July 2021 to outline how they would adapt in line with the new Emergency Department Care Bundle. The target date was changed to July 2021. Action 22 - Escalation from Board – Bed Plan – This action wasn't due to until July 2021. A meeting would take place prior to the next meeting to discuss the winter plan. Action 23 – Escalation from Quality and Effectiveness Committee – A verbal update would be provided during item FP21/06/B1. A written report was expected at the July 2021 meeting. Actions closed: 2, 3, 5, 7, 8, 9, 11, 12, 13, 14, 16, 17, 18, 20 and 21.	
	The Committee: - ***Noted the updates and agreed, as above, which actions would be closed.***	
	Action: Claudia Gammon would update the Action Log.	
FP21/06/ B1	**Ophthalmology Update (Enclosure B1)** Pat Drake advised the Committee that the Quality and Effectiveness Committee had agreed to escalate this item to the Finance and Performance Committee following four serious incidents that had happened within the department, which caused loss of sight in one patient, and partial sight loss in three patients. Jane Tombleson provided an overview of the serious incidents, and it had since been identified that patients had not received correspondence to attend for appointments. An action plan was in place to support recovery. A monthly meeting would take place with Consultants, and a weekly operational administration team meeting would take place. Additional sessions would be added to see patients, and a retrospective audit of all patients dating back to August 2020 would take place to ensure that patients who required a follow up would be seen. A two-weekly performance reporting meeting would take place to ensure that there was full oversight of patients. There were two critical "failsafe" administrative vacancies within the team which had been recruited to. Following a review of the three patient tracking lists (PTL), it was identified that there were 1,400 patients that did not appear on any of the three lists, since their last appointment which generated the outcome of 'Book Follow Up Now'. These 1,400 patients would require	

	validation,it was anticipated that the Trust would bring in external validators and a clinical insourcing team to assist. There would be a first line administrative validation review of each patient followed by a clinical desktop review by a Consultant. A further 11,308 patients who were on one of the three patient tracking lists who were "COVID backlog" patients required investigation & potentially validation and a clinical review by a Consultant. It was noted that the single PTL would reduce the risk around the the issues, by having all patients on one list. However, there were other required actions set out in the division's action plan focusing on administrative processes, training, workforce issues and wider related issues. . There was a need for a comprehensive induction programme for administrative staff at the point of entry to the Trust. Following a question from the Chair regarding the management of the patients with damaged eyesight, it was advised that contact had been made with the patients. The Chief Operating Officer would come back to confirm that all Duty of Candour requirements had been met. The Director of Finance advised that this type of incident had been an issue previously, and therefore as part of the review, there would need to be an understanding of the key issues to rectify the systems to ensure that this break down in governance did not happen again. Pat Drake asked whether this should be regarded as a serious incident and/or be placed onto the Corporate Risk Register. This was because the patients experiences had been judged as a serious incident and reported to the Quality and Effectiveness Committee and Duty of Candour would be implemented. It was agreed that this would be discussed at the Executive Team meeting for agreement. Kath Smart highlighted that as part of the root cause analysis, an understanding was required on how the governance systems in place did not highlight this issue sooner. It was agreed that the Finance and Performance Committee should receive a report on the root cause analysis of the incident. The Chief Operating Officer noted the importance of the administrative training and development plan that the Committee had been briefed on previously, and advised that this would support the governance framework. There would need to be an understanding of the scope of this issue within other services, and this would form part of the overall action plan. This was supported by the Director of Finance who advised that standardised procedures and centralised booking was required.	
	<u>Action</u>: A situation report and action plan would be provided to the Finance and Performance Committee in July 2021.	**RJ**
	<u>Action</u>: Clarification was required on how the patients who had been harmed, had been communicated with, and confirmation that the duty of candour procedures had been followed.	**RJ**
	<u>Action</u>: The Executive Team would discuss and agree on whether the overall incident should be raised as a serious incident. An update to be provided at the July 2021 meeting.	**RJ**
	The Committee: - ***Noted the update provided on the Ophthalmology Validation Position.***	

FP21/06/ C1	**<u>Financial Performance (Enclosure C1)</u>** The financial position for month 2 was reported as positive, with a surplus position of £323k which was £315k favourable to plan. The Trust's Year to Date (YTD) surplus was £691k, which was £433k favourable to plan. The favourable variance against plan was mainly driven by a favourable position on ERF. However there remains a number of financial risks to note including: - Delivery of activity and non-activity related requirements for ERF. ERF would become more difficult to achieve in the coming months as the targets increase and spend would need to increase in order to meet them. - There remains a lack of clarity in terms of some of the Trust's work force plans including: • Finalisation of bed plans. • There remained a concern regarding the impact of theatres staffing gaps on delivery of activity plans and agency spend in future months. - H2 financial arrangements - There remained no guidance for the second half of the year with regards to financial arrangements, therefore the significant risk remained that the potential that system top up funding received under current arrangements (c. £19m) was removed causing a potential significant deficit in the second half of the year. - Impact of major incident at Women and Children's Hospital on delivery of 21/22 capital and revenue plan. However, c. £1m had been included in the current revenue position regarding this risk. Capital expenditure spend in month 2 was £1.3m against a plan of £1.1m. Year To Date capital expenditure was £2.0m against the plan of £1.8m. YTD capital expenditure was £0.2m ahead of the plan, mainly due to donated assets in month. The cash balance at the end of May was £44.5m (April: £44m) versus the cash flow forecast of £43.8m. Cash had marginally increased by £0.5m since month 1, with capital creditors now £4.2m and thereby the underlying cash position of the Trust was c£40.3m. The Trust delivered £393km CIPs in month 2 compared to an NHSI plan of £398k. This represents an under-delivery of £5k. Year to date the Trust's efficiency programme had delivered £433k against a plan of £447k an overall under-delivery of £14k. Following a question from Kath Smart regarding whether the Trust would receive a dispensation for achieving increased activity targets due to the impact of the incident within the Women and Children's Hospital, it was advised that this was not the case. The Chief Operating Officer advised that this had been flagged as a risk to the future position. In response to a question from Kath Smart regarding the finalisation of the bed plans, the Director of Finance advised that there was clarity on the Theatre plan as agency nurses would commence in post for a six-month contract in July to fill the vacancy gap. There was a clearer understanding of the bed plan for H1 (month1-6 2021/22), however, work was required to identify the bed plan for H2 (month 7-12 2021/22). Kath Smart noted that she attended the Clinical Specialities Division meeting the previous week which the Finance Team were in attendance at to listen and take feedback from which was good to see. Following a question from Pat Drake relating to cost improvement programmes, it was advised that the Efficiency Team were reviewing Model Hospital, GIRFT (get it right first time) reports and business cases to understand the benefits.	

	Jane Tombleson left the meeting.	
	The Committee: - ***Noted and took assurance from the Finance Report.***	
FP21/06/ C2	**<u>Financial Review and Control Projects 2021/22 (Enclosure C2)</u>** To help maintain and improve robust financial controls a number of areas for review had been identified for 2021/22. This includes the following areas: - Approvals and Ledger Integrity - Budget reporting and maintenance - Financial Reporting - Forecasting - Finance training (non-finance and finance staff). - Finance staff responsibilities and skills - Fixed Asset Register System and Fixed Assets processes and controls The projects were still in the early stages, with the main progress to date outlined: - Approvals and Ledger Integrity – Approvals review completed, with system update expected by the end of June. - Budget reporting and maintenance – Key principles agreed, and draft reports developed. - Standardised Reporting- Phase one – Stakeholder surveys issued and focus group set up to capture reporting requirements and feedback on current practices. - Standardised Reporting- Phase Two – Discussions have commenced with SBS regarding how we get the most out of our reporting systems, future system updates and how we can build capability through different training options. - Finance Training – Key areas of focus for training improvement identified (as set out in the table above), with subject matter experts now working on content development. Kath Smart noted the previous concerns regarding Divisions returning back to a culture of sound financial process and authorisation and that the introduction of training would contribute positively towards that, however asked for clarification on how the Trust would ensure that Divisions access the training. It was advised that the Divisions were supportive of the training, and the measure in place to score Divisions against their financial compliance would take account of the training required for key roles. Following a query from Kath Smart regarding the absence of the Vacancy Control process from the priorities, it was advised that this formed part of the budget work underway. Pat Drake advised that she was supportive of the training, however advised that this should be addressed during appraisals and through the objective setting process.	
	<u>The Committee:</u>	

	- ***Noted the update on Financial Review and Control Projects 2021/22.***	

FP21/06/ D1	**Elective Restoration and Accelerator and Operational Update/Recovery Update (Presentation) (Enclosure D1)**
	
	The Chief Operating Officer reported that there was an increase in Emergency Department attendance both nationally and locally. COVID-19 levels remained low. The total COVID-19 occupancy was 0.7%, of which 0.2% were active cases. The Trust had no COVID-19 patients on ITU. The Delta variant was of significant concern.
	
	Kath Smart noted that the achievement of day case activity for May was high at 94.42%, however elective activity was lower at 84.92%. The Chief Operating Officer explained that the 52-week position continued to improve with week-on-week improvements seen for approximately 12 weeks. The Trust had two 12-hour breaches within the Emergency Department due to challenges with bed flow. A harm review had taken place and no harm had occurred to the two patients.
	
	Pat Drake asked about the current wait time on appointments this was confirmed that it was dependant on the clinic. 60% of appointments conducted face to face.
	
	The Chief Operating Officer provided an update of the key issues identified from the Women and Children's Water Leak Incident that took place on 27th April 2021:
	
	• Paediatrics would be in South Block which provides some risk with medical cover over night, mitigated through additional agency medical shifts booked.
	• There were 21 bed spaces for paediatrics (and whilst similar to pre-incident levels, note this is still well below BAU levels of up to 40 beds,).
	• Therefore was a key risk to capacity challenges with fewer beds available than pre-Fire Works and an expected respiratory surge in August 2021.
	• Ward moves would allow for Medicine to return to their pre-COVID-19 bed base
	• There were fewer emergency surgery beds than pre COVID-19.
	• Longer length of stay resulting in fewer discharges due to acuity of patients remains a key risk.
	• Winter plan was needed to address bed capacity issues as there was a risk in terms of paediatric capacity, medical capacity & maintenance of elective work.
	• Usual plans around outliers would not be possible due to protected pathways.
	• Key risk was if critical care surge required, Ward 22 not "immediately" available. Escalation process being agreed, to step up ward in portions for DCC
	• Two modular wards were being built with an expected onsite delivery at the end of October. These would be used for acute paediatric inpatients and would address the split site risks. These would provide separate Children's ward and Children's observation unit to reflect our normal pathways. The risks of this were:
	  • Potential delay in delivery
	  • Surge in respiratory expected in August – further planning required
	
	The challenges of the Radiology department were then discussed regarding the demand, the growing backlog and the delay on patient pathways. There were also the challenges of COVID-19 where the walk in service was ceased in line with other units. The intention was to achieve a robust demand and capacity plan with a sustainable plan moving forward rather than reliance on extra sessions.
	
	Alex Crickmar left the meeting.
		R

	The Chief Operating Officer gave an over view and noted that more attention needed to be given to emergency flow and challenges, bed plan for September onwards (Winter Plan). Thresholds for Emergency Care Bundle not yet published but good planning. Delta variant had an impact on hospitalisations/deaths we were unclear on this however some early signs have impacted.	
	The Committee: - ***Noted the update provided on the Elective Restoration and Accelerator and Operational Update / Recovery Update.***	
FP21/06/ D2	**Integrated Performance Report (Enclosure D2)** This was discussed as part of item FP21/06/D1.	
	The Committee: - ***Noted the Integrated Performance Report.***	
FP21/06/ D3	**Learning from the Women and Children's Hospital Water Leak Incident (Verbal)**	
	This item was deferred.	
	The Committee: en - ***Agreed to defer the item.***	
FP21/06/ E1	**Board Assurance Framework SA1 and SA4 (Enclosure)**	
	There were no questions raised.	
	The Committee: - ***Noted the Board Assurance Framework SA1 and SA4.***	
FP21/06/ E2	**Corporate Risk Register (Verbal)** Kath Smart noted the use of the wording 'This was inadequate as a medium or long term solution' within RISK 2664 – Staff Shortage – Consultant Intensive Care, and reiterated that this was a public document. It was agreed that the wording would be reviewed and updated. Kath Smart noted that the RISK F&P 4 – Inadequate Infrastructure had not been updated since November 2020, and asked if the Women and Children's incident should be reflected in this risk. It was agreed that the Director of Finance would take this as an action to review. Kath Smart noted that there was an empty column on the Corporate Risk Register for RISK 2147 – Edge Protection of DRI. It was agreed that this would be updated. It was agreed that the Company Secretary would circulate the final Internal Audit Report on Risk Management.	

	Action: The use of the wording 'This was inadequate as a medium or long term solution' within RISK 2664 – Staff Shortage – Consultant Intensive Care would be reviewed and updated.	**FD**
	Action: The Director of Finance would take an action to review whether the impact of the Women and Children's Hospital Water Leak incident should be added to RISK F&P4 – Inadequate Infrastructure.	**JS**
	Action: The empty column on the Corporate Risk Register for RISK 2147 – Edge Protection of DRI would be updated.	**JS**
	Action: The Company Secretary would circulate the final Internal Audit Report on Risk Management.	**FD**
	The Committee: - ***Noted the Corporate Risk Register.***	
FP21/06/ E3	**Finance and Performance Committee Terms of Reference (Enclosure E1)**	
	The Committee: - ***Approved the Finance and Performance Committee Terms of Reference.***	
FP21/06/ E4	**Assurance Summary (Verbal)** The Committee was asked by the Chair if it was assured, on behalf of the Board of Directors on the following matters. Any matters where assurance was not received, would be escalated to the Board of Directors: - Matters discussed at this meeting, - Progress against committee associated Executive's objectives, - Divisional compliance with the Trust's risk management process.	
	The Committee were assured on behalf of the Board of Directors on: - ***Matters discussed at this meeting,*** - ***Progress against committee associated Executive's objectives,*** - ***Divisional compliance with the Trust's risk management process.***	
FP21/06/ F1	**Governor Observations (Verbal)** Bev Marshall gave input that that QEC and the Committee worked alongside each other and worked together on any issues that occurred. The Governors would also need to be made aware of this. It was also raised that the future of the Women and Children's unit should not be about another Hospital in North Lincolnshire. We need to gain the backing from local MP's which would then give us a stronger case. Lynne Schuller added about the waiting lists and commended all that they have shortened. Lynne raised that the DNA rate for in patients had risen and there was an increase in A&E attendance.	

	The Chief Operating Officer concluded patients accessing Mental Health care were now accessing Secondary Care as Primary Care isn't always accessible. DNA rate had come down due to patients receiving text reminders. This had created a more efficient way to communicate with patients.	
FP21/06/ G1	**<u>Any Other Business</u>** **<u>Women and Children's Services: Recovery Strategy.</u>** The Director of Finance shared his presentation titled Women and Children's Services: Recovery Strategy. Discussing the next steps forward for the Women and Children's hospital following the incident. The forecast annual revenue cost associated with the management of the estate due to its poor condition was £1.84m, which when projected over the ten-year duration the total revenue cost was £21.94m (allowing for future inflation costs). It was discussed that the Flood & Fire Maternity was reported to the CQC (28/04/2021) and they visited 29/04/2021 to assess arrangements for reallocated patients. There were some direct costs that have been incurred after responding to the event. - Provision of temporary modular ward and theatre capacity - £7259,880 - Temporary admin accommodation (estimate) - £300,000 - Links and ground works - £2,249,061 - Rapid response capital works to make building safe post incident - £217,599 - Trust costs additional: clinical, security, estates and admin costs to end May 21 - £134,189 - Sub-total - £10,397,729 - Minimum rectification and repair costs (electricals) - £1,980,000 - Total Direct costs to date from incident - £12,377,729 - Funding (£2m insurance and local ICS capital as central funding unavailable) - £2,000,000 It was discussed that the potential options to resolve impact of the incident and deliver a long-term solution. 1. Repair damaged electrics £2m 2. Repairs & essential safety works to East Side wards (fire management and windows) £14.9m 3. Repairs, essential & backlog maintenance to condition B (whole building) £39.4m 4. Backlog maintenance for whole building + 2018 scheme: resolves operational shortfall £129.8m 5. Replace with a New W&C Hospital (preference Basin Site) as part of DBTH DCP £277.5m *****Options 3&5 looked to be the most viable alternatives. **<u>Alternative Options</u>** There were multiple permutations and configurations possible across current and future sites. The options described were potential alternatives and would be refined through the business case process and the evolving plans of our ICS and neighbouring ICS's	

	- Options 1 & 5 result in total new build and whilst Option 5 was the best approach, Option 1 provides the opportunity to phase the programme, accelerate the solution for W&C services and was currently the preferred way forward. - Options 2,3 & 4 look at alternate site use and seek to maximise refurbishment to deliver potentially cheaper, though sub-optimal, alternates. - Option 5 was considered in more detail	
	Action: The presentation slides would be circulated to Committee members.	**KS**
	The Committee: - ***Noted the update provided on the Women and Children's Services Incident Recovery Strategy.*** -	
FP21/06/ G2	**Minutes of the Sub – Committee Meetings (Enclosure)** ***The Committee noted:*** - ***Capital Monitoring Committee – 15/04/2021*** - ***Cash Committee – 16/04/2021 and 13/05/2021***	
FP21/06/ G3	**Minutes of the meeting held on 17th May 2021 (Enclosure)** ***The Committee approved the minutes of the meeting held on 17th May 2021.***	
FP21/06/ G4	**Date and time of next meeting (Verbal)**	
	Date: Monday 26th July 2021 **Time: 09.00am** **Venue: Microsoft Teams**	
	Meeting Close Meeting closed at 15.17pm.	

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

QUALITY AND EFFECTIVENESS COMMITTEE

Minutes of the meeting of the Quality and Effectiveness Committee
Held on Monday 14th June 2021 at 13:00 via Microsoft Teams

Present:	Mark Bailey, Non-Executive Director Pat Drake, Non-Executive Director (Chair) Sheena McDonnell, Non-Executive Director (until item QEC21/06/D1) Dr T J Noble, Medical Director David Purdue, Chief Nurse	
In attendance:	Fiona Dunn, Deputy Director Corporate Governance/Company Secretary Lois Mellor, Director of Midwifery (Item QEC21/06/B2 and QEC21/06/D3) Stacey Nutt, Deputy Director of Nursing (Patient Experience) (Not present for item QEC21/06/B1-B2) Katie Shepherd, Corporate Governance Officer (Minutes) (KAS) Nicola Wilkinson, Senior Research Nurse (From item QEC21/06/C4)	
To Observe:	Peter Abell, Governor Lynne Logan, Governor	
Apologies:	Sam Debbage, Deputy Director of Research and Education Karen Humphries, Clinical Governance & Professional Standards Co-ordinator Marie Purdue, Director of Strategy and Transformation Cindy Storer, Deputy Director of Nursing (Patient Safety) Alasdair Strachan, Director of Education and Research Abigail Trainer, Deputy Chief Nurse	
		ACTION
QEC21/06/A1	Welcome, apologies for absence and declarations of interest	
	The Chair welcomed the members, attendees and governor observers. The apologies for absence were noted. No conflicts of interest were declared. The Chair advised that the expected ReSPECT deep dive had been delayed, to ensure that the results of the audit could be included.	
QEC21/06/A2	**Action Notes from Previous Meeting (Enclosure A2)**	
	The following actions were closed 1-13, 16, 19-28, and 30. Action 14, 15 and 17 were deferred to August 2021. Updates were provided on actions below: Action 1 – Corporate Risk Register and BAF – Following a request for views from the Chair, it was agreed that the action would be closed as the review of the Board Assurance Framework was completed, and the clinical governance committee review would not impact on the strategic aims and risks. Action 2 – Development of Medicines Safety Committee – The Chief Nurse advised that all meetings had been planned. It was confirmed that when wrong administration of medication	

	occurred, support was provided to individual colleagues alongside a review of DATIX, key themes, ward areas. Action closed. Action 4 – Escalation of matters through the governance framework – A review of the policy would take place to include the protocols of each police force. In some circumstances, the police would need to assist when a patient was missing. Ant reported missing patients would be captured and reported via the Health and Safety Committee. Action closed. Action 9 – Thank You Email – Completed, action closed. Action 10 – Award – The End of Life Care Team had been nominated for an internal staff award. Action 12 – Links to actions – Board Assurance Framework – It was advised that this was included as part of the Board Assurance Framework progress section. Action closed. Action 16 – National Planning Guidance – The Trust had taken account of this. Action closed. Action 26 – Quality And Effectiveness Committee Terms of Reference – Although the outcome of the clinical governance review was to be included within the terms of reference, it was agreed that the Committee would review and approve the Quality and Effectiveness Committee terms of reference, with further small amendments to be made following the approval of the review. Action closed. Action 28 – Overdue Policies Update – Item on the agenda. Action closed. Action 30 – Challenges with the completion of the Friends and Family Test – Item on the agenda. Action closed. The Chair advised that the Committee would receive an update on Sepsis at the August 2021 meeting. This would include an update on the national pilot within Paediatrics. Lee Cutler and Dr Chadha would be invited to the meeting.	
	Action: Katie Shepherd would update the Action Log.	
	The Committee: - ***Reviewed the action log and agreed to close actions.***	
QEC21/ 06/A3	**Request for Any Other Business (Verbal)**	
QEC21/ 06/A3i	Ophthalmology Serious Incidents The Executive Medical Director advised that at the previous Clinical Governance Committee a presentation had been received from the Ophthalmology Department regarding the backlog of work and the risks associated with that, following a number of serious incidents in which patients were harmed. Four patients lost partial sight, and one lost full sight. Work had been undertaken to verify the patient tracking list. The Chair advised that the matter would be escalated to the Finance and Performance Committee to receive an update and action plan on the Wet AMD pathway, administrative processes in this area and concerns and the way forward for Backlog of Ophthalmology cases.	

	Following a question from the Chair regarding whether there was an internal operations group that this should have been escalated through, the Chief Nurse advised that it had been escalated through the Clinical Governance Committee. Following a request from the Chair, it was requested that the Chief Nurse would check that the incidents within the Ophthalmology Department had been reported as a serious incident. It was agreed that the outcome of the Ophthalmology serious incident would be provided as part of the Patient Safety Report. To include an update on how duty of candour was followed and how support was provided to patients. In response to a question from Mark Bailey asking if there had been any other similar incidents or near misses, the Chief Nurse advised that all waiting lists had been reviewed and there had been no further identification of similar issues, however noted that there had been a similar issue within the Ophthalmology Department seven years ago in which a robust process had been implemented to prevent this taking place again. It was advised that due to the COVID-19 pandemic, there had been issues with handovers.	
	Action: Following a discussion regarding patient safety within the Ophthalmology Department following the recent outcome of serious incidents, it was escalated for the Finance and Performance Committee to receive an update on: - ***Wet AMD pathway*** - ***Admin processes in this area and concerns*** - ***Way forward for Backlog of Ophthalmology cases***	**RJ**
	Action: The Chief Nurse would check that the incidents within the Ophthalmology Department had been reported as a serious incident.	**DP**
	Action: The outcome of the Ophthalmology serious incident would be provided as part of the Patient Safety Report. To include an update on how duty of candour was followed and how support was provided to patients.	**DP**
QEC21/ 06/B1	**Deep Dive: Complaints Internal Audit Recommendation (Enclosure B1) (Presentation)**	
	Following the receipt of the internal audit report on Complaints at the previous meeting, it was requested that the Committee undertake a deep dive into the recommendations. The Deputy Director of Nursing (Patient Experience) provided an overview of the background and current factors affecting the complaints process and team which highlighted that the new Deputy Director of Nursing (Patient Experience) commenced in post on 1st December 2020. During the COVID-19 pandemic, the timeframe allowed for a response to a complaint had been relaxed nationally, however, the Trust continued to endeavour to meet the national timescale of six-months to continue with best practice. The PHSO continued to investigate complaints. The resources within the Patient Advice and Liaison Service (PALS) team was outlined, which demonstrated that out of 5.8WTE, there was a total of 2.4WTE in the office. The number of open cases and overdue cases had reduced since December 2021, however there had been an increase in the number of complaints since March 2021. A number of analytics relating to complaints were shared including ethnicity which showed that the majority of people making a complaint identified as White British, by subject, which demonstrated that the majority related to COVID-19 , 'lack of information/discussion' and 'attitude and behaviours'. Significant learning had been taken from complaints made relating to visiting, effective communication, virtual consultations, catering, PPE and the complaints process. A comprehensive review of the complaints process had been undertaken which included the alignment of the subjects within DATIX to the KO41 national submission, which were to be finalised at the end of the complaints, instead of at the beginning.	

	The timeframe for complaints to be dealt with had reduced from 90-days to 60-days, and if a concern had not been answered within the timeframe, it would be prompted to move to a complaint. A complaints panel meeting now takes place weekly, chaired by the Chief Nurse. The action plan following the internal audit review was shared, the majority of which was either completed or progressing well. Next steps included that the Complaints Policy would be completed during Q2 of 2021-22. There would be a continued focus on the reduction of re-opened complaints. The Trust would endeavour to meet the target to respond to complaints within agreed timescales 95% of the time. Training and education would be provided to investigating officers. Sheena McDonnell noted that the number of complaints were an indication that people knew how to provide feedback to the Trust, which was not necessarily a negative thing. Following a question from Sheena McDonnell regarding progress made following the KPMG internal audit report, it was advised that many of the actions had been completed ahead of time. Following a question from Sheena McDonnell regarding the information provided on resources within the presentation, the Deputy Director of Nursing (Patient Experience) advised that during the COVID-19 pandemic there had been two colleagues that had worked from home throughout, and there had not been a full team for some time. Recruitment had taken place and a new member had commenced that week. The Chief Nurse noted that staff retention within the department was challenging due to the nature of the role.	
	Stacey Nutt left the meeting.	
	Mark Bailey noted the good progress made regarding learning from complaints and closing of open complaints. Mark Bailey suggested that encouraging patients to talk about their experiences would be very beneficial to colleagues, and would link to the outstanding agenda the Trust had engaged in. The Chief Nurse advised that this would be included as part of the Quality Framework to ensure that the Trust celebrated the things that the Trust did well. Sheena McDonnell noted that the medical staff were the most complained about and asked for a comment on how this would be reduced. The Executive Medical Director advised that the Trust had embarked on a civility programme and this would include how messages should be delivered to patients.	
	Action: Following the Internal Audit Report on Complaints and the action plan received at the June 2021 meeting, the Committee would receive a deep dive in February 2022 on progress.	**SN**
	The Committee: - ***Noted and took assurance from the deep dive into the Complaints.***	
QEC21/ 06/B2	**Maternity Transformation Update (Enclosure B2) (Presentation)**	
	The Director of Midwifery outlined the background of the Maternity Transformation Programme (MTP). Following the water leak in the Women and Children's Hospital on 27th April 2021, approximately half of the building remained unusable. Maternity Services remained open at both Doncaster and Bassetlaw, and since visiting had increased, the Trust had encouraged people to use lateral flow kits provided by the Government.	

	Medical staffing remained stable, however there were significant vacancies within the midwifery workforce, which was a national problem. The recent Ockenden submissions evidenced a shortfall of approximately 2,500 midwives nationwide. The Trust had made, for October 2021 28.5WTE offers to midwives through the Local Maternity Services (LMS) combined recruitment process. The Trust was looking into an incentive scheme to encourage band 6 midwives to come and work at the Trust. Engagement work had been undertaken within the Maternity Services Team. A timeout session had taken place with managers within Maternity Services on morale. Funding had been secured to refurbish the Central Delivery Suite within the Women and Children's Hospital. Work would commence in January 2022. The continuity of care programme continued throughout the COVID-19 pandemic where possible. The Trust was working to achieve 51% of all patients engaged in continuity of carer by 2022. An update was provided on the Maternity Voices Partnership (MVO), and it was noted that the MVP chair had raised areas that could be improved by the maternity service on the 11th February 2021 via email after seeking user feedback. The themes identified include a lack a communication, continuity of carer, negative experiences of women who'd had miscarriages and a lack of a birthing pool at Doncaster. It was noted there was a birthing pool at Bassetlaw Hospital. An update was provided on the several local and national schemes in place to reduce harm and improve outcomes in maternity. The Trust was fully compliant with the Saving Babies Lives Bundle and had set up a pre-term and twins' clinic. There was an improved triage service, and the Trust had recruited a band 7 Lead to lead further improvements. The refurbishment of the Central Delivery Suite would allow for a fit for purpose triage area. Continuity of Carer had been implemented with a high proportion of BAME women. The Trust was working with the LMS to provide a service for women with PTSD. There had been no improvement in the breastfeeding rates, however there had been a reduction in smoking during pregnancy from 20% to 13%. There was band 3 Midwifery Support Worker development in progress to improve post-natal care. The submission date for CNST was 15th July 2021 and the service was on target to achieve the ten safety actions. Part 2 of the Ockenden Report was expected towards the end of the calendar year. The Chief Nurse undertook a timeout session with Consultants to discuss the Ockenden Report which was well received. There would be ongoing and increasing scrutiny of maternity services from many different stakeholders.	
	Stacey Nutt arrived back at the meeting.	
	The Chair noted the comprehensive report. Following a request from the Chair regarding the timeout session with the Obstetricians and Matrons, it was advised that this included reporting, the Ockenden Report action plan and the Quality Framework. It was a positive session. Sheena McDonnell noted that following the recent presentation with KPMG, that one of the challenges found following feedback was that nursing and medical colleagues were not working at their grade they should be, and others could be undertaking some of those tasks to allow them to do so, and therefore asked for an update on the future of the maternity workforce. It was	

	advised that the Trust used Birth Rate + which was a workforce modelling tool which ensures that the Trust can only apply a 10% skill mix. In response from a question from Mark Bailey, regarding the complexity of the different reporting steams, it was advised that where the different reporting streams did not work together and there wasn't any evidence that it would be made simpler. There would be further actions as part of CNST and the Ockenden Report. The Chief Nurse noted that the Board were required to review the Perinatal Mortality Review Tool each month, along with other required maternity, to ensure that there was full Board oversight of Maternity Services. The Chair noted that there had been some issues with the achievement of CNST however it was good news that the Trust would complete the actions. Following a question from the Chair regarding the website, it was advised that the Trust was working through the comments posted.	
	The Committee: - ***Noted the information provided in the End of Life Care presentation.***	
QEC21/ 06/C1	**Board Assurance Framework (Enclosure C1)**	
	The Committee received the up-to-date Board Assurance Framework risk to the achievement of the Trust's strategic aim 1 – to provide outstanding care and improve patient experience. The Chief Nurse noted that business planning measures had been agreed and therefore this would be updated within the board assurance framework.	
	The Committee: - ***Noted the board assurance framework.***	
QEC21/ 06/C2	**Quality Framework and Strategy (Enclosure C2)**	
	In response to a question from the Chair regarding the progress made on the Quality Framework Strategy, it was advised that the Chief Nurse had met with three out of four Divisions to discuss this further. It had been piloted within the Education and Research Directorate. This would be presented back to the Committee in August 2021, with a full update provided to Board in September 2021.	
	Action: The Quality Framework Strategy pilot in Education and Research would be presented to the Committee in August 2021.	**DP**
	Action: An update on the Quality Framework Strategy would be provided to Board in September 2021.	**DP**
	The Committee: - ***Noted the update provided on the Quality Framework Strategy development process.***	
QEC21/ 06/C3	**Stabilisation and Recovery (Enclosure C3)**	
	As of 19th May 2021, 94% of patients on the admitted RTT active waiting list (excluding planned waiters and diagnostics) have been stratified. The narrative would be updated in time for the	

	next meeting. Cardiology patients were not stratified as they only have a 1-week wait for appointments. The fifth and final national upload of data as part of the National Clinical Prioritisation Programme was submitted on 9th April 2021. This took into account those patients who had been risk stratified and those patients on an admitted pathway (elective or day case) allocated the new status codes of P5 (delay due to COVID-19 reasons) and P6 (delay due to non-COVID-19 reasons). As of 19th May 2021, 292 priority 2 patients have been waiting for surgery for 4+weeks following date of listing or priority 2 categorisation (upgrades). Following agreement from all stakeholders, the patient communication plan commenced on Monday 8th March 2021, with letters sent to the agreed cohorts of patients: - Acknowledging the delay, but to provide assurance that the patient had not been forgotten and would be sent an appointment / date for treatment in due course. - To provide an opportunity for the patient to contact the hospital if they had decided they no longer require hospital input. - The Trust had received draft national guidance for the prioritisation and management of long-waiting patients for diagnostics and the team were working to amalgamate the previously agreed process with some of the National requirements to ensure any agreed process would capture the necessary data sets to allow accurate submissions to be made without any further changes. The revised process would be taken through the appropriate governance structure for sign off. Following a request from the Chair, it was agreed that the risk stratification process would be linked with the serious incident process.	
	<u>Action</u>: Dr Noble and Cindy Storer would link the risk stratification process with the serious incident process.	**TN/CS**
	The Committee: - ***Considered and noted the update provided on the risk stratification assurance body.***	
QEC21/06/C4	**<u>Quality Assurance Report (Enclosure C4)</u>**	
	<u>COVID19 Update</u> The Chief Nurse advised that there were four patients in hospital following admission due to COVID-19, one of which was still in active COVID-19. The Executive Medical Director advised that cases had not increased within South Yorkshire as had been seen in other areas. The Chief Nurse advised that the Trust was undertaking the duty of candour process of nosocomial transfer COVID-19 deaths. The reporting process had been agreed by the Trust and the CCG, and each outbreak would be reported as a serious incident followed by a review of all patients. The identification of any patient that acquired COVID-19 within hospital would receive a duty of candour letter. The Deputy Director of Nursing (Patient Experience) advised that the responses would be overseen by the Patient Experiencer Team and the Bereavement Office. Phone calls would be made prior to a duty of candour letter being sent. This would be managed sensitively. An update would be provided on the process to review all patients who acquired COVID-19 whilst in hospital. This would be included as part of the Patient Experience Update, as it was the Patient	

	Experience Team and Bereavement Team that were to oversee the phone calls/letters to patients/families. <u>Clinical Governance Committee Activity</u> The themes of learning identified included that patients ID bracelets being in place on the admission assessment was completed and signed accurately. Consideration must be given on an individual basis with regards to visiting. Challenges of families reporting difficulties with contacting the wards during the COVID-19 pandemic. A meeting was due to take place with Sheffield Teaching Hospitals with regard to the laser support, UV light and ultrasound machine. A process of 'pause and wait' prior to each exposure of radiation, with fewer staff in rooms had helped to remove distractions and contribute towards the achievement of no more than ten - wrong site' image. It was noted that there was no longer a shortage of defibrillators. An update was provided on infection prevent and control. There would be an update to JAC imminently. Following a question from the Chair regarding the administration of medicines to patients safely following the report that there had been missing patient ID bracelets, it was agreed that an audit to be undertaken on the concerns raised regarding lack of patient ID bracelets. A consideration of the safe administration of medicines would be made. Following a request from the Chair, it was agreed that an update would be provided on radiation following the meeting with Sheffield Teaching Hospitals (STH) regarding laser support, UV light and ultrasound machine. In response to a question from the Chair regarding infection prevention and control, the Chief Nurse advised that a business case would be presented to the Capital Investment Group to look at acquiring a new PCR testing kit due to the sensitivity regarding C-Difficile. There was no C-Difficile trajectory for 2021/22, however it was noted that in 2018/19 the trajectory was 44. The Trust had, to date, reported 45 cases, however it was noted that community onset cases were included in the figures where they had not been previously. The Infection Prevention and Control Board Assurance Framework was to go to Clinical Governance Committee, followed by the Quality and Effectiveness Committee, then to Board. This would be added to the work plans to ensure that this reporting route was followed. <u>Clinical Governance Review</u> The outcome of the Clinical Governance Review would be reported to the Clinical Governance Committee in June 2021, and the Quality and Effectiveness Committee in August 2021. <u>Patient Safety Learning Quarterly Report</u> The duty of candour standard letter had been reviewed, as was the CQC pathway for duty of candour. It would be decided whether a handbook should be included with the letter when sent. An important element of learning was from the HSIB reports to identify key themes and to ensure there weren't recurrent themes. Open incidents would remain a standing item as part of the	

	Quality Assurance Report. Further detail would about open incidents was to be included in the report. The Trust was issued with two separate Regulation 28: Report to Prevent Future Deaths relating to two patients that had fallen and suffered severe harm in the Division of Medicine. Work had been undertaken to ensure that staff understood the changes to MIFIT. The falls Qi pilot had commenced in ward 16, 17 and 24. The Trust was RAG rated red for some of the actions within the National Patient Safety Strategy action plan, one of which related to the current DATIX system which was an unsupported version. A business case would be produced to source DATIX iCloud at a cost of £130k. The current version of DATIX the Trust used was £30k. In response to a question from Sheena McDonnell regarding the timescale for the duty of candour process in relation to nosocomial infection, it was advised that the the first letter was sent as soon after the incident as possible, followed by a second letter as soon as reasonably practicable after the error was identified and understood. In response to a question from Sheena McDonnell regarding the serious incident action plan, who noted that all serious incidents overdue by one-month or more, were all rated as medium or low priority, it was noted that there was no indication of how long the actions had been outstanding for. This would be included in future reports. Sheena McDonnell noted the many different ongoing action plans in place and asked for assurance of how this was managed. The Chief Nurse advised that there was a robust process in place to manage the action plans via DATIX, which escalates the actions when not achieved. It was noted that once the syllabus was received in June, the Chief Nurse would triangulate what action/changes were required. In response to an update request from Mark Bailey regarding the safety culture index work underway, it was advised that the result would be received early summer which would then be triangulated with the data within the staff survey. Following a question from Mark Bailey regarding the alerting mechanisms in place to alert Executives of serious incidents, it was confirmed that once a serious incident was identified it was reported quickly to the Chief Nurse of Executive Medical Director. Mark Bailey noted that the Trust was utilising a tracker system from KPMG to track the recommendations from internal audits and asked if this could be used for other areas. The Company Secretary advised that the JIRA system would be trialled that week to track the internal audit recommendations. It would allow for all action plans to be monitored in one place. The Chair asked for clarification on when the PFDR action plans had been completed. The Chief Nurse advised that updates had been sent to the coroner. Most actions were completed. In response to a question from the Chair regarding the dissemination of NICE guidance and NPSA safety alerts, it was advised that these were disseminated quickly to the right areas as soon as they were received. The Chair noted that the Trust had a solicitor working on site three days per week. The Chair noted the progress made on learning from falls.	

	An update was required on the AAR (action after review) process. Following a request from the Chair, a progress update on accessible information standard would be provided. To include a consideration of 'easy to read' content and the option of an alternative language.	
	Action: An update would be provided on the process to review all patients who acquired COVID-19 whilst in hospital. This would be included as part of the Patient Experience Update, as it was the Patient Experience Team and Bereavement Team that were to oversee the phone calls/letters to patients/families.	**CS/ SN**
	Action: The outcome of the Clinical Governance Review would be reported to the Clinical Governance Committee in June 2021, and the Quality and Effectiveness Committee in August 2021.	**TN**
	Action: An audit to be undertaken on the concerns raised regarding lack of patient ID bracelets. A consideration of the safe administration of medicines would be made.	**CS**
	Action: An update would be provided on radiation following the meeting with Sheffield Teaching Hospitals (STH) regarding laser support, UV light and ultrasound machine.	**TN**
	Action: The Infection Prevention and Control Board Assurance Framework was to go to Clinical Governance Committee, followed by the Quality and Effectiveness Committee, then to Board. This would be added to the work plans to ensure that this reporting route was followed.	**DP**
	Action: It was noted that once the National Patient Safety Strategy syllabus was received in June, the Chief Nurse would triangulate what action/changes were required.	**DP**
	Action: An update was to be provided on the AAR (action after review) process.	**CS**
	Action: Progress on accessible information standard would be provided. To include a consideration of 'easy to read' content and the option of an alternative language.	**SN**
	The Committee: - ***Noted the update provided on clinical governance activity,*** - ***Noted the Incident and Serious Incidents Action Plan Position Statement,*** - ***Noted the update provided on Serious Incidents and Never Events within the ICS during COVID-19.***	
QEC21/ 06/C5	**Safer Staffing (Enclosure C5)**	
	Triangulation would take place with Directors of Nursing, Heads of Nursing and the Director of Midwifery to set the ward establishment and agree the skill mis for each area with the Chief Nurse. There had been an improvement see for ward distribution of planned versus actual rate within 5% from 50% to 56% in April 2021. It was noted that the Respiratory Unit would be split into two wards. There were 39 international nurses to commence within the Trust, which would result in zero vacancies. In response to a question from the Chair regarding the improvement of skill mix it was advised that the skill mix was at 60-to-40 and 55-to-45 in some areas.	

	Following a request from the Chair it was agreed that an update was requested on how the cross pathways would work across the three new Matron posts. This would be escalated to the people Committee.	
	Action: Escalation to the People Committee - An update was requested on how the cross pathways would work across the three new Matron posts.	**DP**
	The Committee: - ***Noted the update on safer staffing.***	
QEC21/ 06/C6	**Overdue Policies Update (Verbal)**	
	The Chair noted that policies were not for approval at this Committee, however wanted assurance that the governance process was in place for policies. The Deputy Director of Nursing (Patient Experience) advised that it was difficult for colleagues to access policies online as sometimes the links don't work. This was being reviewed by the Chief Information Officer. In terms of the overdue policies, big improvements had been made, and thirty-seven had been reviewed. All except one corporate employment policy were resolved and up to date and with the Policy Approval Group. It was advised that the Trust needed to re-establish the Policy Approval Group and introduce a reader panel, and there was a need to develop a Corporate Policy Committee. Work was ongoing with IT for an interim solution to store all policies within MS Teams. This would allow for reminders to be sent when policies were due for review. It would be asked if DATIX could be used for this also. The target date for the new structure to be in place was September 2021. A progress update was required at the October 2021 meeting, then it would be delegated to the Clinical Governance Committee for oversight. The Chair asked for, and received assurance that there were no safety risks. Sheena McDonnell noted the longer-term process in understanding what policy and procedure was and how the Trust would manage this. It was advised that there were particular sections within policies that required updating such as data protection which forms part of each policy. The aim was to ensure that the process was as simple as possible to undertake such changes.	
	The Committee: - ***Noted the Overdue Policies Update.***	
QEC21/ 06/C7	**Update on the Royal College of Obstetricians and Gynaecology (Enclosure C7)**	
	An update was provided on the two main outstanding items in relation to midwifery led care following the Royal College of Obstetricians and Gynaecology (RCOG) review in 2016. Two midwifery led care rooms had been identified at both Bassetlaw and Doncaster site, however the plan for the side-by-side unit at Doncaster had been delayed due to the damage to the Women and Children's Hospital following the water leak incident that took place on 27th April 2021. The Central Delivery Suite was due to be refurbished in January 2022 and this would include the midwifery led unit.	

	In relation to the development and implementation of a rotation programme for current band 6 midwives, it was advised that plans were in place but had been superseded by continuity of carer. All other aspects of the action plan were complete. The Trust was reviewing the workforce plan for a Maternity Consultant Midwife and what such a role would undertake.	
	The Committee: - ***Noted the update provided on the Royal College of Obstetricians and Gynaecology.***	
QEC21/ 06/D1	**<u>Patient Experience Report (Enclosure D1)</u>**	
	The Chair noted the uplifting patient story, which demonstrated the care and compassion that the Trust endeavoured to provide. In Quarter 4, there were 95 complaints closed with only 20% of cases closed that did not have an outcome recorded which was a significant improvement from the previous quarter of 46.5%. The annual total for 2020-21 was 368 closed complaints of which 14% did not have an outcome recorded. Of the 368 12.5% were upheld, 43.5% partly upheld and 30% not upheld. The themes identified from complaints included visiting, communication, virtual appointments, catering, PPE and person-centred care. Following the complaints relating to catering, the Head of Dietetics had developed the new Food and Drink Strategy, and in the future would involve the public or complainants in tasting menus if they wished to. Themes identified within the Emergency Department related to patients with Dementia and the environment. The Holistic Care Team were undertaking work to identify where improvements could be made. It had been identified that a number of completed Friends and Family Tests had been sent to the wrong location and had not been forwarded to the correct department. These had since been received. It was reported that there had been an increase in compliments received. Sheena McDonnell made a plea to move the paper-based surveys to a digital version to avoid the potential for them to be lost. *Sheena McDonnell left the meeting.* In response to a question from Mark Bailey regarding how the Trust could better share the learning with colleagues, it was advised that learning was shared at high level meetings, however noted that it doesn't always effectively filter to colleagues. The team had been proactive in adding information to the staff Facebook page, however further work was required to identify how colleagues would like to receive the information. The Chair noted that the Trust gained a considerable amount of patient feedback. However, approaches need developing to include the patient voice when services were being developed or changing.	
	The Committee: - ***Noted the Patient Experience Report.***	
QEC21/ 06/D2	**<u>Inpatient Survey Action Plan (Enclosure D2)</u>**	

	The Inpatient Survey Action Plan was received and noted. The Chair noted that bringing the Divisions on board with the action plan was key. It was agreed that an update would be provided at the Quality and Effectiveness Committee in October 2021, and at the Board in September 2021. It was confirmed that this was on the Clinical Governance Committee agenda.	
	Action: A progress update in the Inpatient Survey Action Plan was required at the October 2021 meeting.	**DP**
	Action An update on the Inpatient Survey Action Plan to be included as part of the Chief Nurse Report to Board.	**DP**
	The Committee: - ***Noted the inpatient survey action plan.***	
QEC21/ 06/D3	**Maternity Voices Partnership Feedback and Actions (Enclosure D3)**	
	This was discussed as part of item QEC21/06/B2.	
	The Committee: - ***Noted the update provided on the maternity voices partnership and actions.***	
QEC21/ 06/E1	**MAGNET4EUROPE Study (Enclosure E1)**	
	Nicola Wilkinson, Senior Research Nurse, provided the Committee with an outline of the MAGNET4EUROPE study which highlighted that the Magnet Recognition Program provided a roadmap to nursing excellence, which would benefit the whole of an organisation. To clinical staff, Magnet status means working in a culture of shared decision-making, and supporting education and development through evidence-based practice leading to greater autonomy at the bedside. To patients, it means the very best care, delivered by nurses and the wider interdisciplinary teams who were supported to be the very best that they can be. For the Trust it would be a model to help us be safe and outstanding. Magnet hospital status demonstrated high standards of excellence in five key areas: - Transformational leadership - Structural empowerment - Exemplary professional practice - New knowledge, innovation and improvements - Empirical outcomes The Trust had joined the international MAGNET4EUROPE study, to allow us to 'test' implementing the Magnet recognition programme to: - Improve hospital work environments - Improved mental health and wellbeing in the healthcare workforce - Improved recruitment and retention of staff Following a request from the Chair, it was advised that shared governance involves the identification of how colleagues can be involved in the study and contribute towards its development. It was agreed that a further update on progress would be provided in February 2022.	

	***Action*: An update required at the Quality and Effectiveness Committee in February 2021.**	**SD**
	The Committee: - ***Noted the update provided on the MAGNET4EUROPE study.***	
QEC21/ 06/F1	**Corporate Risk Register (Enclosure F1)**	
	The internal audit on Risk Management was completed. The recommendations had been finalised with the Chief Nurse and would be presented to the Audit and Risk Committee in July 2021 for review. Following a comment from the Chair that risks 16 and 19 had not been reviewed since February, it was agreed that this would be undertaken.	
	***Action*: Risk 16 and 19 had not been reviewed since February. The review date was May 2021. The risks would be reviewed.**	**FD**
	The Committee: - ***Considered and noted the corporate risk register.***	
QEC21/ 06/F2	**CQC and Regulatory Visits – including CQC Action Plan Update (Verbal)**	
	The Chief Nurse advised that the Trust had received a letter from the CQC asking several questions following the panorama programme that featured the previous month. The deadline for responses was 21st June 2021. It was noted that there was no flags within Insights. Sarah Dronsfield, Head of Hospital Inspection for the Yorkshire and Humber Region attended the Trust Executive Group the previous week who provided an excellent presentation on the role of CQC and how they seek assurance.	
	The Committee: - ***Considered and noted the update provided on CQC and regulatory visits.***	
QEC21/ 06/F3	**Quality and Effectiveness Committee Terms of Reference (Enclosure G3)**	
	The Committee: - ***Approved the Quality and Effectiveness Committee Terms of Reference.***	
QEC21/ 06/H1	**Governor Observations (Verbal)**	
	Lynne Logan commented in relation to patient experience, that there was likely a missed opportunity to understand patient expectation, as this affected their experience with the Trust and could lead to reasons why they make a complaint, and asked if it could be made clear upon admission what they should expect. The Chair noted that expectations were difficult to address. The Deputy Director of Nursing (Patient Experience) noted that this was picked up within pre-operative assessment and patient information.	

	Peter Abell noted that when a patient's name was called within Outpatients, they were often called out behind them, and this was often the first encounter you have with patients and could be linked to patient complaints with attitude and communication. Peter Abell commented regarding the issue with the timing of duty of candour letters, and the importance that colleagues were aware of the closure that this brings to patients/families. The Chair advised that a serious incident wasn't always declared immediately after an incident as further information and investigation was required. Peter Abell noted that duty of candour had been discussed for some time. Peter Abelll advised that prior to the COVID-19 pandemic, he had visited Maternity Services at Bassetlaw Hospital, and was shown an examination room that women presenting with a miscarriage were taken to, which used to be a store room, and asked for clarification if this had been changed. The Chief Nurse assured Peter Abell that the Early Pregnancy Assessment Unit had been revamped for those presenting prior to 16 weeks, and women pregnant over 16-weeks would attend the Maternity Unit. Peter Abell noted the great MAGNET4EUROPE study, and commented that this had been a good meeting.	
QEC21/ 06/I1	**Sub-Committee Meetings (Enclosure I1):**	
	The Committee noted: - ***Minutes of the Clinical Governance Committee – March 2021.*** - ***Research and Innovation***	
QEC21/ 06/J1	**Any Other Business (Enclosure J1):**	
	There were no items of any other business.	
QEC21/ 06/J2	**Update on National Patient Safety Strategy (Enclosure J2):**	
	The Committee: - ***Noted the update provided on the National Patient Safety Strategy (discussed as part of Item QEC21/06/C4).***	
QEC21/ 06/J3	**Minutes of the meeting held on 6th April 2021 (Enclosure J2)**	
	The Committee: - ***Noted and approved the minutes from the meeting held on 6th April 2021.***	
QEC21/ 06/J4	**Assurance Summary** The Committee was asked if it was assured, on behalf of the Board of Directors on the following matters. Any matters where assurance was not received, would be escalated to the Board of Directors: - Matters discussed at this meeting, - Progress against committee associated Executive's objectives,	

	- Divisional compliance with the Trust's risk management process		
	<u>The Committee were assured on behalf of the Board of Directors on:</u> - ***Matters discussed at this meeting. The Infection Prevention and Control Board Assurance Framework, and the Ockenden Report were to be presented to the Board.*** - ***Progress against committee associated Executive's objectives,*** - ***Divisional compliance with the Trust's risk management process. It was noted that open incidents remained an issue.*** ***The Committee did not take assurance from matters relating to the Ophthalmology serious incidents as discussed as part of item QEC21/06/A3i.This was escalated to the Finance and Performance Committee to receive an update on:*** - ***Wet AMD pathway*** - ***Admin processes in this area and concerns*** - ***Way forward for Backlog of Ophthalmology cases***		
QEC21/ 06/G4i	**<u>Date and time of next meeting (Verbal)</u>**		
	Date: Time: Venue:	**Tuesday 3rd August 2021** **13:00** **Video-Conference**	

FINAL

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

PEOPLE COMMITTEE

Minutes of the meeting of the People Committee
Held on Tuesday 6th July 2021 at 09:00am via Microsoft Teams

Present:	Sheena McDonnell, Non-Executive Director (Chair) Mark Bailey, Non-Executive Director Pat Drake, Non-Executive Director Kath Smart, Non-Executive Director (Left after item PC21/07/F1) Karen Barnard, Director of People and Organisational Development Anthony Jones, Deputy Director of People and Organisational Development Jayne Collingwood, Head of Leadership and Organisational Development Dr Tim Noble, Executive Medical Director (Left after item PC21/07/D1) David Purdue, Deputy Chief Executive & Chief Nurse (Left after item PC21/07/C4) Dr Sam Debbage, Deputy Director of Education and Research (Left after item PC21/07/C3)	
In attendance:	Fiona Dunn, Deputy Director Corporate Governance/Company Secretary (Left after item PC21/07/G2) Stacey Nutt, Deputy Director of Nursing (Patient Experience) (Item PC21/07/B2 – Left after item) Cindy Storer, Deputy Director of Nursing (Item PC21/07/C6 – Left after item) Kirsty Edmondson-Jones, Director of Estates and Facilities (Item PC21/07/C7 – Left after item) Hayley Findlow, Corporate Governance Officer Claudia Gammon, Secretarial Support Officer (minutes)	
To Observe:	Mark Bright, Public Governor – Doncaster Kay Brown, Staff Governor	
Apologies:	Alasdair Strachan, Director of Education and Research Marie Purdue – Director of Strategy and Improvement Susan Shaw – Partner Governor	
		ACTION
PC21/07/A1	**Welcome, apologies for absence and declarations of interest (Verbal)**	
	The Chair welcomed the members and attendees. Apologies for absence were given. No conflicts of interest were declared. The Chair advised that Sue Shaw, Partner Governor Observer was stepping down from the People Committee due to other commitments. A replacement Partner Governor Observer would be sought.	
	Action: A replacement Partner Governor Observer would be sought for the People Committee.	**FD**
PC21/07/A2	**Requests for Any Other Business (Verbal)**	
	There were no requests for any other business.	
PC21/07/A3	**Actions from previous meeting (Enclosure A3)** Actions closed – 1, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 16, 19, 21, 22, 23, 26.	

	Action 1 – Annual Leave – Although the action was closed, Kath Smart asked how the People Committee would monitor the carry through of annual leave. The Director of People and Organisational Development advised that the plan was to include quarterly updates within the Workforce Assurance Report. Action 2 – Workforce Assurance Report - Item on the agenda. Action closed. Action 3 – On call accommodation rooms – Item on the agenda. Action 15 – Staff Survey Feedback – You Said, We Did – Issues identified related to Covid-19, And communications would be circulated to colleagues following the 19th July 2021. The quarterly staff survey would commence in July 2021. Action 17 – Performance Assurance Framework – Fiona Dunn to obtain update from Julie Thornton prior to the next meeting. Action 18 – Workforce related Corporate Risks - The Director of People and Organisational Development had commenced the review. Further work to be completed. Action 20 – Free Text Comments from Staff Survey – Item on the agenda. Action closed. Action 24 – Escalation from Quality and Effectiveness Committee – This would be discussed as part of Item C2. Action closed. Action 25 – Escalation from Quality and Effectiveness Committee – The Chief Nurse would provide an update at next meeting. The target date was changed to September 2021.	
	Action: A quarterly update on annual leave usage would be provided within the Workforce Assurance Report.	**KB**
	The Committee: - ***Noted the updates and agreed, as above, which actions would be closed.***	
	Action: Claudia Gammon would update the Action Log.	
PC21/07/ A4	**Terms of Reference (Enclosure A4)** Training and Education Committee The Director of People and Organisational Development noted that the terms of reference narrative outlined that the Training and Education Committee would report to the Quality and Effectiveness Committee and Teaching Hospital Board. It was agreed that the Quality and Effectiveness Committee would be removed. The Executive Medical Director noted that the terms of reference did not stipulate that all staff groups were represented. Whilst the current Director of Education and Research was a doctor, this may not always be case as it wasn't a requirement of that role. It was important that the medical staff group were represented within the meeting. Workforce Planning	

	The Director of People and Organisational Development advised that the amendments included the inclusion of digital and a change of membership. In response to a question from Pat Drake regarding whether this group would be responsible for reviewing the workforce strategy, the Director of People and Organisational Development advised that this was the case. It was agreed that this would be included in the terms of reference.	
	***Action:* The Training and Education Committee terms of reference would be updated to remove that it reports to the Quality and Effectiveness Committee.**	**SD**
	***Action:* The Training and Education Committee terms of reference would be amended to include that the medical workforce were to be represented within the membership.**	**SD**
	***Action*: The responsibility for the review of the workforce strategy would be added to the Workforce Planning Committee terms of reference.**	**KB**
	The Committee: - ***The Committee approved the Training and Education Committee and the Workforce Planning terms of reference subject to the agreed amendments.***	
PC21/07/ B1	**Agile Working (Enclosure B1)** Agile working was described as 'The ability to work in the place and at the time most appropriate for the task in hand'. It had been discussed that due to Covid-19 working from home had become a normality for many. Karen Barnard discussed the benefits, risks, downsides to the future of working from home. The following key elements of the report were discussed. This included the key benefits of agile working for both colleagues and the Trust including that colleagues felt more productive, and it would widen the talent pool for the Trust. There were risks and downsides to agile working including the set up at home, isolation, motivational preferences and styles and the appropriateness of the role. The Director of People and Organisational Development advised that the future of agile working was unclear and would become more apparent after the 19th July. The next steps would include a review of the immediate approach to home working, the next 6-9 months and the future beyond of agile working. Pat Drake noted that the presentation gave a complex image and the widening of the talent pool of staff that work from home. Agile working could be beneficial to colleagues with a disability. In response to a comment by Pat Drake regarding accountability of working hours whilst agile working, it was advised that the staff would be expected to deliver outcomes – part of the research had been to find best practice in this area David Purdue asked for further information on risk assessments undertaken within the home of colleagues to ensure that it was suitable place to work. It was noted that further discussions were required on the employer and individual responsibilities. Kath Smart made comment that having meetings online also meant that there were zero carbon emissions and makes people consider if a meeting requires physical attendance or can it be conducted on teams.	

	The Chair agreed with this point and it was good to highlight this on the People Committee and would be a large piece of work.	
	The Committee: - ***Noted and took assurance from agile working paper.***	
PC21/07/ B2	**<u>Volunteers and Response Volunteers (Enclosure B2)</u>** The Deputy Director of Nursing (Patient Experience) provided an update regarding volunteers which highlighted that due to the COVID-19 pandemic, all volunteers were suspended from their duties in March 2020, following Government guidance. Since April 2021, the Trust had commenced the reintroduction of volunteers. It had previously been reported that patients' families and carers had experienced difficulties in contacting the wards to receive updates, and therefore the Trust had put a bid into NHSE with the idea of recruiting Communication Volunteers, who would be placed on wards with the ability to relay information to patients and help support virtual visiting. Whilst the recruitment process was successful, due to vaccination priorities within Occupational Health, the volunteers were not able to go through Occupational Health clearance as quickly as hoped. Prior to the commencement of Stacey Nutt in post as the Deputy Director of Nursing (Patient Experience), there was work ongoing to recruit Responder Volunteers, however due to the COVID-19 pandemic this was halted. Work was required to repackage the Trusts Voluntary Services, and this would include a review of the offer to those who wish to volunteer and the introduction of a Volunteering Strategy. The Trust was in partnership with St. Johns Ambulance and the NHS Cadet Scheme, commissioned as a pilot by NHSEI. In January 2022 the Trust would welcome 20 Cadets aged 16-18-years form a health inequality background for a period of 12-months. The Cadets would volunteer for 2-hours per month. Work would commence in September 2021 through engagement events with ward colleagues to identify what it was that they require from a Ward Volunteer. Recruitment would run alongside this. The Deputy Director of Nursing (Patient Experience) was working with the Education Department to promote volunteers within colleges. The Trust had 40 volunteers on site currently, from a pool of c.220. The 40 volunteers had been part of the vaccination programme and were undertaking the lateral flow testing as part of the NHS programme. Further work was required to recruit Volunteers at Bassetlaw, as there was only three Volunteers based there. A base was required for Volunteers at Bassetlaw. The Deputy Director of Nursing (Patient Experience) requested support from the People Committee to redesign voluntary services strategy and vision. The Chair noted the Committees support. The Deputy Director of Education and Research noted her support to the promotion of voluntary services as part of the widening participation programme, and further linking volunteering with work experience. Pat Drake suggested that an improved recruitment process seems appropriate, and the Trust had the opportunity to revise and refresh the strategy to support this. The Deputy Director of People	

	and Organisational Development advised that the recruitment of volunteers had not traditionally been undertaken via the central recruitment team, but the ambition was to centralise all recruitment processes and this review would provide the opportunity to refresh how the Trust advertises and attracts volunteers to the Trust. Kath Smart welcomed the refresh of the voluntary services strategy and the opportunity to attract younger volunteers, whilst ensuring that the Trust retains longer-serving volunteers through reward and recognition. In response to a question from Kath Smart regarding the potential of virtual volunteers, it was advised that the Deputy Director of Nursing (Patient Experience) was reviewing the Carers Strategy, because volunteers can play a crucial part for patients following discharge from the hospital. Further work was required to reaffirm partnerships with organisations that provide support following discharge from hospital. The Chair noted her support to the refresh of the Voluntary Services Strategy and asked for further updates on progress. The Chair noted that uniforms for volunteers had been discussed previously as a recognition for volunteers and the importance of the role. The Chair asked if there was an opportunity to link with the Princes Trust for further volunteering opportunities. The Deputy Director of Education and Research advised that she was working closely with the Deputy Director of Nursing (Patient Experience) and noted that uniforms relate to patient safety and ensuring that patients understand who colleagues or volunteers within the Trust were.	
	The Committee: - ***Noted the information provided on Volunteers and Response Volunteers.***	
PC21/07/ C1	**<u>Workforce Assurance Report (Enclosure C1)</u>** The Director of People and Organisational Development advised that work was ongoing with the Finance Department who hold the establishment data to identify the vacancy rate for the Trust. It was expected that this would be included in future reports. The Trust had three retirement seminars planned. There had been a high number of bookings with 75 colleagues booked to attend, the majority of which were qualified nurses, administrative and clerical staff, and nursing support workers. There had been a small increase in the number of staff testing positive for COVID-19. To date there had been 221 positive lateral flow tests results, of which 169 were confirmed COVID-19 positive following a PCR test. The appraisal season continued, and a further update would be required at the next meeting following the end of the four-month season. Pat Drake suggested that with fewer nurses taking the option of flexible retirement, that this be closely monitored. Pat Drake noted a discrepancy between the Workforce and Casework report in relation to the reported number of colleagues on long-term sick. It was requested that in future reports there be further detail on the reasons for long-term sick leave. The Director of People and Organisational Development advised that an analysis had been undertaken of colleagues on sick leave due to 'stress/anxiety/depression' and 'MSK' related illnesses to understand the length of sick leave.	

	Kath Smart requested information on how the People Committee would be assured of appraisals and absence management as it wasn't comprehensively covered within the Workforce Assurance Report. It was noted that as the report as part of item C5 included the majority of absence data, it had not been included in the Workforce Assurance Report. Efforts would be made to ensure that appraisals and absence management was reported at each meeting. The Chair noted that due to the Trust absence position, it would be helpful to see what support NHSEI would be able to provide with regards to anxiety and depression as the number of colleagues that had reported absence due to this accounted for almost a sixth of the workforce. In response to a question from the Chair regarding the skill level of managers to support colleagues on sick leave, the Head of Leadership and Organisational Development advised that managers and leaders were critical in the process to support colleagues on sick leave with anxiety and depression. Support had been provided to managers and leaders on how to undertake compassionate conversations, however further work was required. In response to a question from the Chair regarding the number of appraisals that had taken place during appraisal season, it was advised that each Division had been requested to submit a plan to ensure that all appraisals would be undertaken in during the appraisal season. This would then be followed up as part of the accountability meetings. In response to a question from Mark Bailey regarding the correlation between the areas with a low appraisal rate and a higher absence rate, the Director of People and Organisational Development advised that she was yet to review the analysis data of sickness absence, however it was likely that in clinical areas that there would be a correlation due to pressures.	
	<u>Action</u>: It was requested that further information relating to long-term sickness absence and the implications to be included in future reports.	**KB**
	The Committee: - ***Took assurance from the Workforce Assurance Report.***	
PC21/07/ C2	**<u>Recruitment and Retention including Workforce Planning Update (Enclosure C2)</u>** The Deputy Director of People and Organisational Development provided a comprehensive report on the key areas of activity ongoing relating to recruitment, education, and workforce planning. The first cohort of ten from the planned fifty international nurses were due to commence on 29th July 2021. There was an opportunity to work within an NHS Trust in Yeovil who had undertaken a successful international recruitment campaign for Radiographers. To date, the Trust had made offers for 27 newly qualified Midwives and 38 newly qualified Nurses. Thanks, were given to Kelly Turkhud, Vocational Education Manager who had contributed to the report from an educational perspective. The degree nursing course had been offered on a part-time basis. Due to some funding issues, the plan presented within the report would be amended and reported back to the Committee once updated. The workforce planning process flow chart was shared, and the Trust was planning the deep dive sessions for Divisions. It was noted that due to operational pressures, planning the sessions in was difficult. Further discussion was due to take place at the Accountability Meetings, however two of these had been cancelled due to operational pressures.	

	Following a question from the Director of People and Organisational Development regarding the low numbers of newly qualified nurses being recruited, which was different to the levels previously recruited, the Chief Nurse agreed that it was lower than normal, however the Deputy Director of People and Organisational Development advised that the figure had not yet been confirmed, however the Trust had received an increased number of international nurses. The Deputy Director of Education and Research noted that the Trust had many routes for professional careers and noted that the Trust was one of the leading Trusts in England. There were part-time routes in place with DN Colleges. Pat Drake noted that it was important that areas such as Radiology and Diagnostics were included in the workforce planning work as that was where tensions were. Pat Drake noted that she was surprised that Theatres were not included as an area that required support as part of the workforce planning. In response to an assurance request from Pat Drake, regarding the baseline staffing was accurate, the Chief Nurse advised that all budgets had been signed off, with the exception of paediatrics which was being finalised. Work was ongoing with enhanced care, which would likely lead to a business case requested at the Capital Investment Group. Kath Smart noted that the Chief Operating Officer had previous advised as part of the training and development plan for administrative and clerical colleagues, that there would be cohort recruitment to take place. The Deputy Director of People and Organisational Development advised that the work had not yet commenced for this yet. Kath Smart noted that no update had been provided relating to the extreme risk detailed on the corporate risk register relating to staff shortages for Consultant Intensive Care, it was advised that the Deputy Director of People and Organisational Development had been asked to present a report to the Trust Executive Group to outline a case for funding for international medical recruitment. Updates would be included in future reports. In response to a question from Mark Bailey in relation to the number of patients that the Trust was unable to see due to the number of vacancies, it was advised during the workforce planning pilot within Ophthalmology, work was undertaken to identify staff shortages, activity, waiting times and how that impacted on the service that was provided. Alternative patient pathways were considered and this informed decision making on the staffing model going forward. Although this work was halted due to the COVID-19 pandemic, this work would be picked up as part of the new process. In response to a further question from Mark Bailey regarding the operational pressures that were preventing Divisions from planning the deep dives, then the vacancies causing operational pressures needed to be a priority. The Chief Nurse advised that the base establishments for wards were established and when discussions took place regarding opening of beds, it related to the opening of additional beds in each ward, as part of the process of flexible beds. It was confirmed that the base capacity was not restricted, however this was managed on a daily basis to ensure that capacity levels were safe. This was further managed with the use of bank and agency staff. *David Purdue left the meeting.* Following a request from the Chair for further information on the ambitions to centralise recruitment, the Deputy Director of People and Organisational Development advised that the Executive Team supported this, and this had been successfully piloted within the Finance Directorate. This allowed for the identification of the resource that would be required to	

	centralise a further two thirds of the Trusts recruitment into the central team. Following a benchmarking exercise within the region, it had been identified that the Trust had a much smaller recruitment team than other Trusts did for the level of recruitment that the Trust undertook. There had been a high turnover of staff within the Recruitment Team. The Director of People and Organisational Development advised that individuals within Divisions that undertook the recruitment administrative tasks and other HR type tasks, would still have a proportion of their duties required within the Division and therefore a challenge was how that transition would be managed. The Chair noted that the ambition to recruit people as a local employer should be improved, and that the People Committee would support where possible. The Deputy Director of People and Organisational Development advised that he would provide a report of the projects being undertaken currently at a future meeting. In response to a question from the Chair regarding the receipt of the KPMG report and the robustness of the workforce planning process, it was advised that a meeting would take place with KPMG to receive further information on the workforce planning tool. Work was underway within Place to look at pathway and workforce planning.	
	The Committee: - ***Noted and took assurance from the Recruitment and Retention including Workforce Planning Update.***	
PC21/07/ C3	**<u>Education Assurance Report (Enclosure C3)</u>** The Deputy Director of Education and Research advised that there should be an improvement in resuscitation training compliance as training was now underway in a larger space to increase the numbers that could attend training. The overall statutory and essential training (SET) compliance was reported as 87.03%. Pat Drake requested assurance that there was always a member of staff compliant with resuscitation training on shift within the paediatric and maternity departments. The Chief Nurse advised that this was a requirement within the electronic roster system to ensure that there would be someone trained at all times. In response to a question from Kath Smart regarding any intelligence from other Trusts regarding ways that SET compliance could be improved and the view of the CQC, it was advised by the Chief Nurse that the CQC continued to review training compliance, and it was expected that other Trusts were in a similar position. The CQC had requested information on training levels, and this had been submitted alongside the action plans to deal with levels that were lower than required. The Deputy Director of Education and Research advised that in relation to other Trusts within the SYB region, the Trust benchmarked well for resuscitation training.	
	The Committee: - ***Noted and took assurance from the Education Assurance Report.***	
PC21/07/ C4	**<u>Health and Wellbeing Report (Enclosure C4)</u>** The Head of Leadership and Organisational Development provided an overview of the report which included that the Health and Wellbeing Committee undertook an NHS Workforce	

	Wellbeing diagnostic framework which was a useful exercise to identify the key enablers of the health and wellbeing offer and area where further effort was required. This related to building self-resilience and making healthy lifestyle choices. An update was provided on the current wellbeing initiatives which included the well-received Reiki interventions and the Climbing Out Charity Partnership. The Wellbeing Champions continued to work effectively in operational areas to signpost and promote wellbeing across the organisation. The Wellbeing Team were working with architects to explore the possibility of creating an additional space for a 'garden room' where more treatments and therapies could be offered to support and enhance the wellbeing offer. The Wellbeing Team continued to work in partnership with Andy's Man Club to encourage male colleagues to talk and access support to help them deal with any challenges they have. In response to Kath Smart's question regarding the access time for colleagues to receive intervention help, it was advised that colleagues that access the 24/7 helpline were all assessed within seven days. In response to a question from Kath Smart regarding the need for staff break areas, it was advised that further break areas were required, and that the marquee at DRI could be used more efficiently. The Head of Leadership and Organisational Development advised that clear domes had been implemented at Bassetlaw, to create a safe place for colleagues to have a break. Kath Smart noted that there were only three tables within the marquee at the DRI site, and therefore the Director of People and Organisational Development advised that she would look into this. Mark Bailey noted his appreciation on the improvements made as part of the health and wellbeing agenda to date, however asked what the key actions were as part of the People Plan for the next 12-months. The Head of Leadership and Organisational Development advised that she wished to strengthen the link between occupational health and the wellbeing teams as an integrated service, however a specific plan was required to look at the priorities for the next 12-months. In response to a question from Mark Bailey regarding the use of charitable funds for some of the wellbeing offers outlined within the report, it was advised that additional funding had been secured from the South Yorkshire and Bassetlaw Hub for additional complimentary therapies. The price for the garden room was expected imminently. The Director of People and Organisational Development advised that further work was required to identify what additional resources were needed and how funding would be accessed.	
	The Committee: - ***Noted and took assurance from Health and Wellbeing Report.***	
PC21/07/ C5	**<u>Review of Case Work Data (Enclosure C5)</u>** The report was taken as read. In response to a question from Kath Smart regarding the length of time that some of the cases had been open for, it was advised that timescales were regularly reviewed, however it was advised that the production of the data presented was a timely process, which led to the decision to purchase a casework data management system to assist with this and improve the quality and detail of reports. Feedback had shown that the case work process was too long, however work was underway to try to reduce the administrative requirements such as organisation of dates in advance for appeals.	

	Following a question from Pat Drake regarding how the Trust assists managers in dealing with cases, and whether a good practice guidance would be beneficial, it was advised that case reviews were undertaken following each case to identify learning, and the policy had been reviewed to ensure it aligned to the just culture work, however work was required to ensure that managers understood the changes to the policies. In response to a question from Pat Drake regarding the number of anonymous complaints received and how these were dealt with, it was advised that proactive work was undertaken to encourage people to advise of who had raised complaints as it was difficult to provide feedback to complainants. It was noted that efforts were made to triangulate information from an anonymous complaint. In response to a question from the Chair regarding the update of the disciplinary policy as outlined the NHS Chief People Officer as a requirement of all Trusts by March 2021, it was advised that the review of the policy had to be undertaken in conjunction with Staff Side. The Director of People and Organisational Development assured that although the policy had not yet been reviewed, the report presented to the Committee included the detailed work being undertaken to support this.	
	The Committee: - ***Noted and took assurance from the review of the case work data.***	
PC21/07/ C6	**<u>Staff Claims (Enclosure C6)</u>** The Deputy Director of Nursing (Patient Safety) advised that there had been 111 Liabilities to Third Party Scheme claims made against the trust between 1st April 2017 and 6th June 2021, ninety of which were Employer Liability, and twenty-one Public Liability. There were 32 claims closed during the period 1st April 2020 and 31st March 2021, 27 Employer Liability and 5 Public Liability. The first £10,000 of Employer Liability Claims and £3,000 for Public Liability Claims. An action plan had been set for the 28th July to include a pilot for dementia patients. The Chair raised if the work plan could be changed from every 6 months to every 12months which was agreed.	
	The Committee: - **Noted and took assurance from the Staff Claims paper.**	
PC21/07/ C7	**<u>Accommodation Progress Update (Enclosure C7)</u>** The Director of Estates and Facilities shared a presentation with the committee and gave a detailed update on both the accommodation within the Trust and privately rented. There were currently 243 rooms split over DRI and Bassetlaw, with no rooms at Montagu. However, 90 of these we were not available for use due to Covid-19 and social distancing requirements. After the 19th July the room usage would increase to the full capacity. The standards were different for medical students. The Director of Estates and Facilities added that a discussion would take place between herself, David Purdue and Ken Agwuh to discuss the standards.	

There was a requirement to significantly invest in Lister Court and D Block Accommodation at DRI. These units of accommodation had been reviewed against the following standards to support future planning:

- Government Decent Homes Standards
- Government Fit for Human Habitation Act
- Governor How to Rent a Safe Home

The Director of Estates and Facilities explained that the old Silks restaurant within DRI had been converted into a Doctors Mess rest area with a kitchenette after a £200,000 investment. The standards were significantly increased. Sleep pods were also to be introduced, 2 at the DRI, 1 at Bassetlaw and 1 at Montagu for Doctor who require a rest. The sleep pods were similar to a flight bed, having a visor for darkness, ability to play music, timer and provide comfort.

The Director of Estates and Facilities discussed that we were using Club Properties to locate rentable properties for our overseas staff. They were within a small quarter and were within walking distance of DRI. The properties were modern, high standard, all staff received a welcome and care package in their new home. We do rent some of these properties privately if required. The accommodation policy sits under Estates and Facilities in which there was a point system, highest points were allocated to the overseas students and the lowest points for private residents within the area. The tenancy terms were either 3, 6 or 12 months. We have 5 cohorts of staff that would arrive from India and would all require accommodation.

A business case would be reviewed on Friday 9th July Estates and Facilities Committee, this would then go to the Corporate Investment Group on the 26th July.

In response to a question from Kath Smart regarding how staff would benefit and what would happen with Lister Court, it was advised that Club Properties provide a service in which the accommodation would be fully furnished. It was possible that Lister Court would be demolished as it wasn't fit for usage.

Following a request from Kath Smart regarding the Committee that accommodation updates would be provided, the Director of Estates and Facilities advised that the best place currently would be the Finance and Performance Committee. The Chair advised that a discussion would take place to confirm the right Committee for this to be reported to.

Mark Bailey observed that if we put more pastoral care towards our overseas staff when they first arrive then this would be more cost effective in the long term and save on re-recruiting. He advised that other trusts welcome their staff at the airport and continue with pastoral care after the initial joining with the trust. It was advised that Kirsty Edmondson-Jones and Anthony Jones would discuss this further.

The Medical Director thanked and fully supported this explaining that due to Junior Dr's having short contracts it was difficult to find accommodation. He supported the Sleep Pods and felt they were a benefit to the trust.

Following on from an observation raised by Pat Drake regarding Visa's it was noted that the Visa was linked to the job and cannot be moved. Pat Drake also advised that the overseas staff would find their own links as a lot were from Kerala, India.

Jayne Collingwood would discuss with Kirsty Edmondson-Jones if sleep pods were to put into the Emergency departments.

	The Chair agreed that she supported the future plan for the accommodation and believed it would help with student retention. Following a question from the Chair it was established that there was no one living in the accommodation at Lister Court.	
	The Committee: - ***Noted and took assurance from the Accommodation Progress update***	
PC21/07/ D1	**<u>Job Planning (Enclosure D1)</u>** Following the internal audit report on job planning which received 'no assurance', the Medical Director presented the action plan place to meet the recommendations from KPMG. The main issues identified were that the Trust did not have a centralised file of all job plans which would be mitigated through the introduction of electronic job planning within Allocate. There was a lack of clear annual review process, which would be resolved by a number of actions. The Trust was expected to publish a procedure guide to assist colleagues within job planning. Following the initial analysis, it had been identified that the policy was in line with NHSE/I best practice, however the Local Negotiating Committee (LNC) would not agree following two-years of engagement. A Job Planning Consistency Committee would commence, the terms of reference were being written. The existing job planning template was inadequate which led to some data not being captured. Standards of business conduct were held elsewhere in the Trust. The timeline for completion of the actions was presented. The key risks to delivery included the available staffing resource to deliver all of the requirements to meet the recommendations, the additional administrative resource required was not yet in post, recruitment was ongoing for the Medical Director workforce and the LNC had not approved the current job planning guidance and therefore posed a risk that approval would not be achieved within the timescales presented. In response to a question from Pat Drake regarding the reasons for non-approval of the job planning policy by LNC, it was advised that this was due to the allocation of supporting professional activities and an expectation that some were paid for, and challenges around administrative time. In response to a question from Mark Bailey regarding the support required to meet the recommendations, it was advised that the Executive Medical Director would receive some project planning support, however it was noted that wider support was required. Following a question from Kath Smart, regarding the achievement of the actions The Executive Medical Director advised that things had progressed. Kath Smart suggested that it be agreed how the follow up of the project plan would be reviewed. The Audit and Risk Committee would ensure that the actions had been completed, however the People Committee would need to receive ongoing assurance and updates on progress. Following the review of progress against actions at the Audit and Risk Committee in October 2021, if sufficient progress had not been made, the matter would be escalated to the People Committee for further review.	
	<u>Action</u>: Following the review of progress against actions at the Audit and Risk Committee in October 2021, if sufficient progress had not been made, the matter would be escalated to the People Committee for further review.	**KS**

	The Committee: - ***Noted and took assurance from the Job Planning update.***	
PC21/07/ E1	**<u>People Plan Update (Enclosure E1)</u>** There were no questions raised.	
	The Committee: - ***Noted the People Plan Update report.***	
PC21/07/ F1	**<u>Emergency Department Organisational Development Update (Enclosure F1)</u>** The Director of People and Organisational Development provided an update that highlighted that next steps would include a review of the progress that had been made and the benefits that had been achieved from this. The Director of People and Organisational Development advised that she would meet with the Senior Leadership Team within the Emergency Department to discuss how this programme would be taken further forward. Kath Smart welcomed the review of what the next steps would be as part of the programme and how the good work would continue. Kath Smart noted that to date, the backfill pay for colleagues in the Emergency Department to undertake had not been utilised however noted a significant risk discussed at the Board of Directors meeting and the Finance and Performance Committee relating to the increased attendance seen within the Emergency Department and suggested that this message be reinforced to ensure that the organisational development work would continue through the pressures. Pat Drake was supportive of the review and would like to see a formal exit strategy agreed with the Emergency Department Team regarding how much further support they would receive from the central team and how they would take ownership to lead this into the future.	
	The Committee: - ***Noted the update provided on the Emergency Department Organisational Development Update.***	
PC21/07/ G1	**<u>Board Assurance Framework – True North SA 2 & 3 (Enclosure G1)</u>** The Committee reviewed the Board Assurance Framework aligned to the True North Objectives 2 and 3.	
	The Committee: - ***Noted the Board Assurance Framework.***	
PC21/07/ G2	**<u>Corporate Risk Register (Enclosure G2)</u>** The Company Secretary outlined that there had been no additional risks to the corporate risk register. For assurance the Trust risk managed the process, and it was being followed. There were no new corporate risks added or escalated from Management Board. There were 122 risks logged	

	rated 15+ within the Trust, fourteen of these risks were currently monitored via Corporate Risk register (CRR)	
	The Committee: - ***Noted the Corporate Risk Register.***	
PC21/07/ I1	**Governor Observations (Verbal)** Kay brown observed if there was anything that could be done to assist with the Accommodation report and how much was required and the quantity. The Director of People and Organisational Development explained that they were clear about what was required and how much it would cost. Mark Bright also observed and supported the sleep pods in that they were good for Health and Wellbeing. He had mentioned that Junior Drs should be trained in mindfulness techniques. The Head of Leadership and Organisational Development added that this could be promoted via the Facebook page. Mark Bright also mentioned that the sleep pods would be useful to have in the Emergency Department. The Chair confirmed this was something that would be looked into.	
	The Committee: - ***Thanked the Governors for their observations.***	
PC21/07/ J1	**Minutes of the Sub-Committee Meeting (Enclosure J1)**	
	The Committee noted: - ***Equality Diversity and Inclusion Forum Minutes dated 26/04/2021,*** - ***Health and Wellbeing Committee Minutes dated 19/04/2021.***	
PC21/07/ K1	**Any Other Business (Verbal)** There were no items of any other business.	
PC21/07/ K2	**Minutes of the Meeting held on 4th May 2021**	
	The Committee: - ***Approved the minutes of the meeting held on 4th May 2021.***	
PC21/07/ K3	**Items of escalation to the Board of Directors (Verbal)**	
	There were no items of escalation to/from: i. People Sub-Committees ii. Board Sub-committees iii. Board of Directors	
PC21/07/ K4	**Date and time of next meeting (Verbal)**	

	Date: Tuesday 7th September **Time: 9.00am** **Venue: Microsoft Teams**	
	Meeting closed at 12.40pm.	

FINAL

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

TRUST EXECUTIVE GROUP

Minutes of the meeting of the Trust Executive Group
Held on Monday 12th July 2021 via Microsoft Teams

Present:	David Purdue – Deputy Chief Executive and Chief Nurse (Chair) Marie Purdue – Director of Strategy and Improvement Dr Tim Noble – Executive Medical Director Rebecca Joyce – Director People, Organisational Development Mr Eki Emovon - Divisional Director, Children and Families Ken Anderson – Chief Information Officer Kirsty Edmondson Jones – Director of Estates and Facilities Dr Jochen Seidel (JSe) – Divisional Director, Clinical Specialities Emma Shaheen – Head of communication and Engagement (Left at 4pm)	
In attendance:	Fiona Dunn – Deputy Director Corporate Governance / Company Secretary Dr Sam Debbage - Deputy Director of Education and Research Omar Hussain - Clinical Director Surgery Dr Anurag Agrawal - Clinical Director Endoscopy and Gastro Abigail Trainer - Director of Nursing Anthony Jones - Deputy Director P&OD Hayley Findlow - Corporate Governance Officer (Minutes)	
Apologies:	Richard Parker MBE – Chief Executive Ms Antonia Durham–Hall – Divisional Director, Surgery & Cancer Division Alasdair Strachan – Director of Education and Research Dr Nick Mallaband – Divisional Director, Medicine Karen Barnard – Director People, Organisational Development Jon Sargeant (JS) – Director of Finance	
		ACTION
TEG21/07/A1	**Welcome and Apologies for Absence (Verbal)**	
	The Chair welcomed the members and attendees. Apologies for absences were noted	
TEG21/07/A2	**Matters Arising / Action Log**	
	Updates were received on actions: **MB14/10/5** Action 1 ICS update Pathology - The Chair advised the group that at the Acute Federation meeting on Monday 5th July 2021, that following a scoring exercise the second Clinical Service Lines (CSL) would be agreed at the Committee in Common meeting on 2nd August 2021. Histopathology frozen sections work would stay within the local Trusts. Histopathology would remain within the Trust, and the debate about two labs moving into one at the Sheffield campus at either Royal Hallamshire or the children's hospital was yet to be agreed.	

	The Divisional Director, Clinical Specialities gave an update on the Locum who was coming from STH for two weeks. This was still going ahead as planned and the in-house team were looking at it in a favourable way. The Director of Strategy and Improvement updated that the Pathology Transformation Manager, Sarah Bayliss was leaving her role and her replacement was currently out for advert. **MB21/04/A2i** Action 2 New Speciality Doctor – The Deputy Director P&OD updated that all staff that this had impacted on had been written to with an outline of the options and criteria that needed to be met so that they could move across onto new contracts. There are a couple of terms and conditions surrounding annual leave that still needed checking. **MB21/04/B2** Action 4 Terms of Reference for the Trust Executive Group – The Chair advised the group that the Terms of Reference was an item on the agenda. **MB21/04/B3** Action 5 Division/Directorate Quality Framework – The Chair updated that this would be discussed at the Executive Team meeting on the 21st July 2021. **TEG21/05/H1ii** Action 7 Agency Rates – The Deputy Director P&OD updated that work had been undertaken and had highlighted some inconsistencies with the pay rates The Chair added that work was in progress at NHS Professionals (NHSP) surrounding standardisation of rates for bank staff, as they all vary with some staff being paid more than the Sheffield Teaching Hospital (STH) rates. This came from the Theatre staff who were paid more than the standard theatre staff rate. The Deputy Director P&OD added that work was continuing around diagnostic and radiograph agency rates and was being to fed into the working group. Actions closed: 3 & 6.	
	The Committee: - ***Noted the updates and agreed, as above, which actions would be closed.***	
	Action: Hayley Findlow would update the Action Log.	
TEG21/07/ A3	**Conflict of Interest (Verbal)**	
	No conflicts of interest were declared.	
TEG21/07/ A4	**Requests for any other business (Verbal)**	
	1. The Director of Estates and Facilities – to discuss car parking at Spring Wood car park. **2.** The Chief Information Officer – to pick up on the Cyber security issues that were happening across the Trust. **3.** The Divisional Director, Clinical Specialties – asked for clarification about the capital for equipment, how its allocated and the process for this.	

TEG21/07/ B1	**Bassetlaw Emergency care village (Enclosure B1)**	
	The Director of Strategy and Improvement gave an update and shared a slide presentation on the progress of the new Bassetlaw Emergency Village. Work had been completed on the governance structure, stakeholder engagement; with workshops for staff, communities, GP's and other local organisations as well as with other Independent Health Provider (IHP) partners. Site visits had commenced on the existing buildings to evaluate the constraints and opportunities. An Integrated Design Process (IDP) feasibility study had started to identify options available. The planning data had been modelled to evaluate space requirements and to see if it meets the clinical demand. There had been a production of schedule of accommodation options and with everything added the cost modelling based on historical and projected costs were coming over the agreed amount the funding of £17.6 million. Originally the case was written for £17.6 million and submitted to NHS/I. It can be used as a strategic outline case but it would still need an OBC (Outline Business Case) and FBC (Full Business Case) and was noted that there wasn't any room for obtaining more funding. So having clear expectations is important. The purpose of the capital investment was to co-locate paediatrics on the Emergency Department (ED) as the children's ward had been closed for a number of years, meaning that a number of services could still run with the paediatrics nurses in ED. The benefits to the case would see potentially different modules for paediatrics, with an observation area that would be a 23-hour unit. With children and young people that needed more care, being transferred to Sheffield and Doncaster hospitals. A number of things were factored to try and make this venture a value for money (VFM) case: - Removal of emergency overnight transport. - Potential operational efficiency with the Assessment Treatment Centre (ATC). - Looking at how to utilise beds. - A reduction in portering services, due to colocation of services - A reduction in utilities on floor space area that was 2645 m2. There were a number of critical success factors: - Improve the space and conditions in the ED for patient dignity and experience. - Improved staff morale, productivity and ownership of the care that they deliver. - Reduction in the travel distances for patients. - Increased ability to share learning and best practice. - Increase in the Trust to achieve its Carbon Reduction targets. This needs to make sense for the VFM and to get approval by the NHS/I. It has been approved to go to the Outline Business Case, but it still needs clarification. An discussion was had on adjacencies and which teams need to be next to each other. The co-location of ATC and Frailty along with ED and Paediatrics. Where the waiting areas need to be, where the seating areas need to be along with Same Day Emergency Care (SDEC). The other areas that need to be adjacency would be the staff changing room, rest areas and Doctors on call areas.	

	Option 1 - was more of a refurbishment option, but there would be challenges with regards to mental health area. Moving this would mean that the works being carried out wouldn't have an impact on the patients attending. The layout would be restricted because of existing services and structure but in the long term areas could be reconfigured. Option 2, which was the preferred option and consists of an extension built on to the front of the existing hospital. It means that the Children's ED department, ATC and resuscitation would be in the same adjacency areas for nurses to work in each department. The space around SDEC and Primary Care could be utilised more effectively using more of this department for consultation rooms. The Senior Manager for Estates and Facilities, Mr Andy White, is working with the contractors to see what space was available. However this takes the new build over the amount that had been allocated, so a few more options need to be considered. The provisional milestones and moving towards an OBC which would need to be developed by the beginning of December 2021. Before this a pre consultation case around paediatrics would be undertaken with the Clinical Commissioning Group (CCG) as they are responsible for speaking to the public about the potential new model. Once the OBC has been finalised in December there would be another three months to pass the case through the NHS/I and Council of Governors (CoGs) to allow it to move to stage three and to an FBC. By August 2022 and September 2024, the actual building work would commence. The next steps were: • to review the enclosed information and accept that option two as the preferred way of moving forward. • to agree a draft programme • to make a potential name change from Bassetlaw Emergency Village. The Divisional Director, Clinical Specialities asked whether there was a plan regarding space that ATC would vacate, particular around surgery and planned services at Bassetlaw outside the ED set up. Option 2 would also eradicate the car parking spaces from the front door and would this have an impact on the car park spaces lost? The Director of Strategy and Improvement acknowledged that the vacated space hasn't any fixed plan at the moment. There was an opportunity to increase more elective surgery, more space for potential service lines and utilise the mental health block upstairs. The car parking would need further investigation to make sure that patients attending the hospital would be able to park as close as they possible could. A further look as to how the ambulance flow could be altered and maybe if the consultant car park could be utilised for a patient car parking. The Director of Estates and Facilities added that there was sufficient car parking opportunities on site and a few buildings that were standing empty have now been demolished, so this would enable to re provide the lost car parking spaces, but this hasn't been designed as yet. The costs would need to be factored into the overall amount. The Chair made a valid point that ATC was a great ward and it would need further investigation for where it would be and the flows for surgeries. Conversations had commenced to move to endoscopy, it would have a cost implication but would be nearer to theatres to make it more	

	efficient. This would be discussed at great lengths at the Trust Executive Group in September 2021. The Divisional Director, Children and Families asked if the mental health housing in option 2 was already incorporated into the plan? The Director of Strategy and Improvement explained that it was incorporated into the plan and the area was to be used and at what cost to refurbish it. There were conversations on going as to the timescales to vacant the bottom floor and what can be put in there. SDEC / Primary Care may fit in better as at the present its consultation rooms and the refurbishment would be minimal. Other issues would be line of sight and how it was going to be staffed. Staff areas, staff changing facilities and staff rooms could also go in the area and there had been some good engagement from Medicine and Women's and Children's departments to help understand what was important to them. The Deputy Director Corporate Governance / Company Secretary asked if they had been any plans to bring basic diagnostics nearer to the area, particularly from a pathology point of view with regards to testing? The Director of Strategy and Improvement replied it was in the initial discussions, but the money was set at £17.6 million and this wasn't in the final costings. The Divisional Director, Clinical Specialities made a valid point regarding radiology and the wait times, travelling and the portering times and if point of care test that can be done. Option two was realistic and more Value for Money on the return of investment and capital. Co-location of staff and teams and being able to provide overnight care for children is key. It would be hard to bring it in under the £17.6 million. The estimates that have been received have taken it over the predicted amount and a more proactive approach on what to do with the existing mental health area. Conversations with the CCG and the Primary Care Network (PCN) regarding having a small ED department for the amount of people it serves. The Chair made it clear that this case was first put together two years ago without any scope for increase in inflation or any COVID related issues. So, what seems to be exciting news that the bid had been agreed, it was formulated on costs from two years ago. The key difference of option one to option two was the co-location of areas to sit beside each other to make it easier to utilise staff and services. The Director of Estates and Facilities added there was no scope to revisit the figures to add extra for inflation. It would be a challenge to get the work done with increasing costs due to the pandemic on a bid that was now two years old.	
	<u>Action .</u> • work continues with project group.	
	The Committee: - ***Noted the update on the Bassetlaw Emergency Village.***	

TEG21/07/ B2	**<u>Service Line Assessment & Clinical Strategy review steering group (Verbal)</u>**	
	The Director of Strategy and Improvement updated that the Service Line meetings have been removed from the diaries with the Divisional Directors prior to TEG. SL Assessment was to be a standing agenda item on Trust Executive Group and would be monitored through the service line review. There was a staff change at the present so there would be no meetings for a while longer until the new recruit had had time to settle into to their new post. The model at Bassetlaw would be reviewed in September and in future meetings a review on Montagu.	
	<u>Action</u>: • ***Hayley Findlow would update the Standard agenda***	**<u>HF</u>**
	The Committee: - ***Noted the update on the Service Line Assessment and Clinical Strategy Review.***	
TEG21/07/ C1	**<u>Operational Update Including Elective Restoration and Accelerator Programme (Enclosure C1)</u>**	
	The Director People, Organisational Development referred to the slide presentation in the PDF Portfolio and gave an overall demand picture for COVID infection levels, the demand for Emergency attendance. Emergency admission remains high both locally and nationally across each Trust. There had been a slight increase with COVID in patients roughly 15/18 patients at one time. When the last of the restrictions end on the 19th July there is an expectation to see an increase on those numbers. The attendance in ED was significantly greater than pre COVID levels and the social distancing rules in the department was delaying treatment and having staff implications. With the Elective Plan , the Trust was judged on a proportion of 19/20 return with the plan for June , to deliver 84% and 87%, was delivered. The benchmark picture around the North East and Yorkshire was that a number of providers had restored 100 % of their elective activity and this had been done by insourcing some of the sessions through the independent sector. As members of the accelerator program, there is monies to support efforts for elective restoration and insourcing. The Trust faces staff challenges and has been realistic about what additional activity can be done on site. The next part was about transformational pre assessment and there was a plan to look at what a Bassetlaw hub would look like for some of the Elective procedures. Lastly there was work being done across the region to see what could be done differently in a number of specialties by collaboration. It was highlighted to the group that there was great progress on reducing cancer waits. The cancer team were on track with their reduction of over 60's to two day waits and that was the best in South Yorkshire and Bassetlaw areas. The 52-week waiters had also been reduced with figures showing that from mid-March there were 2500 thousand down to 1200 three months later.	

	Key risks in Radiology show that there is a short-term capacity plan to support the reduction in the backlog and engagement with intensive support team to support the department to get a longer-term plan together. There's lots of focus on the Winter plan and what it would look like, with the move to increase paediatric capacity which took place at the end of June 2021. The Trust needs to build on the outputs of the winter plan to increase bed capacity and give further opportunities to improve discharge lounge. There would be a significant challenge for paediatrics and all the teams involved with Respiratory Syncytial Virus (RSV) possibly being a significant challenge with the bed base of 25 beds. Changes to the Elective Restoration (ER) reference criteria by which the Elective fund was sent out to Trusts was currently 85% for 19/20 activity levels, in value terms that had now been increased to 95% from the end of July 2021. To access the additional monies through the tariff incentive fund, the base line position that the Trust has to deliver was 95% rather than the previous 85% and there isn't any addition funding for the extra 10% workload. The criteria around Health and Equalities regarding waiting list and clinically validation would be much tougher from the guidance set out by NHS England (NHSE) The Clinical Director for Endoscopy and Gastro referred to collaborative working and how we can support each other for example endoscopy there was a huge backlog of 2000 patients, general surgery had 1500 new patients that would need to be seen in the future. This would then put more pressure on the endoscopy services and was there a way that we can work with radiology to support endoscopy to reduce the waiting times. The Director People, Organisational Development answered by saying that there was a regional speciality endoscopy workshops coming up and from the Foureyes and T&O workshops there had been more support to enabling patients to move around the sector. The Divisional Director, Clinical Specialties said he didn't know how he could upscale capacity in radiology diagnostics at this time. There was currently a pinch point in Interventional Radiology (IR) when someone was unavailable for a short but important time and staff would have to concentrate on IR work and drop diagnostic in favour of the interventional side. The long-term effects of CT Colonography (CTC) was the better test for some patients and from a quality point of view it was desirable, but not in terms of capacity. Over the next 3/6 months the emergency workloads would have to be prioritised over planned activities. Patients would have to be relisted and if they were category 3 or 4 in surgical cases, they may be stood down again. The isolation period that takes staff away from the hospital was combined with an increase in patients needing care, which then reduces the services that can be provided. If there was a third wave and an increase in hospitalisations in paediatrics along with the staffing issues respiratory support could be needed for children then there was no capacity for the elective workload to go forward at the current rate. The Chair responded that there was a massive spike expected in Paediatrics from August 2021 onwards with a view that adult intensive care would be used for children from the age of 12 upwards.	

	The Chair asked the Clinical Director Endoscopy and Gastro if they were to starting screening services yet? The response was that screening had started a few months ago, but the threshold age for screening had been lowered from 60 to 75 to 55 and this would put more pressure on endoscopy team to carry on with the screening along with trying to get through the backlog on the elective work. The Director People, Organisational Development stated that the "theatre module" from October 2021 would be for a short time a backup for women's theatres due to the fire works. There would be other times that it isn't needed so more of an opportunity to reduce the backlog when it isn't in use. This would mean recruiting staff for longer periods of time to work theatres or potentially endoscopy and it's an option to consider. At the Foureyes meeting there had been more desire for supporting others and looking at the 52-week profile which shows that different organisations were challenged by different specialises and whether some gynaecology staff could support in other areas under the same specialised area. The Director of Strategy and Improvement updated on the Community Diagnostic Hubs (CDH) and that the Trust has got the agreement on the temporary CT scanner and MRI, but it was whether there were available. The feasible way of this happening was to get staffed models onsite at Mexborough, for the additional endoscopy capacity with the RDC build. A business case was currently been worked on for October 2021, but again the challenge was staffing. The Chair concluded that the changes to the Elective Recovery Fund (ERF) would make things more challenging as we start to move forward. The Director People, Organisational Development reminded the group that the key next step and focus point was to make sure that the Winter plan options were ready.	
	The Committee: - ***Noted the update on the Operational Update Including Elective Restoration and Accelerator Programme.***	
TEG21/07/ E1	**<u>Finance Update (Verbal)</u>**	
	The Chair gave a financial update on behalf of The Director of Finance. The June position was good and that pay was overspent. The biggest issues were H2 from October onwards. Discussions took place on the H2 and what it potentially could mean. There would still be a block contract for the second half of the year but not very much detail in what that actually meant. The Trust is on a block currently with H2 with a reduction of 3% in the second half block of the year. The biggest challenge was around the ERF which would increase to 95% at the end of tariff for elective activity and there was a view that COVID funding may also be tapered unless there was a significant new wave. No planning guidance as yet until September 2021 with the planning guidance for the rest of year being at the end of December 2021. This would have significant impact on our current spend and expenditure and the group would be updated as soon as the figures were available	

	The Committee: - ***Noted the Finance update.***	
TEG21/07/ E2	**<u>Consultant Vacancies (Enclosure E2)</u>** - Consultant in Acute and Stroke Medicine, 1.0 WTE, Trac Vacancy ID 3200247	
	The Clinical Director Endoscopy and Gastro submitted the proposal for a Consultant in Acute and Stroke Medicine. The business case had been approved by the Vacancy Control Form (VCF) panel and the Medical Director. It was within the existing budget and was currently awaiting Royal College approval. The key points are: - Strengthen delivery of high-quality acute and stroke medicine services across the hospital and community. - Responsibility towards Acute Medicine / Expected responsibility - Developing Same Day Emergency Care service (SDEC) - Commitment to the Hyper Acute Stroke Unit (HASU) - Contribute to the regional Stroke thrombolysis rota - Appointee would be working at least one day, a month on Acute Medical Unit (AMU) Electively with additional responsibility on AMU. At the present time on a weekend there were five consultants, who provide a one in five service, with the new recruit contributing this would go down to one in ten. The Chair mentioned that it had already been approved at the VCF and further discussions to come to the Trust Executive Group regarding job planning. The Deputy Director of Education and Research added if in the job plan there was education and research it would make it attractive for a new recruit. The Clinical Director Endoscopy and Gastro answered that the expectation was that the Trust would be able to recruit to this post and currently there was one potentially candidate. The interviews were commencing in the second half of August, pending Royal College approval.	
	The Committee: - ***Approved the Consultant Vacancy in Acute Medicine***	
TEG21/07/ F1	**<u>Items for escalation to the Corporate Risk Register (Verbal)</u>** i) Review of Risks rated 15+	
	The Deputy Director Corporate Governance / Company Secretary gave the verbal update on the risk register. With two key aspects: - Any risks that the Divisional Directors would like to raise for consideration on the Corporate Risk register. – None raised for escalation. - More work at Divisional levels on the risk mitigations and documentation	

	The spread sheet identifies all the risks within the Trust and Divisions that were rated 15+. There is a mis-understanding that every risk 15+ logged on DATIX was actually on the corporate risk register. Lots of work had been done to try and collate and review all the risks, but still there was a list of 122 risks that were all 15+. It was noted that not all of the risks have followed the Trust's Risk Management process in terms of: - Risk validation - Is the risk correct with the scoring and grading. - Does this risk impact on other areas. - Have the risks been mitigated and action plans developed if not mitigated. - Can the Divisions actually manage those risks at the particular level. - Does it actually need going through the Trust Executive Group for management consideration and escalation to the Corporate risk register. There were still a lot of risks around the 20+ mark and all Divisional Directors should be aware of the risk, its status and what the actions to try and mitigate the risk are within there Divisions. The way forward was to discuss, agree and condense the list to understand what the true risk levels were and if they belong on the Corporate Risk Register. The Chair highlighted that some of the risks had been on the register for some time and that Divisions should follow the Trust Risk Policy process, where the risks can be escalated when they reach 15+ on to the Corporate risk register Issues had been highlighted in other Trusts when they've had Care Quality Commission (CQC) inspections and there have asked the team what the biggest risks were and whether thaty had been triangulated that with the risk register. The Chair requested that Divisions need to take responsibility and ownership of what risks they see going on to the Corporate Risk Register, how they were rating the risks and that everyone followed the correct process for recording and reviewing the risk. The suggestion was that this should go to Clinical Governance for each Clinical Governance lead to review their divisions risks and bring them to Clinical Governance meetings. The Deputy Director Corporate Governance / Company Secretary added to make the Divisional Directors aware that Datix was a tool that was used to pull the information from source and for this to be a completed accurately, all the fields have to be filled in on the risk register. The system had been designed with separate fields to allow for the escalation for Speciality to Division and this allows to attach the action plans. From a CQC point of view there would want to know about the risks that were all the risks that were 15+ where were the actions are, they attached within that particular risk or within individual actions DATIX allows you to do this. Historical practice was that risks had been logged on DATIX but the actions plans have been monitored elsewhere.	

	The Executive Medical Director clarified that the risks were discussed at specialty Governance meetings and the higher risks were discussed in the Divisional Governance meetings, the part that may be missing was that simply been on the risk register doesn't create an action or mitigation it just creates a knowledge that the risk was there. From the Divisional Governance meeting This would mitigate the risk and rounding and centralising the risk register. The Chair commented that some of the review dates passed a while ago and it was knowing the process to be able to pull it all into one place. The process should fit into the Clinical Governance and Quality board and reviewed on a quarterly basis. The Executive Medical Director responded that the job of the Divisional Director was to make sure that they were reviewed on time. The Chief Information Officer commented that he would report through the Finance Information and Digital Committee and work was increasing to make sure that the standards were consistent across the Directorates. The Deputy Director Corporate Governance / Company Secretary reported that consistency was needed in the policy once the level was reached to make it clear who had ownership and views welcomed by others. The Deputy Director P&OD responded that it was a sensible option and would affect more corporate areas. Risks were more Trust wide and having something sited as not all risks were the same across the area. The Deputy Director Corporate Governance / Company Secretary clarified that there may be risks that cannot be mitigated, however documenting through DATIX and via policy would allow the board to be aware of the decision made and sited on the risk that it had gone through the appropriate validation routes and to accept or not accept the risk.	
	Action: • ***Divisional Directors to ensure that all risks rated 15+ on DATIX have been reviewed and that all controls and escalation fields in DATIX are complete, with relevant action plans attached.***	**DDir**
	The Committee: - ***Noted the update Items for escalation to the Corporate Risk Register***	
TEG21/07/F2	**Co-Chair for the Medical Advisory Committee (Enclosure F2)**	
	The Executive Medical Director referred to the group for the approval of the Draft Terms of Reference for the Co-Chair. The contributors felt that a Co-Chair would be more fitting to share the responsibility for chairing meetings. Recruiting to the role and offering re numeration of an hour a week to give it a term of office for three years. The difference of what was originally aired with the Medical Advisory Committee that it was going to be like an election and the Executive Medical Director preferred an application and interview. Trust Medical Committee Chair (TMC) or LNC members could sit on the interview panel.	

	The Deputy Director of Education and Research supported an application for an expression of interest and it clearly outlines the roles and responsibilities for the post. The Divisional Director, Children and Families made a point about where the re numeration would come from. The Executive Medical Director replied that it would come from the surplus budget like many of the other roles it comes from any division and any area. The Chair explained it was part of job planning and the Supporting Professional Activities (SPA) was where the monies would come from. The Divisional Director, Clinical Specialties asked how many times the Medical Advisory Group meets and would an hour a week would be feasible The Executive Medical Director answered every month and for an hour half. This would be a planning meeting to create a portfolio for previous presentations. Every month it takes time to come up with the topics and get the speakers prepared. If the time was halved to .125 that's two hours a month and would that be sufficient for the workload and not maximising the benefit of the Medical Advisory Committee (MAC) as time was a major factor The Divisional Director, Children and Families asked about the way that things were put into the allocate system such as time and billing the system may double count, so having a starting basis would be preferred for any further adjustment. The Clinical Director Endoscopy and Gastro added that Allocate does allow the remuneration but using the software you have to show exactly where the time was coming from. The Deputy Director Corporate Governance/ Company Secretary added that the Executive Medical Director would need extras cover for secretary support and could not rely on the current PA hours/work. Extra resource would be required.	
	The Committee: - ***Noted the update Co-Chair for the Medical Advisory Committee***	
TEG21/07/ F3	**<u>Terms of Reference for the Medical Advisory Committee (Enclosure F3)</u>**	
	The Divisional Director, Children and Families noted to the group that two hours a month for the work that was involved and the preparation wouldn't be feasible. The Executive Medical Director responded to the question from the Divisional Director of Children and families that if the meeting was an hour and half then half an hour a month to prepare that isn't enough time. The time would be set at .125 and if no one was to apply then it would be looked again at a view to changing the hours. The Divisional Director, Clinical Specialities noted that they are not paying for the attendance of the meeting, they were paying for the Chair aspect of the meeting. The MAC had a different outlook on the integration of the consultant body and the existing meetings that the TMC have would be worth engaging with the senior clinicians to make the investment.	

	The Director of Strategy and Improvement responded and asked whether the benefits outweigh the costs and were they creating a cost pressure? Would it come out of existing SPA's. Had the discussion appeared here or should it be a conversation at the CIG meeting. The Executive Medical Director answered that one of the objectives was to have a Consultant body. The job description for the Co-Chair and the terms of reference for the meeting needed to be discussed and approved through the Trust Executive Group (TEG). The Chair concluded that if the monies were to come through the Division then where would that fit into the job planning. The Director of Strategy and Improvement noted that normally items don't get agreed at the TEG meetings without going through CIG group first. It was a different process for what normally would be done. The Deputy Director Corporate Governance / Company Secretary needed clarifying under the duties and work programme the statement reads that the committee would receive regular reports from The Chair or Non-executive Director etc would this be a regular report or a report where appropriate. Regular report to be changed to an annual work plan, so that it doesn't hold to a regular report each month. The Executive Medical Director responded that the TMC expects the Executive Medical Director to attend every meeting and give a report, at the present this doesn't happen so it was agreed that all those involved would report to the committee throughout the yearly cycle as needed	
	The Committee: - ***Noted the update Terms of Reference for the Medical Advisory Committee***	
TEG21/07/ F4	**<u>Terms of Reference for the Trust Executive Group (Enclosure F4)</u>**	
	The Chair provided information to the group about changing how the Trust Executive Group meeting works with a view to more strategic decisions making and looking at how Divisions were able to transfer what was working well and what isn't through learning across the organisation. The terms of reference had been changed slightly. The Deputies needed to be changed to make use of the Clinical Directors more and/or the Clinical Governance Lead or could it be both. The Executive Medical Director pointed out that if the divisional director was absent, not all divisions have a deputy, then it might be Clinical Director. A Governance Lead may give a different perspective on the discussion, as governance lead had a different remit to a clinical director or a divisional director. More specification in the representation in the absence of the Divisional Director would be needed. The Chair asked the group if they would like the Clinical Governance lead to be a deputy? The Executive Medical Director expressed that having the Clinical Governance leads as deputy could cause conflict of interests.	

	The Governance Lead shouldn't be the first choice for deputising in the absents of the Divisional Directors. The first choice should be the General Manager or a Senior medical colleague, as this would provide the ongoing medical input into the meeting. The Director People, Organisational Development asked a question to The Chair about the duties and work programme and the broader groups of the Divisional Directors, Executives and Corporate Directors and how do these compare to the Executives terms of reference and how that shapes the agenda. The Chair explained that the setting of the agenda and how it works had changed along with the title and this reflects the Executive Team agenda and how we look across the divisions and how decisions were made. The Divisional Director, Children and Families agreed that the General Manager or the divisions directors would be better option for deputising than the clinical leads as they would have a would have a conflict of interests. The Chair noted to the group that the Clinical Governance lead, acting as a deputy would be taken out of the Terms of Reference for the Trust Executive Group. The Director of Estates and Facilities asked why for this committee, Corporate Directors were not included in the membership and were in attendance. The Chair did agree that this would be changed and included in the Terms of Reference, and there may be an element of voting at this group. The only people with the right to vote would be the Executive Directors and Divisional Directors. The Director of Strategy and Improvement added that if there was to be voting like at board that shouldn't only the Executive Directors vote as the Divisional Directors don't vote at board. The vote should come from both groups or only from the Executives Directors The Chair agreed that the Terms of Reference would be changed to reflect who had a vote. The Deputy Director Corporate Governance / Company Secretary stated that the Executive Directors would have the vote and if they made voting allowed for the Divisional Directors then the Corporate Directors would also have the right to vote and who can vote would need to be made clear. The Executive Medical Director raised that in the absence of himself he would like his Divisional Director to attend the meeting and contribute including vote. The Chair highlighted that there was usually a compromise position and how the Corporate and Board work. If there was a deputy at the Board of Directors then they wouldn't get a vote. It was being made to be more of a decision making.	
	The Committee - **Noted the update on the Terms and Reference for the Trust Executive Group including the element of voting.**	

TEG21/07/ G1	**Any other Business (Verbal)**	
	Bassetlaw Potential Name Change The Chair asked the group about the Bassetlaw Emergency Village name change The Deputy Director of Education and Research asked about engaging the local public of Bassetlaw including schools and the opportunity to ask the partners. The Director of Strategy and Improvement was going to take back the suggestions made by the group and have a rethink on the name change. Car Parking The Director of Estates and Facilities explained to the group the pressures regarding car parking at the Springwood car park close D block. Consultant had asked for it to be raised on behalf of the Consultants and Doctors about the struggles to park through the day. The building work had exacerbated the issue and the suggestion from one Consultant was to take some of the patient car park spaces from outside the Women's and Children' s department and encourage patients to use the park and ride so that staff can park in the spaces. It was clarified that the Springwood car park was for allocated permits holders. Having a permit doesn't grantee a car parking space, but by allocating the right amount of permits it should mean that there should be enough spaces to park. Permits were allocated through percentage amounts based on the highest peak of usage and factoring in staff been on annual leave and training. If this was to be considered it would be on a temporary basis until the capital works were completed and then it would revert back to the originally agreement. The Chair asked how many consultants have had their car parking spaces moved. The Director of Estates and Facilities answered that it was roughly 10 spaces that had been moved and re-located to the Springwood car park and those that use that car park that haven't got allocated spaces would now like to have allocated spaces. If this isn't possible then could more car parking spaces be created. It was a temporary situation that was causing daily problems with staff that use the car park. The Executive Medical Director responded saying that if the car parking spaces were given to allocated permit holders then this would have an impact on the those that work across the site. There was currently no system in place for those who were on annual leave, so that when a staff member was away their space reminds unused. It's the functionality of how it can be used to its full potential and there were still empty spaces while people were away and more could be done to ensure that all the spaces were been used throughout the week. The Director of Estates and Facilities explained that there was a system in place and it was down to the individual person to contact Saba to say when they were on leave so that the space can be utilised.	

	The Director of Strategy and Improvement agreed with The Executive Medical Director that it was a bit difficult to take patients car parking spaces if spaces were lying empty this would be hard to manage daily. The Chair highlighted that taken patient car parking spaces wasn't the appropriate decision to make. The Director of Estates and Facilities summed up that the update would be fed back to the Consultant to say that at the Trusts Executive Group, thought it wasn't appropriate to re-designate patients car parking and to ask them to use the park and ride at this moment in time. The situation would be monitored and reviewed. <u>Cyber Security</u> The Chief Information Officer gave an update on the cyber security scam that was circulating within the Trust at the present time. There had been an email sent by a Chief Executive Gmail account. It was a false account and not one of The Chief Executive accounts. There had been a conversation and the Chief Executive had confirmed that it was not one of his email accounts. If anyone receives the email it must be reported by pressing the phishing icon at the top of outlook and then delete the email. There had been two members of staff that had already responded to this. The email just states, "are you free at the moment" and looks like a normal email. It proves how simple the scams can be. They are being received increasingly more within the NHS and so it is important to remain vigilant and report them. <u>Capital Equipment</u> The Chair shared with the group the discussion with the executive team about the ongoing work within the Women's and Children's and that there was no contingency for capital at the present time. The IT and MEG group would be looking to see what can be funded and what contingency can be taken out. The Divisional Director, Clinical Specialties reported that the MEG group meeting had requested a few capital priorities that total to £3.9 million pounds and the originally assumption that £5 million pounds would be available. At present it had been agreed on the £3.9 million pounds of equipment that areas felt that they need. The last few weeks have been spent collating a wish list for the other £1.1 million of equipment which was in doubt regarding the capital, which was now to go towards the Women's and Children's building. The £3.9 million could be reasonably expected with the £1.1 million there was a rank priority list for the equipment in case the money was available. Looking at to what extent the executives had signed off the original £5 million was still realistic or to what amount it had been decreased to. Some of the equipment that was on the £1.1 million list was vital equipment which was needed. It would be important for the MEG group to know what extent the £3.9 million and the £1.1 million was feasible and if that information was available.	

	The Chair advised that the information was not available at this time and the lists need to be looked at again to see what items can come off for the contingency and to consider the risk assessment. The Executive Medical Director summarised that the MEG group met and was given the information that the £3.9 million was dealt with and the £1.1 million was the reserve list with all intentions that the money would come through. It now appears that this money may be unlikely but there are some red rated items that are on the list which were needed. A meeting took place with each Division to determine what items on the £1.1 million list could still be obtained and what items on the £3.9 million could be scaled down. The Divisional Director, Clinical Specialties answered that out of the reserved list a contingency list had been collated. The Chair highlighted that at the present time they have no contingency money for anything that may arise, whether that be to do with flooding or other incidents that may occur. The contingency amount that was looked at was around the £750 thousand amount. <u>COVID Update</u> The Chair gave an update on the COVID Pandemic within the Trust, taking into account the lockdown restrictions that end on the 19th July 2021. The advice that was being given across the Trust was that the Infection, Prevention and Control (IPC) guidance from Public Health England would remain the same as it was now up until September 2021. This includes: - wearing a face mask - 1 Metre social distancing All the Trusts in the South Yorkshire and the North areas would still comply with the rules as they were now. Staff would still be required to wear face masks and if visiting, visitors would be expected to wear a face mask. It was acknowledged that it was going to be a challenging time for staff when visiting returns back to normal. Whilst there were high numbers of COVID in individual communities the Trust can make the decisions as would happen surrounding any other hospital infection. Staff challenging members of the public was going to be really difficult and it was agreed to request extra support from Saba to help with this.	
	The Committee: ***Noted the updates for*** - ***Name change for Bassetlaw Emergency Village*** - ***Car parking*** - ***Cyber Security*** - ***Money for equipment*** - ***COVID lifting of restrictions on the 19th July 2021***	
TEG21/07/ G2	**<u>Sub-Committee Reports/Minutes (Enclosure G2)</u>**	
	The Committee: - ***Noted the minutes of the CIG meetings – 24th May 2021.***	

TEG21/07/ G3	**Minutes of the Trust Executive Group meeting dated Monday 7th June 2021 (Enclosure G3)**		
	The Committee: - ***Approved the minutes of the meeting 7th June 2021.***		
TEG21/07/ G4	**Date and time of next meeting (Verbal)**		
	Date: Time: Venue:	**Monday 9th August 2021** **15:00 – 17:00** **Via Microsoft Teams**	
	The meeting closed at 17:20.		

TRUST EXECUTIVE GROUP

Minutes of the meeting of the Trust Executive Group
Held on Monday 9th August 2021 via Microsoft Teams

Present:	Richard Parker – Chief Executive (The Chair) Ms Antonia Durham–Hall – Divisional Director, Surgery & Cancer Division Alasdair Strachan – Director of Education and Research Karen Barnard – Director People, Organisational Development David Purdue – Deputy Chief Executive and Chief Nurse Marie Purdue – Director of Strategy and Improvement Rebecca Joyce – Director People, Organisational Development Kirsty Edmondson Jones – Director of Estates and Facilities Mr Eki Emovon, Divisional Director, Children and Families	
In attendance:	Dr Anurag Agrawal, Clinical Director Endoscopy and Gastro Hayley Findlow – Corporate Governance Officer (Minutes) Ray Cuschieri, Deputy Medical Director James Nicholls, Nicholls Healthcare Advisory Ltd Joanne Wright, General Manager Clinical	
Apologies:	Dr Nick Mallaband – Divisional Director, Medicine Jon Sargeant (JS) – Director of Finance Ken Anderson – Chief Information Officer Dr Tim Noble – Executive Medical Director Dr Jochen Seidel (JSe) – Divisional Director, Clinical Specialities Fiona Dunn – Deputy Director Corporate Governance / Company Secretary Emma Shaheen – Head of communication and Engagement Abigail Trainer - Director of Nursing	
		ACTION
TEG21/08/ A1	**New Building Update (Presentation A1)**	
	James Nicholls, Nicholls Healthcare Advisory Ltd presented the New DRI Project case to the group. It was noted that there were two processes which were interlinked. The expression of interest would provide the opportunity to be on the national program, and at the same time a strategic outline case would be developed which would go into NHSE/I in January 2022. The presentation outlined the reviews, feedback and key deliverables which would be agreed as the business case for the new build as it develops and moves forward through the Finance and Performance Committee. The Business Case process was outlined which would include the strategic outline case, outline business case and the full business case stage. The business case was based on the five-case model set out by Her Majesties Treasurer: - Strategic Case (Strategic fit and case for change)	

- Economic Case (Value for Money)
- Commercial Case (Procurement)
- Finance Case (Affordability)
- Management Case (Delivery arrangements)

The clear delivery milestones were presented, and the stakeholders list had been reviewed by the Executive Team and updated to include Health Education England and Academic Health Science Network.

In light with the current incident in the Women's and Children's Hospital at DRI, the drive and focus of the business case would be on the condition of the estate and the feasibility of the Trust's ability to provide fit-for-purpose facilities for current and future services at DRI. A new build would resolve critical risks, backlog maintenance and safety challenges and support the ongoing viability of the site. It would also provide the public with a modern healthcare environment and service.

The New DRI Project would be aligned to the achievement of the vision and strategic objectives with a focus on creating safe and modern hospital facilities with high-quality responsive services. It would provide the opportunity to continuously develop the skills, innovation, and leadership to support the retention of colleagues. It would provide the capacity, co-location, and quality of clinical space to optimise productivity and efficiency for high-performing services, therefore enabling colleagues to deliver outstanding care safely. The facilities would be designed to reflect partnership working within the ICS. The new build would have a pandemic proof design which would support the development of enhanced community-based services, prevention, and self-care. This would include the methodology of 'digital by design' to ensure that there was scope to continually make quality improvements. Other factors that would be considered included the alignment of the project to national and local strategy. The many benefits that a new build at Doncaster would provide were outlined with a focus on patients and the public, staff, operations, finance and infrastructure. The draft project risks were discussed and were categorised by business, service and external type risks. A video was shared on what the new build would potentially look like. Feedback from colleagues on the matters discussed were required by 13th August 2021.

The Chair thanked James Nicholls for the presentation and advised the group that NHSE/I had commissioned a risk summit to discuss with partners within West and South Yorkshire what steps would be taken if there was a significant service failure. A meeting with local MPs would also take place to discuss how they would support the case. The Acute Federation had received a presentation of the New DRI Project who were supportive of the case.

The utilisation of space and the lessons learned from the pandemic would be a significant consideration within the case for the new DRI with an expectation that 70% of the build would be side rooms. This would increase the number of staff required to manage this scenario.

The Director of Education and Research wished to emphasise the importance of the inclusion of research in the case as there were some services that the Trust would not be able to provide if the research function wasn't in place such as haematology and oncology services; and therefore, suggested that it not be referred to as only innovative research but compulsory for the Trust to deliver the breadth of care that it wants to. The Chair noted that further discussions were required to determine whether how research would be funded for

	the Trust, with a potential to undertake as a partnership if there was the capital required to do so. It was noted that the research centre would be collated with clinical areas. In response to a question from Dr Agrawal regarding the size of the New DRI in relation to the current site and any opportunities to expand, James Nicholls advised that at this stage it was difficult to determine what the bed status would be and further discussions would be required to identify this. Demand growth work had been undertaken and it was expected that there would be as much as 300% growth in some areas of activity, particularly within older patients, and therefore the case would be based on growth and how services could be managed much more innovatively. Following a question from Dr Agrawal related to the development of new services on a new hospital site, it was advised that the case was for a new DRI site to provide the public with an improved service through a new facility, however further discussions were required to determine any additional factors that would be required to enhance those services further as an ICS. Following a question from Eki Emovon in relation to the phased approach to the potential build and the timeframe for the Women and Children's Hospital to be completed, it was advised that this would be dependant on the funding and when it would become available. The Trust would provide a range of options as part of the case and the outcome would be determined by the Chancellor. Antonia Durham-Hall noted from the presentation the suggestion that the emergency hospital would be on a separate site to the elective site for a period of time and advised that the workforce required to run two sites would be significant and therefore the case would need to account for a doubling of the surgical workforce. The Chair noted the challenges that this would bring and advised that all considerations would be made to ensure that the best possible solution was sought so that the Trust would be able to provide the high-quality service. The next key meeting was the 24th August 2021 which would be the risk summit and the expression of interest needs to be in by the 9th September 2021.	
	Action: The Trust Executive Group were required to provide feedback to James Nicholls by email on the New DRI Project by Friday 13th August 2021.	**All**
	The Committee: - ***Noted the New DRI Project Update.***	
TEG21/08/ B1	**Welcome and Apologies for Absence (Verbal)**	
	The Chair welcomed the members and attendees. The apologies for absences were noted.	
TEG21/08/ B2	**Matters Arising / Action Log**	
	Updates were received on actions: **MB14/10/5** Action 1 ICS update Pathology – The Chair advised the group that STH had agreed to appoint two vacancies on behalf of the Pathology Network as host organisation,	

	however it was noted that this didn't mean that Trusts could not appoint individually. The Chair advised that this item would be closed. MB21/04/A2i Action 2 New Speciality Doctor – The Director of People and Organisational Development advised the group that 35 SAS Doctors had expressed an interest to move onto the new terms and conditions. The closing date for this was in September 2021. Following this, the job plans would be devised. Discussions had taken place with Clinical Directors and an SAS Charter meeting was to be held the following week with the SAS Tutor to encourage colleagues to express an interest. MB21/04/B3 Action 4 Division/Directorate Quality Framework – Deputy Chief Executive and Chief Nurse advised the group that there were no further updates. TEG21/05/H1ii Action 5 Agency Rates – The Director People and Organisational Development advised that discussions had taken place at ICS level however there was not agreement to standardise the agency rates. The Chair advised that this item would be closed. TEG21/07/B2 Action 6 Service Line Assessment and Clinical Strategy Review – The Chair advised the group that this item would be added to the Trust Executive Group work plan and the monthly agenda. The Chair advised that this item would be closed. TEG21/07/F1 Action 7 Items for escalation to the Corporate Risk Register – The Chair advised the group that this item was on the agenda and that it would be closed. Actions Closed: 1,3,5,6 and 7.	
	The Committee: - ***Noted the updates and agreed, as above, which actions would be closed.***	
	Action: Hayley Findlow would update the Action Log.	
TEG21/08/ B3	**Conflict of Interest (Verbal)**	
	No conflicts of interest were declared.	
TEG21/08/ B4	**Requests for any other business (Verbal)**	
	Bassetlaw ICS Boundary changes The Chair provided a brief update of the Bassetlaw ICS boundary changes as part of the new Health and Social Care Bill that would see the ICS become a statutory body, and the CCG be dissolved. The Government was in the late stages of introducing boundary changes to make the ICS work alongside local authorities with a small number of ICS changes across the country. Trusts were asked to make representation for their positions. Bassetlaw would become coterminous with local authority in Nottinghamshire and therefore would be part of the Nottingham and Nottinghamshire ICS. The Trust would therefore report into two ICS. Assurance had been provided that there would be no change to the provision of healthcare services by the Trust, however the Trust would need to work differently in light of the changes. This could potentially have a significant impact on time of the Board and Senior Management. It was unknown how activity would be counted and reported. The Board had	

	planned a development session discuss the matters further and determine the implications. Collaboration would be a statutory requirement. Plans were in place to propose the formal establishment of the Acute Federation as a collaborative Board. This would mean that associated resources would be part of the Acute Federation with a formally established agreement between the Trusts to work together to deliver the aims of improved patient care and the better use of public money. There would be a requirement for a Managing Director who would be required to product a work programme for the Acute Federation relating to clinical services, strategy, and work programmes already in existence. There were many uncertainties regarding the allocation of money to Trusts, however, it was known that it would be allocated via the ICS, and therefore this collaboration as an Acute Federation would allow for input into the allocation of resources and money. The organisational structure was yet to be developed and agreed; however, it was expected that it be proposed that this commences on 1st April 2022. All strategy responsibilities would remain with the Trust, however there would be new strategies linked to the statutory work in partnership and collaboration with other to improve the services provided to patients. In response to a question from the Director of Education and Research regarding PLACE partners and further collaborative work at PLACE level, the Chair advised that guidance received refers to PLACE as a partnership as opposed to a collaborative and therefore the existing work in place would continue. The Deputy Medical Director observed that Bassetlaw was and important part of the Trust, to maintain the viability of some clinical services and therefore the coterminousity issues could pose a risk if there was a separation of services. Following the Board discussions, efforts would be made to ensure that solutions were in place to allow management the much-needed time to work with Nottingham and Nottinghamshire ICS. Following a question from the Divisional Director for Surgery and Cancer regarding the understanding of patient pathways and the control of this where there were complex patient pathways, The Chair advised that the Trust had received short-term assurance that no resources would be lost, and Bassetlaw services would remain in South Yorkshire. It was noted that it may change overtime. **ICS Response to COVID-19** The Chair provided an update on the ICS COVID-19 response. There were some concerns regarding the lift of national guidance on 16th August 2021, particularly within schools and universities at the beginning of September 2021. It was expected that COVID-19 cases would increase at this point. The COVID-19 vaccination programme had been extended to 16- and 17-year-olds. There was an expectation that by the end of October 2021 that there would be an increase in hospital COVID-19 cases that would need to be carefully managed. Significant efforts were going into planning for winter, particularly as there was a risk of COVID-19, influenza and Children's related viruses being in circulation at the same time. It was expected that the booster programme would commence in September 2021 and would be provided to the public based on the order that they received the first vaccination. It would be targeted to people aged over 50 and health and social care workers. Planning was underway for the delivery of the COVID-19 booster and flu vaccination for all colleagues in the shortest time possible to ensure that the Trust was in a good position for winter. It was noted that there may potentially be a strain on the recovery of the elective services throughout the winter period. Work was on going with ICS partners to review a wider winter	

	plan, particularly for paediatric services following the incident in the Women and Children's Hospital, and an increase in the transmission of respiratory viruses amongst children.	
TEG21/08/ C1	**<u>Service Line Assessment & Clinical Strategy Review Steering Group (Verbal)</u>**	
	The Director of Strategy and Improvement stated that the Service Line Assessment meetings that previously took place prior to the Trust Executive Group would now take place at this meeting due to low attendance. The Chair advised that the discussions were to contribute to the development of a new hospital. This would be a standing item on the agenda.	
	<u>Action</u>: Service Line Assessment would be a standing item on the Trust Executive Group agenda.	**HF**
	The Committee: - ***Noted the update on the Service Line Assessment and Clinical Strategy.***	
TEG21/08/ C2	**<u>SYB Pathology Transformation Outline Business Case (Enclosure C2)</u>**	
	The Director of Strategy and Improvement presented the SYB Pathology Transformation Outline Business Case and outlined the recommendations: - The formation of the pathology network to be configured as described in the economic case as the recommended Target Operating Model, - The SYB Pathology Service to be established between five partner Trusts as a Hosted Network, operating as a single service, with STHFT as the Host Organisation. - A Pathology Partnership Board and Operational Board should be appointed to lead the delivery of the substantial reconfiguration of services as described in the recommended Target Operating Model. Final comments on the outline business were to be submitted by the 16th August 2021 so that they could be considered by the Board of Directors from 7th September onwards. A discussion had taken place at the Committees in Common meeting of the Chairs and Chief Executives. All agreed to recommend the outline business case to their Board of Directors. It was expected that it would be agreed and approved for completion to a full business case. It was estimated that there would be an overall saving of £5m subject to the conclusion of whether there would be one or two essential laboratory services on the central university site in Sheffield. If it was decided that one essential laboratory service was required, it was expected that there would be a £6m saving per annum. As a system three proposals had been submitted, and there had been an indication that this had been successful and was therefore expecting to received funding to commence the three programmes to be achieved within two-to-four years. In response to a question from Joanne Wright regarding the communication strategy with staff, it was advised by the Chief Executive that a letter was being written to be sent to all affected colleagues. It was confirmed that there would be a statement within the letter detailing that there would be no compulsory redundancies. The letter would be sent to relevant colleagues prior to the first Board meeting in September 2021. The Divisional Director of Surgery and Cancer raised an immediate concern from the Cancer Senior Management Team relating to the ongoing and immediate problems resulting in a significant number of breaches, and asked for further information on any steps being taken for patients going through the system now. The Chair advised that it was known that the	

	collaborative approach taken throughout the COVID-19 pandemic was the process to be undertaken going forward, and any organisations experiencing challenges need to be addressed as a partnership. Any specific challenges need to be recognised with agreements and actions through the cancer networks. The implementation of the pathology network would provide those solutions however in the interim, there needed to be partnership working to identify solutions. The Chair noted that this service provision would be highly beneficial to the Trust through collaboration.	
	The Committee: - ***Noted the update provided on the SYB Pathology Transformation Outline Business Case.***	
TEG21/08/ D1	**<u>Operational Update (Enclosure D1)</u>**	
	The Chief Operating Officer presented the Operational Update which highlighted that demand was growing nationally and locally for emergency, emergency department attendance and referrals. COVID-19 cases continued to increase, and modelling suggests that there would be c.35 beds occupied by the end of July 2021. There had also been significant workforce absence issues which was a major risk to service delivery. Record attendance had been seen within the emergency department which was causing social distancing issues and delays. The Trust had delivered the elective 'value' plan for June 2021, an achievement of 87% against the 84% target. It was noted that there was a risk to the delivery for July 2021 onwards due to emergency and COVID-19 pressures. There had been good progress in many areas of activity delivery, particularly within surgery. The approach of 'getting the basics right' was the right strategy. The accelerator programme continued with a current independent sector focus. Good progress had been made on reducing cancer waits with some excellent work seen from the cancer teams. Significant progress had been made on 52-week waits with a 50% reduction seen since March 2021. There was a need for a long-term plan to increase capacity to reduce the backlog within radiology and pre-operative assessment. The H2 (Month7-12 2021/22) plan was completed using six scenarios as part of the process. There had been an increase in respiratory disease in paediatrics which presented a challenge. There was a need to identify surge capacity and a meeting was planned for Divisional Directors, nursing, and General Manager to review the options already available to address the challenges within paediatrics, the options outside of the existing capacity and how this might impact on other services. **<u>CQC Update</u>** The Chief Nurse reported that the Trust had received a Prevention for Future Deaths Report notice (PFDR) following a paediatric case, and in addition to this a difficult inquest, that although it didn't lead to a PFDR, the Coroner advised that there were concerns with elective services at Bassetlaw. PFDRs were sent automatically to the CQC, and the Coroner had written to the CQC suggesting that the elective pathway at Bassetlaw should be reviewed. It was noted that neither paediatrics or the elective pathway have been inspected since 2015, and therefore it was expected that a visit may take place and therefore plans would be put into place to review both of the pathways. Mock inspections would be undertaken at	

	Doncaster and Bassetlaw on the elective pathways and within paediatrics. All were welcome to be involved in the mock inspections. It was not expected that a full hospital inspection would be undertaken however it was anticipated that if paediatrics and the elective pathway was inspected that this may lead to an inspection on both sites within Emergency Department and Maternity Services, and potentially within Medical Imaging in relation to investigation and testing. In response to a question from the Director of Strategy and Improvement regarding the overcrowding in the emergency department, it was advised by the Chief Nurse that the overcrowding was within the waiting areas. Due to social distancing rules, chairs had been removed and therefore a review of how the waiting room space could be managed was required. The Chair noted that there had been a number of changes to processes during the COVID-19 pandemic and therefore efforts were required to ensure that the processes in place to establish learning, and other issues relating to the PFDR had been appropriately managed with a clear understanding of delivery. The Divisional Director of Children and Families noted that the Same Day Emergency Care was put into place to alleviate pressures in the emergency department however noted the staffing issues within the SDEC department. The Chair noted that the Trust was preparing for the autumn and winter months, and this provides the Trust with the opportunity to identify the challenges that the Trust faces and plan in advance to ensure that there was a confident plan in place. Medical Examiner and structured judgement reviews would be included in the process of learning. The letter from the Coroner suggested that the visit should take place after the 29th September which was when the response from the PFDR was required. The Trust now had to assure itself that there were robust plans and learning in place.	
	The Committee: - ***Noted the Operational Update.*** - ***Noted the update provided on the CQC.***	
TEG21/08/ G1	**<u>Items for escalation to the Corporate Risk Register (Enclosure G1)</u>** i) Review of Risks rated 15+	
	The Chair advised that upon review of the corporate risk register, it was difficult to see how some of the risks had been rated 15+. The Chair noted that for those risks rated 25 there were determined to be in absolute certainties as catastrophic and therefore if the Trust was unable to mitigate it down, then further investigation and information was required. The Chair therefore asked all in attendance to review the risks within the corporate risk register to undertake an assessment of the current risk and amend accordingly to demonstrate a true and accurate version of the risk, so that the Trust Executive Group could deal with the risks that were significant enough to warrant that level of management. All present agreed to do this and would liaise with risk owners to ensure that this was actioned.	

	An action identified following the Women and Children's Hospital water leak incident, was that there was a requirement for colleagues with increased health and safety responsibilities to undergo additional training on managing, identifying and assessing risk. The Chief Nurse advised that all Clinical Governance Leads had been asked to review all risk by early September 2021. The Divisional Director of Children and Families wished to escalate on behalf of the Children and Families board, the staffing issues within nursing and midwifery areas. The Chair noted that this was a significant risk and this should be alleviated by the commencement of new registrants during September and October 2021.	
	Action: Members of the Trust Executive Group were required to review all risks within the Corporate Risk Register to ensure that the risks managed by the Trust Executive Group were significant enough to warrant the level of management required.	**ALL**
	The Committee: - ***Noted the update provided on the Corporate Risk Register.***	
TEG21/08/ H1	**Any other Business (Verbal)** None.	
	The Committee: - ***Noted No other Business***	
TEG21/08/ H2	**Sub-Committee Reports/Minutes (Enclosure G2)**	
	The Committee noted the: - ***Covid – 19 DBTH Wave one Review Action Plan*** - ***Covid – 19 NHSE/I Wave one Review Action Plan***	
TEG21/08/ H3	**Minutes of the Trust Executive Group meeting dated Monday 7th June 2021 (Enclosure H3)**	
	The Committee: - ***Approved the minutes of the meeting dates 12th July 2021.***	
TEG21/08/ H4	**Date and time of next meeting (Verbal)**	
	Date: **Monday 13th September 2021** Time: **14:00 – 17:00** Venue: **Via Microsoft Teams**	
	The meeting closed at 16:30.	

TEACHING HOSPITAL BOARD

Minutes of the meeting of the Teaching Hospital Board
Held on Friday 11 June 2021 at 09:00am via Microsoft Teams

Present: Mark Bailey, Non-Executive Director (Chair)
Karen Barnard, Director of People and Organisational Development (DBTH)
Sam Debbage, Deputy Director of Education and Research (DBTH)
Tim Noble, Medical Director (DBTH)
David Purdue, Deputy Chief Executive & Chief Nurse (DBTH)
Alasdair Strachan, Director of Education and Research (DBTH)
Rupert Suckling, Director of Public Health (DMBC)
Kathryn Brentnall, Principal and Deputy CEO (Doncaster College and University Centre)
Tracey Moore, Faculty Director of Engagement and Development, Faculty of Medicine, Dentistry and Health (University of Sheffield)
Jonathan Wheat, Associate Dean of Research and Innovation (Sheffield Hallam University)
Toni Schwarz, Dean of Health Wellbeing and Life Sciences (Sheffield Hallam University)
Nicole Chavaudra, Programme Director (Notts Healthcare)

In attendance: Leanne Shaw, Executive PA (minutes)
Parveen Ali, Professor of Nursing

Apologies: Fiona Dunn, Deputy Director Corporate Governance/Company Secretary (DBTH)
Simon Swain, Principal (Hallcross Academy)

ACTION

THB21/06/A1 **Welcome**

The Chair welcomed members to the first Committee and thanked the external key stakeholders for their engagement.

Introductions were made and the Chair gave a brief overview of the purpose of the meeting, to drive forward the Teaching Hospital ambitions of the Trust.

THB21/06/A2 **Apologies for absence**

The apologies for absence were noted.

THB21/06/B1 **Background and ambitions**

Alasdair Strachan shared a presentation with the Committee, and focussed on the following key points;

- Current strategic objectives for the Trust and overarching ambition
- The journey of becoming a teaching hospital
- The restructure of education and the development of an Education and Research directorate
- Significant investment in an academic hub (REACH)
- *Reaching for the Stars* vision and areas to be focussed on

- Next steps; to commission a high level strategic review, to understand the Trust's research priorities

Positive comments and feedback on the presentation had been provided and there was broad support for the aims of the Committee.

Action: A copy of the presentation would be shared with the Committee. **LS**

THB21/06/B2 **Stakeholder introductions**

Stakeholders gave a brief overview on their key initiatives and ambitions as follows;

Rupert Suckling, Director of Public Health (DMBC);

- Key roles of a local authority and their mission for thriving people, place and planet
- The 5 key elements of the new education and skills strategy 2030 includes;
  - Best start in life
  - Accelerated achievement as people go through school
  - A new model of post 16 education
  - Skills and pathways into fulfilling work (how could the relationship with Hallcross Academy be expanded into other pathways)
  - Equitable and inclusive approach (not just a university hospital but university city)
- Aspirations to be a research city
- NIHR, Clinical Research network, member of Applied Research Collaborative / data and integrating systems
- The big 'R';
  - Finalising NIHR 2030 to look at the overall capacity for research in local authorities
  - Co-applicant on an adult social care partnership led by York to look at adult social care research capacity
  - Part of the Public Health research school
  - NIHR funded research studies underway - incentives to healthy food
- Keen to develop a 'born and bred in Doncaster' approach and a cohort study around young people
- Work in Europe around environmental factors
- Hoping to be part of the 5 health determinants research collaborations that NIHR would fund across the country in local authorities
- The local authority's support of Team Doncaster to develop a new 2030 borough strategy (with particular focus on a healthy and compassionate place)
- Digitalisation / innovation eco system

Kathryn Brentnall, Principal and Deputy CEO (Doncaster College and University Centre);

- Doncaster College and Scunthorpe College merged in 2017 to become DN Colleges Group - job outcomes meeting local needs and employer driven curriculum
- Apprenticeship programmes with DBTH
- Collaboration with DBTH and Sheffield Hallam regarding the validation to run the foundation degree in Adult Nursing from September 2021
- Challenges around placements
- DC6 initiative - creating additionality and clear opportunities to participate in careers events, to understand the various career pathways in health and social care
- Centre of Excellence for Health
- Aspirations - *you can't be what you can't see*

Toni Schwarz, Dean of Health Wellbeing and Life Sciences (Sheffield Hallam University);

- Educational engagement;
  - University strategy refreshed
  - 3 colleges on site with approximately 8,000 students
  - Working with 7 FE colleges across the region
  - 14 different health and care disciplines at undergraduate level, as well as post graduate pre-registration courses, and post graduate post-registration courses
  - Growing apprenticeship portfolio spread across 5 academic departments across the college

Jonathan Wheat, Associate Dean of Research and Innovation (Sheffield Hallam University);

- Research engagement;
  - 2 research centres within the department of Health, Wellbeing and Life Sciences (Applied Health and Social Care research centre and the Advanced Wellbeing research centre)
  - In the process of developing Applied Health and Social Care research centre, with 4 predominate research themes;
    - Maternal child and family health and social care
    - Aging and long terms conditions
    - Technology, data and digital innovations
    - Health and social care organisation and workforce
  - Currently out to advert for 3 Professor posts within the research centre
  - The Advanced Wellbeing research centre has 3 predominate research themes, to focus on the innovations that help people move and physical activity to improve health and wellbeing;
    - Healthy and active 100
    - Living well with chronic disease
    - Technology and digital innovations to promote independent lives
  - A collaboration agreement had been signed with Yorkshire Cancer Research to develop and run rehabilitation services for cancer treatment
  - Wellbeing accelerator project developed to engage local, regional and national companies and SMEs around health and wellbeing innovations

Tracey Moore, Faculty Director of Engagement and Development, Faculty of Medicine, Dentistry and Health (University of Sheffield);

- Within the Health Sciences School;
  - Nursing and midwifery programmes
  - Speech and language therapy
  - Communication sciences
  - Orthotics and ophthalmology
- Within the Faculty;
  - Health related research centre
  - Dentistry and medicine
- Successful partnership with DBTH including;
  - Apprentices
  - Trainee Nursing Associate success rate (top 3 providers nationally at 92%, national average of 62%)
  - One of the only organisations who started a cohort of trainee nursing associates during the pandemic
  - The speech and language therapy placements developed some telehealth initiatives and clinics - this was broadcasted nationally during the pandemic
  - The only Cardinal nursing student doing a PHd is from Doncaster

- Part of the 'born and bred in Doncaster' working group
- Research ongoing with Looked After Care Services in relation to unmet needs for speech, language and communication abilities of young people and children in care - would like to engage with DBTH
- Approval given for a master's degree in midwifery to start in September 2021
- One of the challenges is how to attract students to choose Doncaster as their first placement choice

Parveen Ali, Professor of Nursing;

- Lots of opportunities locally, how to develop engagement at national and international level
- Potential to hold the Strategic Research Alliance conference in Doncaster
- Working to develop links around foreign placements - challenges with organising
- Starting in August - Appointed as Editor & Chief of International Nursing Review (official journal of international council of nurses)
- ACP programme - look at how many ACPs are coming from Doncaster

Nicole Chavaudra, Programme Director (Notts Healthcare);

- Skills gaps and priorities identified by the North Notts Employment and Skills Board includes health and care careers
- Workforce events to engage secondary schools were well attended pre-Covid
- Key developments in Bassetlaw - Bridgecourt Education Centre
- Digital, technology and engineering priorities, working with businesses
- New roles emerging within the community / acute sectors
- Notts Healthcare Foundation Trust has a research programme and includes Covid, palliative care, dementia, new epilepsy drugs, return to work after a stroke
- How we reach out to the population

THB21/06/C1 **Terms of Reference (Enclosure C1)**

The terms of reference were discussed, to agree the key areas of duties, and comments were made as follows;

- The purpose of having ToR, for accountability and governance arrangements
- The importance of having a work plan and how it will feed into this Committee
- The importance of aligning research and education to improve the quality of care experience and outcomes for people that live
- Key deliverables and understanding what the scope is
- Future ambitions and focus to be University status
- Stakeholder attendance at future meetings

Action: A copy of the Terms of Reference would be shared again with the Committee. **LS**

THB21/06/D1 **Agree agenda items for future meeting**

It was suggested that the next meeting would focus on the following;

- Work plan proposal
- Stakeholder input and shared vision / direction
- Areas for joint acceleration
- Areas of celebration / excellence and how this can be communicated

THB21/06/D2 **Date and time of next meeting**

Date: Tuesday 7 September 2021
Time: 3.00-5.00pm
Venue: MS Teams

DRAFT

BOARD OF DIRECTORS – PUBLIC MEETING

Minutes of the meeting of the Trust's Board of Directors held in Public on Tuesday 20th July 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 Dr T J Noble – Executive 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:	Fiona Dunn – Deputy Director Corporate Governance/Company Secretary Abigail Trainer – Director of Nursing Emma Shaheen – Head of Communications and Engagement Katie Shepherd – Corporate Governance Officer (Minutes) Malcolm Veigas – Associate Non-Executive Director	
Public in attendance:	Peter Abell – Public Governor Dennis Atkin – Public Governor Mark Bright – Public Governor Lynne Logan – Public Governor Steve Marsh – Public Governor Pauline Riley – Public Governor Sue Shaw – Partner Governor Vivek Pannikar – Staff Governor Lynne Schuller – Public Governor (from P21/07/C3)	
Apologies:	Sheena McDonnell – Non-Executive Director Marie Purdue – Director of Strategy and Transformation	**ACTION**
P21/07/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 apologies for absence were noted. No declarations of interest were declared, pursuant to Section 30 of the Standing Orders.	
P21/07/A2	**Actions from Previous Meetings (Enclosure A3)**	
	Actions 1-5 were closed.	

	The Board: - ***Noted the updates and agreed which actions would be closed.***	
P21/07/ C1	**<u>Board Assurance Framework – SA1 (Enclosure C1)</u>**	
	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. This had been updated to include that the Trust submitted evidence to the Ockenden Report Portal on 1st July 2021 as per national guidance. The Safer Nursing Care Tool had been completed in June 2021 for all nursing areas. There had been additional risks added relating to COVID-19 which included a risk to the waiting list and the Ophthalmology plan.	
P21/07/ C2	**<u>Chief Nurse Update (Enclosure C2)</u>**	
	There had been three serious incidents reported in June 2021. All three were under investigation to identify any learning from them. 'After action reviews' continued as part of the National Safety Syllabus, which was used as a means of framing a structured facilitated discussion of an event that had occurred. Of the 123 reported falls in June 2021, five resulted in moderate harm. Learning had been collated and circulated to all Trust staff to raise awareness of key themes. The learning identified at the Falls Panel in June 2021 was focused upon early referral and assessment by physiotherapy, walking aid provision and implementing and maintaining the assessed level of supervision/utilising next best options if the assessed supervision cannot be achieved, and improving the knowledge and understanding of cohort and 1:1 Supervision for Trust staff and NHS Professionals/agency staff. There were no category three hospital acquired pressure ulcers (HAPU) reported in month. The skin integrity team were focusing on the support on wards to reduce the incidents of grade 2 pressure ulcers. Learning in month included documentation and prevention with the use of medical devices. An electronic risk assessment would be undertaken through Nerve Centre on falls and HAPU. The Trust had followed the guidance by NHS England to identify patients who had subsequently died from probable hospital onset of COVID-19 and definite hospital onset of COVID-19 and report as a patient safety incident. A task and finish group had been formed to undertake this analysis. The recommendations and actions had been completed, and work to ensure that the Duty of Candour process was duly followed with bereaved families would commence in July 2021. There were two cases of Clostridium Difficile in June 2021, both of which were community onset, hospital acquired. There was no national target for the year, however the Trust was using the target of less than 44 set for 2020/21. The framework for involving patients in patient safety was released in June and was split into two parts: - Part A which would require the involvement of patients in their own safety - Part B which requires the implementation of Patient Safety Partner involvement in organisational safety. It was expected that the Patient Safety Partners would be in post by the end of Q1 2022/23. The Trust was preparing to deliver phase 2 of the Digital Transformation Programme with the introduction of the Core Risk Bundle of Nursing Assessments. The roll out of E-Observations would be expanded to include Paediatrics, which was more complex due to the observation escalations for the three age categories within sepsis screening for paediatrics.	

	A new policy had been written in order to comply with the NHS England mandate to implement the National Safety Standards for Invasive Procedures (NatSSIPs). To improve the informed consent process, the EIDO library had been updated to the full library. There were two outstanding actions following the review of all perinatal deaths using the real time data monitoring tool. One related to the sound proofing of rooms however a plan was in place to review the bereavement facilities. It was noted that this had been delayed due to the Women and Children's Hospital water leak incident that took place in April 2021. The second outstanding action related to CTG compliance however this had been escalated to the senior leadership team who would review the guidance. There were no new HSIB reports for June 2021. It was reported that Consultants and Staff Grades were 100% compliant in PROMPT training, and the remaining Anaesthetist staff that required training had been rostered to attend the virtual training. The Ockenden Report feedback was completed and was uploaded to the portal on 1st July 2021. Funding had been received for three additional Obstetricians as CTG Leads and one additional midwife. A further £44k had been received for maternity related training. It was noted that there had been only one red flag on the Maternity Dashboard in month relating to staffing due to COVID-19 isolation, which had impacted many services within the Trust. It was reported that there had been a response rate of 17.7% from patients for the Friends and Family Test survey which demonstrated a good improvement. The Trust would work in partnership with St John's Ambulance in hosting 20 NHS Cadets between the ages of 16-18. The Trust was also partaking in a PACT research study with the aim of the research being to improve the safety and experience of care transitions for older people. The Trust would take over the management of the Bassetlaw Hospice and community palliative care service from 1st October 2021. The service would be added to the Trust's existing CQC remit and be part of the End-of-Life Service line when the Trust was inspected in the future. Over a 12-month period the Trust had seen a reduction of 10% under its planned versus actual safer staffing data. Pat Drake wished to congratulate the work undertaken on falls with a particular focus on prevention. Pat Drake reported to the Board that the Quality and Effectiveness Committee would receive information relating to e-Observations, sepsis, NatSSIPs and Local Safety Standards for Invasive Procedures (LocSSIPs), and hospital acquired pressure ulcers on 3rd August 2021. A meet was planned with the Chair of the Maternity Voices Partnership at Doncaster and contact had been made to plan one for Bassetlaw. Pat Drake noted that it was good to see that Continuity of Care was established at Bassetlaw. In response to a question from Pat Drake regarding risk assessments, the Chief Nurse advised that the inclusion of the risk core bundle in E-Observations would be rolled out from September 2021. It was noted that if the risk assessments weren't completed, the system would not allow for the continuation of the admission process for a patient, therefore they would not be missed. There was a similar mechanism in place for sepsis scoring within the Emergency Department to ensure that the process could not be missed. In response to a question from Pat Drake regarding the benefits to the Trust in taking over the Bassetlaw Hospice, the Chief Nurse advised that the Trust would have an active role in the community and palliative care which would provide a good service to the Bassetlaw community. The specification of expectations had been reviewed. The Director of Finance advised that the due diligence process had been undertaken, however noted that there may	

	more staff to transfer over than initially advised of, and therefore noted the small risk however advised that the Trust would be required to legally transfer them. In response to a question from Pat Drake regarding the rules for healthcare workers around isolation, it was advised that if a member of staff was 'pinged' by the NHS Track and Trace App, there would be an individual risk assessment undertaken to allow people to get back to work quicker. The Director of People and Organisational Development advised that new guidance was being devised for the risk assessment process, which would undergo the approval process by the Executive Team. Following a question from the Chair regarding the provision of twice-weekly lateral flow kits, and the need to ask colleagues to undertake daily lateral flow tests when required, it was advised that the Trust had a supply of approximately 1,000 further boxes, and once they had run out, colleagues would be required to order their kits via the Government website. It was noted that whilst there had only be 38 applications for the newly qualified nurse posts which was lower than previous years, it was expected that this would increase slightly. The Workforce Matron post would be advertised shortly and would support the work to be undertaken to implement safer staffing within the Allocate system. Following a question relating to national guidance on mask wearing in hospital, it was advised that the NHS Chief Nurse noted that it would be expected that all patients, staff, and visitors continue to wear face masks whilst in hospitals. The Audit and Risk Committee had reviewed the health and safety and security report, and action had been agreed to support colleagues in how they challenge or speak to members of the public with non-mask wearing. Saba reported the number of challenges they made with patients and visitors. In response to a question from Kath Smart regarding the many recommendations that come from different sources and how the Trust tracked that, the Chief Nurse advised that the majority of this was tracked within the DATIX system, logged by theme and with action plans. Kath Smart noted that there had been an increase in staff absence and the number of children from schools isolating in Doncaster as the COVID-19 cases increased; and asked for confirmation of the mitigations in place to manage this. The Chief Nurse advised that the daily review of staffing took place at the Operational Meeting, and where staffing was inappropriate this would be recorded on DATIX. There had only been one instance to date, and this coincided with the Euro Football Final. Mark Bailey took assurance from the report that actions were being undertaken in relation to complaints and patient experience, following discussions at the Quality and Effectiveness Committee. In response to a question from Mark Bailey regarding the introduction of E-Observations for sepsis management in paediatrics, it was advised by the Chief Nurse that work was ongoing with the clinical teams to implement this as soon as possible. The most recent audit undertaken for compliance of sepsis screening in paediatrics, the Trust achieved 100%. Neil Rhodes supported the discussions in relation to the challenge required for those that were not wearing face masks on the hospital site. The Chief Nurse advised that the Communications and Engagement Team were in the process of devising posters to advise visitors and patients of the rules surrounding mask wearing. Face-mask dispensers would be stationed at all entry points. To date there had been one reported incident within the Emergency Department	

	related to mask wearing. The Medical Director noted that there were very few that were exempt from mask wearing, many of which were respiratory patients, however it was reenforced to such patients that they were amongst the most vulnerable and visors were recommended.	
	The Board: - ***Noted and took assurance from the Chief Nurse Update.***	
P21/07/ C3	**<u>Infection Prevention and Control Board Assurance Framework (Enclosure C3)</u>**	
	The Board received the updated Infection Prevention and Control (IPC) Board Assurance Framework. Research had been undertaken by Cambridge University regarding the use of FFP3 face masks. These had been introduced into the Emergency Department Resuscitation Unit and the COVID-19 section of the Respiratory Unit. In response to an update request from Kath Smart in relation to the Infection Prevention and Control Team provided support to Place working within the care homes in Doncaster and the mitigating action reported being that PHE had provided equivalent funding for two Band 6 IPC nurses, the Chief Nurse advised that an initial meeting had been undertaken with RDASH and Public Health Doncaster. Both posts would be filled on a temporary basis.	
	The Board: - ***Noted and took assurance from the Infection Prevention and Control Board Assurance Framework.***	
P21/07/ C4	**<u>Executive Medical Director Update (Enclosure C4)</u>**	
	The Executive Medical Director advised that as of 12th July 2021, 95% of patients on the admitted RTT active waiting list had been stratified using the guidance issued by the Royal College of Surgeons. Further detail was expected on those with lower reported rates; however, a small data issue had been identified and rectified, and assured the Board that no patients had been missed. As of 4th July 2021, there were 282 priority 2 patients that had been waiting for surgery for 4+weeks following the date of listing or priority 2 categorisation. Work continued to address this. The patient communication plan had ended in July 2021. Only a small number of patients wished to be discharged from the follow up process. The Trust received additional national guidance for the prioritisation and management of long-waiting patients for diagnostics and a proposal was being written by the Department with recommendations for the most safe and effective process for managing the backlogs. In May 2021 the Medical Examiner Team scrutinised 100% of all hospital deaths which was a credit to the team. Following the successful implementation of the Medical Examiner system, the Trust had been tasked with expanding the service to cover all deaths within the geographical area including that of community, hospices, and mental health trusts. The Trust had agreed to pilot this in a few areas, and it was noted that challenges to this included the need for space and resources.	

	Recent activity on the role of the Caldicott Guardian was shared, as the individual responsible for safeguarding patient confidential data and information. The overall mortality rate continued to show an improvement at 111.2, particularly so in non-elective patients at 110.8. Crude mortality had flattened after a steep fall reflecting a more accurate position in relation to pre-COVID-19 pandemic levels. The Medical Advisory Committee had become a fully established monthly meeting where presentations on a broad range of topics were received. The terms of reference were ratified at the Trust Executive Group and there would be a co-chair who would chair each alternate meeting. The launch of the new clinical governance structure would take place in September 2021 and meetings were in place to undertake the final arrangements. Interviews had taken place for two Medical Director posts and offers had been made subject to pre-employment checks. The Senior Manager post had been advertised on a secondment basis and had attracted significant interest. Shortlisting was ongoing. Pat Drake noted the good work undertaken as part of the patient communication plan and suggested that finding a modern way of communicating in this way would be beneficial. Pat Drake had observed the Mortality Group Meeting during July 2021 and noted the good work of the Medical Examiner Team in scrutinising 100% of deaths for the previous three months. Following a question from Pat Drake regarding the steps that would need to be taken to follow the process of scrutinising community deaths, it was advised by the Executive Medical Director that discussions had taken place with the Chief Information Officer on how the information gathering could be achieved, however noted the tight timescales for 100% scrutinised within the community by April 2022. In response to a request from Neil Rhodes on how the balance of confidential patient information alongside the public health need for lots of data to be shared, it was advised by the Executive Medical Director that generally outline data required usually did not contain an identifiable information. In response to a question from Mark Bailey regarding the scale of the increase in work for the Medical Examiner Team when including all community deaths, it was advised that this would be a doubling of numbers as half of all local death were outside of the hospital. There were plans in place to expand the team, and due to the sensitively surrounding the discussions that would take place with bereaved families, additional space was required. Following a question from the Chair regarding the financial support for this, the Director of Finance advised that it wasn't wholly clear however it was expected that there would be funding. It was agreed that this would be followed up by the Finance and Performance Committee. Kath Smart noted that significant assurance had been received following the DSP Toolkit audit and noted the positive outcomes in data protection and security of information. Following a question from Kath Smart regarding the Medical Examiner activity and the level of confidence in the data that supports the report, the Executive Medical Director noted his confidence in the data.	

	***Action:** The Finance and Performance Committee would take an action to follow up on the funding arrangements in place to support the expansion of the Medical Examiner function to include the scrutiny of all community deaths.*	**JS**
	The Board: - ***Noted and took assurance from the Executive Medical Director Update.***	
P21/07/ D1	**Board Assurance Framework – SA2 & 3 (Enclosure D1)**	
	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. There had been no changes made. The board assurance framework would be reviewed prior to the next meeting.	
P21/06/ D2	**Our People Update (Enclosure D2)**	
	The Director of People and Organisational Development provided the highlights of the report which included that in addition to the annual staff survey, there would be a national quarterly pulse survey which would be based on the staff engagement score of the annual staff survey. The first of its kind would be circulated to colleagues for completion during July 2021. The People Committee took place on 6th July 2021 and received comprehensive reports on Health and Wellbeing which included an update on the Diagnostic Framework Self-Assessment that the Trust undertook with support from the Wellbeing Guardian, Mark Bailey. Whilst the planning process had commenced, the Trust was awaiting further guidance regarding the expectation of the vaccination programme for winter 2021, however the flu vaccines had been ordered for all colleagues. It was expected that the Trust would be required to simultaneously offer vaccinations to colleagues for both COVID-19 and flu. The Chair noted that the results of the Diagnostic Framework Self-Assessment, Board Leadership achieved 67% and requested that further information be provided on what was analysed to determine that and what actions were required to achieve 100%. Pat Drake noted that the work undertaken on Just Culture could not be underestimated and noted the good work on policy and procedure. It was agreed, following a question from Pat Drake that the Director of People and Organisational Development would identify how many staff who had tested positive for COVID-19, had received the COVID-19 vaccination. Pat Drake advised the Board that it was reported at the People Committee that there were 4.7% of staff on long-term sick leave and asked for further information on that. The Director of People and Organisational Development advised that a further detailed analysis was underway, and support had been sought from NHSE/I, but noted that the Trust was not an outlier. Pat Drake noted that there was a concern regarding the lack of consistent pay rates for bank and agency within the ICS. The Chief Nurse noted the concern and advised that work was underway to improve this. In response to a question from Pat Drake regarding the additional pastoral care that would be provided to the overseas nurses who would be arriving at a difficult time, it was advised by the	

	Chief Nurse that work had been undertaken with the Infection Prevention and Control Team and from an estates perspective to ensure that the transition was a smooth as possible. The Director of Nursing advised that pastoral support would be provided through the HR and Education Teams however the Director of Nursing would meet with the international recruits weekly ensure that they were welcomed and were provided with support. Neil Rhodes complimented the comprehensive and thorough disciplinary policy that had been reviewed and noted that for many managers undertaking disciplinary proceedings was rare and therefore it was important that there were systems and process in place to support this. In response to a comment from Mark Bailey regarding the concerns raised on the staff Facebook page regarding the hot weather expected and the use of PPE, the Chief Executive advised that similar concerns were raised each year, and there was a reliance on other means to control this such as ensuring that people drink water regularly. Whilst the Trust endeavoured to respond to all problems raised by colleagues, this was done in a practical way and through the use of Staff Side and agreed mechanisms. An external review had been undertaken to identify the main infrastructure issues but advise of the appropriateness of when the hospital required refurbishment or replacement.	
	Action: Action would be taken to determine the information provided to arrive at the outcome of the Diagnostic Framework Self-Assessment for Board Leadership and what steps would be required to make improvements.	**KB**
	Action: The Director of People and Organisational Development would identify of the number of staff that had tested positive for COVID-19, how many received the COVID-19 vaccination.	**KB**
	The Board: - ***Noted and took assurance from the Our People Update.***	
P21/07/ E1	**Board Assurance Framework – SA4 (Enclosure E1)**	
	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 Director of Finance advised that there had been some additions to the board assurance framework, the majority of which were emerging and required further work. There were concerns regarding the clarity of workforce plans and rotas that were being used. There had been a change in the Elective Recovery Fund guidance which meant that the Trust would not receive additional payment for activity undertaken as previously planned for. This would be backdated to 1st July 2021. There was a risk to the delivery of the 2021/22 capital and revenue plan due to the water leak incident that took place in the Women and Children's Hospital in April 2021. The provision of the temporary ward and theatre area would cost £12.5m. Work had commenced as the Trust had received clearance to do so, however the funding source was not yet confirmed. The Trust had commissioned a series of specialist reports on backlog maintenance. An update would be provided to the Board at a future meeting. Kath Smart noted the difficult position that the changes to the Elective Recovery Fund provided the Trust and asked for further information. The Director of Finance advised that this was an	

	issue and work was ongoing to establish what this would mean, however guidance had not been received for H2 2021/22 (Months 7-12). The Chair noted that whilst the changes to the financial regime were not helpful, work would be undertaken with ICS partners to establish how this would affect the Trusts. Neil Rhodes noted that the Finance and Performance Committee would review the implications of the changes to the Elective Recovery Fund guidance.	
P21/07/ E2	**<u>Finance Update (Enclosure E2)</u>**	
	The Trust's surplus for month 3 (June 2021) was £596k, which was £615k favourable to plan. The Trust's Year to Date (YTD) surplus was £1,287k, which was £1,049k favourable to plan. The favourable variance against plan YTD was mainly driven by a favourable position on Elective Recovery Fund, which was £0.8m favourable to plan. Pay spend however continues to increase on previous months with pay spend increasing by £644k since April (£435k from May to June). The increase in spend over the previous months was due to bank and agency spend increasing, especially in Nursing. As part of a national update on potential funding arrangements for H2 2021/22 (Months 7 -12), the Trust had been informed that the ERF thresholds have now been increased from 85% in Q2 to 95%. This causes a significant risk to delivery of the Trusts financial plan as the Elective Recovery Fund would now be significantly lower than previously expected. This change in financial arrangements and also other potential changes in H2 2021/22 (Months 7 -12) were being reviewed by the Trust, with an initial impact assessment being presented to Finance and Performance Committee in July. Capital expenditure spend in month 3 was £3.9m. Year-to-date capital expenditure was £6.0m against the plan of £2.7m. Year-to-date capital expenditure was £3.3m ahead of the plan, mainly due to the Women's & Children's modular costs (£3.3m) and donated assets. The cash balance at the end of June was £38m (May: £44.5m). Cash had reduced by c.£6.5m as a result of the Trust paying capital invoices totalling £3m in month, as well as non-NHS revenue spend of £3m. Some of this cash spend relates to expenses relating to previous periods (e.g., Sodexo). A review of the increase in cash spend in month was being undertaken as part of updating the cash flow cash forecast which would help to determine whether any of the increase in the cash spend was recurrent.	
	The Board: - ***Noted and took assurance from the Finance Update.***	
P21/07/ E3	**<u>Estates Returns Information Collection (ERIC) Return (Enclosure E3)</u>**	
	This Estates Return Information Collection (ERIC) forms the central collection of Estates and Facilities data from all NHS organisations in England providing NHS funded secondary care during the fiscal year ending 31st March 2021. ERIC data provides the Government with essential information relating to the safety, quality, running costs and activity related to the NHS estates and also supports work to improve efficiency. The key issues were highlighted which included that there had been an increase in backlog maintenance from c.£81k to c.£149k, delivering an overall increase of 82.91%. The last survey was undertaken for year 2014/15. The report highlighted that there was a lot of space that did not meet the required standard, however it was advised that this did not mean that the space was not safe. The report had provided the Trust a good baseline to work with and to support the new build bid.	

	It was reported that there had been a decrease in facilities management costs on all three Trust sites due to a revised categorisation of Director and Senior management positions and other management costs associated with individual services re-aligned. There had been an overall increase of £0.2m in waste management distribution of costs and volumes due primarily to the COVID-19 pandemic. The Chair noted the comment relating to the required standard and level of safety and asked for assurance that the Trust was able to undertake planned maintenance safely. The Director of Finance provided assurance on this and advised that as the hospital ages it was reasonable to expect more issues arise and therefore systems were required to identify potential issues and introduce contingency plans for them. There was a defined standard that advises of the things required to meet that standard, however it was reiterated that this did not make the building unsafe for use. Neil Rhodes noted the report however advised it would have been helpful to receive the level of analysis undertaken.	
	The Board: - ***Approved the Estates Return information Collection submission.***	
P21/07/ E4	**<u>Premise Assurance Report (Enclosure E4)</u>**	
	The Board received the Premise Assurance Report. The Director of Finance advised that there were a number of different definitions from the ERIC Report and noted that the reported high and significant backlog maintenance within this report was c.£124.4m. This was known as critical infrastructure risk and excludes the cost of reconfiguration. The Director Estates and Facilities would work through the two reports to ensure that the Trust was clear on the definitions within them. Due to the COVID-19 pandemic the Trust was not able to participate in the Patient Led Assessment of the Clinical Environment (PLACE) programme due to service delivery pressure and patient safety, leading to the Trust requiring minimal improvement in all 4 PLACE related self-assessment questionnaire elements within the Patient Experience domain. It was noted that the Trust had undertaken additional planned preventative maintenance, in additional to the normal process to monitor pipe work. Normal procedures don't the removal of pipe lagging, however this had been undertaken following the water leak in the Women and Children's Hospital.	
	The Board: - ***Approved the Premise Assurance Report.***	
P21/07/ E5	**<u>COVID-19 Update/Recovery of Elective Work – Looking Forward (Verbal)</u>**	
	The vaccination programme had progressed well in Doncaster and Bassetlaw which had weakened the link between community cases and hospital admissions, however the Trust had admitted patients, the majority of which were not fully vaccinated. Total COVID-19 occupancy	

equated to 2.8%. The active COVID-19 case occupancy was 0.2%. The Delta variant remained a significant concern and national modelling indicated that there would be an increase in COVID-19 hospital occupancy to 35 by the end of July 2021. There were significant COVID-19 pressures across South Yorkshire and Bassetlaw, and a further concern regarding greater pressure following the lockdown lifting on 19th July 2021. It was expected that this would impact on critical care, general beds, and elective care. Other providers within the North West and South Yorkshire and Bassetlaw were under pressure.

There continued to be a high level of emergency department attendance, particularly with minors and paediatrics. Many days had seen close to, or record attendance, with a 25% increase in attendances in June 2021 compared to June 2020. Higher acuity had been reported resulting in a longer length of stay for patients. There had been an increase across all Urgent and Emergency Care sites with Mexborough seeing a significant increase in patients from surrounding CCGs. Action had been taken to mitigate pressures within the department and wider partnership discussions would continue to consider the root cause of the increase in attendance and further action to be taken. Challenges had been seen with bed flow. Culture and organisational development work continued with the Emergency Department and remained key with forward planning. The Trust was formulating its H2 (Months7-12 2021/22) bed plan.

Within Critical Care there had been variability with demand. The network was under pressure and there had been few non-clinical transfers from other regions.

The Trust had delivered 83% of its theatre activity. 17% had been lost due to incident in the Women and Children's Hospital, however the Women's Theatre would be in use from 31st August, therefore theatre activity would increase to 100%. Theatre staffing remained a challenge.
There was a need to increase paediatric capacity whilst ensuring that elective capacity and medical beds were safeguarded. The H1 (Months 1-6 2021/22) plan had been agreed and implemented to support paediatrics.

Planning for winter was underway and bed modelling had taken place in the form of six scenarios. There would be additional capacity plans and a focus on improving processes in place. This was being progressed by the Weekly Winter Delivery Cell. Work would continue with partners to refresh and improve escalation plans, build on COVID-19 plans and improve information flow.

Performance against the activity plan and elective incentive fund were shared for June 2021 which demonstrated that the Trust achieved 99.1% for new Outpatients. There was an achievement of 103.3% of activity for Outpatient follow-ups, 114.9% achievement for elective activity and 81.5% for day case activity.

There continued to be good progress made within Cancer Services and the patients waiting over 62-days continued to reduce. The breast two-week-wait position was reported as 93% for June 2021 which demonstrated an excellent recovery. The Faster Diagnosis Standard was reported as 73% against a 75% target which had shown an improvement. The 62-day position was improving in line with the trajectory with an expectation that it would recover to an achievement of over 85% by September 2021. There were a small number of patients that had waited over 104-days however these had been managed at patient level.

	The 52-week position continued to improve with 1,221 patients waiting over 52-weeks as of 12th July 2021. It was reported that the Trust had a more improved position that most within the North East and Yorkshire region. There was an ongoing focus on priority-two patients and the use of the independent sector carpal tunnel procedures would help. The Chair noted the proud position that the Trust was in during a difficult period. The Chair noted that prior to the COVID-19 pandemic there was usually a slight reprieve during the summer months prior to the busier winter months, however this had not happened due to ongoing pressures. There were concerns nationally with the increased emergency department attendance with many areas reporting record attendance. In response to a question from the Chair regarding plans regionally and nationally to consider partnership working for a solution with the challenges seen, the Chief Operating Officer advised that partnership discussions were taking place. The Chief Nurse advised that the emergency standards had changed and therefore would change the perception. The 4-hour access target had been removed. The Trust was working with partners within PLACE to establish plans to change attendance at the emergency department. The Bassetlaw Front Door model would allow for the clinical triage of patients and referral back to GP within the need to undertake lots of diagnostics. It was confirmed that a different approach was required. In response to a question from Kath Smart regarding the rise in staff absence and the impact this would have on governance systems in response to the increase in COVID-19 cases, the Chief Operating Officer advised that there was a deliberate measured approach during wave 1 of the pandemic, however this required further consideration of the enhanced operational support required in the future. The Chief Executive advised that the management of winter would be based on good planning and what could reasonably be predicted such as a COVID-19, flu and norovirus being in circulation at the same time, and plan accordingly to respond to that. Further work was required to establish a new relationship with patients regarding visits to the emergency department as the messaging had become confused over the previous months. More communications were required to outline that the Trust was unable to deliver services within a four-hour period as previously expected. Neil Rhodes supported this noted the high-quality report and presentation. The Chief Operating Officer noted that it was important for the Trust to help the public to understand the difference between elective and emergency services through health promotion messages. There would be a deep dive at the Finance and Performance Committee on 26 July 2021 into capacity planning. Pat Drake added that it may be sensible to consider the inclusion of a primary care facility within the potential new build site to assist in the flow of patients into primary care. In response to a question from Pat Drake regarding challenges in radiology and the impact this had on other pathways, the Chief Operating Officer advised that there had been an impact, mainly on routine pathway. Plans were in plan for additional MRI, CT, and non-obstetric ultrasounds to take place.	
	The Board: - ***Noted and took assurance from the Operational Update.***	
P21/07/ E6	**<u>Performance Update (Enclosure E6)</u>**	
	There had been a stead decline in the number of patients waiting over 52-weeks and it was noted that there were challenges within diagnostics.	

	A discussion had taken place within item P21/07/E5 regarding the change to standards as part of the Emergency Care Bundle. Work continued to embed this. There continued to be a challenge with 4-hour access, however noted that for May 2021 the Trust saw 80.28% during the period where the highest attendance had been seen. Discussions with ambulance Trusts continued to improve the ambulance handover. Work was ongoing to put plans into place to improve the direct admission to stroke unit target. There remained some challenges within Cancer Services. It was noted that there were key plans in place as part of the restoration strategy for elective and cancer performance. There had been a significant step up of activity since April 2021. There had been a focus on getting the basics right, and there was a clear focus on recovering the radiology position and improving timely access for patients. There would be a further focus on emergency flow and planning for winter which would include developing the bed and capacity plan for September onwards, planning for the unpredictable context for emergency flow and emergency attendance, working to improve key metrics such as ambulance handover and the forthcoming Emergency Care Bundle standards, and balancing elective recovery with improving resilience and capacity for emergency flow.	
	The Board: - ***Noted and took assurance from the Performance Update.***	
P21/07/ G1	**<u>Corporate Risk Register (Enclosure G1)</u>**	
	There were no new corporate risks added or escalated from the Trust Executive Group. It was noted that the majority of updates were provided through the reports at the meeting specifically relating to COVID-19 and the Women and Children's Hospital Water Leak Incident. The final report from KPMG on the Risk Management audit had been received. The audit had reviewed the design of the risk management framework and sampled its operating effectiveness. There were medium and low-level recommendations. Kath Smart noted that she had reviewed the internal audit report on Risk Management and advised the Board that this would be presented to the Audit and Risk Committee on 12th October 2021. It had been discussed in great detail at the previous meeting, and the revised position following the receipt of the audit recommendations would be discussed in October 2021.	
	The Board: - ***Noted the Corporate Risk Register.***	
P21/07/ G2	**<u>Terms of Reference for the Trust Executive Group (Enclosure G2)</u>**	
	The Board received the terms of reference for the Trust Executive Group, which was previously known as Management Board.	
	The Board:	

	- ***Approved the Terms of Reference for the Trust Executive Group.***	
P21/07/ G3	**Trust Annual Report 2020/21 including Annual Governance Statement, and Annual Accounts 2020/21 (Enclosure G3)**	
	The Trust's Annual Report had been presented to the Audit and Risk Committee on 21st May 2021 by the Chief Executive. The Annual Accounts had been presented to the Audit and Risk Committee on 9th June 2021 by the Director of Finance.	
	The Board: - ***Approved the Trust Annual Report including the Annual Governance Statement for 2020/21.*** - ***Noted the Annual Accounts for 2020/21.***	
P21/07/ G4	**Standing Financial Instructions, Standing Orders and Scheme of Delegation (Enclosure G4)**	
	The Director of Finance presented the revised Standing Financial Instructions, Standing Orders and Scheme of Delegation to the Audit and Risk Committee on 15th July 2021. The Audit and Risk Committee recommend the Standing Orders, Standing Financial Instructions and Reservation of Powers to the Board and Delegation of Powers for approval by the Board of Directors.	
	The Board: - ***Approved the Standing Financial Instructions, Standing Orders and Scheme of Delegation.***	
P21/07/ G5	**Audit and Risk Committee Annual Report (Enclosure G5)**	
	There were no questions or comments.	
	The Board: - ***Noted the Audit and Risk Committee Annual Report.***	
P21/07/ G6	**Terms of Reference for Finance and Performance Committee (Enclosure G6)**	
	There were no questions or comments.	
	The Board: - ***Approved the Terms of Reference Finance and Performance Committee.***	
P21/07/ G7	**Terms of Reference for Quality and Effectiveness Committee (Enclosure G7)**	
	There were no questions or comments.	
	The Board:	

	- ***Approved the Terms of Reference for the Quality and Effectiveness Committee.***	
P21/07/ G8	**Terms of Reference for the Charitable Funds Committee (Enclosure G8)**	
	There were no questions or comments.	
	The Board: - ***Approved the Terms of Reference for the Charitable Funds Committee.***	
P21/07/ H1-	**Information Items (Enclosure H1 – H11)**	
	The Board noted: - ***H1 Chair and NEDs Report*** - ***H2 Chief Executives Report*** - ***H3 ICS Update*** - ***H4 SYB ICS Acute Federation – Digital Transformation Strategy*** - ***H5 Minutes of the Finance and Performance Committee 15 April 2021 and 17 May 2021*** - ***H6 Minutes of the Audit and Risk Committee 25 March 2021, 21 May 2021, and 09 June 2021*** - ***H7 – Minutes of the Quality and Effectiveness Committee 06 April 2021*** - ***H8 – Minutes of the Charitable Funds Committee 11 February 2021*** - ***H9 Minutes of the Trust Executive Group 10 May 2021 and 07 June 2021*** - ***H10 Minutes of the People Committee 04 May 2021*** - ***H11 Minutes of the Council of Governors 29 April 2021***	
P21/07/ I1	**Minutes of the meeting held on 15th June 2021 (Enclosure I1)**	
	The Board: - ***Approved the minutes of the meeting held on 15th June 2021.***	
P21/07/ I2	**Any other business (to be agreed with the Chair prior to the meeting)**	
	There were no items of any other business.	
P21/07/ I3	**Governor Questions regarding the business of the meeting (10 minutes) ***	
	Hazel Brand, Lead Governors asked the following questions on behalf of the Council of Governors: In relation to the External Audit Report, and the difficulties seen in collating documentation for starters and leavers may leave the Trust vulnerable if there was a dispute. How would this be monitored so not to put the Trust at risk? The Director of Finance advised that contracts of employment were managed and monitored through the TRAC recruitment system. The issue identified within the External Audit Report	

	relate to lack of centralised recruitment within the Trust which means that some recruitment was managed locally within departments. There was assurance receive within the audit, however this was a long-standing recommendation that would mean a significant change for the Trust. It was discussed at the Audit and Risk Committee in detail where it was advised that this was a challenge in most NHS Trust's. Kath Smart noted that the Audit and Risk Committee would follow up on all ISA260 recommendation at the meeting on 12th October 2021. <u>There was a concern regarding the high number of complaints relating to 'values and behaviours'. was this the same as 'staff attitude and behaviour' as a category previously reported?</u> The Chief Nurse advised that it was the same. The Trust was actively tackling these challenges in a number of areas and additional training would be provided where required. Hazel Brand observed that this meeting was the first opportunity that the Governors had seen the Annual Report and Accounts, and the External Auditor Annual Report. Hazel Brand advised that it was statutory that the Trust present the reports to the Council of Governors formally at the Annual Members Meeting, and whilst Governors have the opportunity to comment, they do not have the scope to make changes. Hazel Brand noted that in her role as a Bassetlaw District Councillor she had received many complaints form from constituents in regard to access to primary care and dentistry. Hazel advised that she had referred this to the Council's Overview and Scrutiny Committee, and many colleagues had done the same. It was suggested that this was a significant cause of the increase in emergency department attendance. The Chief Executive advised that primary care and other community facilities have faced similar challenges seen in acute care over the previous 18-months and noted that patient and public perception hasn't necessarily changes as quickly. Ongoing work with the communications to patients was required as it was unlikely that services such as the use of virtual and telephone for appointments, would return to pre-COVID-19 levels for some time. The Chair wished to thank Governors for their attendance at the Board.	
	The Board: - ***Noted the comments raised, and information provided in response.***	
P21/07/I4	**<u>Date and time of next meeting (Verbal)</u>** **Date:** Tuesday 21st September 2021. **Time:** 09:30am **Venue:** Star Leaf Videoconferencing	
P21/07/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.***	

P21/07/J	**<u>Close of meeting (Verbal)</u>**	
	The meeting closed at 12:20.	