Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting Held in Public
To be held on Tuesday 24 May 2022 at 09:30
Via MS Teams

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* *Members of the public and governor observers will have both their camera and microphone disabled for the duration of the meeting*			10
A2	Actions from previous meeting *Suzy Brain England OBE, Chair*	*Review*		
B	**PRESENTATION**			**09:40**
B1	Safeguarding Update *Abigail Trainer, Acting Chief Nurse* *Gill Wood, Safeguarding Lead*	*Note*		20
C	**True North SA1 - QUALITY AND EFFECTIVENESS**			**10:00**
C1	Board Assurance Framework *Dr Tim Noble, Executive Medical Director – SA1* *Abigail Trainer, Acting Chief Nurse -SA1 Covid*	*Assurance*		10
C2	Chief Nurse Update *Abigail Trainer, Acting Chief Nurse*	*Assurance*		15
C3	Infection, Prevention & Control Board Assurance Framework *Abigail Trainer, Acting Chief Nurse*	*Assurance*		10
C4	Maternity Update *Lois Mellor, Director of Midwifery*	*Assurance*		10
C5	Executive Medical Director Update - Learning from Deaths Report Q3 2021/2022 *Dr Tim Noble, Executive Medical Director*	*Assurance*		15

	BREAK 11:00 – 11:10			
D	**True North SA2 & 3- PEOPLE AND ORGANISATIONAL DEVELOPMENT**			**11:10**
D1	Board Assurance Framework *Anthony Jones, Acting Director of People and Organisational Development*	*Assurance*		10
D2	Our People Update *Anthony Jones, Acting Director of People and Organisational Development*	*Assurance*		10
D3	Staff Survey Results 2021 *Anthony Jones, Acting Director of People and Organisational Development*	*Assurance*		10
D4	Freedom to Speak Up Annual Report 2021/2022 *Anthony Jones, Acting Director of People and Organisational Development* *Paula Hill, Freedom to Speak UP Guardian*	*Assurance*		5
E	**True North SA4 - FINANCE AND PERFORMANCE**			**11:45**
E1	Board Assurance Framework *Alex Crickmar, Acting Director of Finance*	*Assurance*		10
E2	Finance Update *Alex Crickmar, Acting Director of Finance*	*Note*		10
E3	Annual Accounts - Going Concern 2021/2022 *Alex Crickmar, Acting Director of Finance*	*Approve*		5
E4	Operational Update – Looking Forward *Gill Marsden & Debbie Pook, Deputy Chief Operating Officers*	*Assurance*		10
E5	Performance Update *Gill Marsden & Debbie Pook, Deputy Chief Operating Officers*	*Assurance*		10
E6	Ambulance Handover Delays *Gill Marsden & Debbie Pook, Deputy Chief Operating Officers*	*Assurance*		10
E7	Recovery, Innovation & Transformation Update *Jon Sargeant, Interim Director of Recovery, Innovation & Transformation*	*Note*		10
	BREAK 12:50- 13:05			
F	**STRATEGY**			**13:05**
F1	2021/2022 Corporate Objective Outcome *Richard Parker OBE, Chief Executive*	*Assurance*		*10*
F2	South Yorkshire & Bassetlaw Pathology Partnership Agreement *Richard Parker OBE, Chief Executive*	*Approve*		10
F3	Nottingham & Nottinghamshire Integrated Care Board Provider Representative *Jon Sargeant, Interim Director of Recovery, Innovation & Transformation*	*Note*		*5*

G	**GOVERNANCE AND ASSURANCE**			**13:30**
G1	Corporate Risk Register *Fiona Dunn, Deputy Director Corporate Governance/Company Secretary*	*Review*		5
G2	Use of Trust Seal *Fiona Dunn, Deputy Director Corporate Governance/Company Secretary*	*Approve*		5
H	**INFORMATION ITEMS (To be taken as read)**			**13:35**
H1	Chair and NEDs Report *Suzy Brain England OBE, Chair*	*Information*		
H2	Chief Executives Report *Richard Parker OBE, Chief Executive*	*Information*		
H3	Performance Update Appendices Gill Marsden & Debbie Pook, Deputy Chief Operating Officers	*Information*		
H4	Minutes of the Finance and Performance Committee – 19 January, 24 February & 23 March 2022 Neil Rhodes, Non-Executive Director	*Information*		
H5	Minutes of the People Committee – 1 March 2022 Sheena McDonnell, Non-Executive Director	*Information*		
H6	Minutes of the Audit & Risk Committee – 24 March 2022 Kath Smart, Non-Executive Director	*Information*		
H7	Minutes of the Trust Executive Group – 13 December 2021 & 14 February 2022 Richard Parker OBE, Chief Executive	*Information*		
I	**OTHER ITEMS**			**13:35**
I1	Minutes of the meeting held on 26 April 2022 *Suzy Brain England OBE, Chair*	*Approval*		5
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 28 June 2022 **Time:** 9:30 **Venue:** MS Teams	*Information*		
I5	**Withdrawal of Press and Public** Board to resolve: That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. *Suzy Brain England OBE, Chair*	*Note*		

J	MEETING CLOSE	13:50

***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, Lynne Schuller, as Interim Deputy Lead Governor will be able to make a point or ask a question on governors' behalf. If any governor wants Lynne to raise a matter at the Board meeting relating to the papers being presented on the day, they should contact Lynne directly by 5pm day 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 theday.
- Questions must be submitted in advance to Lynne Schuller, Interim Deputy Lead Governor.
- Questions will be asked by Lynne Schuller, Interim Deputy 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: 26 April 2022

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Action Log

Meeting:	Public Board of Directors
Date of latest meeting:	26 April 2022

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

No.	Minute No.	Action	Lead	Target Date	Update
1.	**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**~~ ~~**January 2022**~~ ~~**February 2022**~~ ~~**March 2022**~~ **May 2022**	To be included in the Chief Nurse Update Full Board agenda postponed to February 2022 due to planning/response to Omicron **Update 29.3.2022** - Safeguarding Lead unable to attend, delayed to May 2022 Board
2.	**P22/03/F1**	**Principles for 2022/2023** Corporate objectives to be brought to April's Board of Directors Meeting.	**RP**	**July 2022**	Update 26.4.2022 – paper received, objectives to be refined based on suggestions, considered by the aligned sub-committees and to return to a future public Board meeting for approval.

Presentation by Gill Wood, Head of Safeguarding DBTH

Context

- Safeguarding is one of the most complex tasks carried out in the public sector. It can only be achieved effectively when the system designed to keep people safe works well and that system is necessarily complex and multi-faceted. At the heart of an effective safeguarding system must be an effective and comprehensive Learning and Improvement and Performance and Quality process and whilst it need not be complicated, it does need to reflect the complexity of the task.

Service Review

- The Director of Nursing requested a review of the Safeguarding service in 2021 to ensure the service was fit for purpose and able to deliver requirements now but also was horizon scanning for future changes
- The review was conducted by our CCG colleagues and the terms of reference were agreed and shared with all interested parties

Terms of Reference of the Service Review

- Evaluate the current staffing configuration of the team
- Provide a view on the impact that the team has both internally and externally
- Review current capacity of the team
- Establish the demands placed on the team
- Provide a view of the management and leadership model in place within the team
- Ensure the leadership in the team can horizon scan in relation to the safeguarding agenda for both adults and children and has a work plan in place to evidence this
- Review how the changes with evolving ICS would impact on Safeguarding services both in primary and secondary care

Team Progress / Initial Planning

- Regular 1-1 implemented with clear line management
- All appraisals reviewed and clear roles and responsibilities identified
- Workstreams identified with clear work plans for all team members
- Priority work and gap analysis identified in the service
- Internal communications channels in the team reviewed to ensure information sharing took place
- Devising the team's inspiring vision and strategy thus creating innovation

Visibility Externally what's working well

- Ensuring all external meetings across the partnership both children and adults are attended and relevant information disseminated within the Trust
- Ensuring representation at strategic level for all boards across the partnership and health systems and providing assurances to external partners in respect of safeguarding within the Trust
- Ensuring the voice and influence of DBTH is heard within all the strategies i.e. Mental Health, Neglect, Domestic Abuse and CSE / CCE (Criminal and Sexual Child Exploitation)
- Understanding the legislation and implementation from the ICS / ICB and the collaboration at Place level

Visibility Internally

- Attendance and contribution from the Head of Safeguarding at strategic meetings and disseminating information as appropriate
- Triangulating information from external and internal meetings
- Aim to provide assurance at QEC with regular updates planned for the meeting
- Visibility / accessibility within the ward settings and other support settings
- Building relationships

Areas to Address in Children's Safeguarding

- Increase in Child Protection planning
- Increase in CIC (Children in Care)
- Increase in SEMH (Social and Emotional Health)
- Increase in Neglect
- Increase in CSE / CCE (Criminal and Sexual Child Exploitation)
- Impact on services / team, financial implications
- Safeguarding Supervision
- Reacting rather than Proactive

Areas to Address in Adult's Safeguarding

- LPS (Liberty Protection Safeguards) DOLS (Deprivation of Liberty Safeguards)
- Domestic Abuse
- Impact on service delivery and wider teams across the organisation
- Financial implications
- Expectations of the partnership and expectations internally regarding new legislation
- Training

Mitigating the Risk / The Future

- Involvement from staff at early Child Protection planning / strategy meetings attended
- Neglect strategy implementation Graded Care Profile early stages
- SEMH (Social and Emotional Health) PM&S (Proactive monitoring and support) weekly CEDS (Children with eating disorders) weekly
- ICS meetings attended LPS (Liberty Protection Safeguards) DOLS (Deprivation of Liberty Safeguards) at place and discussions within the organisation
- Review of staffing requirements to support new legislation
- Business case for IDVA (Independent Domestic Violence Advisor)
- Potential review to restructure existing team with a view to a business case due to future statutory roles that will be required in the team
- Review of existing training and what will be required in the future, this is in conjunction with the training department

NHS
Doncaster and Bassetlaw
Teaching Hospitals
NHS Foundation Trust

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**	**Team DBTH feel valued and 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:** 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.	**Breakthrough Objective:** Team DBTH feel valued and the Trust is within the top 25% for staff & learner feedback	**Breakthrough Objective:** Every team achieves their financial plan for the year

Current Risk Level Summary

The entire current BAF was last reviewed in April 2022 reviewed alongside the corporate risk register.

The entire BAF and CRR were reviewed at Board Sub Committee meetings during Mar/April 2022 and by the Strategic aim sponsors in May 2022. The individual BAF sheets indicate the assurance detail and the risks have been discussed and captured via the minutes at Board and its sub committees.

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 April/May Sub Committee and Trust Board.

The key risks to achieving 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 May Trust Board and its subcommittees. The risk score for SA1-COVID as decreased from 20 to 15 (see BAF for details) and no other changes have been recorded in the overall BAF risk scores for SA1-SA4.

There has been one change in the BAF risk level during quarter 1 2022/2023. (COVID 2472- SA1COVID)

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					
Possible 3				3 , F&P5, Q&E1, ARC01	2 **F&P11**, **COVID 2472**
Likely 4			1 F&P12	6 Q&E9, **F&P1**, F&P3, F&P6, F&P8, , PEO3, PEO2	4 F&P4, F&P20 Q&E12, F&P12,
Certain 5					

Overall change per Strategic Aim (SA)

	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2021/22	No of risks/SA	Change
SA1	⟷			⟷		⟷
SA2	⟷			⟷		⟷
SA3	⟷			⟷		⟷
SA4	⟷			⟷		⟷
COVID	↓			⟷	several	↓

Appendix Level1

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

True North Strategic Aim 1 – To provide outstanding care & improve patient experience.- COVID19 Major incident

Risk Owner: Trust Board – Medical Director/Chief Nurse/COO **Committee: Q&E, F&P,**	**COVID19 Major incident - Addition to SA1**	**Date last reviewed : May 2022**		
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. **Comments: points to consider** • Corridors now reopened but social distancing still in encouraged. • High risk areas continue to adhere to the 2 metre social distancing rule • Some reduction in Planned Care – Outpatients & Surgery but risk reducing as Covid numbers decline • Vulnerable Patients – support still required to support high risk patients • Minimal impact on critical care currently with only 1 patient requiring this level of care at time of update • Consolidation of maternity and Delivery of Children's Services • Trauma Consolidation- Increasing trauma capacity as COVID allows • Diagnostics and Pharmacy • Care of Deceased Patient • People Planning, Education and Research • Ethical Decision Making • Infection Control and Prevention Support • Partnerships, Communication and Engagement • Visitor restrictions reviewed with a return to 'open visiting' for 2 visitors in areas where there are no active Covid cases • Visitors encouraged to continue to wear masks at all times and not to attend if they are displaying any Covid symptoms • To support patient flow all patients continue to be screened on admission, then days 3, 5 and 7 of their hospital stay. If they remain negative no further action is required, however if symptoms are noted patients are then managed in accordance with Covid / IPC guidelines. • Alternate day screening for contact patients has ceased which has seen an improvement in patient flow and minimal impact on patient safety. This is in accordance with guidance issued in April by NHSE/I. **Comments:** • See evidence of plans in link (Overall Plan) • Risk log (see link) • High Level COVID Narrative • Post implementation review	**Risk Appetite:** The Trust has a **high appetite** for risks that impact on patients and staff during a worldwide pandemic. **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 • Risks on staffing numbers in relation to vaccination awaiting final decision nationally. • Risks to patient flow due to external availability of care provision, which adversely affects patient experience **Risk references:** link CRR Risk ID2472 on DATIX **Opportunities:** • Change in practices, new ways of working	**Initial Risk Rating** **Current Risk Rating** **Target Risk Rating**	5(C) x 5(L) = 25 extr 5(C) x 3(L) = 15 extr 3(C) x 3(L) = 9 low	Risk Trend ⇩
		Rationale for risk current score: • Previous unknown pandemic ○ Patients, staffing, resources etc • Significant reduction in Covid numbers both in the Trust and the community • Review of patient visitor arrangements and further changes implemented to support open visiting • Data modelling predictions based on "best" guess principles from previous flu epidemics • Unknown timescale of outbreak			
		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 women's hospital. • Uncertainty re COVID recovery outcomes • Uncertainty re SYB ICS changes			

Controls (mitigation to lead to evidence of making impact):	**Last Review date**	**Next review date**	**Reviewed by**	**Gaps in Control**
Pandemic incident management plan implemented. • National reporting & monitoring eg PHE, NHSI/E, WHO etc ○ Level 4 incident stood down & local reviews still in place weekly or as new guidance is issued	May 2022	June 2022	Director of Infection Prevention and Control Chief Nurse	No unexpected identified

Appendix Level1

Accountability Framework & Quality framework process ○ Scrutinization of patient pathways	May 2022	June 2022	Director of Infection Prevention and Control, Chief Nurse & COO	Action plans in place
Full projections of C19 demand & other emergency flow modelled with partners, & supporting bed modelling. This informs week to week operational plans	May 2022	June 2022	Deputy Chief Executive COO	Work plans in place to support flow internally and externally
Urgent and Emergency Care Improvement Programme – underway & reviewed as part of the recovery programme	May 2022	ongoing	Deputy Chief Executive COO	Focused work on ED medical staffing
Ongoing daily operational reviews to allocate or redeploy staff to maintain safe care, or mitigate risks in a particular service as appropriate	May 2022	Ongoing	Chief Nurse COO	Ongoing rota management
Vulnerable Patients- mMAbs service running since Dec21 and request to run for further 6 months	May 2022	June 2022	Deputy Chief Executive COO	Cost of providing service and risk to services being reviewed as part of wider recovery programme

Assurances received (L1 – Operational L2-Board Oversight L3 External) **		**Last received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
L1,L2,L3	National reporting & monitoring eg PHE, NHSI/E, WHO etc	Nov 21	F&P, Board	ongoing	On going
L1,L2	Enhanced operational meetings currently stepped down due to significant decline in patient numbers. However ongoing incident management arrangements dependent on COVID infection rate at current time and reviewed if further increase in patient and staff numbers which could impact on daily performance	May 2022	F&P,QEC, Board	Full – ongoing review through phases	Action plans in place & continual review
L2	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.	May 2022	F&P, Board	Full – ongoing review through phases	Action plan in place & continual review
L1,L2,L3	BAF completion on specific areas, evaluated by CQC, IPC BAF reviewed at Board of Directors December 2020. BAF reassessed 14th July 2021, to be reassessed with latest guidance. Updated BAF shared with Board on the 25th January 2022. Updated IPC BAF shared with QEC 3/4/2022. New IPC Board Assurance Framework due out imminently and will be shared a relevant committees once received.	May 2022	QEC	Full	None
L2,L3	KPMG Internal Audit reviews on quality outcomes: ○ Covid-19: Business Continuity, Pandemic Response Plan and Remote Working - October 2020 - ○ COVID-19 Financial Governance and Controls - October 2020 -	October 2020	Board	- Significant assurance with minor improvement opportunities	Actions complete

Corrective Actions required	**Action due date**	**Action status**	**Action owner**	**Forecast completion date**
Discussions required to understand future funding model for Vulnerable Patients- mMAbs service (been running since Dec21 and request to run for further 6 months)	**30/4/2022**	**ongoing**	**Deputy Chief Executive**	**30/4/2022**

Assurances received (L1 – Operational L2-Board Oversight L3 External) identify the range of assurance sources available to an entity:
—L1 Management –such as staff training and compliance with a policy
—L2 Internal Assurance –such as sub-committees receiving evidence of L1 working effectively; and
—L3 External Assurance –such as internal and external audits.

Areas in yellow highlight indicate change from last version

Appendix Level1

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

True North Strategic Aim 1 – To provide outstanding care & improve patient experience.

Risk Owner: Trust Board – Medical Director/Chief Nurse **Committee: QEC**	**People, Partners, Performance, Patients, Prevention**	**Date last reviewed : MAY 2022**		
Strategic Objective To provide outstanding care and improve patient experience **Breakthrough Objective** Achieve measurable improvements in our quality standards & patient experience **Measures:** • Ward/department quality assessment scores, recommencement of quality frameworks. Work on the roll out of the Perfect ward to commence in quarter 3. • Evidence of "closing the loop", through sharing of learning from incidents and follow up from QI processes • Focus on key safety risks – IPC Outbreaks - 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 • Feedback from patients via compliments and complaints. • Patient survey outputs and effectiveness of action plans • Co-production of changes with patients • Insights profiles from CQC • Board Assurance Frameworks • External review of patient safety and clinical governance which will incorporate patient experience	**Risk Appetite:** The Trust has a **low appetite** for risks **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 • Risk to safety and poor patient experience if we do not improve emergency flow in our capacity constrained environment • Current gaps in registered workforce whilst new registrants and international nurse's complete preceptorship with increased reliance on agency staff. • Risks to patient both in terms of flow and communication as a result of the pathways relating to Infection, Prevention and Control measures	**Initial Risk Rating** **Current Risk Rating** **Target Risk Rating**	4(C) x 5(L) = 20 extr 4(C) x 4(L) = 16 extr 3(C) x 3(L) = 9 low	Risk Trend ⟷
		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		
	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 • Review of quality processes within the ICS	**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 women's hospital. • Uncertainty re COVID recovery outcomes • Uncertainty re SYB ICS changes		
		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		

Controls (mitigation to lead to evidence of making impact):	**Last Review date**	**Next review date**	**Reviewed by**	**Gaps in Control**
BIR Data targets & exceptions	Jan 2022	Feb 2022	Med Director (TN)	No unexpected identified
Accountability Framework & Quality framework process ○ Securitization of pt pathways – risk stratification of patient pathways ○ ~~Winter plan implementation~~	Jan 2022	Feb 2022	Med Director (TN) & COO	Action plans in place
Clinical Governance review complete. Awaiting completion of external review prior to implementation.	May 2022	June 2022	Med Director (TN)	None identified
Urgent and Emergency Care Improvement Programme – underway & reviewed weekly	April 2022	March 2022	COO	Actions & plans in place
Action plans to respond to CQC patient surveys	Dec 2022	Feb 2022	Chief Nurse	Action plans in place
Patient Experience process, review of PPI and Accessible Standards – will form part of the patient safety workplan review		March 2022		Reviews in place to ensure compliance
Risk stratification of patient pathways established. KPMG working with medical director on patient pathways as part of outstanding outpatients forum.	May 2022	June 2022	Med Director (TN)	

Appendix Level1

Assurances received (L1 – Operational L2-Board Oversight L3 External) **		Last received	Received By	Assurance Rating	Gaps in Assurance
L3	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.	June21	ARC, Board	Full	None
L2,L3	SNCT undertaken to ensure safe staffing completed in June 2021. Nurse Staffing Assurance Framework shared at Board on the 25th of January 2022	Jan 22	QEC, Board	Full	Action plan in place
L2,L3	Okenden feedback received from the LMNS, action plans developed to achieve 7 key actions	Dec 21	Board	Full	Action plan in place
L1,L2,L3	BAF completion on specific areas, evaluated by CQC, IPC BAF reviewed at Board of Directors December 2020. BAF reassessed 14th July 2021, to be reassessed with latest guidance. Updated BAF shared with Board on the 25th January 2022	Jan 22	Board	Full	
L2	Nurse Staffing Assurance Framework shared at Board on the 25th of January 2022	Jan 22	Board	Full	

Corrective Actions required	Action due date	Action status	Action owner	Forecast completion date

Assurances received (L1 – Operational L2-Board Oversight L3 External) identify the range of assurance sources available to an entity:
—L1 Management –such as staff training and compliance with a policy
—L2 Internal Assurance –such as sub-committees receiving evidence of L1 working effectively; and
—L3 External Assurance –such as internal and external audits.

Areas in yellow highlight indicate change from last version

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	24 May 2022	**Agenda Reference:**	C2		
Report Title:	**Chief Nurse Report**				
Sponsor:	Abigail Trainer, Acting Chief Nurse				
Author:	Kirsty Clarke, Workforce Lead Stacey Nutt, Head of Patient Experience Marie Hardacre, Head of Corporate Nursing Abigail Trainer, Acting Chief Nurse				
Appendices:	0				
Report Summary					
Purpose of report:	The Board are asked to approve the ongoing work to improve patient quality against the True North Objectives				
Summary of key issues/positive highlights:	The paper outlies the March outcomes in relation to the key patient safety measures in falls, hospital acquired pressure ulcers, infection prevention and control and serious incidents, highlighting what learning has been undertaken and how this is shared across the Trust. The paper highlights patient experiences in March. Focused on the effectiveness of the complaints procedures, themes of complaints and how we evidence learning. The paper also gives an insight into the current position on safe staffing, highlighting the mitigations in place and the future developments to support safety.				
Recommendation:	To approve				
Action Require:	Approve	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:	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 2022	**Decision:**	Regular updates required to QEC
Next Steps:		Update progress to QEC	
Previously circulated reports to supplement this paper:		None	

BIR May 2022 (March and April 2022 data)

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. The Trust continues to adhere to the serious incident framework. NHSE are publishing guidance in June 2022 regarding the transition to the patient safety incident response framework (PSIRF). The guidance will provide feedback from pilot Trusts regarding their experience of implementation and will provide the Trust with a clear timeframe of 12 months for full implementation.

Safer Culture, Safer Systems

Safety culture indicators can be measured by reviewing the safety questions on the NHS Staff Survey. DBTH results are in line with national results and demonstrate a reduction in the positivity percentage. It is clear more work is needed to support and enable Trusts to improve safety culture through embedding a continuous cycle of understanding the issue - developing a plan - delivering the plan - evaluating the outcome.

The Patient Safety Specialists have liaised with the People and Organisational Development team and plan to create an overarching improvement plan. Each division has been informed of department level data to ensure robust action plans can be developed to address local issues.

Insight

Serious Incidents

There were three serious incidents in March 2022:

- A patient fall resulting in a head injury (acute subdural haematoma).
- A patient fall resulting in fractured neck of femur.
- A complication arising from the replacement of a chest drain resulting in haemathorax.

There were two Serious Incidents and one Never Event in April 2022:

- A patient having multiple clinic outcomes on the E-rec patient booking system leading to a delay in ophthalmology treatment.
- A delayed diagnosis of squamous cell carcinoma.
- A reported never event that relates to a retained guidewire following insertion of a chest drain.

This is a total of three serious incidents reported year to date, all related to care issues.

In 2021-2022 there were 36 serious incidents reported on STEIS, with two incidents being delogged following a full investigation. Of the incidents, 25 were care issues, 6 were HSIB investigations (all reported on STEIS), 6 falls and no Hospital Acquired Pressure Ulcers.

HSIB Investigations
There have been no HSIB investigations, year to date.

Patient Safety Incident Response Framework (PSIRF)
Guidance is expected in June 2022 from NHSE for the transition to PSIRF over the next 12 months period.

The patient safety specialists have commenced work with the Quality Improvement team to develop a plan and prepare for the PSIRF guidance. Details on how we measure success of the five identified patient safety improvement priority and monitor success have commenced. Each of the five patient safety prioritise below will have a work stream supported by the Qi team:

- Skin integrity
- Falls
- Discharge
- Recognition of deteriorating patient
- Medication safety officer

DBTH is also involved in collaboration with the Nottinghamshire ICS who have organised a steering group to ensure learning ICS wide and alignment with our patient safety improvement prioritise.

Patient Safety Specialists
The Trust Patient Safety Specialists are Dr Juan Ballesteros (Associate Medical Director for Clinical Safety), Ms Marie Hardacre (Head of Nursing for Patient Safety and Quality) and Ms Nicola Severein-Kirk (Lead Nurse for Patient Safety and Quality). There is significant change surrounding how we investigate, learn and develop a safety just culture.

Falls
There have been 138 falls in March 2022. Of these, 102 resulted in no harm of which 6 were non-inpatients. 34 falls have resulted in low harm and one of these was a non-inpatient. There have been two moderate harms, and no severe harms.

There have been 129 falls in April 2022. Of these, 93 resulted in no harm, and 12 were non-inpatient falls. 29 falls have resulted in low harm and one of these was non-inpatient. There have been three moderate harms, and four severe harm falls.

The Falls Safety Improvement Panel meet monthly and analyse all moderate and severe harm from falls and any themes identified for learning. The themes are communicated to the wider DBTH team via a monthly ‘shared learning from falls’ newsletter.

With the changes expected with PSIRF in June the Quality Improvement (Qi) team are supporting the falls team to create clear aims and objectives of improvement work.

Hospital Acquired Pressure Ulcers (HAPU)
There were 64 HAPU's in March 2022 affecting 53 patients. Of these patients, 6 were category three HAPU's, 5 were unstageable HAPU's, 0 category four HAPU's, 1 mucosal pressure ulcer**.**

There were 87 HAPU's in April 2022 affecting 65 patients. Of these patients, 3 were category three HAPU's, 7 are unstageable HAPU's, 0 are category four HAPU's, 2 are Mucosal Pressure Ulcer and 1 is an Uncategorisable Pressure Ulcer.

This brings the total number of HAPU's year to date to 87, affecting 65 patients.

Learning from the skin integrity improvement panel continues monthly with the use of a Trust social media page, Trust Intranet page (Hive), bespoke ward training and Trust wide training via eLearning and Face to Face.

The Skin Integrity Team commenced a Quality Improvement (Qi) target in October 2021 with the aim of achieving a 20% reduction across the Trust of category two and above HAPU's (based on the 2020/2021 figures) by the end of March 2023.

The Pressure Ulcer Reduction Strategy was commenced in October 2021, at the end of March 2022 there was an overall 13% reduction in low harm, and a 5% reduction in moderate harms. This is a fantastic achievement and testament to all the ward and department, and skin integrity teams efforts in improving the quality of care.

Infection Prevention and Control
Clostridioidies difficile - there were 9 in March 2022 and 3 in April 2022. All 3 of these cases were Hospital Onset, Hospital Associated (HOHA) infections.

This is the total number of cases of Clostridioides difficile for the financial year, against a trajectory of 48.

E-Coli Bacteraemia - there were 8 cases in March 2022, 5 of these cases were hospital onset, hospital associated (HOHA) infections and 4 were community onset hospital associated (COHA).

In April 2022 6 cases were reported. 5 were classed as HOHA and one as COHA. This is the year total with a current trajectory of 115 for the year (still awaiting confirmation of 22/23 trajectory).

MRSA bacteraemia - there were no MRSA bacteraemia reported in March or April 2022. This is against a trajectory of zero. The Trust has not had an MRSA bacteraemia since 26 February 2021 which is a fantastic achievement of zero bacteraemia for 440 days (on 12 May).

MRSA Colonisation - there were zero in March and two reported colonisations reported in April 2022. This is the year total and will be closely monitored by the divisional teams and IPC.

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

The patient safety specialists have reached out to the inequalities in health team for support with recruiting patient safety specialists from our local community. The guidance is expected in June 2022 with job description and person specification. Contact and information has been shared with recently retired staff to gauge interest before this is officially advertised.

Patient Safety Syllabus

The Patient Safety Syllabus (level one) is now on the ESR system and available for all staff to use. This is a national e-Learning package to improve safety culture. Communication has been added to the Trust newsletter to inform staff. The patient safety specialists are working with the education team to launch the safety syllabus to coincide with the world patient safety day in September 2022.

Improvement

Shared Learning

Following investigation, recommendations and learning from patient safety incidents, the monthly patient safety review group hear presentations on the agenda each month. These presentations share learning across all divisions. This allows operational discussion surrounding learning surrounding an incident and to share and cascade through governance processes.

The newsletter Sharing How We Care (SHWC) saw October 2021 being the 30th edition. This is temporarily suspended and is being reviewed and refreshed to ensure multi-disciplinary involvement in the editorial process. The patient safety specialists are working with the education team to relaunch to coincide with the world patient safety day in September 2022.

Digital Transformation

The TENDABLE accreditation application is being launched in June 2022. This will allow wards and departments to undertake electronic audits on the Trust handheld devices. The first two audits to launch are the ward/department weekly audit and the matron's assurance monthly audit. A cross divisional and speciality steering group is then being launched, plus staff engagement sessions to ensure feedback and evaluation. This will help shape what the future audits will look like as we progress to introduce the next seven audits.

The quality dashboards (currently named the hard truths data) are being redesigned alongside the clinical audit and effectiveness team to pull data from our electronic system - ie. Nervecentre and relevant quality indicators to assess performance in relation to bed days per month data to make the dashboards more representative of activity and percentage of harm.

The digital transformation programme continues and has introduced risk assessment documentation Trust-wide and is trialling care planning on ward C1 at BDGH. The move towards electronic patient records is welcome and builds on the success of the electronic observations and sepsis screening. Learning is shared at the digital clinical governance meeting.

The paediatric transition to electronic observations has been disrupted due to the requirement for Wellsky electronic prescribing to be embedded and launched as a priority.

Complaints

In April the number of complaints received was 50, consisting of 44 40 working days, 5 60 Working days and 1 MP complaint. This was a welcomed reduction compared to the 70 received in March. Quarter 4 (2021/22) saw the Trusts highest activity for complaints and concerns with a 57% increase to Quarter 4 in 2020/21.

When split by Division Medicine had 25 complaints, Surgery and Cancer 9, Childrens and Families 9, Clinical Specialties 4 and Other (corporate areas) 3.

The number of concerns registered were 58 which was a slight reduction compared to March (61).

Compliance with acknowledging formal complaints within 3 working days was 96% demonstrating consistency now for the last 3 months.

The number of complaints closed in April was 49 with only 33% meeting the timeframe for closure. There were significant challenges through April with Easter Bank Holidays and availability of final sign off which unfortunately had a big impact on complaints resolution performance.

Of those complaints that were closed 9 were upheld, 20 partly upheld, and 20 not upheld, all closed complaints had an outcome recorded and 90% had learning recorded which is an improvement from 83% in March. Each Division now present a highlight report to PEIC every month which particularly focuses on what they are learning from complaints and what actions they have taken to address them. Top themes of complaints in April were Patient Care (including hydration, nutrition and maternity) with 18, Diagnosis (including tests, delays and missed) (16), Communication (13), Values and Behaviours (10) and Trust Admin (including IG) 6.

Subjects of complaints are identified when a complaint is first registered on DATIX but following the complaint investigation this can often wither be not upheld or be something different. Therefore, we have agreed to review the closure section of Datix to see if we can add the theme following completion of the investigation.

In April we have had 3 contacts from the PHSO - 1 was a request for information which was provided and following initial review a suggestion of financial remedy was made to the Trust of which we accepted. This was in relation to a case where the patient claimed £13,500 for missing jewellery that we did not uphold, the PHSO suggested we offered financial remedy between £500-£950 due to there were elements where the Trust valuables policy had not been followed. The other contact was to inform the Trust intent to investigate and the third contact was a decision to not uphold a complaint.

Claims relating to lost valuables is increasing therefore a piece of work is being undertaken in order learn from the associated complaints and incidents. A working group will review the policy, documentation and processes at ward level for managing patient's personal items and then the governance process around decision making and handling of associated claims.

April has seen a big improvement in the inpatient Friends and Family Test response rates with a combined rate of 9.11% (DRI 10%, BDH 5.9% and MMH 13.2%). The Trust performance trajectory for 2022/23 is to have achieve a 15% response rate by year end, so this is a pleasing start. For ED this was 0.2% in April (with a year-end target of 10%), we are working with IT and graphics to look at how we can use of technologies and media to improve this.

Work continues in collaboration with the Deaf Society to improve patient's experience when visiting the Trust with a meeting planned imminently to engage with the deaf communities to understand the difficulties they experience. The Trust have worked closely with the Deaf School as part of Deaf Awareness week encouraging staff through social media to learn some very basic sign language and to film themselves doing so and posting it on the Trust social media page. Comms team ran a week's long campaign sharing useful information and resources with Trust staff.

We have successfully recruited new volunteers to the Trust who's primary appointment is to be ward based as 'befriender volunteers'. In patient ward volunteers have been severely lacking over the last 2 years during the Covid-19 pandemic for obvious reasons. The role has been reviewed learning from feedback from patients and relatives and it is very much a role to support patients and will include being a companion, helping patients and relatives keep in touch, supporting at mealtimes to prepare for the meal and also will receive appropriate training to be able to assist the patient with their meal. This builds on the work being undertaken by the dietetics team and review of the patients dining experience.

It is national Carers week 6th-10th June and the patient experience team will be working in conjunction with the comms team and EDI to plan a week's long event to try and reaffirm the importance of embracing carers and promoting the value to the patient and staff experience. Carers experience has been very challenging during COVID-19 due to visiting

restrictions and as we see visiting steadily returning to those of pre-covid we want to use it as an opportunity to reengage with carers and families and recognise them as a very important aspect of patient wellbeing. This will also see patient experience work join up with our 'people' work as many staff members are also carers. We will also be working with Doncaster CCG to look at encouraging patients with paid carers to continue to support patients whilst being in hospital.

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 an increasing number of areas 10% under their planned versus actual.

There were currently 40 established inpatient wards open at Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust during this reporting period. The below provides data for the March reporting period - previous report included up to February 2022, this has been left in the report to show comparisons as April data not ready in time for May 2022 board report:

The actual versus planned percentage is detailed below;

Ward distribution of planned versus actual rate	**February 2022**		**March 2022**	
	No.	%	No	%
Within 5%	**17**	**42.5%**	**15**	**37.5%**
5% under planned versus actual	**6**	**15%**	**8**	**20%**
5% over planned versus actual	**1**	**2.5%**	**3**	**7.5%**
10% under planned versus actual	**16**	**40%**	**13**	**32.5%**
Surplus over 10%	**0**	**0%**	**1**	**2.5%**
Total IP wards	**40**		**40**	
Number of wards closed	**0**		**0**	

March 2022

The on-going Covid 19 pandemic has created additional workforce challenges across the breath of the organisation, these pressures are seen across maternity, paediatrics, Surgery, Critical Care and medical areas along with an increase in patient acuity and enhanced care needs. This has been reflected in the safe staffing data throughout the winter period with an increasing number of areas 5 % or 10% under their planned versus actual, with a very slight improvement over all noted during March 2022.

In addition to the above actual V planned staffing data the tables below details the average bed occupancy of each ward or department in month who were under their planned versus actual. This can then be triangulated against staffing fill rates.

March narrative
40 inpatient wards were open throughout March 2022.

15 (37.5%) were on green for planned v actual staffing.
8 (20%) wards were on amber for being 5% under planned v actual staffing (26, A4, ATC, AMU, 22, 16, 18, NNU).

3 (7.5%) wards (Rehab 1, Mallard, St Leger) that was amber for being 5% over planned v actual staffing during March and this reflected adhoc increases in acuity and enhanced care requirements.

13 (32.5%) wards were red for being 10% under planned v actual staffing (S10, C1, 17, CCU/C2, CDS, M1, 24, 21, 20, 32, A2L, DCC, B6). It should be noted that S10 and B6 are elective admissions wards – with S10 having a reduction in patients on a weekend and ESSU having low overnight stay patient numbers. These areas are ring fenced for elective activity and therefore will have empty beds, allowing staff to be utilised in other areas of need without affecting elective patient care. This results in the wards actual V planned looking negatively affected.

There was 1 ward (G5) rated red for being over 10% of their planned v actual staffing during March. This reflected the move from a 23 bed temporary ward location back to the 16 bed gynaecology bed base and the staffing of a standalone SDEC facility.

CHPPD March 2022

CHPPD (March 2022)					
Site Name	RN/M	HCA	REG NA	NON REG NA	TOTAL
BH	5.22↑	3.10↑	0.00	0.30↑	8.62↑
DRI	4.22↑	3.28↑	0.12	0.11↑	7.73↑
MMH	2.30↑	3.80↑	0.02	0.13↑	6.26↑
Total	4.11↓	3.28↑	0.09	0.14↑	7.79↑

CHPPD - has shown a slight increase across all staff groups during March 2022.

March 2022 bed occupancy data - wards with 10% deficit

Red - above 85% bed occupancy Amber above 70% bed occupancy

Wards with deficit of 10%	**Bed base number**	**Average beds occupied at midnight**	**Average % of beds occupied per month**
M1	26	15.8	61%
CDS	14	4.5	28.2%
A2L	6	2	3.33%
DCC	22	12	54%
Ward 17	26	26	100%

Ward 32	18	14.9	82.78%
C1	24	22.3	92.92%
CCU/C2	18	16.6	92.2%
Ward 24	30	27.9	93%
Ward 20	27	26.4	97.8%
Ward 21	27	26.7	98.9%
S10	20	15.6	78%
B6 (ESSU)	8 overnight beds	1.2	15%

Future developments

Safe Care

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

The Trust is currently undertaken the first nursing workforce data collection set for 2022 using the Safer Nursing Care Tool across the adult and paediatric inpatient wards, including assessment areas. This data collected be shared with the Chief Nurse and Divisional Directors of Nursing and inform ongoing discussions relating to optimal nurse staffing levels and workforce planning. This is a 4-week data collection process which concludes on 22nd May 2022 and will then go through the analysis process before being shared with the Chief Nurse.

As part of the future developments for 2022/23 the senior nursing leadership team are progressing the utilisation of the Allocate Safe Care model to support effective utilisation of nurse staffing resource. Safe Care is x3 times a day staffing software that supports review or staffing levels against patient acuity, providing control and assurance from bedside to board. It allows comparison of staff numbers and skill mix alongside actual patient demand in real time, allowing you to make informed decisions and create acuity driven staffing. This is utilised alongside real time data that can be streamed from varying digital solutions used at DBTH including Well Sky Pharmacy solution and Nerve centre (E observations, risk assessments) which also provide red flag data utilised in support safe staffing allocation.

The implementation of Safe Care was planned to be led by the newly appointed Head of Nursing for Workforce & Ward accreditation (commenced in post November 2021), in conjunction with the Trust E Roster team, however due to other pressures in the corporate nursing team /patient safety additional responsibilities / priorities will further delay safe care roll out. Additional resource to support the administration requirements within the E Roster team is progressing to recruitment and the Senior Nursing team have secured additional resource to ensure that this is rolled out effectively and principles well embedded. This roll out will be supported by an experienced matron who is flexibly retiring and returning mid-April 2022 whose focus will be to complete the safer nursing care tool audit and then commence roll out of the safe care model.

Registered Nurse Recruitment

The Trust participated in an ICS review of the process for recruiting newly qualified nurses and this has resulted in a streamlined ICS approach. All SYB ICS Trusts advertise for newly qualified registered adult nurses at the same time and progress assessments / interviews

and job offers within the same time period. This applies to all adult nurses and has resulted in a bi-annual agreed recruitment process for newly qualified staff.

This has been utilised for the September 2022 Newly Qualified cohort of nurses and the DBTH has so far offered approx. 70 posts, with the majority of offers being made based on candidate's 1st or 2nd preferences of clinical area to complete their 12-month preceptorship programme in.

Focused recruitment campaigns for clinical areas that are facing challenges is progressing, with plans for additional recruitment resources similar to HCA resources, to support more aggressive recruitment for targeted areas. Further practice development posts have been funded for a 6-month period to support our newly qualified nurses in their transition from Student Nurse to Staff nurse across Medicine and Surgery, in addition to posts across other clinical areas including theatre specialities supporting newly qualified operating department practitioners. This is a positive message to new starters as they will be supported not only through ward based and Trust preceptorship processes but also by a team of skilled and knowledgeable clinical education and practice development teams who will support their transition within the Trust and their new role.

International Nurse Recruitment

The Trust worked in partnership with NHS Professionals to recruit 50 international nurses from India for 2021 and all 50 are now in place. NHS Professionals have provided recruitment support to all of the other trusts in the SYB ICS so our involvement will strengthen partnership working further. Continuing to work in partnership with NHSP a further 50 adult nurses and 5 paediatric nurses will be recruited across 2022/2023 to DBTH. To support this continued international national nurse recruitment strategy additional support has been secured to provide a second practice educator who will work in conjunction with the temporary Pastoral Care Officer and Practice Educator who already oversee this staff group to ensure integration and support through the Trust induction, orientation and OSCE training programme.

A stay & thrive matron post commenced in January 2022 and works with the internationally recruited nurses to support as seamless a transition into nursing in the UK as possible. This approach is based on prior experience and learning from each cohort recruited to DBTH. This post was progressed in recognition of learning from other organisations to maintain effective retention of this valuable nursing resource. Progression of this as a substantive post will be supported by an impact evaluation and via a business case process during May / June 2022. The focus of the stay and thrive matron will be to support international recruitment with a focus on further developing the nurses, recognizing and rewarding prior experience and also supporting them to thrive within the NHS and at DBTH.

Assistant Practitioner and Nurse Associate Recruitment Strategy

The Trust continues to explore all avenues of recruitment, this includes Nurse Associates and Assistant practitioners. Currently the following plans are in place and include:

- Approximately 5 to 10 Trainee assistant practitioners per intake, with a focus on areas such as Ophthalmology, Breast, Urology, Orthopaedics, Radiology. There is

continual adhoc recruitment to TNA posts throughout the year on top of the planned intakes.

- For Nurse Associates there is a twice yearly recruitment - approx. 15 per intake, which focus mainly on ward areas and the emergency department

Healthcare Assistant recruitment

Health care assistant recruitment remains a focus for the nursing teams and the Trust are continued to work with Indeed as part of the national zero HCSW programme and has now moved to a Trust monthly recruitment process. Recruitment has been challenging and on the whole the starting salary for HCAs in training and on qualification is not seen as attractive in comparison to other local employers including distribution companies. Since the beginning of 2022 we have recruited 80 HCAs with a further 20 in the pipeline to commence in post.

Although the Trust cannot influence change on salary, as this is set nationally via agenda for change, it can place focus on flexible working, job satisfaction, employee benefits and career progression as methods to recruit and retain staff. Development of recruitment resources to support healthcare recruitment continues including production of a HCA recruitment video which promotes the role and career opportunities at DBTH for staff working within health care assistant roles. Utilisation of other promotional materials including a radio campaign and banners for use across the community setting promoting the Trust and the role.

Further work with Doncaster College, DBTH recruitment, nursing and vocational education teams is underway to secure a feeder stream of Level 2 / 3 health & social care students into the Trust in preparation for winter 2022. This will be set up similar to the feeder streams we already utilise for NQ nurse recruitment with the next recruitment campaign aimed to take place during June 2022 at Doncaster College and Bassetlaw area college (RNN).

The vocational team are also expanding the support provided to HCA in training within the clinical setting with a new Assistant practitioner post, which as well as being beneficial to learners is also an example of career progression for HCA into training and development roles.

Professional Nurse Advocate

The Professional Nurse Advocate (PNA) role initiated by Ruth May Chief Nurse - with Trusts being asked to progress to a 1 PNA to every 20 Nurses / Midwifes ratio by the end of 2024. To support this the Trust appointed a 12-month post for a lead PNA post in partnership with University of Sheffield (UoS). The post holder has placed her initial focus on roll out of PNA's at DBTH including a trainee recruitment process, governance framework, proposal for funding of PNA protected time within clinical budgets and developing and supporting a team of trained and clinically supervised PNA's. The PNA lead is also supporting the UoS with delivery of the national level 7 academic PNA programme with the aim of supporting the majority of trust PNA applicants through the UoS programme, which will also provide consistent support as each academic provider delivers the training programme differently. Initial progress is promising with the likelihood the Trust will achieve the 1 RN to 60 nurses required by the end of 2022/2023 and on plan to achieve 1 RN to 20 nurses by the end of 2024/2025.

The PNA lead is currently drafting a business case with the Senior Nursing team to gain support to fund a permanent PNA lead post and provide PNA's with protected time to undertake the role. Presentation at a national PNA conference has also raised the profile of the way in which DBTH is investing and supporting the PNA initiative.

Agency Usage

The Trust are committed to ensuring safe care is provided across the clinical areas and whilst there are significant staffing challenges use of temporary workforce solutions including agency for Registered Nurse vacancies has supported this commitment.

To support appropriate use of temporary workforce solutions including agency the senior nursing team have implemented an escalation process for release of service essential vacant shifts to agency providers via NHSP. For higher cost agencies this requires a senior nurse / executive to review shortfall requests and when all other opportunities have been explored (including lower cost agency) the nominated senior nurses / executives will authorise vacant shifts to be released to higher cost agency providers. This is undertaken in a tier cascade approach with lower cost agencies being given a longer period to fill a vacant shift and then a golden key approach to enable shifts to be released to higher cost agencies if deemed to be required. The current golden key approach has been reduced back to 48 hours which provides more time for wards, NHSP and lower cost agencies to fill vacancy / short term absence gaps. Decisions supporting escalation of shifts to agency is underpinned by the use of a RAG rating approach of planned V actual staffing and review of other red flags which are provided by a face to face visit to a clinical area and review of digital system data including risk assessment outcomes and E Observation data.

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	24 May 2022	**Agenda Reference:**	C3
Report Title:	**Infection, Prevention & Control Board Assurance Framework**		
Sponsor:	Abigail Trainer, Acting Chief Nurse		
Author:	Dr Ken Agwuh, Director of Infection Prevention and Control Miriam Boyak, Lead Nurse Infection Prevention and Control		
Appendices:	0		

Report Summary	
Purpose of report:	The existing IPC board assurance framework was issued on 24 December 2021 (version 1.8), an updated version is due in May 2022 but at the time of writing has not yet been received from NHSE. The True North Strategic Aim 1 Covid SA1 has been updated with local guidance and changes. This detail is reflected in the BAF update.
Summary of key issues/positive highlights:	NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic. Effective infection prevention and control is fundamental to our efforts. NHSE/I have further developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with UKHSA Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022and other related infection prevention and control guidance to identify risks associated with COVID-19 and other seasonal respiratory viral infections. The general principles can be applied across all settings, acute and specialist hospitals. The framework is be used to assure directors of infection prevention and control, medical directors, and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards. Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.
Recommendation:	For information

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 2022	**Decision:**	Regular updates required to QEC
Next Steps:	Update progress to QEC		
Previously circulated reports to supplement this paper:	None		

Classification: Official

Publication approval reference: C1501

Infection prevention and control board assurance framework

24 December 2021 Version 1.8

Updates from version 1.6 are highlighted in yellow.

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have further developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with UKHSA Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022and other related infection prevention and control guidance to identify risks associated with COVID-19 and other seasonal respiratory viral infections The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors, and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May

Ruth May
Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, guidance on the required infection prevention and control measures has been published, this has now been updated and refined to reflect the learning from the SARS-CoV-2 and to acknowledge the threat from other respiratory viruses. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users, and staff.

This framework has been developed and updated following updates in the guidance to help providers assess themselves as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors, and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

2. Legislative framework

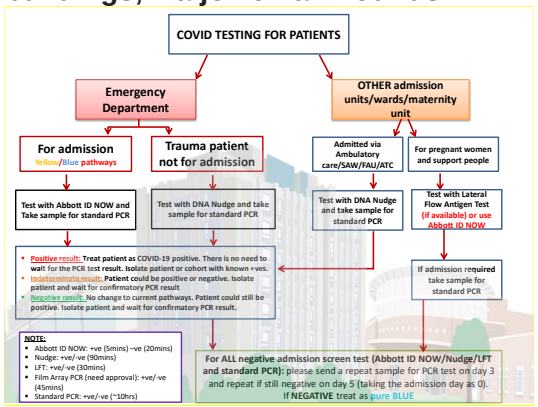
The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. Local risk assessments should be based on the measures as prioritised in the hierarchy of controls. In the context of SARs-CoV-2 and other seasonal respiratory viruses, there is an inherent level of risk for NHS staff who are treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed, and mitigated effectively.

Infection prevention and control board assurance framework

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure that: • a respiratory season/winter plan is in place: ○ that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services ○ to enable appropriate segregation of cases depending on the pathogen. ○ plan for and manage increasing case numbers where they occur. ○ a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan.	**Rapid POCT (ABBOTT ID Now is in place in all admission areas to facilitate testing for COVID-19, for Influenza and for RSV (in Paediatrics). This supports optimum patient placement/segregation and pathway to minimise the risk of cross infection. Trust has designated wards and areas in order compartmentalise cases, with the facility to step up and down as demand changes.** **A multidisciplinary team approach including Senior leaders, estates and facilities, IPC and clinical staff is applied in reviewing services and buildings, via joint walk rounds.** 		

• health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.	**Safer working risk assessments are completed and risk mitigated against. For example screens at receptions and in office areas. Natural ventilation, PPE. Maximum occupancy signage is displayed accounting for safe social distance.** 1a-1b.-COVID-19-Safe-Working-Risk-Asses		
• Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: ○ based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area. ○ applied in order and include elimination; substitution, engineering, administration and PPE/RPE**.** ○ communicated to staff.	**Estates are working across the Trust to assess ventilation in all areas and put into a RAG prioritisation plan for work with regard to ventilation. Where ventilation is not optimum, extraction is being put in place, air scrubbers are being used and where there are high numbers of COVID-19 positive patients with respiratory symptoms and AGPS staff wear a higher level of RPE.**		

• safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems. • if the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems. • risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents.	**Risks are discussed and reviewed through local governance processes.** **National IPC guidance is being followed. Care pathways remain unchanged. Any deviation from guidance is assessed through governance processes and escalated to Execs as appropriate.** **Workplace risk assessments are undertaken by staff who have the skills and knowledge to recognise hazards associated with infectious agents. This work is supported by the members of the IPC team.**		

• if an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered.	**Wards/departments where there are high numbers of COVID positive cases with respiratory symptoms/AGPS FFP3 masks are used as standard.**  covid-19-flowchart (8) 280121.pdf		
• ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services.	**Patients are not moved unnecessarily except for clinical need or if there is a change in their infectious status. Where patients are moved this is done with consideration of the clinical context and where the patient can receive the most appropriate care.**		
• the Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep.in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases	**In place**		
• there are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas.	**Senior leaders are visible in both clinical and non clinical areas and check and challenge IPC practice where appropriate to do so**		
	IPC Ward Accreditation processes are ongoing for wards and		

• resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).
 	
• the application of IPC practices within this guidance is monitored, eg:
  ○ hand hygiene.
  ○ PPE donning and doffing training.
  ○ cleaning and decontamination.
 	
• the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board.
 	
• the Trust Board has oversight of ongoing outbreaks and action plans.
	departments. IPC practice education material has been put out together as part of essential standards that are expected from NHSP/Agency staff when they book shifts in the Trust.
	 
	NHSP educational material.pdf
	
	Hand Hygiene, PPE audits are completed by IPC staff.
	
	In place
	
	Exec representative is invited to outbreak control meetings. Divisional managers and matrons attend outbreak control meetings and action any points raised at the time of the meeting.
		There is a delay on writing up of outbreak control meetings due to IPC workload and increased number of outbreaks. Admin support is now in place for the team since February 2022	At the outset of the pandemic large numbers of staff were trained in donning and doffing correctly and PPE safety officers were in place. PPE safety officers have since returned to clinical practice.
			
			Re-working of the IPC budget has occurred and a band 3 admin assistant has been appointed to release specialist nursing time. The

• the Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required.	**Staff are fit tested on Reusable GVS masks and these are issued to individuals. In addition the Trust has a supply of UK make FFP3 masks should they be required and FIT testing for these are ongoing**	The majority of new groups of staff to the organisation are fit tested if they are working in clinical practice, by the education department. New starters who are not in clinical practice are referred to the IPC team for FIT testing. IPC can only offer a limited number of Fit testing sessions due to the size of the team.	post is at the employment check phase. This has been completed.

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • the Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level. • the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms	**National Cleaning standards have been reviewed by Estates and facilities colleagues with IPC. Risk stratification and gap analysis has been completed. Plan is to implement by May 2022.**  B0271-national-standards-of-healthcare-cle **The Trust has a Space Utilisation Group where functionality is reviewed and agreed. Any changes are discussed with the DIPC/IPC team.**		

• cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	**Environmental audits are completed by the IPC team. Cleanliness audits are completed by estates and facilities staff, frequency dependent on the risk stratification. Any required action is taken to maintain cleanliness standards.**		
• increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas.	**Areas where there is a higher risk of transmission of infectious organisms received enhanced cleaning twice per day and ad hoc as required.**		
• Where patients with respiratory infections are cared for : cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance.	**Peracide is used – Peracetic acid**  PERACIDE SDS V5 28.05.21.pdf		
• if an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses.	**Prior to implementation of Peracide, work was undertaken by Microbiology colleagues and IPC team to test and approve the agent for cleaning. It is effective against enveloped viruses and other infectious organisms.**		

• manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.
• a minimum of twice daily cleaning of:
  ○ patient isolation rooms**.**
  ○ cohort areas**.**
  ○ Donning & doffing areas
  ○ 'Frequently touched' surfaces eg, door/toilet handles, patient call bells, over bed tables and bed rails**.**
  ○ where there may be higher environmental contamination rates, including:
  ▪ toilets/commodes particularly if patients have diarrhoea.
• A terminal/deep clean of inpatient rooms is carried out:
  ○ following resolutions of symptoms and removal of precautions.
  ○ when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens);
  ○ following an AGP **if room vacated** (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).
• reusable non-invasive care equipment is decontaminated:
  ○ between each use**.**
	In place
	
	In place. Estates and facilities clean all except commodes which is done by nursing staff.
	
	In Place.
	
	RAG rate has been devised to assist with level of cleans required and to clarify cleaning roles and responsibilities.
	 
	A3 cleaning RAG.pdf
	In place
	
	In Place.		

○ after blood and/or body fluid contamination ○ at regular predefined intervals as part of an equipment cleaning protocol ○ before inspection, servicing, or repair equipment. • Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	**Cleaning checklists are held at ward level and reporting on the electronic dashboard.** **Cleanliness is audited by estates and facilities and patient equipment is audited by IPC team and is included in the Ward Accreditation.**		
• As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance. In patient Care Health Building Note 04-01: Adult in-patient facilities. • the assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer.	**Ventilation is not adequate in some wards and departments** **The ventilation safety group is in place including estates, ventilation engineer and IPC to inform ventilation assessments and work.**		**Estates are undertaking review of ventilation and are RAG rating areas for work and working to prioritise areas with IPC. Air scrubbers have been purchased to improve air filtration**

• a systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways • where possible air is diluted by natural ventilation by opening windows and doors where appropriate • where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group. • when considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.	**This is in progress** **All external windows and doors are opened where possible to improve natural ventilation.** **Hepa Filtered Air scrubbers have been purchased with a plan to purchase more. Priority list has been drawn up and first machines have been placed in clinical areas.** **Assessments for screens are undertaken and fitted by Estates colleagues where appropriate and are incorporated into cleaning regimes.**	**In older parts of the estate, windows cannot be opened.** **When switched on fully the machines are noisy which may be difficult for patients trying to sleep.**	**Work is planned for estates to construct extraction panels in the windows.** **Machines are being set to 50% to reduce the noise.**
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and process are in place to ensure that: • arrangements for antimicrobial stewardship are maintained • previous antimicrobial history is considered • the use of antimicrobials is managed and monitored: ○ to reduce inappropriate prescribing.	**The Trust has an antimicrobial pharmacist who is works with Microbiologists to optimise antimicrobial stewardship advice.**	**Frequency of auditing has reduced due to increased workload in the Microbiology team**	

○ to ensure patients with infections are treated promptly with correct antibiotic. • mandatory reporting requirements are adhered to, and boards continue to maintain oversight. • risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.	**Antibiotic audits are undertaken by Microbiologists, antimicrobial pharmacist and IPC team.** **Trust guidelines are in place and updated according to guidance.** **In place. Regular audits of high risk antibiotics are completed for wards/departments and are shared through governance processes.** **Antimicrobial guidance and advice is given to minimise the risk of consequences of other pathogens such as Clostridioides difficile and others. Post Infection Reviews identify themes in prescribing of antibiotics which are reviewed via governance processes.**	**and IPC team. The previously fulltime antimicrobial pharmacist has returned from maternity leave on part time hours therefore affecting the pharmacy resource for antimicrobial stewardship**	

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors	**Compassionate visiting guidance is in place to support visiting wherever possible. Visiting at the end of a patient's life and where patients require a relative or carer to be with them is supported as much as possible. When infection prevalence is high in the community and during outbreaks, visiting is restricted.**		

• national guidance on visiting patients in a care setting is implemented. • restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment.	 C1519 Visiting healthcare inpatient s **In the most part in place. Visitors will be asked to complete a lateral flow test prior to visiting.** **During outbreak this is restricted except at end of life and where patient needs a carer or relative to be with them throughout their admission. Where visiting in these circumstances is in place, staff communicate the risk to individuals and provide support to minimise risk, such as wearing of PPE, hand hygiene.**	**Difficulty in policing lateral flow testing and gaining evidence that test has been completed.**	**Questions are asked of visitors on arrival, whether they are symptomatic or have had any known contact with a positive case. Temperatures are taken. Visitors attend by prior arrangement.**

• there is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing.	**There is signage in place.**	**The signage varies between departments**	**Identified member of the IPC team is to work with Comms/medical illustration to rationalise and standardise posters/written information**
• if visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM.	**In place. Type 2R masks are in dispensers in selected high traffic entrances for patients and visitors to take and wear.**		
• visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (eg, parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible.	**All visitors to wards and department are asked standard questions relating to them feeling unwell, having respiratory symptoms or whether they have been a contact of a positive case of COVID-19. Where there is a question of status and to facilitate compassionate visiting, POCT is performed to have a COVID-19 test result within twenty minutes.**		

• visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment eg, carer/parent/guardian.	**Visitors are not present during AGPs. If a patient is at the end of their life or where it is essential that a patient is accompanied a hood can be provided for the visitor to Provide respiratory protection whilst visiting their loved one.**		
• Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been adopted C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	**Elements of the toolkit appropriate to the Trust is implemented.**		
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	**Patients are asked on arrival to departments**	**Notices are not consistently displayed.**	**Member of the IPC team is working with comms and medical illustration to rationalise and standardise signage.**
• infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred.	**In place**		
• staff are aware of agreed template for screening questions to ask.	**In place. Clear and consistent signage will also help.**		

• screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment. • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance. • triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible. • there is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved.	 Screening questions.pdf **Patients attending for elective procedures are screened 72 hours prior to attendance and asked to isolate until their procedure.** **Patients are triaged in admission areas for suspected or confirmed COVID-19. All patients admitted are screened using the ABBOTT ID NOW point of care machine and patients are set on the appropriate patient pathway (Yellow or blue)** **In place** **Compliance with testing protocols is monitored by the IPC team and where compliance is problematic, screening**		

	regimes are altered to minimise the risk of infection based on the patient group and area. For example weekly testing in some inpatient areas where there have been outbreaks. DBTH screening regimes have always been more frequent and robust than national guidance.		
• patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated.	**In place. In patients are given FRSM Type 2 R.** **Outpatients are requested to change face covering to FRSM Type 2R (provided) on arrival to department.**	**Some patients will not wear masks because they are exempt or due to cognitive impairment**	**Where masks are not tolerated, other IPC measures are optimised. For example segregation from others, social distancing and hand hygiene. Staff are asked to wear visors where patients do not wear masks to protect them from COVID-19 passing from infected respiratory secretions to the eyes of the member of staff.**
• patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result.	**Patient with Respiratory symptoms are segregated and POCT test completed on arrival. They are then either segregated or cohorted**		

• patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing. • patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare eg, priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered.	**dependent on results and retested on day 3, day 5, and day 7 of their admission (if they remain negative)**  SOP OPD final.doc **Patients who have respiratory symptoms are treated as suspected COVID 19 until proven otherwise. They are therefore isolated or cohorted. They are tested at the first available opportunity. POCT results are returned within 20 minutes and the patient is placed on the appropriate pathway.** **Patient placement is risk assessed by clinical teams with advice and support from the IPC team. Patients who are high risk are accommodated in side rooms where possible or segregated from others. To further minimise risk, weekly screens are performed on at risk groups. For example Haematology, Chemotherapy patients, Renal**		

	patients and other groups of patients. Patient placement is based on risk assessment by clinical teams with IPC support and advice. Compassionate visiting is in place.		
• where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes.	**The clinical condition and appropriateness of delay is assessed by the clinicians on a case by case basis. Wherever possible treatments/procedures are delayed until symptoms have resolved. Where procedures are not delayed, a higher level of PPE is worn by staff.**		
• face masks/coverings are worn by staff and patients in all health and care facilities.	**All staff wear face masks wherever possible.**	**Some patients cannot tolerate masks for clinical reasons or they are exempt.**	**Where masks are not tolerated, other IPC measures are optimised. For example**

			segregation from others, social distancing and hand hygiene. Staff are asked to wear visors where patients do not wear masks to protect them from COVID-19 passing from infected respiratory secretions to the eyes of the member of staff.
• where infectious respiratory patients are cared for physical distancing remains at 2 metres distance.	**In place**		
• patients, visitors, and staff can maintain 1 metre or greater social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, eg, to protect reception staff.	**In place wherever possible. Screens are in place in reception areas and some office spaces.**	**At times of increased demand, Patients in ED cannot be socially distanced.**	**All attendees are asked to socially distance where possible, wear FRSM and practice good hand hygiene, hand sanitisers are available for patient use as well as staff. Air scrubbers have been sited in the ED department to improve air filtration.**
• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly.	**Where patients become symptomatic and COVID is suspected, they are isolated promptly and screened. This does not happen often due to DBTH screening regimes. All patients are screened on day 0, day 3, day 5, day 7 and day 28 if they remain negative. If they are identified as a contact of a positive case whilst in hospital, they**		

	are screened at least weekly for two weeks. Since prevalence has increased with Omicron variant, the initial screening regime of day 0, 3, 5 and 7 is reset when they are identified as contacts on review by IPC. This means that COVID-19 in asymptomatic patients is detected and action taken to cohort/isolate before symptoms begin. **Contacts are traced on each positive case detected whilst in hospital and a 'pink shield' electronic label is put on to CAMIS, patient placement of contacts are closely monitored and advice given by IPC on a daily basis.**		
• isolation, testing and instigation of contact tracing is achieved for all patients with new-onset symptoms, until proven negative.			

• patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.	**In place as above** **In place. Patients are who attend for appointments are asked screening questions. If identified as having symptoms, they are segregated from others until a clinical decision is made by the clinician as to whether the appointment can go ahead. The patient is advised accordingly.**		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • appropriate infection prevention education is provided for staff, patients, and visitors.	**Staff receive induction – this is via elearning currently. Departments are expected to provide IPC principles to visitors. Ad hoc face to face education is provided by members of the IPC team in the ward or department environment.**	**No formal face to face training is provided by IPC due to increased COVID-19 activity and workload.**	

• training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely.	**The majority of new staff are Fit tested on FFP3 masks by the education team at induction. Those staff who are not working in a high risk area are not fit tested at induction but are referred to the IPC team for Fit testing at a later date. IPC team aim to FIT test one day per week.** **National fit testing team are supporting the Trust with fit testing.**	**Since the onset of the pandemic, the demand for Fit testing has far outweighed what the IPC team can provide. At times of increased workload, the Infection Control Nurses are unable to provide Fit testing once per week.**	**A Band 2 who will provide Fit testing one day per week has been approved at VCF and is going to advert. National fit testers are supporting the Trust with fit testing and the education team are supporting also.**
• all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it;	**At the onset of the pandemic large groups of staff were trained on appropriate use of PPE and how to don and doff safely. PPE safety officers were trained but returned to clinical practice after the first wave of the pandemic. IPC provide adhoc PPE training. Guidance is provided on the HIVE and posters are available on how to don and doff safely.**	**Due to increased workload and COVID activity, IPC team cannot provide formal training in donning and doffing.**	**Reworking of IPC budget has release funds to appoint a band 3 admin worker to release IPC Nurses time. This is at the pre-employment check stage of the appointment process. Band 2 post has been approved at VCF and is going to advert. The band 2 will audit basic IPC**

			practice in addition to fit testing.
• adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	**Ad hoc audits on the use of PPE is completed by the IPC team. Themes are discussed with clinical teams. Guidance is reinforced through HIVE.**	**Due to increased workload IPC team cannot regularly audit.**	**Reworking of IPC budget has release funds to appoint a band 3 admin worker to release IPC Nurses time. This is at the pre-employment check stage of the appointment process. Band 2 post has been approved at VCF and is going to advert. The band 2 will audit basic IPC practice in addition to fit testing.**
• gloves are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's.	**In place**		
• the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance.	**There are no hand dryers in use in the clinical areas. Absorbent paper towels are available and appropriately sited.**		
• staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace	**Staff are aware to maintain social distancing. Reminders are placed in**		

	buzz and social media. Posters are in place.		
• staff understand the requirements for uniform laundering where this is not provided for onsite.	**Staff are aware of requirements for laundering uniform. This is covered in SET. In addition staff are instructed not to travel to and from duty in their uniform.**		
• all staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance.	**Staff are aware of current guidance which is available on the HIVE. The COVID Advice team and IPC give advice throughout the day to staff on isolation requirements. ABBOTT POCT testing is facilitated by the Occupational Health colleagues for rapid testing of staff identified as having contact with a COVID positive case. This is facilitated Monday to Friday 08:00 until 10:00 and 16:00 until 18:00.**		
• to monitor compliance and reporting for asymptomatic staff testing	**Staff are encouraged to undertaken LFT testing routinely and to report results. Results are fed back to**		

	clinical areas periodically on levels of testing. Reminders to test via LFTs are given regularly via different channels and guidance is available on the HIVE.		
• there is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals).	**Cases and contacts are reviewed daily. Local rates are reviewed and discussed in local partner calls and a response. Rates are reviewed in enhanced ops and inform actions.**		
• positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	**All cases that meet the UKHSA criteria for probable or definite hospital acquisition of COVID-19 are reviewed. DATIX completed and PIR completed. Clusters are reviewed by DIPC and identified and reported as outbreak accordingly.**	**Due to number of cases, PIRs from wave one and two are completed retrospectively.**	**Admin post in IPC team appointed to, awaiting pre-employment check and date to start.**

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • that clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs. • separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients. • patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals.	**Where tolerated all patients wear face masks when moving around the Trust.** **Screening questions are asked on arrival. Where patients are identified as having respiratory symptoms, they are segregated and a PCR swab is taken. A clinical decision is then sought as to whether the appointment should continue to be rescheduled. This decision is made on a case by case basis and is driven by clinical need.** **Where appointments go ahead, IPC precautions appropriate to the high risk setting pathway are put in place.**		

• patients are appropriately placed ie, infectious patients in isolation or cohorts.	**In place and reviewed daily by IPC (Monday to Friday)**		
• ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements).	**In place. Senior leaders and clinical staff along with IPC conduct frequent walk rounds considering IPC risk and precautions.**		
• standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result • the principles of SICPs and TBPs continued to be applied when caring for the deceased	**In place** **In place**		
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals.	**Screening is undertaken by clinical staff. Where ABBOTT ID POCT machines are in place, staff are appropriately trained on their use.**		
• patient testing for all respiratory viruses testing is undertaken promptly and in line with national guidance;	**Screening for Respiratory viruses are done on admission, day 3, day 5, day 7 and day 28 if negative. If positive then screening is done at day 14 and every seven days until one negative**		

	us obtained in order to step down IPC precautions.	
• staff testing protocols are in place	**Staff testing protocols are in place and guidance provided on the HIVE.**	
• there is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available. • there is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data). • screening for other potential infections takes place. • that all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission.	**In place** **In Place** **In place** **All emergency patients are testing using PCR and using rapid point of care testing in order to facilitate appropriate care and treatment within 20 minutes.**	
• that those inpatients who go on to develop symptoms of respiratory infection/COVID-19 after admission are retested at the point symptoms arise. • that all emergency admissions who test negative on admission are retested for COVID-19 on day 3 of admission, and again between 5-7 days post admission. • that sites with high nosocomial rates should consider testing COVID-19 negative patients daily.	**In Place** **Screening takes place on admission, day 3, day 5 and day 7.**	

• that those being discharged to a care home are tested for COVID-19, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge.	**Not in place** **Patients being discharged to care homes are tested via PCR within 48 hours. If result is not available to avoid further delays and associated risks, a Rapid POCT is performed. This is communicated to the home and PCR result is followed up by the IPC team who confirm the result with the care homes.**	**Not considered necessary currently**
• those patients being discharged to a care facility within their 14-day isolation period are discharged to a designated care setting, where they should complete their remaining isolation as per national guidance	**In place. DBTH work closely with partners to ensure this happens.**	
• there is an assessment of the need for a negative PCR and 3 days self-isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance.	**All patients planned for elective procedures are screened 72 hours prior to the procedure and are asked to isolate until their procedure.**	
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections		

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure that			
• the application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	**Ward Accreditation is in place, including regular audits. IPC team audit IPC practices.**		
• staff are supported in adhering to all IPC policies, including those for other alert organisms.	**IPC team advise on all aspects of infection prevention and control and support teams to apply best practice**		
• safe spaces for staff break areas/changing facilities are provided.	**Break areas and staff changing facilities are in place.**	**There are limited changing facilities and break areas. Some spaces have been designated staff break areas to assist staff to maintain social distancing during break times and mask removal.**	
• robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	**Policies and procedures are available. Outbreaks are reported on the NHS electronic reporting system.**	**Written summaries of outbreak meetings are behind due to increased workload and no admin support in the IPC team. Admin post has been appointed to and at the pre-employment stage of the recruitment process. Outbreak meetings are held with key divisional leaders so that actions are agreed and taken forward.**	
• all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance.	**Linen/laundry segregation is done in accordance with IPC guidance and policies using the red bags for soiled linen and linen from patients with**		

	infectious organisms. Linen is processed off site.		
• PPE stock is appropriately stored and accessible to staff who require it.	**There is no shortage of PPE. Inventory management and procurement colleagues conduct regular stock checks and top ups to clinical areas. PPE in clinical areas are stored in Danicentres close to the point of care to facilitate appropriate use in accordance with IPC best practice.**		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that:			
• staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy.	Occupational Health, POD and IPC collegues work together to provide advice and guidance in relation to COVID-19 and other infectious organisms		

• bank, agency, and locum staff follow the same deployment advice as permanent staff.	Bank, agency staff are management as permanent staff in terms of deployment.		
• staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-isolate (see Staff isolation: approach following updated government guidance)	Staff are allowed to return to work in accordance with government guidance when they have been a contact of a COVID positive case. Where return to work may be delayed by awaiting PCR results, at times of critical shortages, ABBOTT rapid testing is offered to staff to ensure business continuity and patient safety through safer staffing.		
• staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE. • a fit testing programme is in place for those who may need to wear respiratory protection.	See section 6 above, page 26 See section 6, page 25		
• where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: o lead on the implementation of systems to monitor for illness and absence. o facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce	The COVID Advice team will speak with all staff who test positive and will conduct an assessment. Any breaches in IPC practices are discussed and further tracing of contacts is done. Advice on isolation and treatment are given. Offers of support with daily living such as shopping etc is offered to assist staff to isolate in accordance with guidance. DBTH also offer TLC service		

○ lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19 ○ encourage staff vaccine uptake.	to promote health and wellbeing of staff throughout the pandemic. Flu and COVID vaccination programme is facilitated by OH/HR colleagues and has been very successful. Planning is progress to support the mandated vaccination status of all NHS staff from April 2022.		
• staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance.	All staff whether vaccinated or not are treated the same in terms of PPE requirements and IPC practices. The difference for unvaccinated and vaccinated individuals is around the period of isolation. National guidance is followed in this regard.		

• a risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19. ○ A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups**;** ○ that advice is available to all health and social care staff, including specific advice to those at risk from complications**.** ○ Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff**.** ○ A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.	Individual assessments have been and continue to be carried out for staff in at risk groups. Advice on level of respiratory protection is given and redeployment is advised and put in place according to individual risk assessments carried out by OH colleagues.		
• vaccination and testing policies are in place as advised by occupational health/public health. • staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance and a record of this training is maintained and held centrally/ESR records.	In place See section 6. Standards are in accordance with HSE guidance and record of FIT testing is made against individual ESR records.		
• staff who carry out fit test training are trained and competent to do so.	Staff who fit test are trained and competent to do so.	Refresher training needs to be organised formally by Fit2Fit accredited instructor.	Fit2Fit accredited instructor from the manufacturer of the quantitative testing machines provides refresher training to a limited number of testers commensurate with number of machines purchased. As demand for fit testing has increased significantly and with

			it the number of fit testers required, funding will need be considered to facilitate refresher training for more individuals.
• all staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used.	In place – see section 6		
• all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	This is in progress	Resource required to fit test on two masks is immense and although is being worked towards, this may be unachievable	Fit testing is on reusable GVS masks in the first instance. A GVS is provided to each individual who passes a Fit test with the GVS mask. This is then to be looked after and used by each individual. Filter changes and replacement when damaged or lost is provided.
• a record of the fit test and result is given to and kept by the trainee and centrally within the organisation.	Results of the Fit test (pass or fail) and the name of the masks on which the individual has passed or failed is recorded on ESR. Paper record is also provided to the individual.		
• those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators and hoods.	Reusable GVS masks are used. Where the individual fails on this, alternative UK manufactured disposable FFP3 masks are provided after successful fit test. If individuals fail on all masks, hoods are available in departments for staff to use.		

• that where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions.	Where staff cannot be fit tested or wear a hood are considered for redeployment. No member of staff is expected to work in a high risk areas without the necessary PPE. Redeployment is offered after assessment by OH colleagues.		
• members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm.	In place within OH records. Records are available centrally on ESR, and are provided by Education and Training department on request. Wherever possible staff do not work across pathways.		
• a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health.	In Place		
• boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.	In Place see above		
• consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between	In place see above	In order to maintain safe staffing levels,	This is kept to a minimum and staff

planned/elective care pathways and urgent/emergency care pathways as per national guidance.		staff are sometimes expected to work across pathways	are not moved mid shift. They are expected to wear a clean uniform and shower between shifts.
• health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone. • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing. • staff who test positive have adequate information and support to aid their recovery and return to work.	In place COVID Advice Line and Health and Wellbeing team support staff whilst in isolation.		

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	24 May 2022	**Agenda Reference:**	C4		
Report Title:	**Maternity Update**				
Sponsor:	David Purdue – Board Level Safety Champion for Maternity				
Author:	Lois Mellor – Director of Midwifery				
Appendices:	Perinatal Surveillance Dashboard (March and April 2022) Quarterly review meeting slides				
Report Summary					
Purpose of report:	To update the Board on the progress in the Maternity Service				
Summary of key issues/positive highlights:	• Update on current PMRT reviews for the month and quarter 4 findings • Current HSIB cases in progress, no new cases and no new reports received. • Education and training compliance below the 90% target due to the pausing of training during the recent wave of covid 19 • Trajectories / plans in place to recover the training position • Ongoing work with the maternity voices partnership (MVP) and improved collaborative working • Year 4 CNST standards recommenced 7 May 2022				
Recommendation:	None				
Action Require:	Approval	Information X	Discussion X	Assurance X	Review

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

Implications	
Board assurance framework:	
Corporate risk register:	
Regulation:	
Legal:	
Resources:	

Assurance Route			
Previously considered by:	All parts of this report have been discussed at all levels in the C & F Division.		
Date:		**Decision:**	

Next Steps:	Support to continue with improvements in maternity service, and achieve full compliance with CNST Year 4 standards and the Ockenden immediate actions
Previously circulated reports to supplement this paper:	

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Monthly Board Report

April 2022

Please read this report in conjunction with the Board Surveillance PowerPoint Presentation

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

1.1 Stillbirths and late fetal loss > 22 weeks

April 2022 cases

1. Twin pregnancy babies delivered at 26+5 weeks, one baby died and one survived and is doing well. Known to have ruptured membranes from early pregnancy, has recurrent vaginal bleeds. Pathological fetal monitoring prior to babies being born. Currently under review.
2. Stillbirth at 36+5 weeks no fetal heart present at presentation. Known smoker, declined cessation services and had a previous growth retarded baby

1.2 Neonatal Deaths

Baby born at 29+5 weeks gestation, died at 66 days old due to a life limiting condition.

Actions / Learning from PMRT reviews

1. A need for a self-contained bereavement suite to care for families suffering a fetal loss is required. This is in progress and the work will commence this year.
2. A number of women have has Covid 19 in pregnancy but have had death > 14 days after the infection. There is ongoing surveillance implemented for women who have been admitted with Covid 19, and there is the option for women to use pulseoximetery at home during a Covid 19 infection.

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

Cases to date (No change)	
Total referrals	20
Referrals / cases rejected	4
Total investigations to date	16
Total investigations completed	14
Current active cases	2
Exception reporting	0

2.1 Reports Received since last report

HSIB case number: MI-004981
HSIB criteria: HIE/ Cooling

2.2 Current investigations

HSIB case number: MI-006029
HSIB criteria: HIE/ Cooling
Trust site: Doncaster
Incident date: 13.01.22
Referral date: 18.01.22
Consent date: 25.01.22
Six-month deadline: 18.07.22

Staff interview complete
SMART 2 panel booked 5 May
TOR sent to the Trust and family
Draft report underway

HSIB case number: MI-006325
HSIB criteria: HIE/ Cooling
Trust site: Doncaster
Incident date: 25.01.22
Referral date: 28.01.22
Consent date: 28.01.22
Six-month deadline: 28.07.22

All maternity interviews scheduled
Neonatal review arrange for 4 May
Request for any neonatal will be sent after then

Quarterly Review meeting held on 22 April 22

The full set of slides is contained in the appendices

Since the commencement of HSIB investigations in January 2019 the service has been looking for themes within the reports. HSIB help by collating this information for us and this is represented in the table below

Theme	2019	2020	2021	2022	Total
Escalation		1	3		4
Risk Assessment		2	1		3
Staffing	1		2		3
Clinical Assessment	1	1	1		3
Clinical Oversight		2	1		3
Fetal Monitoring		2	1		3
Training	1		1		1
Situational awareness			2		2
No recommendations					4
Equipment			1		1

Triage	1				1
Induction of labour			1		1
Documentation	1				1
Clinical Appointments			1		1
Guidance	1				1

Service response to themes identified in the Reports

- Situational awareness training included on the CTG training day
- Human factors training on the PROMPT study days
- Birthrate + assessments for midwifery staffing
- Huddles twice a day to manage staffing and on call manager overnight
- Access to equipment addressed in accident and emergency
- Induction of labour processes amended
- Fetal monitoring training day commenced in June 2020, and case review meetings on each site weekly

3. Training Compliance

Due to the recent wave of Covid, and with the current vacancies in maternity service supporting training has been very challenging. The training in December and January was suspended to maintain safe staffing levels in the service due to increased Covid 19 cases in staff. This and the ongoing midwifery vacancies (running at approximately 20%) has had a significant impact on the training delivery, and attendance.

The service is working hard to increase compliance, and achieve the minimum 90% compliance set in the CNST standards whilst maintaining safe staffing levels. The education lead post is now filled, and will assist the service in meeting the trajectory set for improving training.

K2 E learning package for CTG interpretation & CTG Study day

MDT Role	E learning Compliance
Consultants	**100%**
Doctors	**95.3%**
Midwives	**87.8%**
NHSP Midwives	**70%**

	CTG study day
Total compliance	17.7 %

Due to Covid and staff shortages this is limiting courses that can be booked and attended. Plans are in place to improve this position over the coming months.

The service has reminded staff about their responsibility for their own compliance and that they need to book onto course available. The service also supports paying NHSP hours (additional to contracted hours) for attendance to training in their own time.

Persistent nonattendance / noncompliance is escalated to the matron or clinical director for a face to face meeting to understand the issues related to this and put a plan in place to achieve the training.

PROMPT Training

MDT Role	Prompt Compliance
Consultants	**38.5%**
Doctors	**31.6%**
Midwives	**29.8%**
NHSP Midwives	**0.0%**
Support Workers	**25.0%**
Theatre Staff	**43.0%**
Anaesthetists	**25.0%**
Divisional	**30.2%**

The commencement of the education lead will assist in co-ordinting the multidisciplinary faculty for the delivery of PROMPT training. Face to face sessions are planned to recommence. All training sessions will be allocated in eroster to ensure that the trajectory will be met.

4. Service User Voice feedback

The Doncaster and Bassetlaw MVP Group is working closely with the Deputy Head of Midwifery to co- produce a work plan for 2022. A new chair is now in place, and is working with the support of the LMNS and the CCG to settle into the role.

She is keen to visit the units, and work together with the service to develop a work plan for 2022/ 23.

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

None

7. Progress in achievement of CNST 10

Year 4 standards recommenced on 7 May 2022

There have been some amendments to the standards and the service is currently benchmarking against these.

Risks

Safety Action 5 – Midwifery workforce

Safety Action 7 – MVP's / User Feedback due to the inconsistent chair and meetings

Safety Action 8 – Training due the current vacancies in the education team and midwifery vacancies.

Appendix 1

QRM slides

Doncaster and Bassetlaw QRM 28 A

12th May 2022
Version 1
Lois Mellor – Director of Midwifery

HSIB

HEALTHCARE SAFETY
INVESTIGATION BRANCH

Doncaster And Bassetlaw Teaching Hospitals NHS Foundation Trust
QRM – 28 April 2022

Ruth Cartwright – Maternity Investigations Team Leader
Dianne Addison – Link Maternity Investigator

Maternity investigations

HSIB
HEALTHCARE SAFETY INVESTIGATION BRANCH

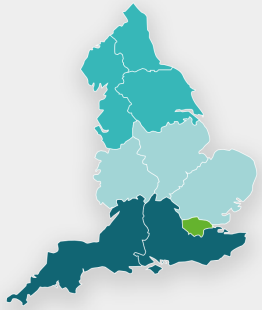
2,585

investigations commenced

2,192 *

reports completed

*As of 28 February 2022



Working with all

125

Acute Trusts in **14** regions

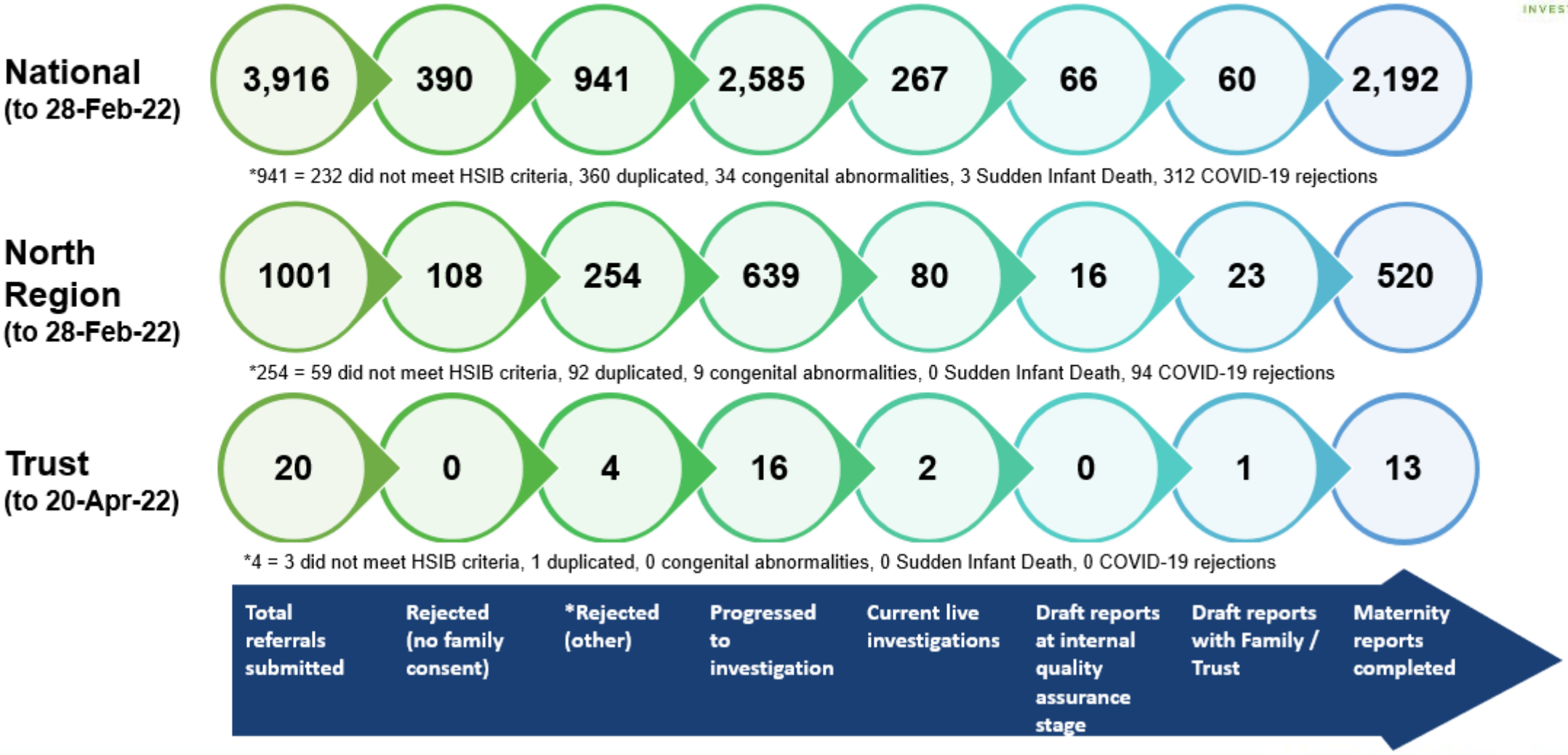
11

NHS Ambulance Trusts

Recent publications:

Maternity referrals: summary

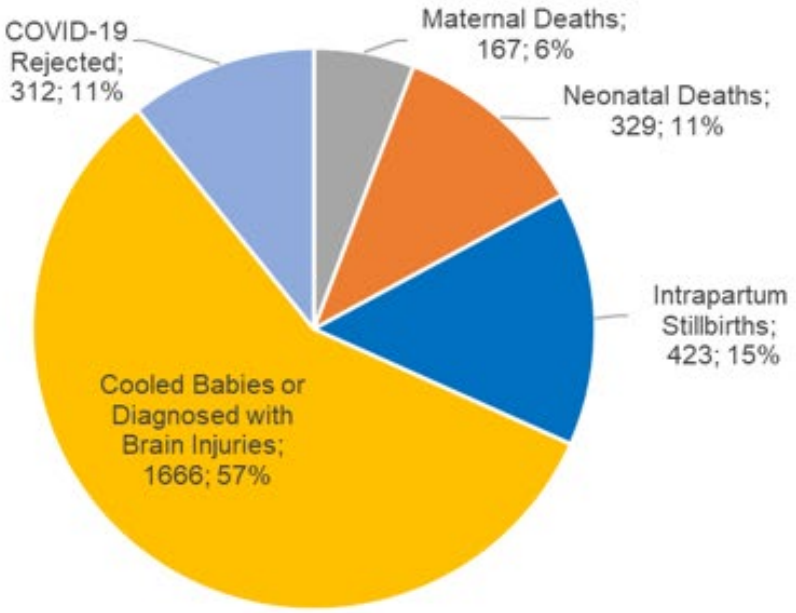
HSIB
HEALTHCARE SAFETY INVESTIGATION BRANCH



Maternity investigations categories

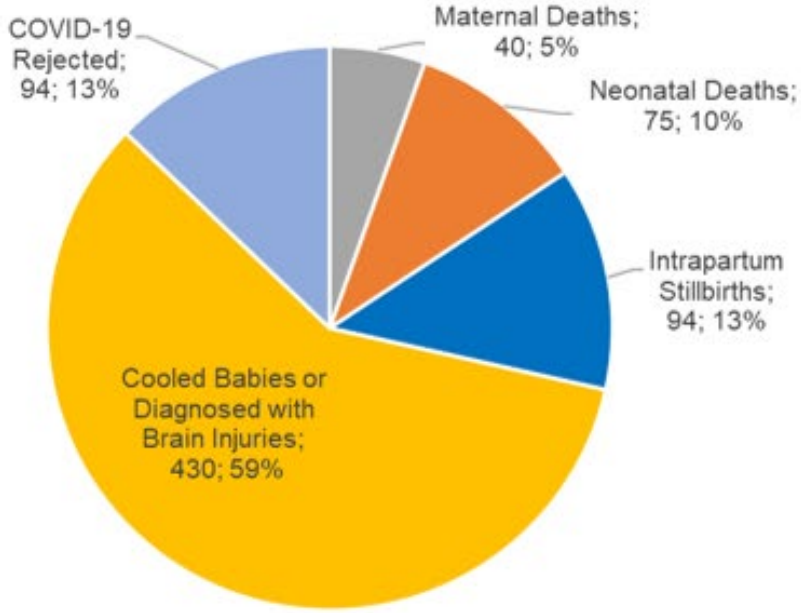
HSIB
HEALTHCARE SAFETY INVESTIGATION BRANCH

National to 28 Feb-22



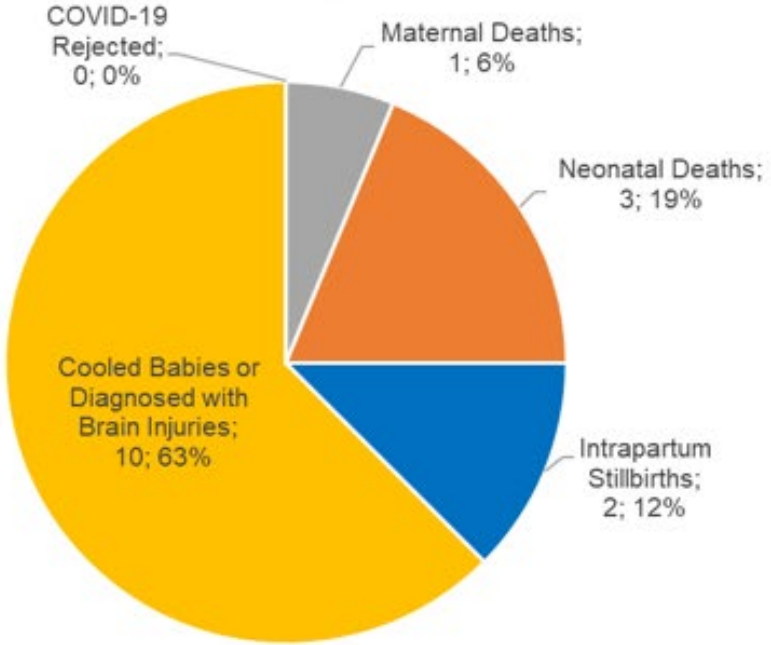
2585 investigations

North Region to 28 Feb-22



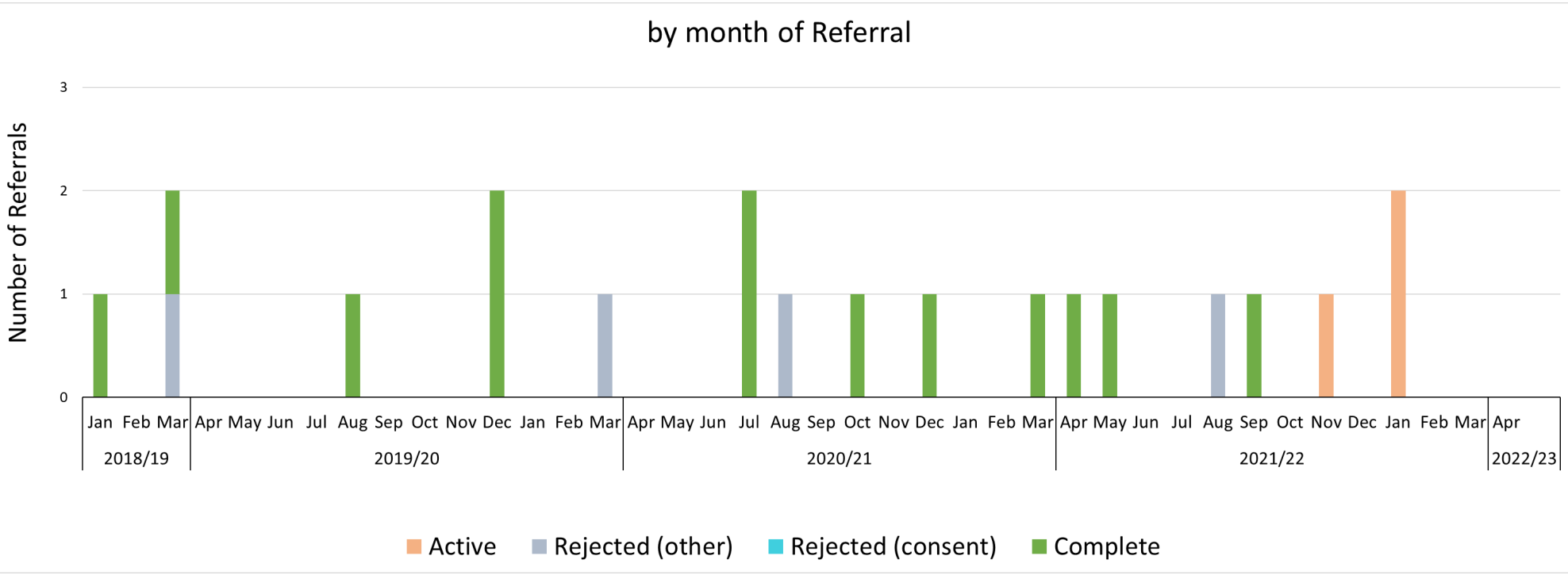
639 investigations

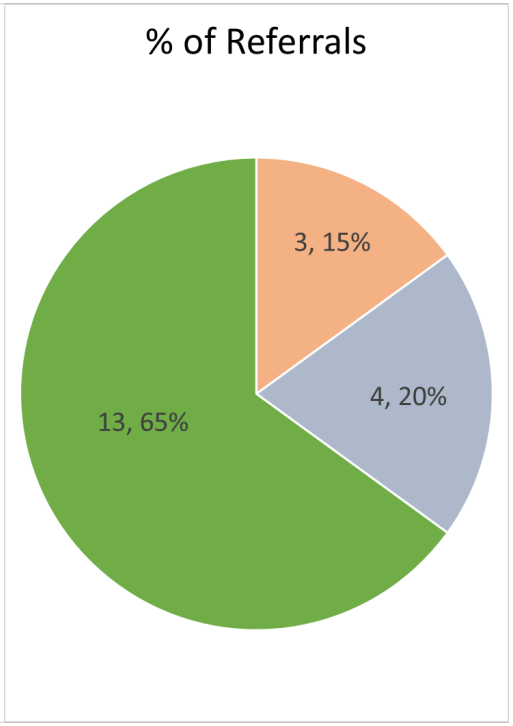
Trust to 20 Apr-22



16 investigations

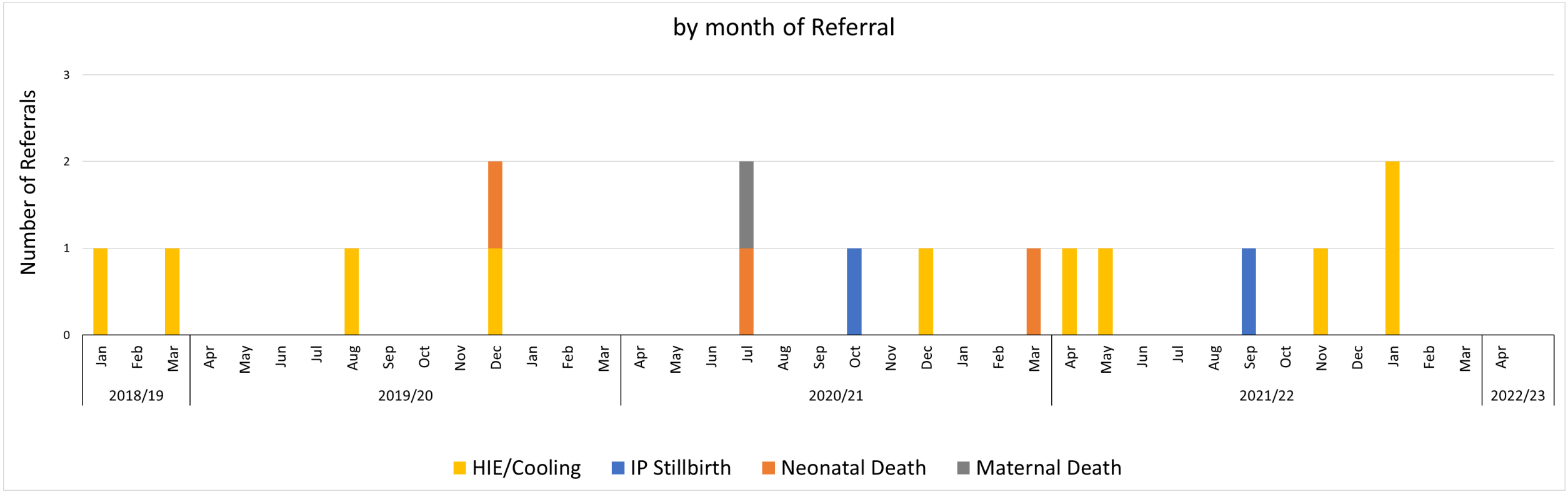
Trend analysis – all referrals





Analysis based on live data and subject to change. Data based on 'Referral Submitted' date; includes all cases referred to HSIB by this Trust. Data accurate at ***20.04.2022***

Trend analysis – investigation criteria



*Analysis based on live data and subject to change. Data based on 'Referral Submitted' date; Investigation = Active + Complete + On Hold Cases. Data accurate at **20.04.2022***

Family involvement in investigations

HSIB
HEALTHCARE SAFETY INVESTIGATION BRANCH

Family feedback – maternity investigations

"I felt supported and listened to"

"Being involved the whole way through the process, having my chance to be heard and express my views."

"The friendly team we were assigned, the up to date information. There compassion to our situation"

"The way XXXX informed us of everything and broke down the medical terms so we understood everything"

When asked, what was most helpful….

"The support and understanding of the investigators. Not too intrusive or persistent. Showed a lot of compassion, with a listening ear. Also a briefing of the report before the report was presented to us in full was very helpful and showed the support was still there."

Maternity investigations: Details of family engagement

Date range	Families not agreeing to contact from HSIB	Families contacted by HSIB but not agreeing to participate	Families engaging with HSIB
Q1 20/21	7.2%	8.6%	84.2%
Q2 20/21	7.3%	10.5%	82.2%
Q3 20/21	7.9%	7.1%	85.1%
Q4 20/21	7.4%	3.5%	89.1%
Q1 21/22	6.2%	6.2%	87.7%
Q2 21/22	6.7%	6.7%	86.6%
Q3 21/22	7.6%	8.5%	83.9%

Maternity investigations: Themes identified where there is no family consent

Investigation process	Social	Emotional
Nothing to learn	Complex social issues	Wanting to be left alone to grieve
Happy with care and have no concerns	Safeguarding	Mental health
Prefer Trust investigation and/or debrief	Language/culture/faith	Too traumatic or distressing
Legal redress preferred	Ill health of mother	No time
	No fixed address	
There were also numerous occasions of no response of any kind or limited responses to the Trust or HSIB and therefore family reasons are unknown.		

Maternity: national learning reports

HSIB
HEALTHCARE SAFETY INVESTIGATION BRANCH

The first report Summary of Themes arising from the Healthcare Safety Investigation Branch Maternity Programme published in March 2020 identified eight key themes for learning.

The themes have been explored further through HSIB National Learning Reports to share the learning from the programme and support national maternity safety improvement.

Analysis of staff feedback

Online survey of NHS Staff interviewed for maternity investigations
01 April 2020 – 24 May 2021

HSIB
HEALTHCARE SAFETY INVESTIGATION BRANCH

Improvement in perceptions of HSIB

Please rate your response to the following statements about HSIB maternity investigations:	'Agree' or 'Strongly Agree'	
	13 January 2020 – 31 March 2020 (n=255)	01 April 2020 – 31 March 2021 (n = 115)
HSIB investigations will help to improve safety of maternity care at my trust.	60.8%	84.3%
HSIB investigations will help to improve safety of maternity care across the NHS.	65.9%	85.2%
HSIB investigations are improving the culture of maternity safety at my trust.	43.1%	73%
HSIB investigations are improving the culture of maternity safety across the NHS.	52.2%	74.8%
I would feel comfortable taking part in another HSIB investigation if asked to.	74.1%	84.4%
I would encourage other staff to take part in an HSIB investigation if they are asked to.	74.9%	87.8%

Regional learning and feedback

HSIB
HEALTHCARE SAFETY INVESTIGATION BRANCH

- Implementation of the BSOTS within maternity services
- Implementation of an agreed list of maternal & fetal conditions requiring early invitation to hospital in early labour
- Respiratory depression in neonates – diamorphine dosage education for midwives
- Improved escalation to the paediatric team using MDT and ‘representative mother’ training – exploring national, local learning & ‘what if’s’
- Skin to skin check in to keep babies safe postnatally
- Differentiation between passive & active phase of labour & timing of IA amended to ensure FH monitored every 5 minutes

Overview of current cases

Case number	Referral date	Type	Current status	Next step
MI-004981	23 Nov 2021	Seizures/comatose/ decreased tone	Closed 25 April 2022	
MI-006029	19 Jan 2022	HIE/cooling	Interviews ongoing	Draft report writing
MI-006325	28 Jan 2022	HIE/cooling	Interviews ongoing	Neonatal review meeting

Top recommendations

HSIB
HEALTHCARE SAFETY INVESTIGATION BRANCH

National

- Guidance
- Fetal Monitoring
- Clinical Assessment
- Clinical Oversight
- Escalation

395 reports have no recommendations

Regional

- Guidance
- Clinical Assessment
- Fetal Monitoring
- Clinical Oversight
- Escalation

88 reports have no recommendations

Trust

- Risk Assessment
- Escalation
- Clinical Oversight
- Fetal Monitoring

3 reports have no recommendations

Recommendations presented in no particular order. National / Regional data covers May-18 to Dec-21 (to end of last full quarter).
Trust data accurate as per date on 'Maternity referrals - summary' slide.

HSIB safety recommendations from completed cases

Type	Recommendation Date & case	No.
Escalation	1903-538 (Mar 2020), 2007-2270 (Apr 2021), MI-003610 (Sept 2021), MI-003301 (Sept 2021)	4
Risk Assessment	1903-538 (Mar 2020), 1903-538 (Mar 2020), 2010-2579 (Mar 2021)	3
Staffing	1901-366 (Sept 2019), MI-003610 (Sept 2021) x2	3
Clinical Assessment	1901-366 (Sept 2019), MI-003301 (Sept 2021), 2007-2270 (Apr 2021)	3
Clinical Oversight	1903-538 (Mar 2020), 1912-1573 (Oct 2020), 2007-2270 (Apr 2021)	3
Fetal Monitoring	1903-538 (Mar 2020) x2, 2012-2795 (May 2021)	3
Training	1901-366 (Sept 2019), 2012-2795 (May 2021)	2
Situation Awareness	2007-2270 (Apr 2021), MI-003610 (Sept 2021)	2
No Recommendations	N/A	4
Ambulance service	N/A	1
Equipment	MI-003610 (Sept 2021)	1
Triage	1901-366 (Sept 2019)	1
Induction of Labour	MI-003301 (Sept 2021)	1
Documentation	1901-366 (Sept 2019)	1
Clinical Appointments	MI-003610 (Sept 2021)	1
Guidance	1901-366 (Sept 2019)	1
Total for the Trust		**29**

Context of recommendations

Escalation (4)	Risk assessment(3)	Staffing (3)
• **1903-538 (Mar 2020)** Emergency cascade bleep system is activated in the event of an obstetric emergency. • **2007-2270 (Apr 2021**) & **MI-003610 (Sept 2021)** Escalation process to the obstetric team when a CTG is difficult to interpret/concerns • **MI-003301 (Sept 2021)** Clear guidance to support managing IOL services including triggers to support robust escalation when delays occur	• **1903-538 (Mar 2020)** All mothers who book following a caesarean section to ensure that risks and benefits are discussed and documented • **1903-538 (Mar 2020)** Any mother having had a previous caesarean section has an agreed management plan documented regarding the birth of her baby. • **2010-2579 (Mar 2021)** Staff are supported to undertake a holistic risk assessment, including a CTG for high-risk mothers	• **1901-366 (Sept 2019)** Appropriate staffing levels on the postnatal ward to care for all mothers and babies • **MI-003610 (Sept 2021)** Staffing model enables the labour ward coordinator to remain supernumerary at all times • **MI-003610 (Sept 2021)** Junior staff & newly qualified clinicians have a personalised support plan in place to consolidate their skills and confidence

Context of recommendations

Clinical Assessment (3)	Clinical Oversight (3)	Fetal Monitoring (3)
• **1901-366 (Sept 2019)** full Breastfeeding assessment prior to discharge & ward handover to include the status and/or outcome of the assessment • **MI-003301 (Sept 2021**) Mothers with cumulative risk factors have an obstetric led individualised discussion about their risks • **MI-003301 (Sept 2021)** Staff are supported to make clinical assessments in real time, & are documented contemporaneously	• **1903-538 (Mar 2020)** Reliable system in place at the antenatal clinic so Mothers are seen at the correct time & by an appropriately experienced clinician • **1912-1573 (Oct 2020)** Mothers - semi-recumbent position when holding baby & are informed of the risks of bed-sharing with their baby when they are excessively tired • **2007-2270 (Apr 2021)** If multiple tasks occur at once, a member of the team maintains the role of a helicopter view' at all times	• **1903-538 (Mar 2020)** Trust guideline and electronic categorisation of the CTG during labour are consistent • **1903-538 (Mar 2020)** Fresh eyes review of a CTG during labour includes a documented assessment of the CTG • **2012-2795 (May 2021)** IA is carried out in line with national guidance ensuring early consideration is given to monitoring a baby's heart rate using CTG when A is not possible.

Trust Quality Improvements

- Active birth & Aromatherapy training
- ANAU and triage – streamlining services and staffing
- Triage unit moved near labour ward and a senior manager in post. Staffing will be with 50% core posts. BSOTS being utilised.
- Refurbishment – CDS, Triage, Enhanced Obs, new MLU and Bereavement Suite at DRI
- Elective CS pathway
- IOL – especially where and why delays occur (monthly audits & learning)
- Culture survey work looking at relationships between medical staff and maternity, includes civility. RCM have been involved in this work too.
- Bias training covering many types on the CTG study day – for awareness
- BR + reassessment in Feb 2022 to review midwifery staffing (last completed 2019)
- Shared learning from incidents & SI across the LMNS implemented
- SYB Escalation Policy now in place and Regional one in development

Discussion slide

- Ockenden report
- Staffing
  - consultant presence on nights, obstetric cover on nights, evening ward rounds
- Recent themes
  - IOL and timeliness of transfers to labour ward, CTG interpretation
- PM, histology and MRI reports
- HSIB maternity programme transition to Special Health Authority

- AOB
  - Governance team
  - Arranging interviews
  - Uploading of medical notes and guidelines/documents

Action log

Action	Lead	Date Due	Status
Description of agreed action	Initials + Trust/HSIB		Active
Description of agreed action	Initials + Trust/HSIB		Complete

Contact Details

Ruth Cartwright

Maternity Team Leader

ruth.cartwright@hsib.org.uk

07522 218 674

Dianne Addison

Maternity Investigator

dianne.addison@hsib.org.uk

07512 194 103

NE&Y Regional Perinatal Quality Oversight Group
Highlight Report

LMNS: South Yorkshire and Bassetlaw

Reporting period: January 2022-March 2022

Overall System RAG:
(Please refer to key next slide)

	MW to birth ratio : BR+ recommendation 1::28.25	Vacancy rate (MW)	LW co-ordinator supernumerary (%)
Jan			
Feb	1:31.4	22.1%	
Mar	1:31.4	22.1%	

Maternity unit DBTH – Doncaster

KPI (see slide 4)	Measurement / Target		Doncaster Rate Jan	Feb	March
Caesarean Section rate	Elective	<13.2 %	13.5%	15.9%	14.3%
	Emergency	<15.2 %	21.7%	21.4%	26.2%
Preterm birth rate	≤26+6 weeks	0	0	2	0
	≤36+6 weeks	<6%	7.8%	9%	12.74%
Massive Obstetric Haemorrhage	≥1.5l	<2.9%	2.05%	3.6%	5.2%
Term admissions to NICU		<6%	2.67%	2.5%	1.38%
3rd & 4th degree tear	SVD (unassist'd)	<2.8%	2.2%	0	2.3%
	Instrumental (assisted)	<6.05 %	4.2%	0	5.9%
Right place of birth		95%	100%	99%	100%
Smoking at time of delivery		<11%	15.3%	14.7	10.9%
Percentage of women placed on CoC pathway		35%	0%	0%	0%
Percentage of women on CoC pathway: BAME / areas of deprivation	BAME	75%	0%	0%	0%
	Area of		0 %	0%	0%

Month/Quarter		Red flag alert	Open > 30 days	Unactioned Datix	Maternity Serious Incidents	Maternity Never Events	HSIB cases	Still Births (All / Term / Intrapartum)			HIE cases (2 or3)	Neonatal Deaths Early	Neonatal Deaths Late	Notification to ENS	Maternal Mortality (direct / indirect)	
2021/2022	Jan	7	13	0	1	0	1	0	0	0	0	0	0	0	0	0
	Feb	63	21	0	0	0	1	1	1	0	0	0	0	1	0	0
	Mar		17	0	0	0	0	1	0	0	0	0	0	0	0	0
	Q4															

Maternity Red Flags (NICE 2015)

		Jan	Feb	March
1	Delay in commencing/continuing IOL process	2	50	
2	Delay in elective work	0	0	
3	Unable to give 1-1 care in labour	0	0	
4	Missed/delayed care for > 60 minutes	5	13	
5	Delay of 30 minutes or more between presentation and triage (LWAU)	0	0	

NE&Y Regional Perinatal Quality Oversight Group
Highlight Report

LMNS: South Yorkshire and Bassetlaw

Reporting period: January 2022-March 2022

Overall System RAG:
(Please refer to key next slide)

	MW to birth ratio : BR+ recommendation 1::28.25	Vacancy rate (MW)	LW co-ordinator supernumerary (%)
Jan			
Feb	1:27.43	18.1%	
Mar	1:27.43	18.1%	

Maternity unit DBTH – Bassetlaw

KPI (see slide 4)3.9%	Measurement / Target		Bassetlaw Rate		
			Jan	Feb	March
Caesarean Section rate	Elective	<13.2 %	7.6%	10.2%	13.2%
	Emergency	<16.9 %	31.9%	17.3%	32.1%
Preterm birth rate	≤26+6 weeks	0	1	0	0
	≤36+6 weeks	<6%	13.5%	6%	8.49%
Massive Obstetric Haemorrhage	≥1.5l	<2.9%	4.2%	6.1%	0.9%
Term admissions to NICU		<6%	3.9%	3.3%	4.1%
3rd & 4th degree tear	SVD (unassist'd)	<2.8%	0%	3.4	2.1%
	Instrumental (assisted)	<6.06 %	0%	20%	0%
Right place of birth		95%	99%	100%	100%
Smoking at time of delivery		<11%	11.2%	10.2%	10.5%
Percentage of women placed on CoC pathway		35%	0%	0%	0%
Percentage of women on CoC pathway: BAME / areas of deprivation	BAME	75%	0%	0%	0%
	Area of deprivation		0%	0%	0%

Month/Quarter		Red flag alert	Open > 30 days	Unactioned Datix	Maternity Serious Incidents	Maternity Never Events	HSIB cases	Still Births (All / Term / Intrapartum)			HIE cases (2 or3)	Neonatal Deaths (Early / Late)		Notification to ENS	Maternal Mortality (direct / indirect)	
2020/2021	Jan	14	4	0	0	0	0	0	0	0	0	0	0	0	0	0
	Feb	2	7	0	0	0	0	0	0	0	0	0	0	0	0	0
	Mar		6	0	0	0	0	0	0	0	0	0	0	0	0	0
	Q4															

Maternity Red Flags (NICE 2015)

		Jan	Feb	March
1	Delay in commencing/continuing IOL process	9	1	
2	Delay in elective work	0	1	
3	Unable to give 1-1 care in labour	0	0	
4	Missed/delayed care for > 60 minutes	5	0	
5	Delay of 30 minutes or more between presentation and triage (LWAU)	0	0	

Assessed compliance with10 Steps-to-Safety

		Oct	Nov	Dec
1	Perinatal review tool			
2	MSDS			
3	ATAIN			
4	Medical Workforce			
5	Midwifery Workforce			
6	SBLCB V2			
7	Patient Feedback			
8	Multi-professional training			
9	Safety Champions			
10	Early notification scheme (HSIB)			

Key	
Complete	The Trust has completed the activity with the specified timeframe – No support is required
On Track	The Trust is currently on track to deliver within specified timeframe – No support is required
At Risk	The Trust is currently at risk of not being deliver within specified timeframe – Some support is required
Will not be met	The Trust will currently not deliver within specified timeframe – Support is required

Evidence of SBLCB V2 Compliance

		Oct	Nov	Dec
1	Reducing smoking			
2	Fetal Growth Restriction			
3	Reduced Fetal Movements			
4	Fetal monitoring during labour			
5	Reducing pre-term birth			

Assessment against Ockenden Immediate and Essential Action (IEA)

	Oct	Nov	Dec
Audit of consultant led labour ward rounds twice daily			
Audit of Named Consultant lead for complex pregnancies			
Audit of risk assessment at each antenatal visit			
Lead CTG Midwife and Obstetrician in post			
Non Exec and Exec Director identified for Perinatal Safety			
Multidisciplinary training – PrOMPT, CTG, Obstetric Emergencies (90% of Staff)	<90% >80%	<90% >80%	<90% >85%
Plan in place to meet birth rate plus standard (please include target date for compliance)			
Flowing accurate data to MSDS			
Maternity SIs shared with trust Board			

Please include narrative (brief bullet points) relating to each of the elements:

Maternity unit	January	February	March
Freedom to speak up / Whistle blowing themes	None	None	
Themes from Datix (to include top 5 reported incidents/ frequently occurring)	Weight unexpectedly below the 10th centile Midwifery Staffing Born before arrival PPH 3rd 4th degree tear	Weight unexpectedly below the 10th centile PPH 3rd 4th degree tear Treatment failed	Weight unexpectedly below the 10th centile PPH 3rd 4th degree tear Shoulder dystocia
Themes from Maternity Serious Incidents (Sis)	HSIB incident which meets SI criteria, missed opportunity to escalate for further review prior to discharge, on re-admission baby PAWS elevated and sepsis IPOC not commenced discharged home to await bloods – bloods abnormal on re-admission baby comatose and fitting	(incident occurred in January however reviewed and STEIS notified on the 3rd Feb) HSIB incident which meets SI criteria, cooled baby no issues identified on initial review of care – SI as HSIB accepted the investigation due to abnormal MRI. Also referred to ENS	Two HSIB reports have been returned from 2021 and have highlighted no care issues and there are no Safety recommendations for either report. No SI declared for March
Themes arising from Perinatal Mortality Review Tool	January meeting care graded for 1 NND which was re-categorised as a stillbirth following PM Graded B and A	February meeting care graded for 1 stillbirth Graded A and A	March Meeting graded two cases on B/A and one A and A no themes highlighted the group noted that more comprehensive dialog should occur where query learning difficulties are thought to be an issue with the learning disabilities team for the trust
Themes / main areas from complaints	Communication / staff attitudes Covid related access restrictions		
Listening to women (sources, engagement / activities undertaken) CQC Women's Experience		MLU/ Bereavement suite/ CDS upgrades – MVP to be involved in the work when it commences in May Fetal movement leaflet reviewed after feedback from family.	MVP meetings Facebook pages Complaints
Evidence of co-production		MVP working to produce an information file for all the bedsides in maternity	Review of the plans for the new CDS, and an additional birth pool added
Listening to staff (eg activities undertaken, surveys and actions taken as a result)	Live drills for obstetric emergencies due to the lack of face to face PROMPT study days ongoing over both sites OCR recommenced for DRI site		
Embedding learning (changes made as a result of incidents / activities / shared learning/ national reports)	WHATS HOT – released in December January edition delayed Ward briefs and emails Face to face discussions with staff	No whats hot in February due to work capacity	Whats hot released in March Comprehensive article regarding types of investigations for staff awareness Created new LASER poster which will start to be rolled out this has come from the LMNS for quick speedy learning the whole reports will continue to be printed and shared with all staff

KPIs: Targets & Thresholds

Ref	KPI	Measurement	Target	Green Range	Amber Range	Red Range	Source
S1	**Caesarean section rate** (Caesarean section targets are based on England HES data for 2019/20)	% Caesarean sections: elective & emergency	29% EL 13% EM 17%	<30% <13.2% <17%	NA	> 33% > 15% > 19%	Trust / MSDSv2
S2	**Preterm birth rate** (Denominator = all births over 24 weeks gestation)	% Preterm birthrate: <27 weeks & <36 weeks	<6%	< 6% achieved in 12 months	N/A	> 6 achieved in 12 months	Trust
S3	**Massive obstetric haemorrhage** (Based on NMPA data for 2017/17 for women who give birth vaginally to a singleton baby in the cephalic position between 37+0 and 42+6 weeks)	Massive obstetric Haemorrhage >1500mls (denominator = total singleton cephalic births)	<2.9%	<2.9%	<3.5%	>=3.5%	Trust / MSDSv2
S4	**Term admissions to NICU** ((from all sources eg Labour ward, postnatal ward / community but not transitional care babies)	% Terms admissions to NICU	<6%	<6%	NA	>6%	Trust / Badgernet
S5	**3rd & 4th degree tear** (3rd/ 4th degree tears are based on NMPA data for 2017/17 for women who give birth vaginally to a singleton baby in the cephalic position between 37+0 and 42+6)	% 3rd & 4th degree tear: NMPA SVD & Instrumental 3rd & 4th degree tear (denominator total singleton cephalic SVD / total Instrumental births / total vaginal births)	NMPA SVD: 2.8% Instrumental: 6.8% Overall: 3.5%	< 3.5%	NA	>5%	Trust / MSDSv2
S6	**Right Place of Birth** (denominator = no of women birthing under 27, 28 with multiple or <800g)	% Right Place of Birth: <27 weeks or <28 weeks multiple & EFW <800g born in tertiary centre	95%	>90%	80% – 90%	<80%	Trust / Badgernet
S7	**Smoking at time of delivery**	% women smoking at time of delivery	6%	<11%		>11%	Trust / MSDSv2
S8	**Percentage of women placed on Continuity of Carer pathway** denominator = all women reaching 29 weeks gestation within the month	% women placed on continuity of carer pathway at 29 weeks gestation	35%	25% - 35%	15%-25%	<15%	Trust / MSDSv2
S9	**Percentage of BAME women or from areas of deprivation placed on Continuity of Carer pathway** (denominator as above)	% BAME women placed on continuity of carer pathway at 29 weeks gestation	75%	65% - 75%	55% - 65%	<55%	Trust / MSDSv2
	Red Flags						

NE&Y Regional Perinatal Quality Oversight Group
Highlight Report

LMNS: South Yorkshire and Bassetlaw

Reporting period: April 2022-June 2022

Overall System RAG:
(Please refer to key next slide)

	MW to birth ratio : BR+ recommendation 1::28.25	Vacancy rate (MW)	LW co-ordinator supernumerary (%)
Jan			
Feb			
Mar			

Maternity unit: DBTH – Doncaster

KPI (see slide 4)	Measurement / Target		Doncaster Rate April	May	June
Caesarean Section rate	Elective	<13.2 %	11%		
	Emergency	<15.2 %	22.4%		
Preterm birth rate	≤26+6 weeks	0	2 (twins)		
	≤36+6 weeks	<6%	6.66%		
Massive Obstetric Haemorrhage	≥1.5l	<2.9%	3.1%		
Term admissions to NICU		<6%	2.56%		
3rd & 4th degree tear	SVD (unassist'd)	<2.8%	0.7%		
	Instrumental (assisted)	<6.05 %	14.3%		
Right place of birth		95%	99%		
Smoking at time of delivery		<11%	13.4%		
Percentage of women placed on CoC pathway		35%	0%		
Percentage of women on CoC pathway: BAME / areas of deprivation	BAME	75%	0%		
			0 %		

Month/Quarter		Red flag alert	Open > 30 days	Unactioned Datix	Maternity Serious Incidents	Maternity Never Events	HSIB cases	Still Births (All / Term / Intrapartum)			HIE cases (2 or3)	Neonatal Deaths Early	Neonatal Deaths Late	Notification to ENS	Maternal Mortality (direct / indirect)	
2021/2022	April	45	22	0	0	0	0	2	1	0	0	1	0	0	0	0
	May															
	June															
	Q1															

Maternity Red Flags (NICE 2015)

		April	May	June
1	Delay in commencing/continuing IOL process	43		
2	Delay in elective work	0		
3	Unable to give 1-1 care in labour	1		
4	Missed/delayed care for > 60 minutes	1		
5	Delay of 30 minutes or more between presentation and triage (LWAU)	0		

NE&Y Regional Perinatal Quality Oversight Group
Highlight Report

LMNS: South Yorkshire and Bassetlaw

Reporting period: April 2022- June 2022

Overall System RAG:
(Please refer to key next slide)

	MW to birth ratio : BR+ recommendation 1::28.25	Vacancy rate (MW)	LW co-ordinator supernumerary (%)
Apr			
May			
June			

Maternity unit DBTH – Bassetlaw

KPI (see slide 4)3.9%	Measurement / Target		Bassetlaw Rate		
			April	May	June
Caesarean Section rate	Elective	<13.2 %	9.8%		
	Emergency	<16.9 %	37.5%		
Preterm birth rate	≤26+6 weeks	0	0		
	≤36+6 weeks	<6%	5.35%		
Massive Obstetric Haemorrhage	≥1.5l	<2.9%	4.5%		
Term admissions to NICU		<6%	11.42%		
3rd & 4th degree tear	SVD (unassist'd)	<2.8%	3.8%		
	Instrumental (assisted)	<6.06 %	0%		
Right place of birth		95%	100%		
Smoking at time of delivery		<11%	10.7%		
Percentage of women placed on CoC pathway		35%	0%		
Percentage of women on CoC pathway: BAME / areas of deprivation	BAME	75%	0%		
	Area of deprivation		0%		

Month/Quarter		Red flag alert	Open > 30 days	Unactioned Datix	Maternity Serious Incidents	Maternity Never Events	HSIB cases	Still Births (All / Term / Intrapartum)			HIE cases (2 or3)	Neonatal Deaths (Early / Late)		Notification to ENS	Maternal Mortality (direct / indirect)	
2020/2021	April	9	18	0	0	0	0	0	0	0	0	0	0	0	0	0
	May															
	June															
	Q1															

Maternity Red Flags (NICE 2015)

		April	May	June
1	Delay in commencing/continuing IOL process	8		
2	Delay in elective work			
3	Unable to give 1-1 care in labour			
4	Missed/delayed care for > 60 minutes	1		
5	Delay of 30 minutes or more between presentation and triage (LWAU)			

Assessed compliance with10 Steps-to-Safety

		Oct	Nov	Dec
1	Perinatal review tool			
2	MSDS			
3	ATAIN			
4	Medical Workforce			
5	Midwifery Workforce			
6	SBLCB V2			
7	Patient Feedback			
8	Multi-professional training			
9	Safety Champions			
10	Early notification scheme (HSIB)			

Key	
Complete	The Trust has completed the activity with the specified timeframe – No support is required
On Track	The Trust is currently on track to deliver within specified timeframe – No support is required
At Risk	The Trust is currently at risk of not being deliver within specified timeframe – Some support is required
Will not be met	The Trust will currently not deliver within specified timeframe – Support is required

Evidence of SBLCB V2 Compliance

		Oct	Nov	Dec
1	Reducing smoking			
2	Fetal Growth Restriction			
3	Reduced Fetal Movements			
4	Fetal monitoring during labour			
5	Reducing pre-term birth			

Assessment against Ockenden Immediate and Essential Action (IEA)

	Oct	Nov	Dec
Audit of consultant led labour ward rounds twice daily			
Audit of Named Consultant lead for complex pregnancies			
Audit of risk assessment at each antenatal visit			
Lead CTG Midwife and Obstetrician in post			
Non Exec and Exec Director identified for Perinatal Safety			
Multidisciplinary training – PrOMPT, CTG, Obstetric Emergencies (90% of Staff)	>85% <90%		
Plan in place to meet birth rate plus standard (please include target date for compliance)			
Flowing accurate data to MSDS			
Maternity SIs shared with trust Board			

Please include narrative (brief bullet points) relating to each of the elements:

Maternity unit	January	February	March
Freedom to speak up / Whistle blowing themes	None	None	
Themes from Datix (to include top 5 reported incidents/ frequently occurring)	Weight unexpectedly below the 10th centile PPH 3rd 4th degree tear Shoulder dystocia		
Themes from Maternity Serious Incidents (Sis)	No SI declared for April One off pathway delivery and NND which will be presented at panel, LMNS peer review and the incident review meeting shortly		
Themes arising from Perinatal Mortality Review Tool	April meeting graded 3 cases B and A AAA AA No themes highlighted		
Themes / main areas from complaints			
Listening to women (sources, engagement / activities undertaken) CQC Women's Experience	MVP chair now in the role and they are actively being involved in the MVP meetings and activities being undertaken		
Evidence of co-production			
Listening to staff (eg activities undertaken, surveys and actions taken as a result)	Feedback encouraged from recent inquests via an MST drop in session being arranged for May Ongoing OCR meeting Ongoing skills and drills scenarios		
Embedding learning (changes made as a result of incidents / activities / shared learning/ national reports)	WHATS HOT Ward briefs and emails Face to face discussions with staff LASER poster		

KPIs: Targets & Thresholds

Ref	KPI	Measurement	Target	Green Range	Amber Range	Red Range	Source
S1	**Caesarean section rate** (Caesarean section targets are based on England HES data for 2019/20)	% Caesarean sections: elective & emergency	29% EL 13% EM 17%	<30% <13.2% <17%	NA	> 33% > 15% > 19%	Trust / MSDSv2
S2	**Preterm birth rate** (Denominator = all births over 24 weeks gestation)	% Preterm birthrate: <27 weeks & <36 weeks	<6%	< 6% achieved in 12 months	N/A	> 6 achieved in 12 months	Trust
S3	**Massive obstetric haemorrhage** (Based on NMPA data for 2017/17 for women who give birth vaginally to a singleton baby in the cephalic position between 37+0 and 42+6 weeks)	Massive obstetric Haemorrhage >1500mls (denominator = total singleton cephalic births)	<2.9%	<2.9%	<3.5%	>=3.5%	Trust / MSDSv2
S4	**Term admissions to NICU** ((from all sources eg Labour ward, postnatal ward / community but not transitional care babies)	% Terms admissions to NICU	<6%	<6%	NA	>6%	Trust / Badgernet
S5	**3rd & 4th degree tear** (3rd/ 4th degree tears are based on NMPA data for 2017/17 for women who give birth vaginally to a singleton baby in the cephalic position between 37+0 and 42+6)	% 3rd & 4th degree tear: NMPA SVD & Instrumental 3rd & 4th degree tear (denominator total singleton cephalic SVD / total Instrumental births / total vaginal births)	NMPA SVD: 2.8% Instrumental: 6.8% Overall: 3.5%	< 3.5%	NA	>5%	Trust / MSDSv2
S6	**Right Place of Birth** (denominator = no of women birthing under 27, 28 with multiple or <800g)	% Right Place of Birth: <27 weeks or <28 weeks multiple & EFW <800g born in tertiary centre	95%	>90%	80% – 90%	<80%	Trust / Badgernet
S7	**Smoking at time of delivery**	% women smoking at time of delivery	6%	<11%		>11%	Trust / MSDSv2
S8	**Percentage of women placed on Continuity of Carer pathway** denominator = all women reaching 29 weeks gestation within the month	% women placed on continuity of carer pathway at 29 weeks gestation	35%	25% - 35%	15%-25%	<15%	Trust / MSDSv2
S9	**Percentage of BAME women or from areas of deprivation placed on Continuity of Carer pathway** (denominator as above)	% BAME women placed on continuity of carer pathway at 29 weeks gestation	75%	65% - 75%	55% - 65%	<55%	Trust / MSDSv2
	Red Flags						

Glossary of Terms for Maternity

CNST	**Clinical Negligence Scheme for Trusts**
CTG	**Cardiotocography** is a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour.
FH	**Fetal Heartbeat**
FMU	**Fetal Medicine Unit**, specialist tertiary centre for complex pregnancy
HSIB	**Healthcare Services Investigation Branch** carry out maternity investigations as a national and independent investigating body to: • Use a standardised approach to maternity investigations without attributing blame or liability. • Work with families to make sure we understand from their perspective what has happened when an incident has occurred. • Work with NHS staff and support local trust teams to improve maternity safety investigations. • Bring together the findings of our reports to identify themes and influence change across the national maternity healthcare system.
MBRACE	**Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries** National body working with the NHS to reduce risks
MTOP	**Medical Termination of Pregnancy**
MVP	**Maternity Voices Partnership**
NHSR	**NHS Resolution**
PET	**Pre-eclampsia**
PMRT	**Perinatal Mortality Review Tool**
PROMPT	**PRactical Obstetric Multi-Professional Training**
DIC	**Disseminated Intravascular coagulation**

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	24 May 2022	**Agenda Reference:**	C5		
Report Title:	**Executive Medical Director Update - Learning from Deaths Report Q3 2021/2022**				
Sponsor:	Dr Timothy Noble, Executive Medical Director & Responsible Officer				
Author:	Dr Timothy Noble, Executive Medical Director & Responsible Officer				
Appendices:	n/a				
Report Summary					
Purpose of report:	This is the Quarter three report for 2021/22 Learning from Deaths, in accordance with the national guidance on learning from deaths, published March 2017.				
Summary of key issues/positive highlights:	The Learning from Deaths Report considers deaths at DBTH in the period October 2021 to December 2021, as follows: • Total number of deaths in the period – 602 • 95% of all deaths in hospital for patients over the age of 18 were scrutinised by the Medical Examiner team • 1 case subject to a Structured Judgement Review • 5 deaths of patients with learning disability, concluded to have received good care				
Recommendation:	The Board is asked to note the update.				
Action Required:	~~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 change
Corporate risk register:	No risk identified
Regulation:	
Legal:	n/a
Resources:	n/a

Assurance Route			
Previously considered by:	• Clinical Governance Committee – February 2022 • Quality and Effectiveness Committee – April 2022		
Date:	As above	**Decision:**	For Information and Assurance
Next Steps:			
Previously circulated reports to supplement this paper:			

EXECUTIVE SUMMARY

The Learning from Deaths Report for Quarter 3 of 2021/22, is presented to the Board of Directors for information and assurance.

Key items for noting are as follows:

- The number of Trust deaths increased from 478 in Q2 to 602 in Q3.
- The Medical Examiner Team scrutinised 95% of all deaths in hospital of patients over the age of 18.
- Structured Judgement Reviews (SJR) continue to be carried out in certain circumstances. This provides a qualitative assessment of each phase of care, the findings of which can also be aggregated to produce knowledge about clinical services and systems of care.
- Where the Medical Examiner identifies any concerns, most will be formally investigated via the clinical incident reporting system (DATIX) and existing governance processes rather than have a SJR.
- There were 3 elective admissions resulting in death this quarter. 2 of these cases did not highlight any issues with care and so an SJR was not requested. 1 case was referred to the Coroner for investigation and to the specialty for an SJR. At the time of reporting this investigation continues.
- There were 5 deaths of patients with a learning disability this quarter, and 5 recorded in the previous quarter. 2 of these were at BDGH and 3 at DRI. All have been referred to the Learning Disabilities Mortality Review Programme (LeDeR). These 5 cases were concluded to have received good care by the ME team.
- An internal 3 working day target to have the Medical Certificate of Cause of Death (MCCD) completed and issued is in place. This quarter the target was achieved 80% of the time at DRI and 83% at BDGH.
- This number of deaths is higher than the number for quarter 3 in pre covid times, demonstrating that Covid is still having an impact on our total mortality, 18/19 (470) and 19/20 (563).
- Pneumonia was the highest cause of death recorded on MCCD this quarter.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Quarter 3

Learning from Deaths Report

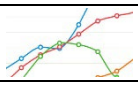
October to December 2021

Karen Lanaghan – Lead Nurse End of life care services

Mandy Dalton & Gemma Wheatcroft – Lead Medical Examiner Officers

Learning from Deaths report, produced in line with the requirements of:

"National Guidance on Learning from Deaths" (National Quality Board, March 2017)

	**Deaths in Quarter 3 (Adult inpatients)** Doncaster = 416 Bassetlaw = 121 **Total Inpatient deaths = 537**
	**Deaths in Quarter 3 (A&E)** Doncaster = 43 Bassetlaw = 22 **Total A&E deaths = 65** **TOTAL DEATHS = 602**
	**Deaths Screened by MEO** Doncaster = 222 Bassetlaw = 110 **Total MEO scrutiny =332 (55 %)**
	**Deaths scrutinised by ME** Doncaster = 348 Bassetlaw = 127 **Total ME team Scrutiny 475 (79)%**
	Total deaths screened/scrutinised by ME team = 572 (95%)
	**Structured Judgement Reviews (SJR)** Following discussion at mortality governance meeting January 2022 a task and finish group has been commissioned to finalise the way forward with SJRs
	**Hospital Standardised Mortality Ratio (HSMR) 12 month rolling** All this quarter's data is awaited from HED as of October 2021 is 100.95
	**Top 5 cause of death recorded on MCCD this quarter** 1. Pneumonia (107) 2. Covid 19 (83) 3. Sepsis (67) 4. Cardiac related (57) 5. Metastatic cancer (43)
	**Top 5 "main condition treated" as coded from the notes:** 1. Pneumonia (85) 2. Covid 19 (74) 3. Other Sepsis (44) 4. Heart Failure (30) 5. Acute Renal Failure (23)
	**Percentage of MCCDs issued within 3 working days of death when no coronial involvement** Bassetlaw 91 (83%) Doncaster 314 (80%) .

Contents

1. Executive Summary and Achievements

This is Quarter 3 (2021/22) Learning from Deaths report in accordance with the National Guidance on Learning from Deaths (March 2017). This quarter has seen a significant increase in numbers from 478 in Q2 to 602. This number of deaths is higher than the number for quarter 3 in pre covid times, demonstrating that Covid is still having an impact on our total mortality, 18/19 (470) and 19/20 (563).

The Medical Examiner (ME) Team have scrutinised 95% (572) deaths this quarter. Although this is a slight decrease of 2% in the number scrutinised, the actual number of deaths is 100 more than in the previous quarter.

The medical examiner team has been recognised by the regional medical examiner's office as performing extremely well in achieving almost 100% scrutiny since January 2021. As a result they have been asked to explore ways of scrutinising non-acute deaths. Initial work has proved extremely challenging due the difficulties in accessing primary care IT systems.

The Chief ME and Lead MEOs have approached some GP practices and hospices across the health care community to pilot the roll out of the medical examiner scrutiny during the non-statutory phase. This has been well received by the majority of general practices that have been approached.

As we have reported since the inception of the ME team, independence is a key element of the service. Although the ME team staff regularly recognise areas of good practice, areas of concern and learning, these are passed to Trust governance processes to action. The ME team has no other roll within this area other than to "identify and pass on". The Trust has recognised the need for a lead nurse to take forward and drive the national learning from deaths agenda and this post is currently advertised.

The ME team continues to alert the risk management team of any potential avoidable deaths by completing a DATIX form thus ensuring they are investigated using existing clinical governance systems and processes. The ME scrutiny form the (ME-1B) is not shared with the trust to ensure complete independence of the ME service.

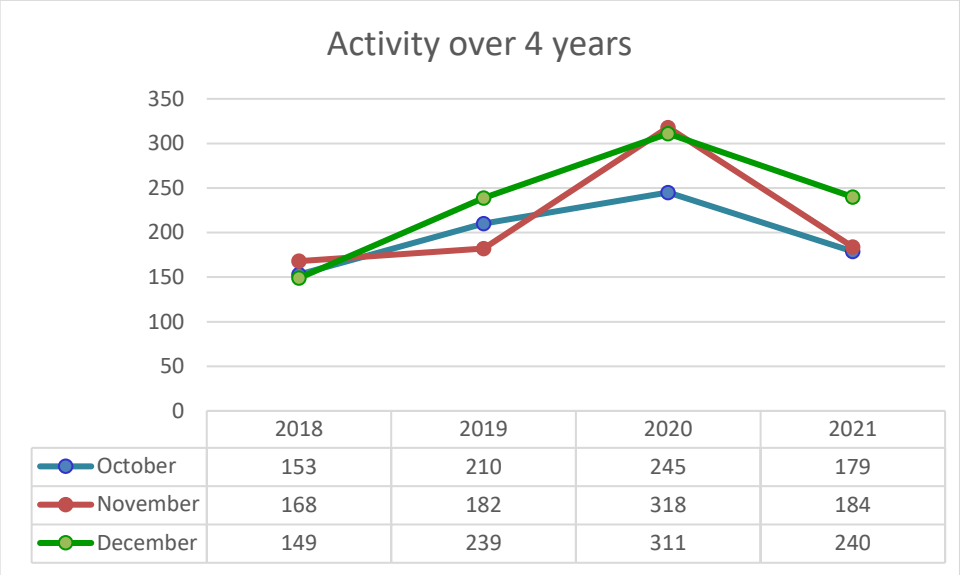
2. Introduction

A quarterly report on Learning from Deaths has been produced since April 2017 as dictated by the March 2017 National Guidance on Learning from Deaths. The report is received by the Quality and Effectiveness Committee. The report has evolved ever since as other processes and ways of working have been introduced. The most significant change since December 2019 has been the introduction of the Medical Examiner (ME) System and of course since March 2020 the national covid pandemic. We saw huge changes in processes due to the changes in legislation laid out by the Coronavirus Act 2020 which was published on 25th March 2020 and these changes have continued throughout the year and remain in place to this date.

3. Overview of Activity

In quarter 3 there has been a total of 602 trust deaths compared to 478 deaths in quarter 2. As can be seen on the table below, numbers are slowly returning to pre covid numbers.

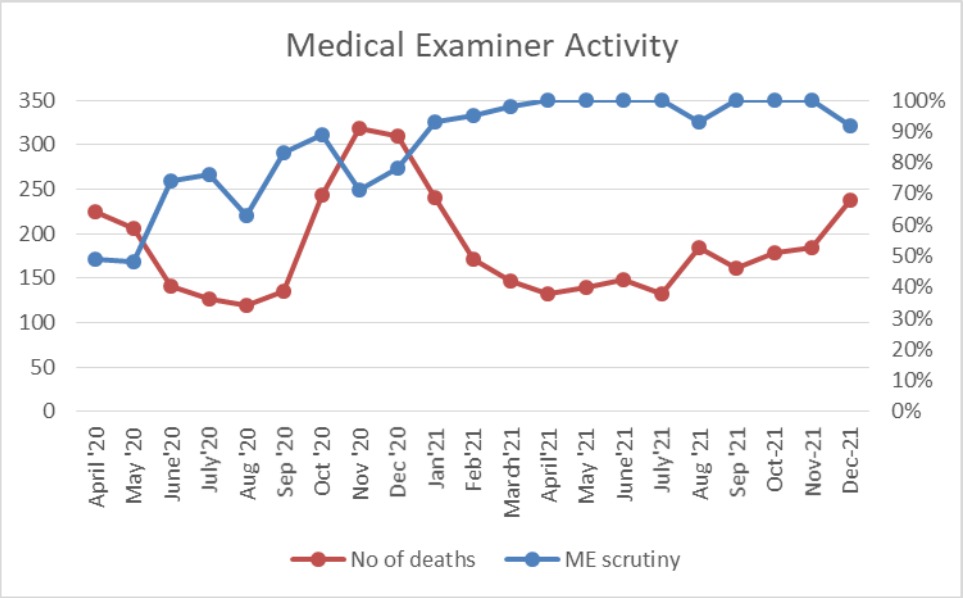
a) Activity (4 years data)



	2018	2019	2020	2021
October	153	210	245	179
November	168	182	318	184
December	149	239	311	240

4. Medical Examiner Team

The Medical Examiner (ME) team consists of 8 part time Medical Examiners, this now includes 3 GP's and 3 WTE Medical Examiner Officers. The service began in December 2019 and has continued to work extremely hard to maintain circa 100% scrutiny of all adult hospital deaths since January 2021. The graph below illustrates the activity since April 2020.



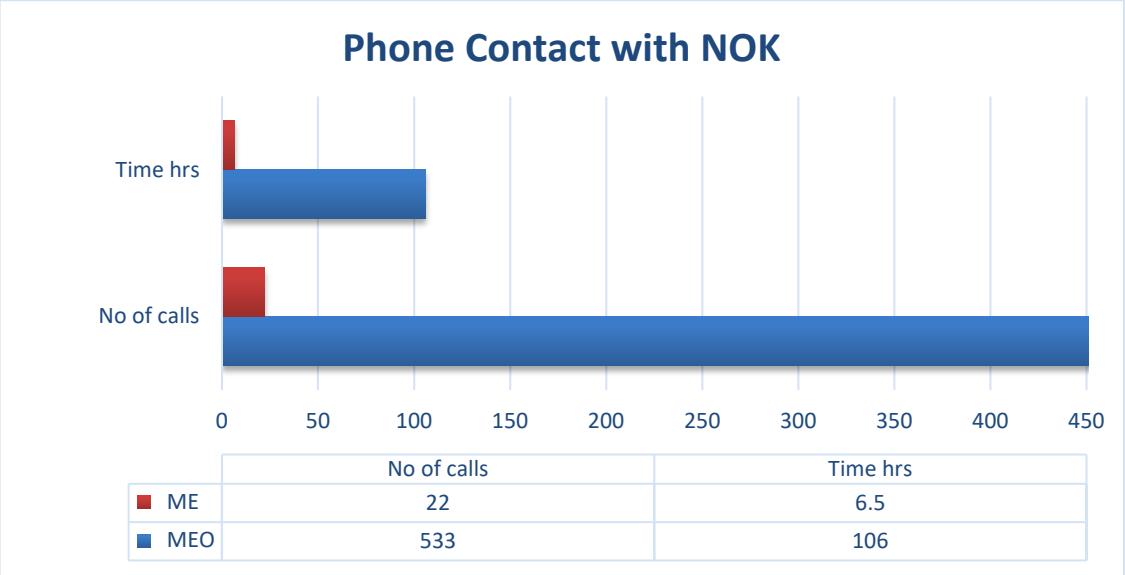
The introduction of medical examiner teams is part of the Department of Health and Social Care's death certification reforms programme for England and Wales and will ultimately be a statutory requirement for all Trusts. Although it was hoped this would be a statutory requirement by April 2021, the covid pandemic has caused a significant delay to this. We have now been informed by the National ME office that it is hoped it will be statute by September 2022.

This independent system is designed to:

- Provide bereaved families with greater transparency and opportunities to raise concerns
- Improve the quality/accuracy of medical certification of cause of death
- Ensure referrals to coroners are appropriate
- Support local learning by identifying matters in need of clinical governance and related processes
- Provide the public with greater safeguards through improved and consistent scrutiny of all non-coronial deaths, and support healthcare providers to improve care through better learning

Whenever the ME team conclude that a death is potentially avoidable or that any care provided has resulted in significant harm then the patient safety team is immediately notified by the completion of a Datix incident and the case will be scoped in line with the governance process for a potential serious incident.

As stated above, one of the most significant aspects of this independent scrutiny is speaking to bereaved people and providing them with an opportunity to raise any concerns they may have with the treatment their loved one received during their hospital stay. In the vast majority of cases, the feedback is highly complementary. This quarter the ME team have spoken to 555 families (97%) and just 28 of these (5%) have raised concerns with 23 of these being offered the PALS contact number. Circa 106 hours has been spent speaking to bereaved people.



The types of concerns raised fall into the following categories:

- Staff attitude was poor in some wards/deparments.
- Unhappy with overnight transfers and NOK not being made aware until they phone the next day.
- Families have raised issues regarding assisting patients with fluid and dietary intake.
- Poor Communication
- Lack of compassionate visiting arrangements.
- Ambulance transfer concerns.

5. Assessment of care provided to adult patients who died using the Structured Judgement Review (SJR) process.

A Structured judgement review (SJR) blends traditional, clinical-judgement based review methods with a standardised format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments and to score each phase of care. The result is a relatively short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care. This whole process was originally designed to review a cross section of cases and NOT solely for those patients that have died. Once the ME team came along, it was suggested by the National ME that SJR's should be requested in the following circumstances:

- Elective admissions
- Patients with a Learning Disability and significant mental health issues
- When staff or bereaved family members have raised concerns
- ME/MEO identifies issues during their scrutiny

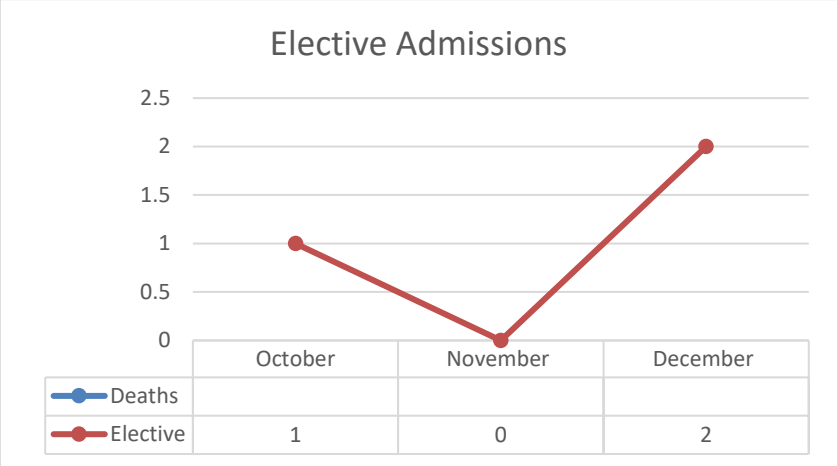
It has now become apparent that as the ME team are scrutinising all in hospital deaths of people over the age of 18 this is superseding the need for an SJR in some cases.

This quarter, just 5 SJRs have been requested.

A Qi project was completed in 2021, however even since that, thoughts and ideas around the process have evolved both nationally and internally. To that end and during discussions at the January mortality governance meeting further suggestions were raised and it was decided that a task and finish group would take this forward so that a clear standard operating procedure can be agreed.

6. Elective Admissions

There were 3 elective admissions resulting in death this quarter. If death results when a patient is admitted electively, it is reviewed by the medical examiner team. 2 of these cases did not highlight any issues with care and so an SJR was not requested. 1 case was referred to the Coroner for investigation and to the specialty for an SJR. At the time of reporting this investigation continues. Over time it has become apparent that the vast majority of "elective" deaths are not what we class as a "true" elective admissions. Most are very ill patients with significant co morbidities who come in for pain relief or symptom management. It is essential that these cases are looked at with some rigor however, to reassure the Trust should any issues with HMSR rates for elective deaths be alerted.



7. Learning Disability deaths

There were 5 deaths of patients with a learning disability this quarter, and 5 recorded in the previous quarter. 2 of these were at BDGH and 3 at DRI. All have been referred to the Learning Disabilities Mortality Review Programme (LeDeR). These 5 cases were concluded to have received good care by the ME team. 4 of these cases are still awaiting SJRs to be returned.

The new policy for LeDeR was published in March 2021 and by April 2022 all changes within the policy must be implemented by integrated care systems. This policy introduces the inclusion of autism into the programme for the first time. We have a robust system for identifying patients with a learning disability but this is not the case for autism. The identification of cases will be dependent on the documentation in the medical notes of such a diagnosis. This has escalated to higher management as a concern.

8. Completion of a Medical Certificate of Cause of death (MCCD)

The timely issuing of a MCCD is crucial to ensure that bereaved families and carers can register the death and progress other essential activities following the death of their loved one. Registration of death, where there is no Coroner involvement should be completed within 5 days. This is only possible once an MCCD has been issued.

An internal 3 working day target to have the MCCD completed and issued is in place. This quarter we have met that target 80% of the time at DRI and 83% at BDGH.

The reason for this slight decrease in number is multifactorial: as already stated numbers have significantly increased this quarter and we have had ongoing challenges with staff sickness and annual leave and extended bank holiday periods.

We have an agreed escalation process should an MCCD not be written within the timescale and should we still not have the certificate at day 6 then a Datix form is completed by the bereavement team.

9. Referral to Her Majesty's Coroner (HMC)

The senior Coroners at both Doncaster and Nottingham have recognised the contribution the ME team provide in ensuring quality referrals and additional information is provided to assist them with their investigation. As a result they have both changed the process for Coroner's referrals. The ME team now quality assure all Dr's Coroner's referral forms prior to submission to the Coroner's Office.

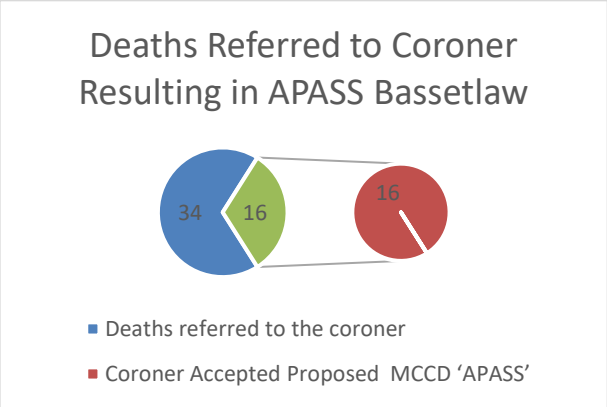
The ME office forward the ME-1B form as additional information to help the coroner conclude their investigation.

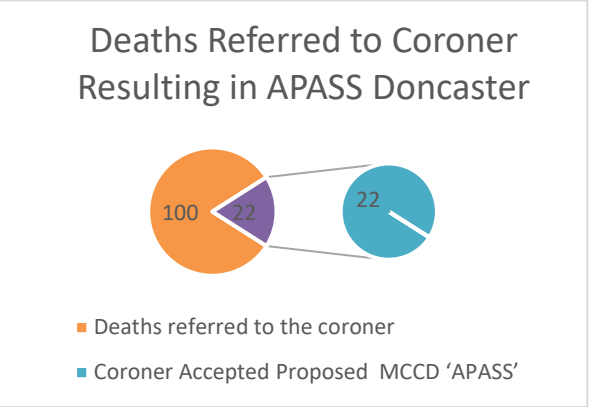
If the ME team identify an inadequate Coroners referral form this is raised internally with the referring Dr to assist with their individual learning.

Referral to the Coroner does not necessarily mean the case will go to Inquest. In many cases the Coroners will review the referral and the ME Scrutiny and proposed cause of death as documented on the MCCD. Following communication and agreement with the family, if the proposed cause of death is accepted a form A is issued. This is commonly known as an 'APASS'

This quarter, Coroner's referrals have slightly increased. However, there are still some delays in receiving the outcome of the referral from the coroner's office at the time of finalising this report.

We have set up a system whereby 1 bereavement officer rings the Coroner's officer on a set date to be informed of the outcomes. This continues to work well.





10. Cause of Death and Hospital Standardised Mortality Ratio (HSMR)

The top 5 causes of death as stated on 1a) of the Medical Certificate of Cause of Death (MCCD):

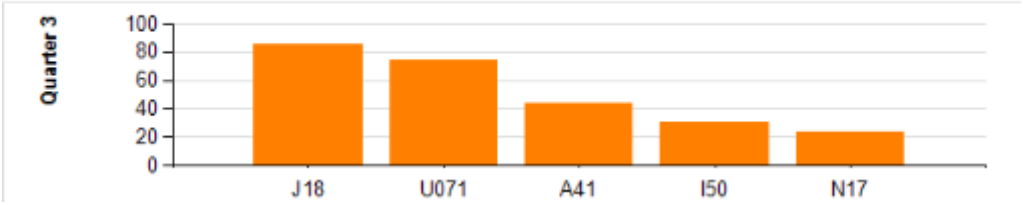
	From MCCD	Count
1	Pneumonia	107
2	Covid-19	83
3	Sepsis	67
4	Cardiac related	57
5	Metastatic cancer	43

The Trust's HSMR is calculated from the information the clinical coding department extract from the clinical notes. It is important to understand national coding rules, which state that we code for morbidity and not mortality. Therefore, the primary diagnosis for the patient should be the main condition treated or investigated during the hospital spell, which may or may not be the actual cause of death. Secondary diagnoses will include those conditions or complications, which the patient has developed during their admission and any relevant comorbidity.

The top 5 main conditions treated were:

Quarter 3

Year	Quarter	Top 5	Count	HSMR ICD	ICD-10 Description
2021/22	3	1	85	J18	Pneumonia, organism unspecified
2021/22	3	2	74	U071	COVID-19 Confirmed
2021/22	3	3	44	A41	Other sepsis
2021/22	3	4	30	I50	Heart failure
2021/22	3	5	23	N17	Acute renal failure



11. Learning

Being able to demonstrate the learning from reports such as this always remains a challenge. Effective clinical governance processes within specialties are paramount in ensuring that this happens. The learning must happen at ward and department level.

The following are subjects for learning/awareness raising as identified from the medical examiner process, feedback received from bereaved people or the findings of SJR are:

- Consideration must be given on an individual basis with regards visiting. This has been detailed in the last 3 quarterly reports. We continue to hear from relatives that they could not stay with their elderly relative when not on the EOL care plan. Compassionate visiting should ALWAYS be considered by the senior nurse.
- A/E staff must consider previous attendances when they are considering whether to admit or not. Bed pressures often dictate action, however bereaved relatives have reported several situations where their loved one attended A/E and felt that they were only discharged home because they were busy.
- Relatives have raised concerns regarding staff attitude in the Trust – stating they felt they were burdens by asking for information.
- Relatives must always be informed of ward and hospital transfers.
- Families have raised issues regarding relatives being offered inadequate fluid and diet. Without visiting they have not been able to help feed and have found relatives have not been helped and encouraged with fluid and diet.
- Increasingly families are reporting that they cannot get through when attempting to contact the wards to enquire about their loved ones. Again, this was raised last quarter but we continue to have many bereaved people telling us that this is a problem. This has been escalated.
- All documentation must be legible, signed, printed name, dated and timed and Drs should be encouraged to put their GMC number within the notes. The use of a name stamp should be encouraged.

The LFD nurse role will be to ensure these themes are translated into meaningful learning through the correct clinical governance processes at specialty level.

12. Bereavement Team.

The layout within the bereavement office has continued to be well received by the whole team. When busy Doctors come to complete an MCCD or refer a death to the Coroner they have a quiet area to sit and have access to the MEO/ME for advice and support.

The bereavement team has expanded which has enabled two bereavement officers on shift daily, covering 8-4 and 9-5. Weekend cover has also begun so the bereaved are contacted in a more timely manner.

There is also an advert out currently to appoint another Bereaved Officer.

The Bereavement team continue to strive for all MCCD's to be completed within a 3 day internal target. This will enable bereaved relatives to register a death within 5 days.

The bereavement team continues to struggle at times with illegible handwriting and this is becoming more challenging when trying to contact the appropriate Dr to complete the MCCD or complete an HMC referral.

This last quarter has seen an increase in the lack of consistent recording of the NOK details. Often CAMIS and the notification of death form are different. Also, the documentation of confirmation of patient ID on a wristband in life is often missing. This can cause much distress for a family as sometimes they have to come into hospital to formally ID their loved one.

13. Recommendations

Recommendations	Progress
To Ensure 100% MCCD's are available to the registrar within 3 days	Q3 82% across the Trust
Task and finish group to determine SJR process	To be completed April 2022
Introduce the scrutiny of non-acute deaths	Continue to communicate with GP Surgeries. Delays in IT access has been escalated to the Trust's Clinical Governance Committee. Providers for IT systems have been received and costings awaited.
Appoint LFD Nurse	Advertisement released February 2022
The Board, via the QEC, to receive this report for assurance of the ongoing work to improve mortality review and the learning across the organisation.	April 2022

14. Conclusion

Following the introduction of the Medical Examiner Team in December 2019 the learning from death lead nurses evolved into Medical Examiner Officers and have been assisting the Chief Medical examiner in ensuring that the independent scrutiny of all in patient deaths has become established. Of course the bulk of this work happened during the pandemic and so it was remarkable that by January 2021 the ME team were scrutinising circa 100% of all adult in patient and ED deaths. The team have consistently raised any areas of concern, using established clinical governance processes. However, it became clear, as we began to emerge from the pandemic that in order to extract and embed the learning across the organisation, a learning from deaths (LFD) lead nurse was required. The position is currently out to advert. The LFD nurse's key aim will be to ensure that issues raised by the ME team are translated into meaningful learning through the correct clinical governance processes at specialty level.

Several areas of learning have been highlighted in the report and all of these have been raised with the clinical governance teams, individual practitioners or ward teams. Any potential serious incident/ avoidable death has been reported via Datix and alerted to the patient safety team. The Medical Examiner (ME) Team have scrutinised 95% (572) deaths this quarter. Although this is a slight decrease of 2%, the actual number of deaths is 100 more than in the previous quarter.

The ME team has been recognised by the regional medical examiner's office as performing extremely well in achieving almost 100 % scrutiny since January. Work has now begun to explore ways of scrutinising non- acute deaths. Initial work has proved extremely challenging due the difficulties in accessing primary care IT systems.

There have been 3 more ME's and 1 MEO recruited so that the introduction of none acute death scrutiny can begin once access to the IT systems has been addressed.

This Q3 reports a very promising position. Although the number of deaths scrutinised by the ME team have dipped slightly, the actual number of deaths has also risen so we are confident that by Q4 cases scrutinised will once again be close to the 100% mark, though we must be mindful that the winter months are fast approaching and numbers may well rise once again.

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust remain committed to investigating, learning from and taking action as a result of individual complaints where concerns have been made or where services can be improved.

Our vision is "to be the safest Trust in England, outstanding in all that we do". To achieve this The DBTH values must be followed which include always putting the patient first and committed to quality and continuously improving patient experience.

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 – Director POD **Committee: People**	**People, Partners, Performance, Patients, Prevention**	**Date last reviewed : May 2022**		
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.** **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.	**Risk Appetite:** The Trust has a **low appetite** for risks **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~~ • ~~Increase in number of staff retiring~~ • Reliance on international recruitment whilst increase in education places come to fruition • Levels of sickness absence impacting on staffing levels	**Initial Risk Rating** **Current Risk Rating** **Target Risk Rating**	4(C) x 5(L) = 20 extr 4(C) x 4(L) = 16 extr 3(C) x 3(L) = 9 low	Risk Trend ⟷
		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		
	Risk references: PEO1 & PEO2 **Opportunities:** • Change in practices, new ways of working • Increase skill set learning	**Future risks:** Morale and resilience of colleagues as we move into recovery phase **Comments:** • Considerations – capacity & capability of workforce including our leaders		

Controls (mitigation to lead to evidence of making impact):	**Last Review date**	**Next review date**	**Reviewed by**	**Gaps in Control**
Monitoring progress of appraisal completion through central regular reporting within P&OD indicating compliance	April 2022	Jun 2022	AJ	No gaps identified
Staff survey and focus groups – positive feedback on staff knowing Trust vision	Mar 2022	Apr 2022	JC	No gaps identified
Staff survey action plans to ensure appraisal conversations are meaningful as defined by the staff survey	April 2022	June 2022	JC	Staff survey results being shared across the organisation
Communication – Staff Brief, Listening Events, Facebook	Mar 2022	June 2022	AJ	Dates to be confirmed with CEO Office & Senior Leadership Teams
Leadership Development Programme to include QI	April 2022	May 2022	JC	Completed

Assurances received (L1 – Operational L2-Board Oversight L3 External) **		**Last received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
L2, L3	Feedback from the appraisal season and quarterly staff survey results	-	People, Board	Full	Action plan in place
L2	Stand survey feedback – 89% staff who responded knew the Trust vision	Jan 22	People	Full	None
L3	NHS - framework of quality assurance for responsible officers and revalidation submission	Nov 21	People	Full	Action plan in place
L1,L2,L3	KPMG Job Planning Audit	Nov21	People, ARC, Board	Partial	Action plan actively monitored by ARC and People Committee

Appendix Level1

Corrective Actions required	Action due date	Action status	Action owner	Forecast completion date
Active monitoring on KPMG Job Planning audit to ensure all actions completed	**Ongoing – 12 month from audit date**	**Amber -ongoing**	**TN**	**Summer 2022**
Executive Team supported proposal to delay the start of the appraisal season from April to June	**Mar 22**	**Amber – ongoing**	**AJ**	**Sep 2022**

Assurances received (L1 – Operational L2-Board Oversight L3 External) identify the range of assurance sources available to an entity:
—L1 Management –such as staff training and compliance with a policy
—L2 Internal Assurance –such as sub-committees receiving evidence of L1 working effectively; and
—L3 External Assurance –such as internal and external audits.

Areas in yellow highlight indicate change from last version

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 – Director POD **Committee: People**	**People, Partners, Performance, Patients, Prevention**	**Date last reviewed : May 2022**		
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** **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	**Risk Appetite:** The Trust has a **low appetite** for risks **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 organisational development strategy that allows implementation of trust values • Negative response and decline in position in staff survey • Negative response via learner feedback • Staffing levels impacting on how colleagues feel	**Initial Risk Rating** **Current Risk Rating** **Target Risk Rating**	4(C) x 5(L) = 20 extr 4(C) x 4(L) = 16 extr 3(C) x 3(L) = 9 low	Risk Trend ⟷
		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		
	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	**Future risks:** Morale and resilience of colleagues as we move into recovery phase **Comments:** • Requires good OD plan “fit for purpose” • Staff survey impact • Need good data • Recruitment & retention – refresh of workforce plan • Involvement in regional retention programme of work		

Controls (mitigation to lead to evidence of making impact):	**Last Review date**	**Next review date**	**Reviewed by**	**Gaps in Control**
Support introduction of Freedom to Speak Up Champions	Mar 2022	Jun 2022	PH	No gaps identified
Improvement in payroll KPIs – to include survey of staff re their experience	Mar 2022	Apr 2022	MB	Analysis of survey complete and paper drafted outlining findings
Staff survey action plans to ensure improvement	Mar 2022	Apr 2022	AJ	Full results available – paper to be presented at next People Committee
Communication – Staff Brief, Listening Events, Facebook	Jan 2022	June 2022	ES	None – ongoing communication process
Development programme to include Everyone Counts/Civility	Jan 2022	April 2022	JC	Completed in circulation – no gaps identified
Strong partnership working with Partnership forum and JLNC	Mar 2022	Sep 2022	AJ	No gaps in assurance

Assurances received (L1 – Operational L2-Board Oversight L3 External) **		**Last received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
L1,L2	Standard POD reports for Board	Dec 21	People, Board	Full	None
L2	Guardian for Safe Working Annual Report	May 2022	People, Board	Full	Report for consideration at People Committee May
L1,L2	Staff networks (BAME, LGBTQ+, Dyslexia & long term conditions; Reciprocal Mentoring programme – feedback to learning partners	-	People Board		Plan to submit to People Committee, recent People Committee Agenda reduced due to impact of Covid in Dec / Jan 2022
L1,L2,L3	KPMG Job Planning Audit	Nov21	People, ARC, Board	Partial	Action plan actively monitored by ARC and People Committee
L1,L2	Strategy listening event – response from circa 1k members of staff – feedback that wellbeing was a high priority for the Trust	Dec 2021	Health & Wellbeing Committee	-	Health & Wellbeing Paper due to go next People Committee March 2022

Appendix Level1

L3	HEE Monitoring and Learning Environment Report	Mar 2022	People Committee	Full	**Non identified**

Corrective Actions required	**Action due date**	**Action status**	**Action owner**	**Forecast completion date**
Active monitoring on KPMG Job Planning audit to ensure all actions completed	**Ongoing – 12 month from audit date**	**Amber -ongoing**	**TN**	**Summer 2022**

Assurances received (L1 – Operational L2-Board Oversight L3 External) identify the range of assurance sources available to an entity:
—L1 Management –such as staff training and compliance with a policy
—L2 Internal Assurance –such as sub-committees receiving evidence of L1 working effectively; and
—L3 External Assurance –such as internal and external audits.

Areas in yellow highlight indicate change from last version

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	24 May 2022		**Agenda Reference:**	D2	
Report Title:	**Our People Update**				
Sponsor:	Anthony Jones, Acting Director of People & OD				
Author:	Anthony Jones, Acting 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 to support the organisation in the achievement of its strategic aims.				
Summary of key issues:	The report this month provides a more detailed focus on sickness absence, summarising the information which was submitted to May's People Committee Meeting. The detailed update includes: ○ To provide an update on sickness absence data ○ To provide a review of existing sickness absence reporting processes and ongoing quality improvement projects ○ To provide assurance on the Health and Wellbeing support for staff ○ To provide an update on Occupational Health services and new developments Included also within this report is an update in relation to Workforce Data & Planning, staff turnover data and summary data regarding staff retirements.				
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:	None		
Legal:	None		
Resources:	None		
Assurance Route			
Previously considered by:	People Committee		
Date:	03 May 2022	**Decision:**	Assurance
Next Steps:	Ongoing discussions at People Committee		
Previously circulated reports to supplement this paper:		None	

Green = previously included charts not yet updated, if chart not highlighted = updated

1. Absence

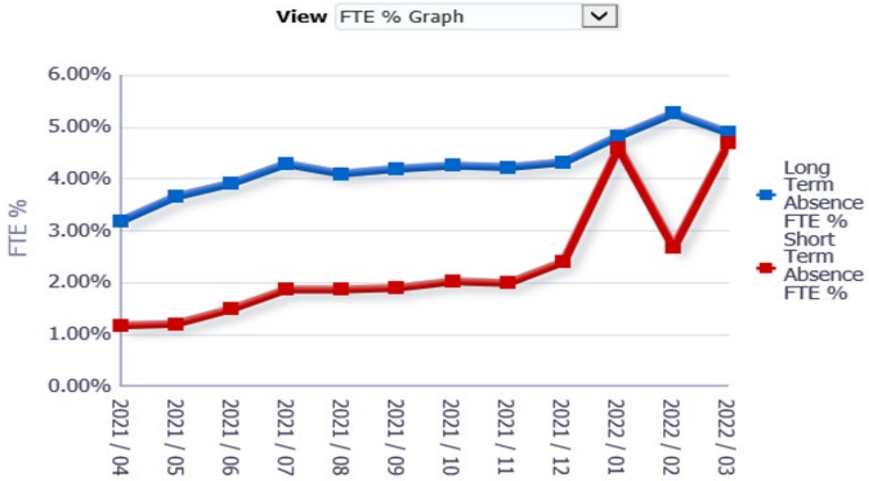
Sickness and related absence

The Trust has experienced high levels of sickness absence throughout the pandemic, however in the last quarter of the financial year 2021/22 we saw the highest absence levels experienced to date. It is therefore essential that all possible supportive actions are being taken and our people have access to a range of health and wellbeing support programmes and packages. At the May meeting of the People Committee a 'deep dive' was undertaken regarding staff absence to provide an update on the current picture across the organisation and review actions being undertaken.

The below report is a summary of the information provided to the People Committee.

The graph below shows an upward trend for long term absence and significant increases in short term absence in the Winter months (see Appendix 1).

Figure 1 - Long term/ short term absence Trust wide April 2021 to March 2022

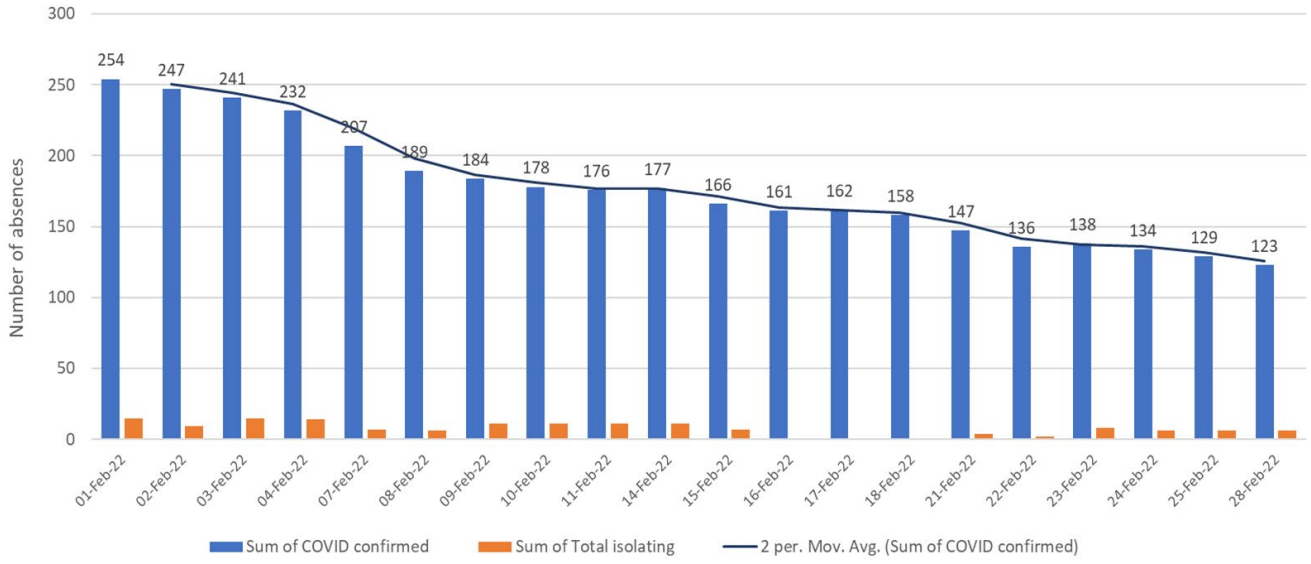


Routinely the top three reasons for absence are Stress/ anxiety/ depression; Musculoskeletal problems and Cough/ cold/ flu (see Appendix 1).

From the breakdown of covid and non-covid absence over the past 2 years (Table 3, 4 and 5) for 7 out of the last 24 months the Trust has been able to sustain sickness levels like pre-pandemic levels at levels of less than 5%. It is worth highlighting that those months either coincide with summer months or with those months where we were seeing the impact of national lockdowns limiting the spread of illness.

Overall, the significant increases in sickness absence can be directly correlated to the peaks in covid rates in the winter months in 2020/21 and with the rise of omicron cases in since January 2021. The Trust sickness absence rate (including covid and non-covid) has remained high since January 2022 (showing the 3 highest months of sickness absence since the pandemic commenced). Long-term absence reaching above 5% for the first time in January 2022 at 5.27%. A general trend demonstrating an increase in long term absence across the Trust can be seen against an irregular short term absence pattern (linked to spikes in covid cases) but one that also shows an increasing trajectory. The total absence for the final quarter of 2021/22 has been the highest since the commencement of the pandemic.

The table below provides a trend line of covid related absences in month, demonstrating the steady reduction in covid related absences that we are seeing across the Trust.



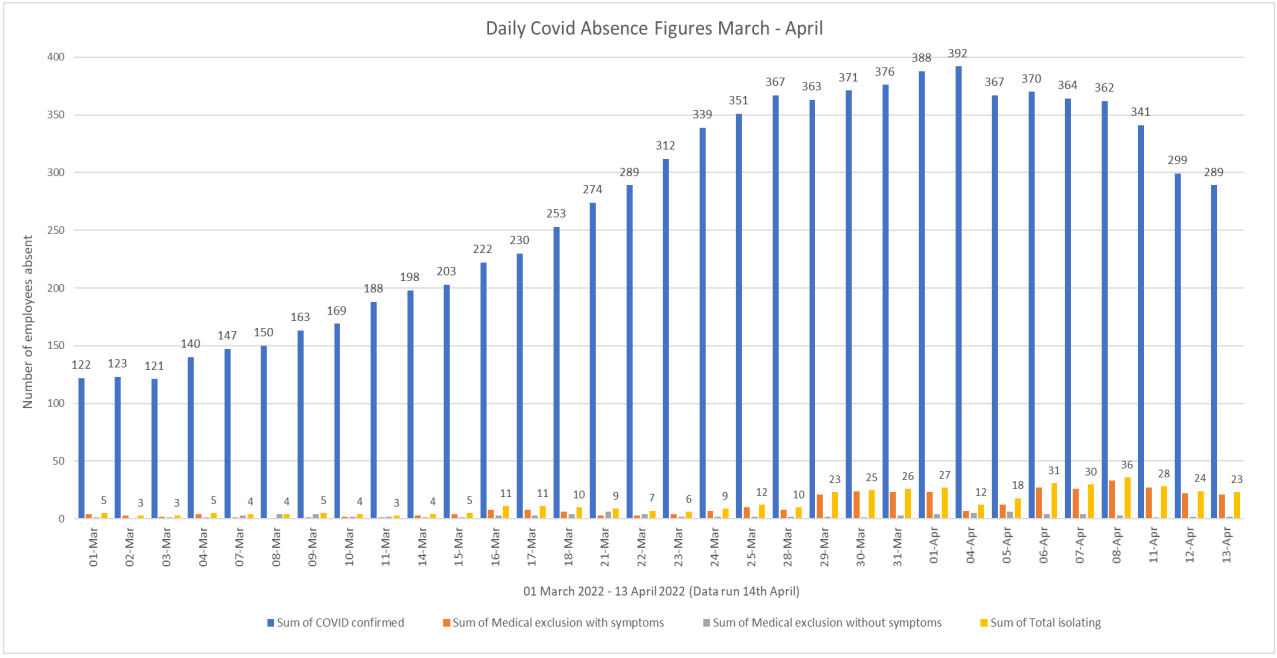


Table 1 – Daily Absence Snapshot, 14 April 2022

Daily Absence				
COVID Absence Reason	**Volume Yesterday**	**Volume Today**	**Change +/-**	**% of total Heads**
COVID confirmed	289	290	1	4.32%
Medical exclusion with symptoms	21	15	-6	0.22%
Medical exclusion without symptoms	1	1	0	0.01%
Test and Trace	0	0	0	0.00%
LFT	0	0	0	0.00%
Side Effects	1	1	0	0.01%

Shielding	0	0	0	0.00%
Carers Covid	0	0	0	0.00%
Total sick absence (Covid & Non-Covid)	603	606	3	9.03%
Total isolating	23	17	-6	0.25%

Table 2 – Daily Absence Snapshot, 21 April 2022

Daily Absence				
COVID Absence Reason	Volume Yesterday	Volume Today	Change +/-	% of total Heads
COVID confirmed	244	239	-5	3.56%
Medical exclusion with symptoms	8	7	-1	0.10%
Medical exclusion without symptoms	0	1	1	0.01%
Test and Trace	0	0	0	0.00%
LFT	0	0	0	0.00%
Side Effects	0	0	0	0.00%
Shielding	0	0	0	0.00%
Carers Covid	0	0	0	0.00%
Total sick absence (Covid & Non-Covid)	545	553	8	8.24%
Total isolating	8	8	0	0.12%

Table 3 – Daily Absence Snapshot, 28 April 2022

Daily Absence				
COVID Absence Reason	Volume Yesterday	Volume Today	Change +/-	% of total Heads
COVID confirmed	200	190	-10	2.83%
Medical exclusion with symptoms	9	11	2	0.16%
Medical exclusion without symptoms	1	1	0	0.01%
Test and Trace	0	0	0	0.00%
LFT	0	0	0	0.00%
Side Effects	0	1	1	0.01%
Shielding	0	0	0	0.00%
Carers Covid	0	0	0	0.00%
Total sick absence (Covid & Non-Covid)	511	501	-10	7.46%
Total isolating	10	13	3	0.19%

The above three tables illustrate the daily figures tracking the increase in levels of covid absences in the later 3 weeks of April 2022, illustrating the reducing trend of covid confirmed cases in the Trust.

Figure 3–All absence (Covid and non-covid) % rate by Division / Directorate March 2022-Feb2022

	Absence Occurrences	Days Lost	% Rate
Doncaster & Bassetlaw Teaching Hospitals NHS FT	**28967.00**	**319998.37**	**7.89%**
Estates & Facilities	2726.00	31699.84	9.46%
Medicine Division	8833.00	100099.72	9.17%
Surgery and Cancer Division	4251.00	51844.03	8.11%
Children & Families Division	3177.00	34357.05	7.87%
Clinical Specialties Division	7519.00	79671.74	7.53%
Nursing Services Directorate	391.00	4349.13	6.75%
Medical Director Directorate	13.00	112.37	5.61%

Performance Directorate	986.00	7041.40	5.26%
Education and Research Directorate	231.00	2386.09	4.86%
Restoration, Innovation and Transformation Division	454.00	4769.70	4.57%
Directorate Of Strategy & Improvement	4.00	17.60	3.78%
Pooled Covid Ward (Temporary Ward)	72.00	548.11	2.82%
People & Organisational Directorate	159.00	1318.75	2.74%
Finance & Healthcare Contracting Directorate	199.00	1534.92	2.67%
Chief Executive Directorate	41.00	233.93	1.67%
IT Information & Telecoms Directorate	3.00	14.00	0.53%

When the Trust is benchmarked against other organisations DBTH demonstrates the highest absence rates within the Northern region see Table 6 below. There are many interrelated factors that may contribute to this including high community transmission rates, how absence is managed, reported, and recorded staff burnout, engagement and the context in which services are provided. This requires further exploration to fully understand and explain this difference. There is further work ongoing to understand our outlier position. At the time of drafting this paper the Trust's absence rate is 6.82% of which 1.95% is covid related absence.

Table 2 – North Region Top Absence Rates (All Absence) 18th March 2022

Organisation	Position 48 Hrs ago	Position 24 Hrs ago
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	9.2%	9.3%
Cumbria, Northumberland, Tyne, and Wear NHS Foundation Trust	8.9%	9.3%
Rotherham Doncaster and South Humber NHS Foundation Trust	8.7%	8.9%
Sheffield Teaching Hospitals NHS Foundation Trust	8.4%	8.8%
York and Scarborough Teaching Hospitals NHS Foundation Trust	8.1%	8.4%
Bradford District Care NHS Foundation Trust	7.3%	8.4%
North Tees and Hartlepool NHS Foundation Trust	8.2%	8.2%

The snapshot of the Integrate Care System (ICS) benchmarking data indicated in Table 7 below demonstrates that DBTH has the second highest infection rates amongst staff after STH. This is comparable in terms of size of DBTH as the second largest Acute Trust in this area and the community experiencing a significant spike from the omicron variant since January 2022.

Table 3 – ICS Staff Covid Rates 18th March 2022

Organisation	Position 48 Hrs ago	Position 24 Hrs ago
South Yorkshire and Bassetlaw ICS	1327	1505
Sheffield Teaching Hospitals NHS Foundation Trust	668	761
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	**284**	**299**
The Rotherham NHS Foundation Trust	99	118
Rotherham Doncaster and South Humber NHS Foundation Trust	96	102
Barnsley Hospital NHS Foundation Trust	80	107
Sheffield Children's NHS Foundation Trust	55	77
Sheffield Health & Social Care NHS Foundation Trust	45	41

The top reason for DBTH staff absence is stress and anxiety. The table 8 below reflects the prevalence by staff group for the rolling 12 months from Feb 2021 to Jan 2022. It is apparent that the two staff groups most affected by stress and anxiety are nursing and midwifery and additional clinical services (which includes roles such as Healthcare Assistants), followed by admin and clerical and estates and facilities.

Those working in patient facing roles and those working in patient and covid areas are likely to have experienced more significant impact during the pandemic. Given the physical nature of the roles it is unsurprising that both nursing and midwifery and additional clinical services feature as the top two staff groups also affected by MSK issues.

We continue to support at pace testing facilities on both Doncaster and Bassetlaw Sites, including the continuation of the provision of testing (Abbott Test) for people who are fully vaccinated, who are asymptomatic and testing negative on lateral flow which facilitates a return to work following the test if negative, resulting in a significant impact on available workforce for deployment.

2. Sickness Absence Process Improvement Project

The centralised sickness absence reporting process was established at in the height of the pandemic and the Absence Line Team have processed a massive call volume approximately 66,720 calls between February 2021 and February 2022, equating to approx. 5,560 sickness records per month. Through stakeholder feedback it has been identified there were approximately 450 errors in sickness records in total during the same period, this equates to 0.7% errors.

In March 2022 the P&OD have established a Sickness Absence Process Improvement Project Group to review the current process and functionality to ensure fitness for purpose. The formation of a multidisciplinary group is to ensure that we are taking the right steps to support people when they are ill, able to report accurately and ensure we have a comprehensive health and wellbeing offer for our people. Early engagement and stakeholder feedback on the current centralised reporting processes has identified:

- Staff not following the process for reporting
- IT and Technical issues between systems
- Inputting and recording errors

The below outlines the current actions being taken to improve the overall sickness absence processes:

- **Transfer of the Sickness Absence Line Team into Occupational Health**
- **Implementation of a New Absence Recording System**
- **Training and Support for Managers**
- **Review of Sickness Absence Policy**
- **Reasonable Adjustments Policy/ Disability Leave Policy**
- **Medical Exclusions Policy**
- **Menopause**

3. STAFF WELLBEING SUPPORT

At DBTH we have a robust employee assistance provision (EAP) which includes 24/7 support line and access to in the moment support and staff counselling. The figures below reflect the number of incoming calls to the Vivup EAP service.

Figure 2 – Incoming Vivup Calls July 2021 to December 2021

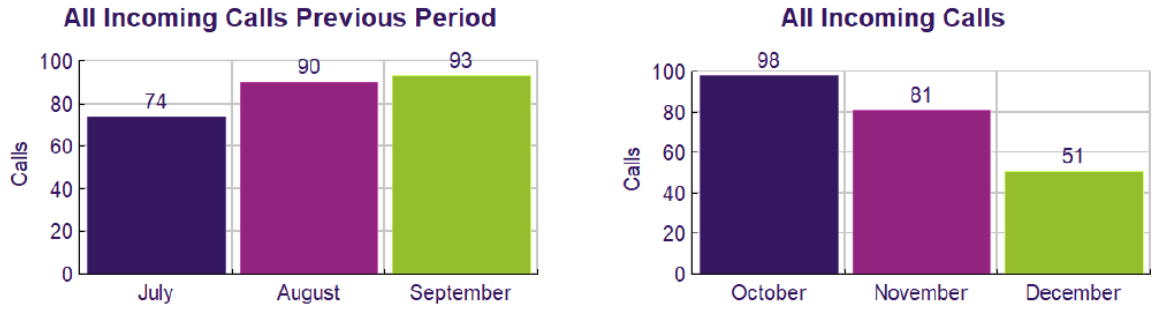
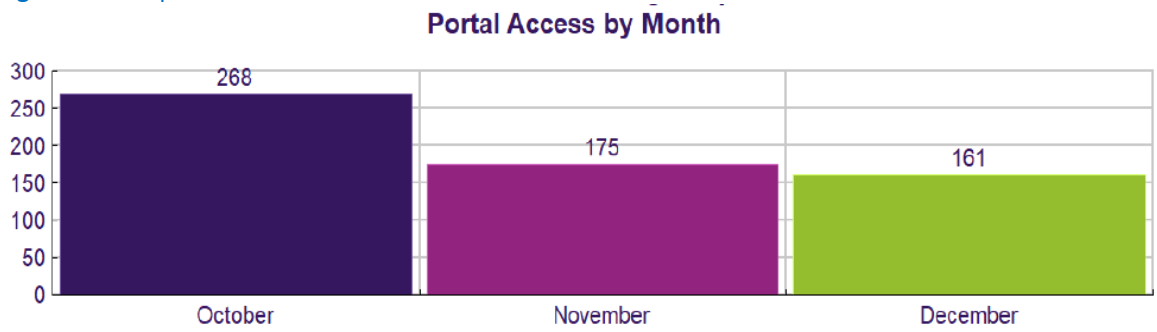


Figure 3 – Vivup Portal Access October 2021 to December 2021



The quarterly figures regarding online downloads (below) are consistent with the main reasons for sickness absence associated with stress, anxiety, depression, and bereavement. It is acknowledged that there is always more work to do to raise awareness regarding the range of EAP that are available to staff and the new Health and Wellbeing Handbook will help to enhance promotion of these services.

4. OCCUPATIONAL HEALTH

Over the last year the Occupational Health Team has seen a total of 1358 referrals with an increase in referrals for mental health (383 referrals for Mental Health associated reasons over the past year). In this category the total number of referrals represents 36% of all stress and anxiety related absences over an annual period. The statistics alone do not reflect the overall increase in time and resources required for referrals associated with mental health which includes assessments, suicide screening and stress risk assessment.

The percentage of MSK related referrals lasting for over a month in duration equals only 23%.

Long COVID and COVID respiratory referrals are seen primarily by the Consultant OH Physician and there is an increase in waiting period for this clinic. The service has identified a need for additional consultant time, and this has been added in the cost pressures list. The intention is to double the consultant support for the service from 2 days per month to 4 days per month. In addition, most of those staff seen by the Consultant for COVID related issues will then need an OH level risk assessment.

On average Management Referral waiting times are 5 days for contact and 10 days for appointment. A recent Cohort record audit report demonstrates significant improvements made in managing referrals over the last 6 months. To support this work there will be a planned program of education to all managers will take place as an outcome of the sickness/absence project.

Assessing people as “Fit for work” and balancing this with reasonable adjustment is also very complex at the minute with several cases needing multiple elements of support including consideration for redeployment. This is a positive way forward in supporting people back to work sooner.

5. HEALTH AND WELLBEING

The Health and Wellbeing Team provide valuable services, initiatives, and support to all our staff at DBTH to bring to life the We Care Values and behaviours. The Health and Wellbeing Team work closely with leads within the South ICS which has enabled staff to access opportunities such as the

- Long Covid Support Pathway
- Training and Development
- Physical and emotional support sessions.

6. RECOGNITION OF THE TRUSTS HEALTH & WELLBEING OFFER

Colleagues will recall that DBTH has achieved the silver level of the Be Well@ work award which validates the work the health and wellbeing team have delivered during the pandemic. It is pleasing to report that the Trust has been nominated for a further health & wellbeing award, recognising the range of support currently on offer to our people, which includes but is not limited to:

- **Wellbeing Champions -** The team continue to support and develop the Health and Wellbeing Champions and their role in communicating the health and wellbeing offer.
- **Wellbeing Handbook -** The team have launched the new Trust health and wellbeing Handbook (copy attached see Appendix 10) which sets out the full range of services to support staff. It is shared across the trust with people and at induction.
- **Know Your Numbers (Wellbeing Health Checks) -**This is a service taken to team areas to check blood pressures and Body Mass Index. So far seen 196 staff over 17 sessions across BH, DRI, MM and Retford, including colleagues from estates and facilities, and clinical teams. There are further sessions planned for both clinical and admin areas.
- **Complementary Therapies for Staff -** SYBICS have increased funding for complementary therapies and this offer for staff has now been extended to October 2022. Feedback from staff is extremely positive with lots of comments thanking the Trust for providing this valuable service.
- **Therapies Garden Room at DRI -**The H&W team have recently been successful in their bid to develop a tranquil garden room to be located at the back of D Block to be able support the expanding range of therapies offered to staff including reiki, complementary therapies, and on-site counselling.
- **Additional Staff Counsellor -** Additional counselling capacity has been secured to offer face to face counselling to staff, an area of focus is the Estates and Facilities team.
- **Highfive App -** The Highfive app is a reward and recognition tool to increase positive acknowledgement in the workplace. It will also operate a platform for the Trust Star Awards and the Trust's Long Service Awards.
- **Wellbeing Trolley -** This trolley is an engagement toll which visits areas to inject positivity and thanks into operational areas across all 3 sites. Most recently the trolley was out on Pancake Day at Montagu Hospital and during Nutrition and Hydration Week serving diluted juice, fruit and handing out water bottles.
- **Climbing Out -**The work with the Climbing Out charity continues to support physical mental wellbeing for our people.
- **Wellbeing Conversations -**As a Trust, we want to embed wellbeing conversations across the whole trust, we aim to create cultures where people feel heard and valued, and in which diversity is respected. This should, in turn, encourage us all to pass care and compassion on to each other and to patients. Wellbeing conversations should consider the whole wellbeing of an individual (e.g. physical, mental, emotional, social, financial, lifestyle, safety) and identify areas where the individual may need support, signpost them to that support, and regularly monitor their wellbeing over time. These conversations may fit within an appraisal, job plan or one-to-one line management discussion, and

should be ongoing throughout the year. P&OD are encouraging managers to undertake these conversations with all staff and, as a minimum, ensure these take place as a part of the annual appraisal process.

- **Talk Listen Care (TLC) -** At the outset of the pandemic the TLC service has provided a valuable support and welfare service for staff. This service is delivered by a redeployed staff member and input from the Health and Wellbeing Team where capacity allows.

  Demand is high for the service due to the recent spike in Covid cases. The focus of the TLC calls is welfare, wellbeing, listening, sign posting and demonstrating care and compassion for our staff. The general feedback that the team receive is very positive and staff express how meaningful and caring it is to receive a TLC call.

- **Trust Screening Service –** To facilitate ease of access to screening services, the Trust has introduced screening clinics across sites for our people to access. The service is supported through the Occupational Health Team and although only in place for a short period of time has proved popular with staff balancing busy home and work commitments.

7. DEVELOPING WORKFORCE PLANNING CAPACITY AND CAPABILITY

Working in partnership with KPMG the Trust is in the process of developing a strategic workforce planning solution to support workforce planning within the Trust. KPMG have commenced building a solution specific to the Trusts' data and strategic requirements, allowing for detailed understanding of current and upcoming workforce profiles and requirements. A presentation regarding the project and the aims and objectives has been presented to the People Committee and a demonstration of the functionality and specification of the tool has been presented to the Trusts Workforce Planning Committee.

The tool will provide workforce planning functionality for all staff groups with the Trust and will incorporate the ability to:

- Forward plan for a period of 10 years
- Support multifaceted scenario planning
- Extrapolate workforce planning metrics and requirements at multiple levels with the organisation.

The project also encompasses a joint piece of workforce planning at place level with RDASH. This is very specific and focuses on Allied Health Professions only from an RDASH perspective but will provide an opportunity to work across care and patient pathways to identify and scope workforce requirements across both organisations.

Key to success of the project will be the engagement with colleagues in key roles across the organisation, to facilitate this early engagement as mentioned previously, a presentation was undertaken at the Trusts Workforce Planning Committee. A Project Implementation Group has also been established, involving colleagues from Finance, Informatics, P&OD as well as Senior Management support. Progress regarding the implementation of the toll will be reported to the People Committee.

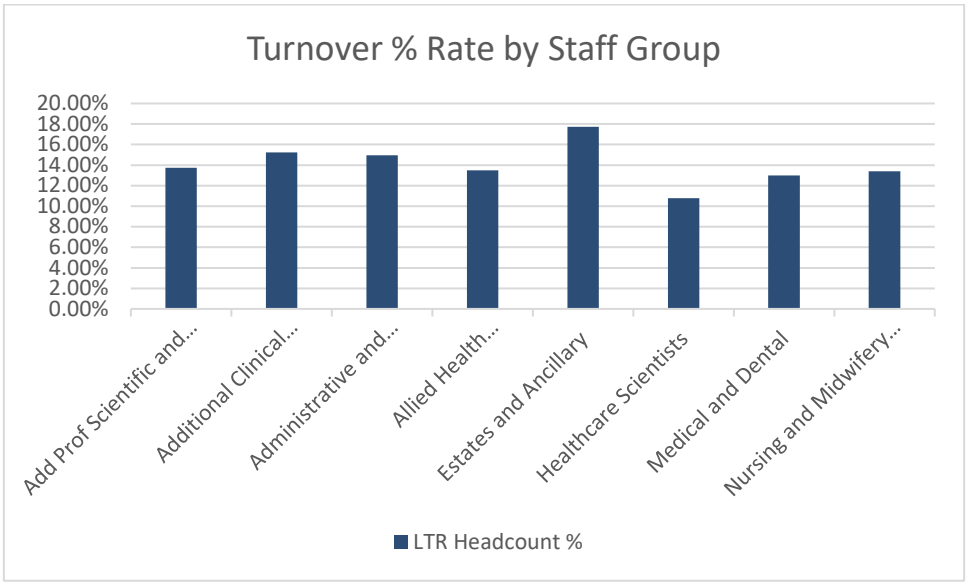
8. STAFF TURNOVER DATA

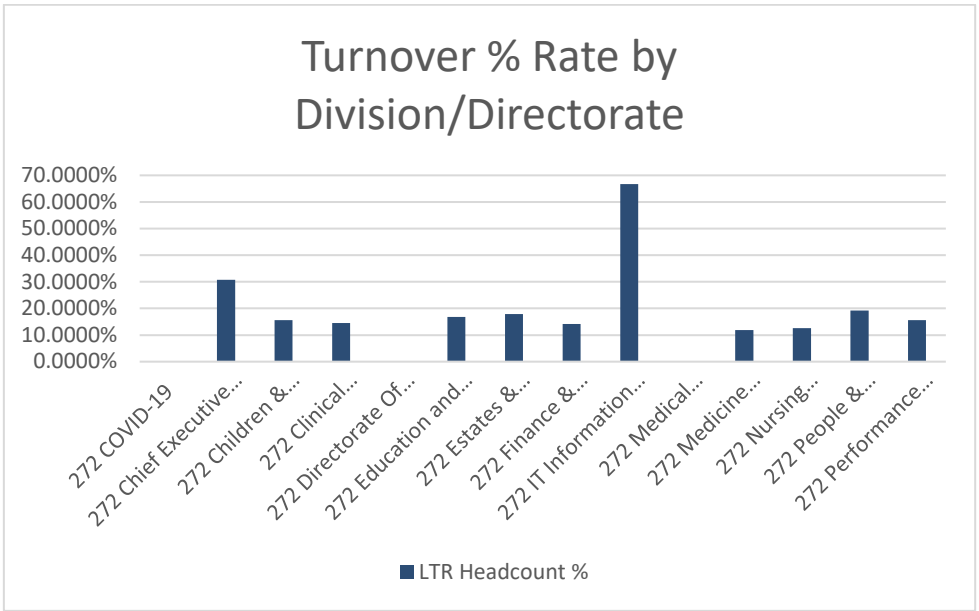
The below table indicates the turnover data in the organisation, identifying starters and leavers by staff group for the time period 01 April 2021 to the 31/03/2022. Areas of concern and focus are with the Nursing and Midwifery staff group where leavers are higher than starters over the period by 73 members of staff. A range of actions are being taken to support the position including international recruitment, newly qualified recruitment and retention strategies and actions such as the employment of practice development nurses to support newly qualified / new starters into the Trust.

Report Title: Our People Update Author: **Anthony Jones** Report Date: **April 2022**

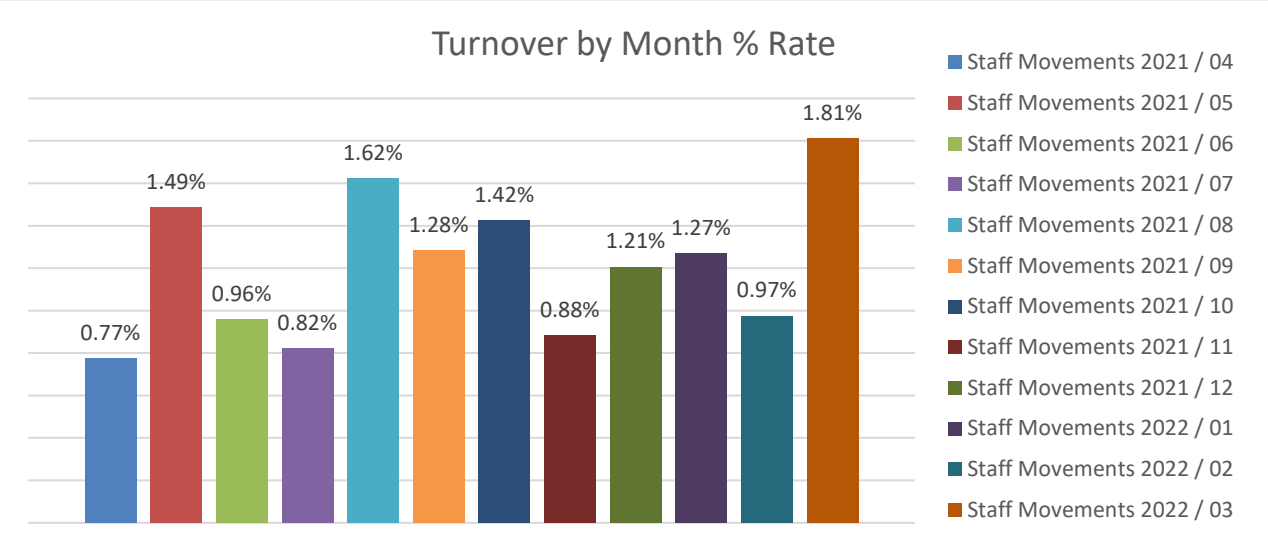
Staff Group	Headcount	Starters Headcount	Leavers Headcount	Starters Headcount %	Leavers Headcount %
Add Prof Scientific and Technic	176	18	25	10.23	14.20
Additional Clinical Services	1,472	268	224	18.21	15.22
Administrative and Clerical	1,408	235	206	16.69	14.63
Allied Health Professionals	406	44	54	10.84	13.30
Estates and Ancillary	650	103	117	15.85	18.00
Healthcare Scientists	137	10	15	7.30	10.95
Medical and Dental	369	50	47	13.55	12.74
Nursing and Midwifery Registered	1,873	178	251	9.50	13.40

The below tables indicate turnover as a percentage, the first table by staff group and the second table by Division / Directorate, again the data presented is for the full financial year, 01 April 2021 – 31 March 2022.





The below table indicates staff turnover as a percentage broken down into each month, again the same period of the full financial year 2021/22 is used.



9. RETIREMENT DATA ANALYSIS

Tabled at the May meeting of the People Committee was some high-level analysis of retirement data. This was raised and discussed in response to observations that it appeared several staff were opting to retire from service. The Trust has historically managed to encourage and support staff to retire and return to work for the Trust, sometimes on reduced hours or in alternate roles as a way of maintaining skills, supporting succession planning, and enabling people to transition into full retirement. It was agreed at the People Committee that further analysis and future reporting would be required to focus on the potential implications of higher numbers of staff opting to retire fully from service. Colleagues are asked to note that this is not an issue impacting solely on DBTH but is being reported as an issue facing the NHS with approximately 7,000 staff opting to leave the service each month.

The below table contains the high-level analysis presented to the committee, outlining the retirement data for the past 5 full financial years and including the current financial year. Although only the month of April is included for 2022, colleagues will note that should this trend continue, the Trust will see significantly higher numbers of staff retiring although of positive note is the continuation of above 30% of staff opting to retire and return. Further analysis in relation to age demographic and staff group is underway and will be presented for discussion at a future meeting of the People Committee.

YEAR	Total No. Retired	Retired Fully	Retired Fully %	Flexi Retired	Flexi Retired %
2017 -2018	161	93	58	68	42
2018-2019	183	117	64	66	36
2019-2020	191	104	54	87	46
2020-2021	211	145	69	66	31
2021-2022	243	137	56	106	44
2022-2023	42	29	69	13	31

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	24 May 2022	**Agenda Reference:**	D3
Report Title:	**Staff Survey Results 2021**		
Sponsor:	Anthony Jones, Acting Director of People and Organisational Development		
Author:	Jayne Collingwood, Acting Deputy Director of People & Organisational Development		
Appendices:	None		

Report Summary	
Purpose of report:	Update Board on the DBTH full Staff Survey results 2021
Summary of key issues/positive highlights:	This paper gives the Board a high-level overview of Staff Survey results for 2021. In 2021 the staff survey saw some radical changes in terms of the design and questions used which are aligned with the NHS People Promise and key indicators within it. The report displays how DBTH staff survey results compare at national, system and organisational level. For 2021 the national response rate was 48%, the SYB ICS was 53% and DBTH achieved a response rate of 63%. In summary there was a deterioration in the results compared to 2020 but DBTH held an average position overall. The areas of focus for DBTH going forward are: • Staff engagement and employee voice • Staff experience • Recruitment and retention, • Leadership development • We are a team • Quality improvement.
Recommendation:	Board is asked to consider the staff survey results in the wider context of events and in relation to system and national data.

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 receipt of current surplus to invest in improving patient care~~*

Implications	
Board assurance framework:	BAF SA3
Corporate risk register:	
Regulation:	

Legal:			
Resources:			
Assurance Route			
Previously considered by:		People Committee	
Date:	3rd May 2022	**Decision:**	People Committee require a more detailed report on Staff Survey.
Next Steps:		Board members to focus attention on Staff Survey action plans from Divsions and directorates	
Previously circulated reports to supplement this paper:			

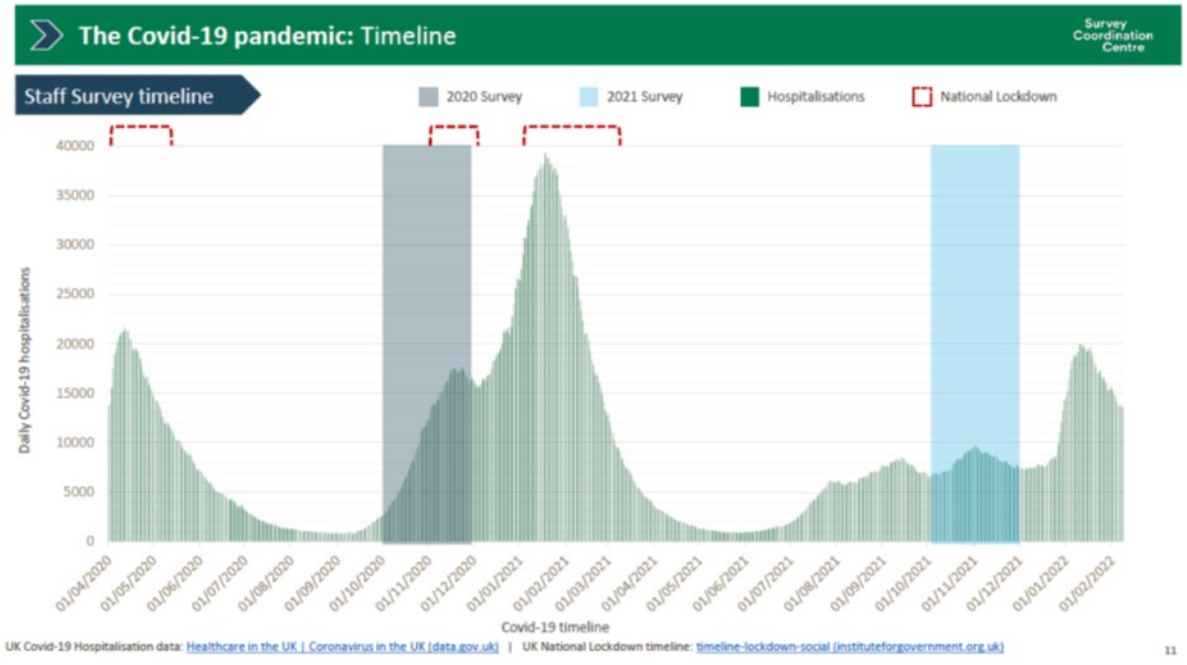
NHS Staff Survey

The NHS Staff Survey is one of the largest workforce surveys in the world and has been conducted every year since 2003 this provides a rich source of data relating to staff experience. This survey is important as it provides essential information to employers and national stakeholders about staff experience across the NHS in England. The participation is mandatory for NHS organisations.

For the first time the 2021 staff survey saw some radical changes in terms of the design and questions aligned with the NHS People Promise and key indicators within it, in summary this means

- New questions have been added to align with the people promise whilst still including the staff engagement and morale measures
- There is the ability to create refreshed interactive dashboards and local benchmark reports
- A new dashboard providing aggregated results at a regional and Integrated Care System (ICS) level for the first time.
- For the first time there is inclusion of a valid and robust measure of 'burnout' as part of the 'We are Safe and Healthy' reporting element.
- A focus on the contextual narrative relating to response rate messaging emphasising that the response rates provide useful insight about the survey but is not a measure of success.
- New demographic questions included for 2021 providing richer reporting and insight into the lived experience of our people.
- New scoring calculation to career progression (Q15).

As with any survey the context of wider events shapes and impacts upon the completion rates and responses to the survey. The infographic below reflects the timeline for waves of the Covid pandemic with related hospitalisations and national lock down periods. On the graph below the blue bar reflects the period when DBTH completed the full staff survey during October and November 2021.



Over recent years there has been a downward trend in completion of paper surveys. At DBTH there we still operate a mixed mode survey with paper survey for Estates and Facilities staff who are considered to have less access to electronic completion methods.

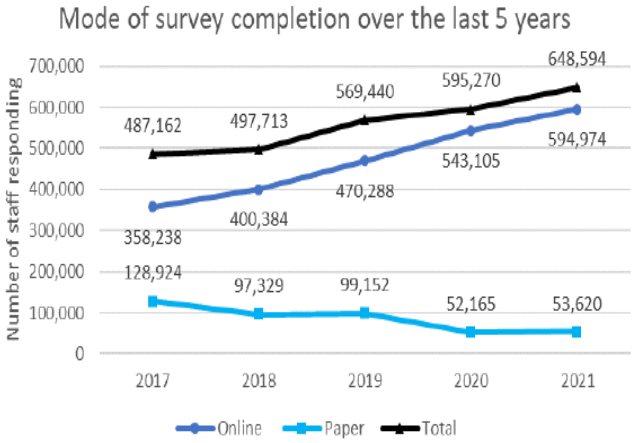
How has the survey mode changed over the last 5 years?

The graph on the right highlights that online completion of the survey has been steadily increasing since 2017. In 2021, 594,974 staff responded online, up from 358,238 in 2017.

Since 2020, the number of staff responding online has increased by more than 50,000 while the number responding on paper has seen little change:

Paper: 2020: 52,165
2021: 53,620

Online: 2020: 543,105
2021: 594,974



The infographic below reflects the National response rate of 48% and DBTH achieved a response rate of 63%. It is positive to report a high level of completion from DBTH staff whilst acknowledging this is not in itself a measure of success.

The following infographic reflects the DBTH results compared to national benchmark results.

The graph below reflects how DBTH compares with national data on the key elements of the People Promise

From the chart above it is evident that DBTH results are the same as the average for acute trusts in the areas of compassionate and inclusive, we have a voice that counts, we are always learning, morale and slightly below average for recognised and rewarded, we work flexibly, we are a team and staff engagement.

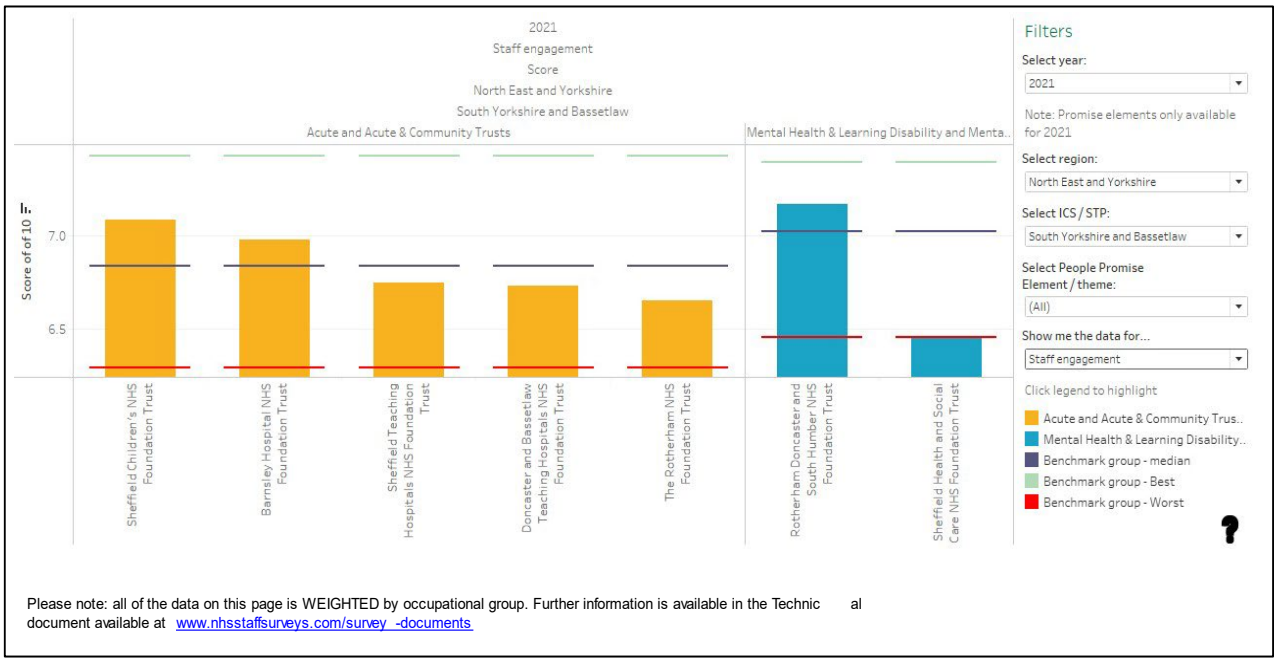
Comparisons across the Integrated Care System

When looking at comparisons across the South Yorkshire and Bassetlaw system the overall response rate was 53.0%, (up from 48.2% in2020) and DBTH was 63%.

Across the ICS the overall highest scoring theme is 'We are compassionate and Inclusive' at 7.3, followed by Staff Engagement at 6.8, 'We Each Have a Voice that Counts' at 6.7 and 'We are a team' at 6.6 (Doncaster and Bassetlaw and Sheffield Health and Social Care are below the benchmark median). The lowest scoring theme is 'We are always learning' at 5.3 (with Sheffield Health and Social Care achieving below the benchmark median)

It is unsurprising that overall, across the integrated care system the scores for Staff Engagement for all trusts in the system have declined compared to 2020 scores.

Staff engagement

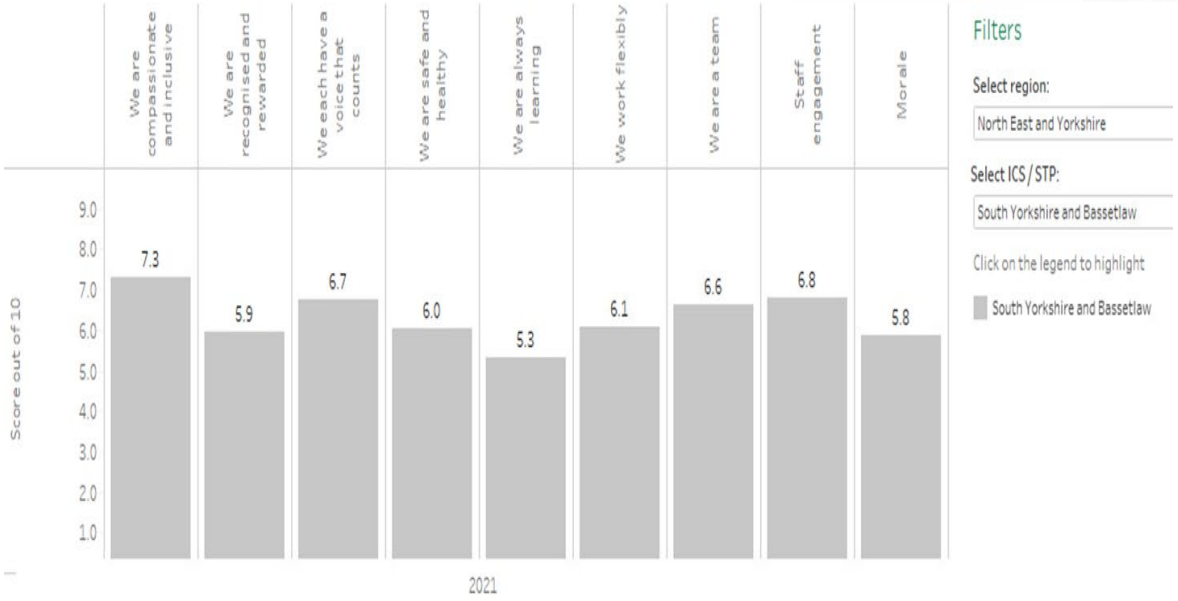


Please note: all of the data on this page is WEIGHTED by occupational group. Further information is available in the Technic al document available at www.nhsstaffsurveys.com/survey -documents

From the above ICS chart, it is evident there is work to do in staff engagement at DBTH when compared to system partners.

South Yorkshire and Bassetlaw

The graph below reflects the results across the 7 People Promise themes and staff engagement and morale.



DBTH Results

A total of 117 questions were asked in the 2021 survey, of these 92 can be positively scored, with 60 of these which can be historically compared. The results include every question DBTH received at least 11 responses (the minimum required). The table below reflects numbers invited and completion rates. The slide below reflects the summary of results.

Executive summary (part 1 of 2) Our Results

This report summarises the findings from the NHS Staff Survey 2021 carried out by Picker, on behalf of DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST. Picker was commissioned by 60 Acute and Acute Community Trusts organisations to run their survey - this report presents your results in comparison to those organisations.

A total of 117 questions were asked in the 2021 survey, of these 92 can be positively scored, with 60 of these which can be historically compared. Your results include every question where your organisation received at least 11 responses (the minimum required).

6576	6500	63%	52%	50%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (4072)	Average response rate for similar organisations	Your previous response rate

56%	q21c. Would recommend organisation as place to work
64%	q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation
74%	q21a. Care of patients/service users is organisation's top priority

Comparison to 2020*

Comparison with average*

*Chart shows the number of questions that are better, worse, or show no significant difference

Picker

As the chart above reflects, DBTH had a response rate of 63% which is the highest response DBTH has achieved to date. It is important to note that this year the survey was incentivised with a random prize drawer which helped to drive completion rates despite this being during the pandemic peak.

The summary slide below reflects the areas of improvement for DBTH compared to the Picker group and compared to previous years.

Executive summary (part 2 of 2)

Top 5 scores vs Picker Average	Trust	Picker Avg
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	51%	44%
q15. Organisation acts fairly: career progression	62%	56%
q16a. Not experienced discrimination from patients/service users, their relatives or other members of the public	96%	92%
q16b. Not experienced discrimination from manager/team leader or other colleagues	94%	91%
q11a. Organisation takes positive action on health and well being	60%	57%

Bottom 5 scores vs Picker Average	Trust	Picker Avg
q7b. Team members often meet to discuss the team's effectiveness	43%	56%
q3e. Involved in deciding changes that affect work	43%	49%
q3i. Enough staff at organisation to do my job properly	22%	27%
q3f. Able to make improvements happen in my area of work	48%	53%
q7g. Team deals with disagreements constructively	50%	55%

Most improved scores	Trust 2021	Trust 2020
q14d. Last experience of harassment/bullying/abuse reported	48%	44%
q13d. Last experience of physical violence reported	66%	64%
q28b. Disability: organisation made adequate adjustment(s) to enable me to carry out work	71%	69%
q17a. Would feel secure raising concerns about unsafe clinical practice	73%	72%
q9c. Immediate manager asks for my opinion before making decisions that affect my work	52%	51%

Most declined scores	Trust 2021	Trust 2020
q3i. Enough staff at organisation to do my job properly	22%	33%
q11d. In last 3 months, have not come to work when not feeling well enough to perform duties	40%	50%
q21c. Would recommend organisation as place to work	56%	65%
q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation	64%	71%
q22a. I don't often think about leaving this organisation	42%	48%

p.6 | DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST NHS Staff Survey 2021

Picker

Tables are based on absolute % differences, not statistical significance

Staff Engagement

Staff engagement is an important indicator of organisational culture and is made of 9 key questions in the areas of Motivation, Advocacy, and Involvement.

- Motivation explores feeling regarding coming to work, looking forward to work and enthusiasm.
- Advocacy explores advocating as a place to work or a place to be cared for.
- Involvement looks at opportunities to use initiatives and, able to make suggestions and improvements in the work area.

The table below reflects the results from 2020 and 2021 for DBTH and the Pickers results for 2021 as a comparator.

Comparator Information			Picker Average 2021	Organisation 2020	Organisation 2021
Section	Q	Description	n = 227091	n = 3157	n = 4072
Motivation	q2a	I look forward to going to work.	6.2	6.3	6.0
	q2b	I am enthusiastic about my job.	7.2	7.4	7.2
	q2c	Time passes quickly when I am working.	7.6	7.6	7.5
	E_1	Motivation sub-group score	7.0	7.1	6.9
Involvement	q3c	There are frequent opportunities for me to show initiative in my role.	7.2	6.9	7.0
	q3d	I am able to make suggestions to improve the work of my team / department.	7.0	6.9	6.8
	q3f	I am able to make improvements happen in my area of work.	6.1	5.9	5.8
	E_2	Involvement sub-group score	6.8	6.6	6.5
Advocacy	q21a	Care of patients / service users is my organisation's top priority.	7.3	7.5	7.2
	q21c	I would recommend my organisation as a place to work.	6.4	6.7	6.2
	q21d	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	6.7	7.0	6.6
	E_3	Advocacy sub-group score	6.8	7.0	6.7
Overall	E_4	Staff Engagement Score	6.9	6.9	6.7

From the table of results above it is apparent that as an organisation there has been a deterioration in the overall staff engagement score and in each of the 3 dimensions. In 2020 where the engagement score was 6.9 whereas 2021 results are 6.7. This is also the case when DBTH is compared to the Picker average for 2021.

The following table reflects the broader engagement scores over a 4-year period, and it is consistent with the wider survey that DBTH results are very reflective of 2018 levels.

Year	2018	2019	2020	2021
Engagement score	6.7	7.0	6.9	6.7

A small snapshot of some of the divisional data is displayed on the following slides, it gives an indicator for some of the areas at divisional and directorate level that need attention. However, the whole data set requires further interrogation at divisional and directorate levels to ensure a focus on key areas.

Q2a, I look forward to going to work.

Locality	Positive Score (%)	Number of Respondents					
		Never	Rarely	Sometimes	Often	Always	Total
Your Organisation	49.5%	164	494	1386	1514	489	4047
Chief Executive Directorate	65.6%	0	1	10	14	7	32
Nursing Services Directorate	62.1%	3	5	25	39	15	87
Education and Research Directorate	60.7%	1	5	18	28	9	61
People & Organisational Directorate	58.5%	0	6	21	34	4	65
Performance Directorate	53.9%	6	16	60	70	26	178
Surgery and Cancer Division	52.9%	29	74	190	249	80	622
Estates & Facilities	50.6%	23	34	97	102	56	312
Children & Families Division	48.5%	16	63	167	180	52	478
Medicine Division	47.7%	35	113	332	315	123	918
Clinical Specialties Division	47.0%	41	143	394	412	101	1091
IT Information & Telecoms Directorate	43.8%	4	16	34	33	9	96
Finance & Healthcare Contracting Directorate	42.1%	6	18	38	38	7	107

Q2b I am enthusiastic about my job.

Locality	Posi-tive Score (%)	Number of Respondents					
		Never	Rarely	Some-times	Often	Always	Total
Your Organisation	67.6%	63	223	1021	1532	1191	4030
Nursing Services Directorate	79.3%	1	2	15	37	32	87
Chief Executive Directorate	78.1%	0	0	7	12	13	32
People & Organisational Directorate	73.8%	0	3	14	30	18	65
Education and Research Directorate	72.1%	2	4	11	25	19	61
Medicine Division	69.2%	13	36	232	336	295	912
Children & Families Division	68.9%	6	24	118	189	139	476
Performance Directorate	68.0%	1	8	47	63	56	175
Clinical Specialties Division	67.0%	13	66	281	454	277	1091
Surgery and Cancer Division	66.3%	12	41	156	219	192	620

Estates & Facilities	63.1%	11	24	79	90	105	309
IT Information & Telecoms Directorate	60.4%	2	6	30	34	24	96
Finance & Healthcare Contracting Directorate	60.4%	2	9	31	43	21	106

q2c Time passes quickly when I am working.

Locality	Positive Score (%)	Number of Respondents					
		Never	Rarely	Sometimes	Often	Always	Total
Your Organisation	73.4%	65	153	856	1554	1406	4034
Chief Executive Directorate	90.6%	0	1	2	13	16	32
People & Organisational Directorate	81.5%	1	1	10	24	29	65
Performance Directorate	78.9%	3	5	29	55	83	175
Medicine Division	76.1%	12	24	182	332	362	912
Education and Research Directorate	73.8%	1	5	10	26	19	61
Nursing Services Directorate	73.6%	4	2	17	28	36	87
Children & Families Division	73.0%	5	19	105	182	166	477
Clinical Specialties Division	72.5%	10	42	248	480	311	1091
Surgery and Cancer Division	71.7%	11	25	140	229	216	621
Estates & Facilities	69.8%	11	19	64	105	112	311
Finance & Healthcare Contracting Directorate	67.9%	4	5	25	41	31	106
IT Information & Telecoms Directorate	66.7%	3	5	24	39	25	96

Q3 a I always know what my work responsibilities are.

Locality	Positive Score (%)	Number of Respondents					
		Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Total
Your Organisation	86.8%	44	191	295	1970	1527	4027
Performance Directorate	91.0%	0	8	8	78	84	178
Children & Families Division	89.7%	3	17	29	237	190	476
Clinical Specialties Division	88.8%	11	43	67	561	403	1085
Education and Research Directorate	88.3%	1	1	5	39	14	60
Surgery and Cancer Division	87.0%	7	34	39	300	235	615
Medicine Division	86.7%	13	35	73	417	372	910
Estates & Facilities	83.2%	2	22	29	146	117	316

Finance & Healthcare Contracting Directorate	**82.4%**	2	10	7	56	33	108
People & Organisational Directorate	**81.5%**	0	3	9	38	15	65
IT Information & Telecoms Directorate	**76.0%**	3	5	15	51	22	96
Nursing Services Directorate	**75.6%**	2	10	9	35	30	86
Chief Executive Directorate	**75.0%**	0	3	5	12	12	32

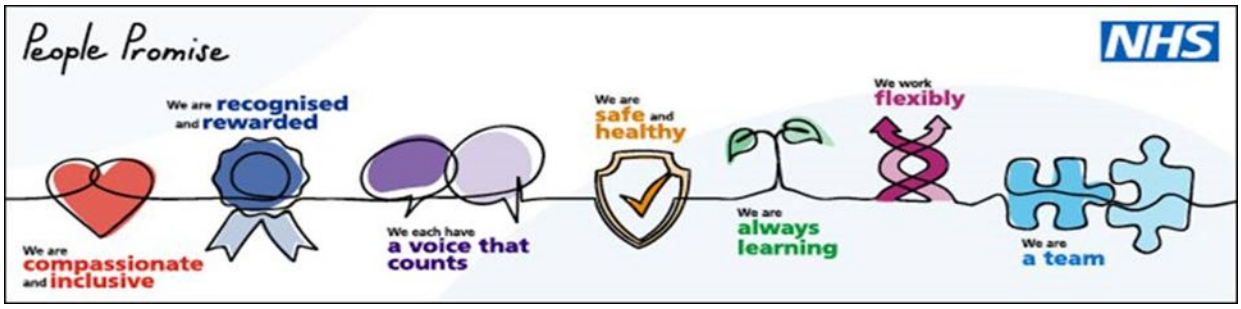
From the slides above and high-level results areas of focus in terms of divisions are IT and Telecoms directorate, Finance and Healthcare contracting Directorate, Estates and Facilities, People and Organisational Development, Nursing and Chief Executive Directorate.

DBTH Overall results and Plan

The results presented in this update paper go some way to validating the work DBTH have invested in living our organisational values, the investment in health and wellbeing and the wider support offer, not tolerating discrimination, reasonable adjustments, managers engaging teams in effective decision making.

However, areas requiring a focus for the coming year include staff engagement, team effectiveness, involvement in deciding changes that affect work, involvement in decision making, enough staff to do the job, recommend as a place to work, happy with standards of care and I don't think about leaving this organisation.

It is increasingly a focus from the centre on how we continue to address the key themes within the NHS People promise as presented in the graphic below.



Going forward there is a need to is strengthen employee voice, build, and invest in teamwork, compassionate leadership and working flexibly. This will be addressed in

- Leadership Development Programmes
- Team Engagement and Development National OD Pilot
- Review and reposition of Staff Sickness absence Processes
- Strengthening the Proactive Wellbeing Offer
- OD Team support and Culture work
- Staff Inclusion, Engagement work and Employee voice

Whilst locally to address the outcomes of the DBTH staff survey divisional leadership teams are required to identify 3 key areas within the staff survey to improve. Progress will be monitored through accountability structures.

The key strategic areas of focus are identified below.

Issue Identified	Action	Director Lead
Enough staff to do the job properly	Introduction of a workforce planning tool to identify and address workforce challenges and ensure the recruitment pipeline is aligned to business priorities	Chief People Officer
Team members often meet to discuss team effectiveness, involvement in decision making	Investment in the development of leaders at all levels to create inclusive team climates	Chief People Officer
Recommend organisation as a place to work	Continued investment in Talent developments, Staff engagement, health and wellbeing Staff experience, reward, and recognition	Chief People Officer
Happy with the standard of care provided	Continued investment in the development of a Quality Improvement culture at all levels within the organisation	Director of Strategy and QI
I don't often think about leaving this organisation	Continued investment in Talent development, Staff engagement, health and wellbeing, Staff experience, reward, and recognition	Chief People Officer

Summary

In summary, whilst DBTH held a reasonable position in terms of staff survey results there is considerable work to do to aid recovery of the people from the impact of the pandemic and move towards our ambition to be outstanding healthcare provider. It is critical that the results from our staff survey are used by leaders at all levels to drive culture change and positive staff engagement, experience, and outstanding patient care.

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	24 May 2022	**Agenda Reference:**	D4
Report Title:	**Freedom to Speak Up (FTSU) – Annual Report**		
Sponsor:	Anthony Jones, Acting Director of People & OD		
Author:	Paula Hill, Freedom to Speak Up Guardian		
Appendices:			

Report Summary	
Purpose of report:	This paper is presented to the Board to provide assurance on matters relating to Freedom to Speak Up strategic direction and operational practice from April 2021 to 31st March 2022.
Summary of key issues/positive highlights:	The paper provides an update regarding National Guidance and DBTH Speaking Up activity and uses the results of local and national data alongside wider information to provide an insight into organisational performance, progress and overall context. It also provides information to support the positive stories, activities and improvements achieved throughout the last year, whilst identifying future learning across all aspects of Speaking up. Strategic drivers are provided by NHSE/I and the National Guardians Office (NGO) to ensure cohesion and consistency across Trusts and supporting the pursuit of a compassionate, open and transparent culture. These include proposed revised criteria for the registration of FTSU guardians, the introduction of all three levels of HEE Speak Up training and the revision of criteria for FTSU case reviews. DBTH has seen varied performance regarding the introduction and use of these new resources during the last year due to constraints in capacity in FTSU services and more widely across the Trust. However, this report highlights where positive use of these tools has been effective and also identifies where further work is still required across all areas of our FTSU strategy. The key areas of focus raised in discussion at the People committee on 3rd May 2022, related to the gap in capacity and demand as our FTSU services continue to see growth in the numbers of staff who are speaking up, alongside the challenges posed by NGO restrictions on our Champions role. Discussion also highlighted the need for commitment to the HEE FTSU “Follow Up” training for senior leaders and the need to strengthen engagement with the Board and senior leaders through the appropriate development programs. However, Organisation wide capacity was also discussed, particularly with a focus on its impact on the roll out of the FTSU HHE program. Finally, the members in attendance discussed the Ockenden report and the recommendation for Listening events and a focus on positive speak up cultures across maternity services. The NHS contractual requirements in relation to FTSU are monitored by the Care Quality Commission (CQC), who assess the Trusts FTSU Culture during inspections

	under the Well Led framework, integral to Key Line of Enquiry 3. FTSU performance is also measured through annual self-assessment and peer review as part of the National Guardians Office/NHSE self-review tool and the staff survey/FTSU index report. In addition, it is well acknowledged that research connects good 'Speak Up' cultures with improved patient safety, higher staff wellbeing and retention, lower levels of dissatisfaction and a higher quality of care. Therefore, it is important to acknowledge that these FTSU concepts underpin the following DBTH Strategic Objectives and Trust Values: • To be the safest Trust in England, Outstanding in all we do. • Patient's, People, Performance, Partners, Prevention • WE CARE
Recommendation:	For the Board members to: 1. Consider the content and context of this paper in conjunction with the additional reading suggested as part of the ongoing FTSU assurance process 2. Acknowledge the continued impact of varied leadership "Buy in" to the FTSU agenda and consider Board level opportunities to support growth and development, in order to effect cultural change 3. 3.Acknowledge the short-term gaps in FTSU strategic focus and commit to address these through consideration of resource commitments and wider strategic review. 4. 4.Consider the focus of discussions at the People Committee on 3rd May 2022.

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:	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. F&P 8 Inability to recruit right staff and have staff with right skills leading to: (i) Increase in temporary expenditure (ii) Inability to meet FYFV and Trust strategy (iii) Inability to provide viable services Q&E 6 Failure to improve staff morale leading to: (i) Recruitment and retention issues (ii) Impact on reputation (iii) Increased staff sickness levels

Corporate risk register:	People – As a Teaching Hospital we are committed to continuously developing the skills, innovation and leadership of our staff to provide high quality, efficient and effective care. F&P 8 Inability to recruit right staff and have staff with right skills leading to: (i) Increase in temporary expenditure (ii) Inability to meet FYFV and Trust strategy (iii) Inability to provide viable services Q&E 6 Failure to improve staff morale leading to: (i) Recruitment and retention issues (ii) Impact on reputation (iii) Increased staff sickness levels
Regulation:	The NHS contractual requirements in relation to FTSU are monitored by the Care Quality Commission (CQC), who assess the Trusts FTSU Culture during inspections under the Well Led framework, integral to Key Line of Enquiry 3
Legal:	
Resources:	

Assurance Route			
Previously considered by:		People Committee	
Date:	3 May 2022	**Decision:**	
Next Steps:		Annual Report	
Previously circulated reports to supplement this paper:			

Introduction

This paper is presented to the Board to provide assurance on matters relating to Freedom to Speak Up strategic direction and operational practice from April 2021 to 31st March 2022.

The paper provides an update regarding National Guidance and DBTH Speaking Up activity and uses the results of local and national data alongside wider information to provide an insight into organisational performance, progress and overall context.

It also provides information to support the positive stories, activities and improvements achieved throughout the last year, whilst identifying future learning across all aspects of Speaking up.

Strategic Context

FTSU principles have been mandated within the NHS contract and monitored by the Care Quality Commission (Well-Led), since the recommendations of the Francis Report in 2016. This mandate requires every NHS Trust in England to recognise the importance of Speaking Up with the identification of a FTSU Guardian, Lead Executive Director and Non-Executive Director, to drive cultural change in relation to empowering staff to speak up and listening to and responding to concerns that are raised.

The NHS People Plan connects good 'Speak Up' cultures with improved patient safety, higher staff wellbeing and retention, lower levels of dissatisfaction and higher care quality and the People Promise identifies having a voice that counts as one of its fundamental principles.

In addition, strategic drivers are provided by NHSE/I and the National Guardians Office (NGO) to ensure cohesion and consistency across trusts and to support learning from both internal and external Speaking Up activity.

2021 to 2022 has seen no change to the NHSE/I Guidance and Supporting information for Boards and the annual self-assessment.

The National Guardians Office has revised its guidance on considering Speak Up Case Reviews, which now uses wider intelligent monitoring to inform when a review should take place. This was previously fed predominantly by individual escalation of cases from individual Trust cases. In addition to this review of guidance, the NGO has published recommendations from all nine of the case reviews that have taken place. In addition, due to the repeated themes and suggested recommendations made, the NGO has also developed an organisational Gap Analysis Tool to enable organisations to have a consistent approach to consideration, reflection and demonstration learning. This is further increased in focus following the Speak Up recommendations of the Ockenden Report which also asks for proactive listening and reflection in order to support our midwifery colleagues.

Finally, the NGO will no longer collate data and benchmark FTSU activity from the National Staff Survey due to the redesign to align the survey with the commitments of the NHS People Promise. However, guidance still requires organisations to consider the key elements of the survey to establish a new baseline on which to build a consistent way to measure improvements in FTSU culture in line with the NHS People Promise. Comparative data is also available through the Model Hospital system.

DBTH has seen varied performance in response to the revised guidance and the introduction and use of new resources during the last year due to constraints in capacity in FTSU services and more widely across the Trust. However, this report highlights where positive response and use of these tools has been

effective and also identifies where further work is still required.

Performance against strategy

In order to achieve a culture where all staff feel empowered to have a voice, DBTH approved a 3 year FTSU strategy in 2019 that focusses on a partnership approach to raising awareness, sharing best practice and supporting staff in a timely and responsive manner when they need it the most. The strategy has key actions to support awareness and prevention, response and recovery and learning and governance. The following sections identify positive performance and continued areas for improvement, which will help to inform the revision of the strategy by November 2022.

Delivery against this strategy in 2021-2022 has seen continued communication and engagement to improve awareness and understanding of what Speaking up means and how everyone can access all speaking up partners across the organisation.

This has most recently seen the revision of a policy on a page, which captures all elements of speaking up and provides information to sign post people to their most appropriate FTSU partner for support. This work is awaiting final approval and will then be disseminated across the Trusts four sites.

FTSU is also firmly embedded in the Trusts Inductions processes and it also forms an integral part of our SET information for staff and the staff handbook.

We have continued to embed a number of slogans which are used to promote different elements of the strategy.

“Speak up to me” (displayed on all publication materials and badges worn by FTSU Guardians, Champions, Partners and Senior Leaders) – This continues to promote an open door and encourages staff to discuss their concerns.

“Speak up to make a difference” (used in the strategy/policy and all promotional materials) – Although this promotes working in partnership to explore issues and encourages staff to engage in service improvement and or personal development, further work is required to drive forward timely exploration, investigation, actions and feedback.

“I support speaking up because…….” (used for senior leader/partner/managers) – This tool is used to create an environment where speak up is actively supported by the organisation and its senior leaders. This also requires a revised focus following the change of key FTSU Directors and partners. This will of course provide an opportunity to refresh this work over the next few months.

FTSU information, new guidance and learning has continued to be shared through BUZZ and on our revised HIVE pages and in special learning publications as part of Sharing our we care.

FTSU month in October 2021 used the launch of the HEE e-learning modules as a catalyst to learn more about how to Speak Up, Listen Up and Follow up at DBTH. Weekly information to support the education packages was provided in Buzz and on the HIVE but take up was variable due to the timing of the launch, the availability of the HEE program via ESR and the ability of staff to find time to complete the training. However, the impact of this additional communication can be seen in the increase in numbers during Q3 of 2021-2022.

The FTSU communication plan will be considered further in 2022 as part of the work to revise the FTSU strategy and achieve a strong symbiotic connection with the wider work to inform organisational culture.

FTSU model and capacity

The FTSU model at DBTH has seen many changes since its inception, in line with revised NGO guidance

and the growth in internal and external strategic drivers. 2021-2022 has been no different, with several changes having a direct impact on how services should and could be delivered. In addition to the impact of the pandemic on direct FTSU resource, the continued impact on staffing and wider partners has resulted in less capacity to resource education, events and support the commitments of the FTSU Forum. This has been identified as an ongoing risk in relation to proactive engagement, but assurance can be provided in relation FTSU responsive services.

In addition, the NGO plans to introduce a register of FTSU guardians which will require all guardians who are in post, to fulfil all elements of the NGO competency assessment framework annually to retain their registration. This will mean that secondary FTSU Guardian roles will need to be reconsidered for the position of FTSU Champions. 2022 has also seen one of the long-standing secondary guardians leave the Trust, resulting in further limitations on Guardian resource at this time.

The development of the FTSU Champion service continues to gain momentum with the introduction of Speaking Up to existing Wellbeing Champions roles. This has proven to be very effective and a wider roll out is now being considered. This has been extended to all Wellbeing Champions, Network Champions and the Trusts Professional Nurses/Midwifery Advocates. All of these roles already provide a listening ear and, in some cases, coaching methodology to provide restorative supervision in order to support staff though the changes or concerns they are experiencing. However, as the revised NGO guidance for Champions and Ambassadors states that FTSU Champions/Ambassadors cannot provide case management support, identification of any support required still requires signposting to the most appropriate FTSU partner. This has resulted in increased activity in partner and Guardian services. However, one positive pattern that is emerging is the number of staff who are not champions who have actively supported staff to speak up to ensure they receive the support they need.

FTSU Guardian capacity to provide strategic focus and lead organisational learning has continued to be reduced throughout 2021-2022 due to the impact of the pandemic and competing priorities. This will need to be reconsidered in 2022-2023 in order to provide a holistic service that can position FTSU as an integral partner to the organisations cultural journey.

The FTSU Forum has also had challenges in retaining attendance throughout the past year as a direct consequence of reduced capacity and competing priorities, impacted by the pandemic and wider absence issues. Therefore, limited FTSU Forum minutes have been provided for consideration.

<u>Education, learning and development</u>

Education, learning and development plans continue to include the roll out of Health Education England's three levels of FTSU training. This includes level 1 - speaking up (for all staff, learners, appropriate volunteers, and contractors) level 2 – listening up (for line and middle managers). These are delivered as an online learning module, and staff have been encouraged to complete this following their induction. The program was also given a high profile as part of the 2021 speak up month. This training has then been supported by local elements to share the DBTH values, by utilising staff voices and sharing personal FTSU experiences and to ensure all staff know how to speak who and who the appropriate partners are.

Level one has also seen a revision of the annual SET information to ensure consistency of messaging across all programs and the introduction of FTSU messages in the Staff handbook and Values based induction program. This is delivered monthly and is received very well. In addition, FTSU messages are tailored to specific induction and or education programs and this has seen continued delivery to all vocational staff groups, preceptorship groups and international nursing/midwifery COHORTS.

Level 2 roll out has been limited with completion by FTSU Guardians, Partners and Champions to date. It is

planned to return to the DBTH additional information to support level 2's part of the L&OD prospectus for 2022-2023. This will focus on how to respond to and support staff who raise concerns. Consideration of linking this work to patient safety training would enable a shared and integrated program that would increase consistency of message and prevent duplication of attendance, therefore increasing time still spent with patients.

Level 3 – Following up (for senior leaders, executives and board members) is now available from and will be delivered in conjunction with DBTH leadership offer through the L&OD service. In addition, the focus of Level 3 should also form a key part of Board development and therefore this will be reflected in the revised Learning Needs Analysis in June 2022.

Understanding Data

Improved data collection and data triangulation continues to be a key focus of the FTSU forum and wider partners. However, sharing the data held by all partners to allow improved learning has been restricted in some cases due to competing priorities and demands. Where this has been able to take place, it has allowed open discussion in relation to layers of information including those from patient safety incidents, L&OD and QI interventions, staff side support, grievances, case management reviews and FTSU cases.

These instances have enabled timely discussion across partners and facilitated timely L&OD or QI interventions to facilitate appropriate support, learning and improvement.

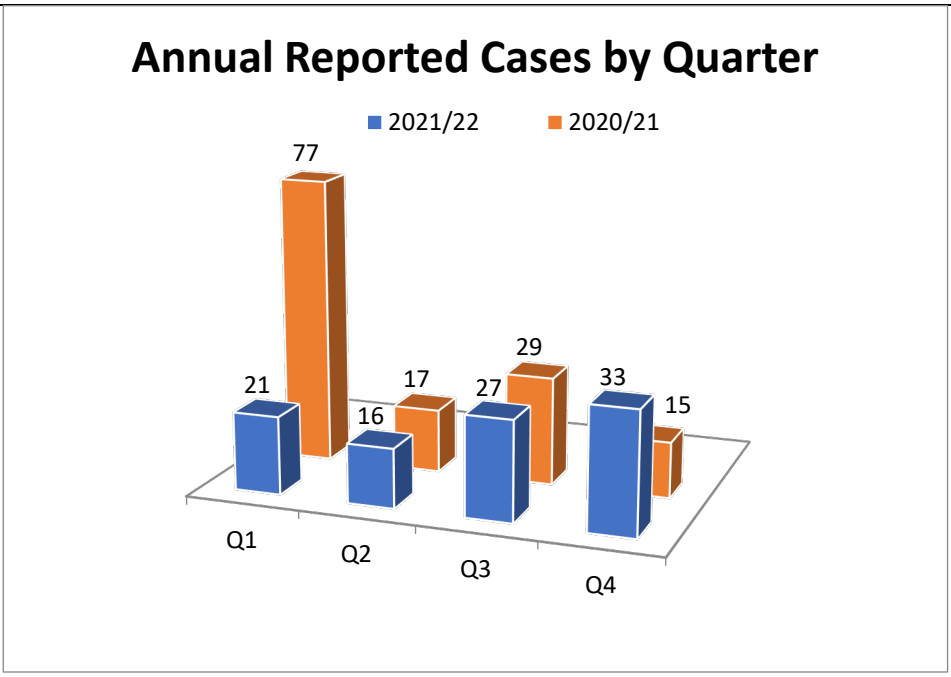
The NGO has produced revised guidance on data collection, recording and reporting, acknowledging further themes and providing an increased focus on outcomes. Work is still required to build on the revised NGO guidance due to the challenges in FTSU Forum attendance. This has made it difficult for effective data sharing in a transparent and useful way. However, the board is assured that individual discussions to allow appropriate responsive data sharing are still effectively taking place in relation to HR Metrics, Staff Side Concerns, Patient Safety and Experience Incidents, H&S issues, L&OD interventions and internal and external FTSU concerns.

Numerical data is also beginning to be supported by softer data derived from the use of "What three words". This has seen some individual staff describe where they feel they are as they raise their concerns and then allows a measure of improvement when their speaking up journey is ended. This work will be considered for wider roll out as part of the FTSU strategic review this year.

Further work is still required to fully apply the data from the FTSU section of Model Hospital, in order to support annual self-assessment and provide greater internal learning and Board assurance in the future

The Assessment of FTSU Issues at DBTH

DBTH has continued to see a significant shift in our FTSU data information, mostly not through the number of cases raised but through changes in who are raising concerns and what concerns are being raised about. There has also continued to be a number of collective concerns raised during 2021-2022, although the number is not as high as in the 2020-2021 ED cases.



The chart above shows a consistant trend in cases raised through FTSU across the last two years. Although it is recognised that Q1 of 2020-2021 was significantly influenced by one case and Q4 of this year significantly influence by the Governments changes in legislation on COVID vaccination.

Understanding 2021-2022 data in detail

Quarter 1 saw 21 individuals raise concerns across 18 Cases. Very few staff raised COVID -19 as part of their concern. However, there was a significant increase in the impact on MH and Wellbeing.

Quarter 2 saw 16 individuals raise concerns across 10 Cases. COVID -19 was not mentioned as part of concerns other than in relation to resilience and relationships.

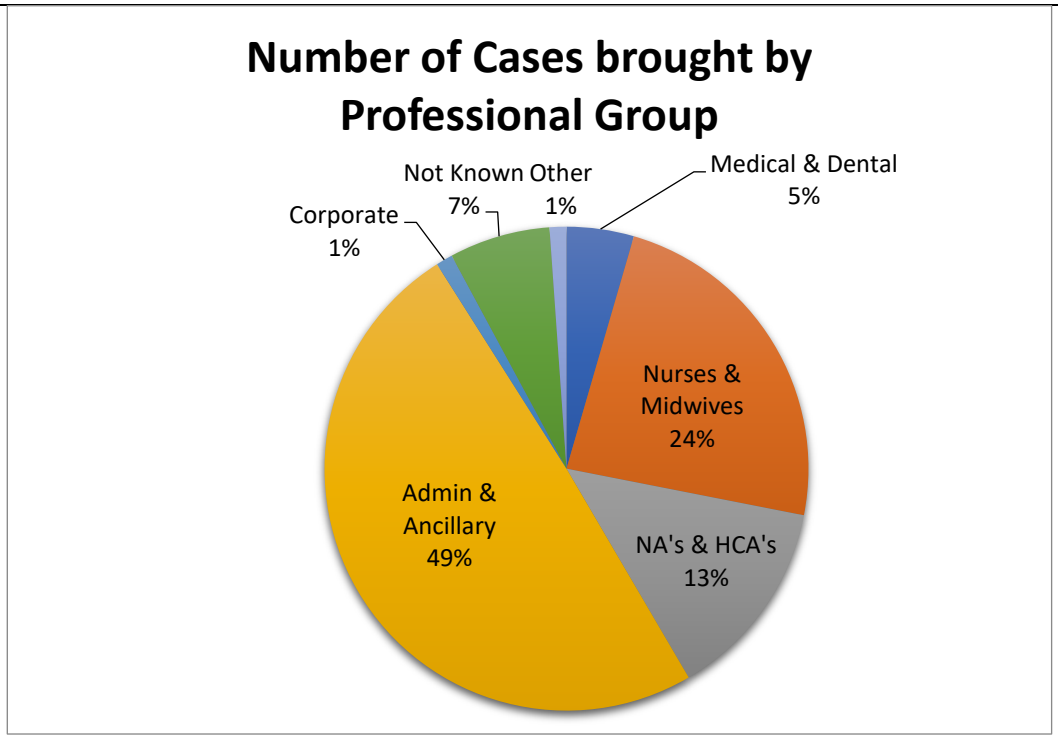
Quarter 3 saw 27 people raise concerns across 22 cases. COVID -19 concerns increased again during this quarter however the key themes centred around relationships and behaviour and conduct.

Quarter 4 saw 33 people raise concerns across 20 cases. COVID -19 and VCOD was raised by most people who raised concerns in Q4. Concerns also focussed on Systems and processes, B&H and fairness.

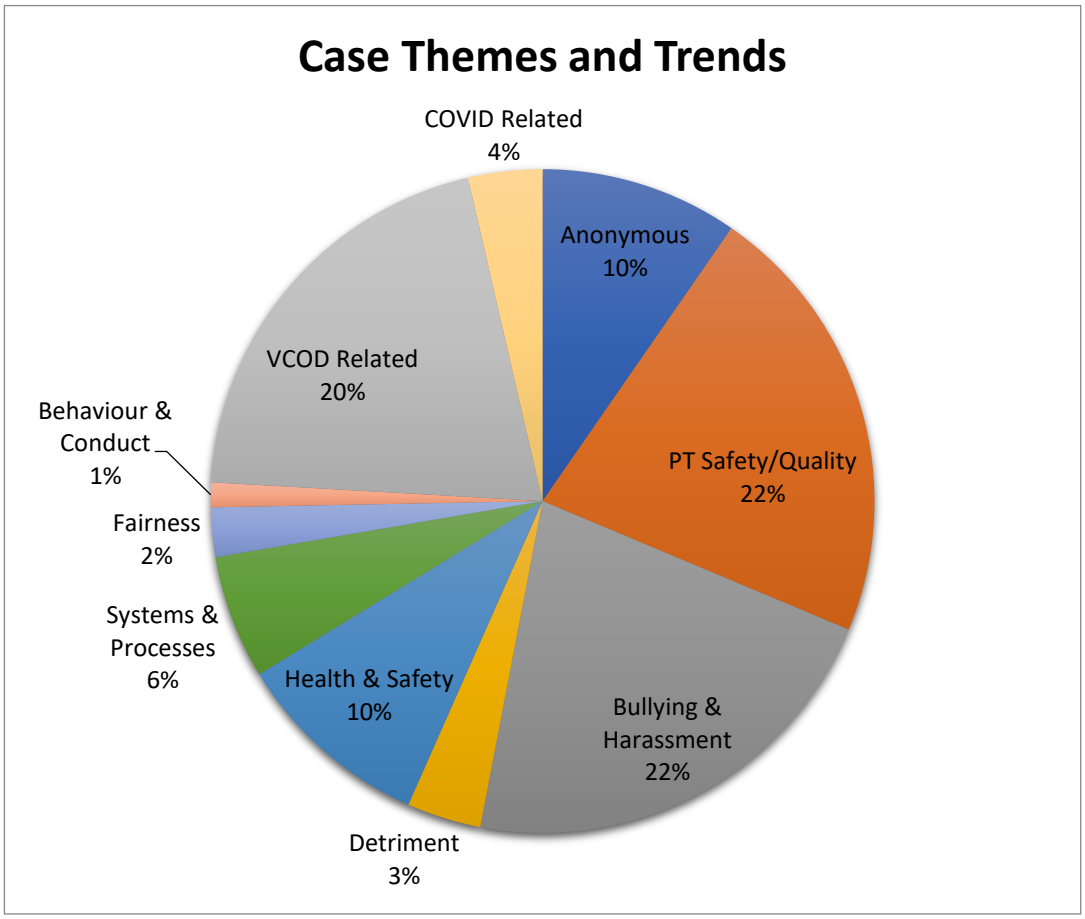
It is important to note that some individuals or cases raised concerns across more than one theme.

Data to support who is Speaking Up

The percentage of staff who are speaking up has previously remained constant with both nurses/midwives and medical staff being our most prominent groups. However, throughout 2021-2022 there has been a significant increase in the number of administration and ancillary (E&F) staff who have been involved in Speaking Up cases and a significant decrease in the cases raised by Medical and Dental Staff. Nursing and midwifery remain consistent. In 2020/21 FTSU services received concerns from a wider range of staff from different roles, directorates and levels of seniority, however throughout 2021-2022 concerns have been predominantly raised by “Workers” and not line mangers and or managers. This is demonstrated in the chart below.



Data to support what people are speaking up about



During 2021-2022 there has been a significant increase in the number of staff raising patient safety concerns and a small increase in the number of staff raising concerns relating to bullying and harassment. Staff safety and wider health and safety concerns have continued to stay stable although concerns in relation to COVID 19 have reduced. This is with the exception of vaccination concerns, which were the

predominant reason for requesting support during Q4.

Staff did not mention culture and leadership as much in their concerns but did use different terminology in relation to conduct and behaviour, fairness and the application of systems and processes.

Freedom to speak up cases with outstanding actions:

Of the 97 individuals (70 cases) that have been supported since April 2021, the majority of cases continue to be successfully resolved through:

- Staff empowerment to work with local managers to address issues and apply any learning
- Mediation or facilitated discussion between staff and managers in certain divisions or departments
- Partnership working with divisional leads/leadership and OD colleagues to encourage staff engagement and exploration of the issues identified.
- Liaison with or escalation to HR colleagues for facilitated discussions and or investigation.
- Escalation to senior leaders for consideration and further review

However, many of these cases have seen an increase in the time it has taken to resolve their concerns and or to receive feedback and supportive action. This is due to the competing priorities across all partners.

In addition, despite close working arrangements and strong partnership working, a number of FTSU cases remain open and have outstanding issues that need to be resolved before the cases can be closed.

Three of these cases continue to be actively supported at Board level and or through L&OD Services. Progress on both ED and T&O services will be presented individually to the Committee by their appropriate Director. Wider support for Midwifery services continues to be required and further listening events are planned in line with the recommendations of the Ockenden Review. This will therefore remain open at this time. Further feedback on this case would need to be reported to the Committee separately.

The final group case that remains open has been open since 2019. However, there is now a great shift in momentum and current QI involvement is supporting wider engagement with staff to address their concerns. It is anticipated that this case will be able to be closed by Q2 of 2022-2023.

One individual case remains open as there have been challenges in understanding the concerns after the staff member resigned last year. This has now been escalated, reviewed, and should be closed by the end of Q1.

It remains important to consider the reasons for the length of time that some cases remain open and acknowledge some will take longer than others to achieve their goals and where this is not the case, it is important to explore ways of improving practice. Whether this is through training and education or simplified processes to support appropriate action. A recent reflection on FTSU capacity and the impact on timely support for staff has identified, ring fenced time and appropriate resourcing to support the differing levels of FTSU activity, allowing concentrated time for strategic focus, relationships/partnership working, case management and learning and development.

Action taken to improve FTSU culture

Self-Assessment

The NHSE/I FTSU Board self-review Tool has 11 areas which cover, individual behaviours, visibility and engagement, commitment to the FTSU process, strategic focus and the governance arrangements for all

of the above. NHSE/I and the NGO, continues to require the senior leaders of the organisation to reflect on their performance across these areas, through the process of a FTSU annual Self-assessment which should be used to identify areas of best practice and inform a focus for improvement.

In 2020-2021 the Board and Executive Team completed their annual self-assessment review. The organisation received a "Full" rating in 8 areas and a "Partial" rating for the other 3, with an acknowledgment that even across those areas rated as "fully achieved" further development and additional actions were still required to embed changes and allow future improvement. The FTSU annual self-assessment for 2021- 2022 has yet to be completed due to changes in the senior leadership that supports this agenda. The FTSU forum members will offer their considerations against all 11 criteria which will be provided to the new Chief People Officer in order to support her in leading the completion of the self-assessment as part of her priority portfolio during Q2 2022-2023.

FTSU Index and Staff Survey

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. This tool established performance for all NSH Trusts in the form of comparative league table, this performance saw direct comparators in good performance for those trusts who were rated Outstanding or Good by the CQC. For the two years following its introduction, DBTH improved on its position nationally in comparison to other Acute Trusts but saw less improvement across our regional partners due to the variation in Trust status, including Mental Health, Community Trusts and Ambulance Trusts.

As previously identified, the NGO will no longer collate data and benchmark FTSU activity from the National Staff Survey due to the redesign of the survey to align it with the commitments of the NHS People Promise. However, guidance still requires organisations to consider the key elements of the survey to establish a new baseline on which to build a consistent way to measure improvements in FTSU culture in line with the NHS People Promise.

The key elements of the revised Staff survey that relate to FTSU are:

"We each have a voice that counts", "Autonomy & Control", "Raising Concerns" and "Compassionate Leadership". In the 2021 annual survey, DBTH received an average performance against each of these areas with improved performance for staff support for personal wellbeing.

Nationally an increased number of staff took part in the survey and DBTH saw one of its highest engagement figures, which cements the survey as a continued positive forum for speaking up.

Further work to compare results across the FTSU elements of the survey will take place in Q2 of 2022-23 as part of the establishment of the ICS level FTSU Group.

Learning and Improvement

For the FTSU strategy and its associated work to be successful in facilitating a transparent speak up culture, it has to do more than purely encourage staff to speak up. In order to influence sustainable change at all levels, it has to proactively identify and use all levels of learning from each and every FTSU case and wider learning event.

Learning from Internal events

Internal learning has been identified through all of the above cases and developments. Some of these have been easier than others to apply into practice. These include changes to how information is shared, cross representation at the FTSU Forum and the quality of feedback and how it is used.

Learning across the organisation form each speak up case needs to be identified as a priority for 2022 - 2023. However, for this work to be effective, a greater transparency and acceptance will need to be achieved. This includes the willingness to hear difficult stories and feel difficult experiences.

Further work to make the most of Internal learning is still required and linked to the revision in FTSU strategy expected later this year.

NGO case review learning

As previously highlighted, the National Guardians Office has revised its guidance on considering Speak Up Case Reviews and committed to using wider intelligent monitoring to inform when a review should take place. The revised process was launched at the end of Q1 2021/22. In line with this review the NGO has published recommendations from all nine of the case reviews that have taken place and developed an organisational Gap Analysis Tool to enable organisations to have a consistent approach to consideration, reflection and demonstration learning. Although further work to review the revised tool has not taken place, previous work still suggests that the following points highlight the recommendations that require key consideration by the trust.

- Lack of appropriate and timely response to FTSU concerns
- Response to minimum training standards
- Appropriate, feedback follow up and closure of FTSU cases
- Action to improve delays in relation to grievances
- Consideration of and response to exit interviews
- Assurance processes that monitoring the culture of the organisation
- Addressing bullying and harassment
- Support for BAME and EDI colleagues who speak up
- Ensure robust links to patient safety and Serious Incident processes
- Improve the use of mediation, coaching and wider OD methods to support those who speak up

Final note

We appreciate that Speaking up, and having your voice heard, is critical in times of challenge and acknowledge that we are continuing through difficult times where staff are experiencing greater personal and professional challenges than ever before.

Therefore, although much has been achieved since the last annual report, we will continue to work alongside our FTSU partners to provide a listening ear, open mind and compassionate voice to ensure that all staff receive the support and guidance that they need at this crucial time. We also need to commit to build on our current work, through challenging boundaries and barriers to ensure DBTH is an excellent place to work, belong, develop and thrive.

Throughout the above work and the completion of this report, a number of national and DBTH documents have been considered and or produced. These are available as additional reading on request. Please see appendix 1.

Appendix 1

Suggested additional reading

National documents:

Guidance for boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts

NHSE/I NGO Revised July 2019

Supplementary Information for boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts - NHSE/I NGO Revised July 2019

Recording and reporting FTSU data, revised 2021-2022 for introduction in Q1 2022-2023

National guidelines on Freedom to Speak Up training in the health sector in England – NGO – August 2019

NGO revised strategy – January 2021

NGO Case Review process – June 2017 – revised January 2021

NGO Learning from Case Reviews – Gap analysis to improve Speaking Up arrangements – 2022

NGO Guidance on FTSU Champions and Ambassadors - 2021

DBTH documents created or revised:

FTSU SET information 2022

FTSU Policy on a page (poster presentation)

FTSU Forum minutes: May 2021

July 2021

Sept 2021

Dec 2021

Mar 2022 (awaiting approval by the forum)

Appendix Level1

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

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

Risk Owner: Trust Board – Director of Finance (AC)
Committee: F&P & QEC

People, Partners, Performance, Patients, Prevention

Date last reviewed : MAY 2022

Strategic Objective
In recurrent surplus to invest in improving patient care

Breakthrough Objective
Every team achieves their financial plan for the year

Measures:

- Delivery of in year financial plan/budgets
- Underlying/recurrent financial position of the Trust
- Trust Cash Balances
- External and Internal Audit outcome

Risk Appetite:
The Trust has a **low appetite** for risks

Risks:

- The Trust has delivered a £2.6m surplus at year end (before technical adjustments e.g., impairments and is subject to external audit). I&E risks now pertain to 22/23 and beyond.
- There is a very significant challenge in 22/23, with the current Trust plan showing a deficit of £25m after CIPs of c4%. ICBs have been asked to further deduce deficit financial plans with a resubmission process to commence in May-June. Therefore, the Trust will be challenged to reduce its deficit plan further.
- Income allocations have been significantly reduced from pandemic levels, including Commissioners removal of previously provided non-recurrent funding. Therefore, focus on efficiency and productivity (see below) and cost reduction moving into 22/23 is paramount.
- COVID assumptions in the plan are based on low levels of COVID as seen in Summer 2021 and are consistent with the ask of the planning guidance. Should COVID levels be higher, the Trusts ability to undertake the required levels of elective activity may be affected and therefore impact the ERF income that can be earned. This may also impact on the level of temporary staffing spend.
- The workforce plan assumes vacancies are recruited to on a substantive basis and the reliance on temporary staffing is reduced. The financial plan and CIP plan is aligned to this and is therefore heavily reliant on the tight management of vacancies and temporary staffing.
- Agency spend is at historical levels, and has been very high in the last two months (£1.9m in Month 12, £1.7m in Month 1), particularly nursing spend which is currently being driven by an increase in expensive agency usage. The agency position is unsustainable and unaffordable with a sustainable solution required regarding temporary staffing along with finalisation of the recurrent nursing workforce requirements which remains outstanding.
- Non-pay inflation is currently very high in the economy and is not funded at those levels within the funding allocations.
- Whilst cash is currently in a healthy position the deficit next financial year will potentially cause cash flow issues in 22/23 impacting on the ability for the Trust to meet its financial obligations, without NHSE/I intervention.
- Productivity reductions have been seen during COVID, where activity being delivered is significantly below pre-pandemic levels, whilst resource (especially clinical resource) has increased. Challenge in 22/23 is to deliver pre-pandemic levels of activity within pre-pandemic resources whilst providing safe and sustainable services.
- Trust's underlying deficit financial position has worsened during the pandemic. There is increasing focus nationally on underlying positions entering 22/23.
- Uncertainty with regards to the future of Commissioning arrangements with the move to ICB.
- Culture Risk – Impact of COVID on re-engaging Divisions with financial processes and controls (by 22/23 will have been two years) and refocus on efficiency.
- Impact of major incident at W&C. The incident highlights significant risks concerning the funding route for and delivery of backlog maintenance costs. However, some additional capital funding has been provided in year of c£1.8m to support this. Limited capital funding especially for significant builds given the Trust's estates risks.
- Impact of inflationary pressures on capital projects with allocated funding – BEV, RAAC

Initial Risk Rating	4(C) x 5(L) = 20	Risk Trend
Current Risk Rating	4(C) x 4(L) = 16	↑
Target Risk Rating	3(C) x 3(L) = 9	

Rationale for risk current score:
Impact:

- Currently the Trust is in a significant underlying deficit position with significant uncertainty regarding the future financial regime.
  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.

Future risks:

- NHS financial landscape, regulatory intervention
- Impact of reduced revenue funding allocations for 22/23 and beyond.
- Change in financial regimes in relation to ICS and Place budgets
- Return to control totals and trajectories in future years including agency caps.
- Increasing costs relating to old and poorly maintained buildings

Risk references:
F&P 1, F&P 2, F&P 3

Opportunities:

- Change in practices, new ways of working
- The Trust is looking at opportunities for funding to support elective recovery and operational requirements, including capital bids.
- Implementation of new Directorate to support improvements in productivity and efficiency.

Comments:

- Forecast to deliver at least a break even position for 21/22. Risks pertain to 22/23 and beyond.

Appendix Level1

Controls (mitigation to lead to evidence of making impact):		Last Review date	Next review date	Reviewed by	Gaps in Control
Key Financial Control Processes: Vacancy Control Panel, CIG, Grip and Control, Capital Monitoring Committee, Cash Committee.		April 2022	Ongoing	AC	Ongoing review of financial controls. No unexpected exceptions identified
Budget Setting and Business Planning		April 2022	N/A	AC/JS	No unexpected exceptions identified
Internal & External Audit programme design & compliance outcomes		April 2022	May 2022	AC	Recent Internal Audit provided significant assurance
Establishment of new Directorate: Recovery, Innovation and Transformation.		April 2022	Ongoing	JS	
Working with the ICS through CEO's and DoFs regarding funding arrangements. Reporting back through F&P and Board.		April 2022	Ongoing	AC/JS	Ongoing monitoring
Assurances received (L1 – Operational L2-Board Oversight L3 External) **		**Last received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
L2, L3	Internal Audit Annual report including Head of Internal Audit Opinion	May 21	ARC, Board	Significant Assurance with minor improvements	None outstanding
L2,L3	Feedback from NHSI/E on statutory returns	Ongoing	F&P, Board	Full	None outstanding
L2	LCFS Annual Report	July 21	ARC	Full	None outstanding
L1,L2,L3	Internal Audit: General Ledger and Financial Reporting	March 22	ARC	Significant Assurance	Nothing significant noted in the Internal Audit
L2, L3	External Auditors Annual Report	July 21	ARC, F&P, Board	Full	None outstanding
Corrective Actions required		**Action due date**	**Action status**	**Action owner**	**Forecast completion date**
1. Completion and setting of 22/23 financial plan		April 22	Ongoing	AC	April 22
2. Working with the ICS regarding funding allocations for Doncaster		Ongoing	Ongoing	AC	Ongoing
3. Delivery of reduced temporary staffing spend especially in Nursing		Ongoing	Ongoing	All Exec Directors especially Chief Nurse	Ongoing
4. Development and delivery of CIP plan		Ongoing	Ongoing	All Exec Directors, JS lead for Efficiency and Effectiveness	Ongoing
5. Development and implementation of financial assurance processes in line with new Governance proposals (including escalation and monitoring processes).		May 22	Ongoing	AC	June 22

Assurances received (L1 – Operational L2-Board Oversight L3 External) identify the range of assurance sources available to an entity:
—L1 Management –such as staff training and compliance with a policy
—L2 Internal Assurance –such as sub-committees receiving evidence of L1 working effectively; and
—L3 External Assurance –such as internal and external audits.

Areas in yellow highlight indicate change from last version

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	24 May 2022	Agenda Reference:	E2
Report Title:	**Financial Performance – Month 1 (April 2022)**		
Sponsor:	Alex Crickmar – Acting Director of Finance		
Author:	Justin Fowler – Head of Business Services Jenny Marsh – Acting Deputy Director of Finance		
Appendices:	Appendix 1 – Medical Equipment Capital Plan		
Executive Summary			
Purpose of report:	To report the Month 1 financial position to the Trust Board including any risks to the delivery of the Trust's financial plan. Please note this is a high level report reflecting that this is Month 1 reporting, with no full reporting due to NHSI/E and the ICB until Month 2 (depending on plan resubmissions).		
Summary of key issues	The Trust's reported financial position for month 1 was a deficit of £2.6m, which was £258k adverse to plan. The Trust's in month adverse position against plan was mainly driven by: • **Clinical Income:** £0.8m adverse to plan, mainly caused by the Trust not achieving the 104% activity target resulting in an under-recovery of Elective Recovery Framework (ERF) income, and a risk adjustment on Bassetlaw CCG following receipt of their latest contract offer. • **Non-Clinical Income:** on plan, with recharges favourable to plan by £0.2m and testing income (£0.1m) and education Continuing Professional Development (CPD) income (£0.1m) adverse to plan, all of which have offsetting increases/reductions in expenditure. • **Pay:** £0.5m adverse to plan, with the variance mainly driven by Medical and Nursing spend in Medicine, Surgery and Children and Families Divisions. Agency spend remains high at £1.7m in month, mainly on Medical and Nursing staff. • **Non-Pay**: £0.9m favourable to plan in month, mainly due to a £0.6m favourable variance on independent sector, linked to the elective recovery plan, a £0.2m favourable variance on clinical consumables and other non-recurrent items of £0.1m. **Capital** Capital expenditure in month 1 was £537k against the plan of £739k (£202k behind plan). Included within the YTD actuals is £1k of donated assets. Key variances to plan are underspends on Estates of £136k and Medical Equipment of £83k. The capital plan for medical equipment has now been agreed at Execs.		

	Cash The cash balance at the end of April was £33.4m (March: £46.4m). Cash has decreased by c £13m compared to month 12 largely as a result of a deficit position in month, payment of capital invoices totalling c £4.5m, which relate to 2021/22 and increased revenue spend of c.£6m, again, which mainly relates to year end creditors. The cash plan for the month was for cash to be £30.7m, but the favourable performance against this plan is due to remaining capital creditors that were not paid in April. As such, the cash position is expected to fall again in May and throughout the year. **Financial Plan 22/23** Following submission of the 22/23 financial plans in April, the Trust has been notified by the ICB that there will be a national financial plan resubmission process (expected from Mid-May – Mid-June) reflecting that systems have not achieved financial balance within 22/23 plans. A verbal update will be provided to the Trust Board and Finance and Performance Committee, with further information expected from NHSI/E and the ICB in the w/c 16th May.
Recommendation:	The Board is asked to note: • The Trust's deficit for month 1 (April 2022) was £2.6m, which was adverse to plan by £258k. • There will be a 22/23 financial plan resubmission. The Board is asked to approve: • Delegated authority for the Audit and Risk Committee (ARC) to sign off the annual accounts, annual report and annual governance statement. • The Medical Equipment Capital Plan (appendix 1)

Action Require:	Approval	Information	Discussion	Assurance	Review
	X	X			

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 1 – April 2022

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

P1 April 2022

1. Income and Expenditure vs. Budget

Performance Indicator	Monthly Performance			YTD Performance		
	Actual £'000	Variance to budget £'000		Actual £'000	Variance to budget £'000	
Income	(39,506)	791	A	(39,506)	791	A
Pay	27,399	471	A	27,399	471	A
Non Pay	14,231	(884)	F	14,231	(884)	F
Financing Costs	567	(27)	F	567	(27)	F
(Profit)/Loss on Asset Disposals	(97)	(97)	F	(97)	(97)	F
(Surplus)/Deficit for the period	**2,595**	**254**	**A**	**2,595**	**254**	**A**
Donated Asset Adjustment	(39)	4	A	(39)	4	A
Adjusted (Surplus)/Deficit for the period	**2,556**	**258**	**A**	**2,556**	**258**	**A**

Income: Over-achieved F | Under-achieved A

Key

F = Favourable **A** = Adverse

Expenditure: Underspent F | Overspent A

2. Statement of Financial Position

	Opening Balance £'000	Closing balance £'000	Current Balance £'000	Movement in year £'000
Non Current Assets	**247,896**	**248,267**	**248,267**	**371**
Current Assets	71,448	66,625	66,625	**-4,823**
Current Liabilities	-84,805	-88,836	-88,836	**-4,031**
Non Current liabilities	-13,867	-13,226	-13,226	**641**
Total Assets Employed	**220,672**	**212,830**	**212,830**	**-7,842**
Total Tax Payers Equity	**-220,672**	**-212,830**	**-212,830**	**7,842**

3. Other

Performance Indicator	Monthly Performance		YTD Performance		Annual
	Plan £'000	Actual £'000	Plan £'000	Actual £'000	Plan £'000
Cash Balance		33,364		33,364	30,698
Capital Expenditure	739	537	739	537	33,094

4. Workforce

	Funded WTE	Substantive WTE	Bank WTE	Agency WTE	Total in Post WTE
Current Month	6,433.02	5,677.83	359.99	169.54	6,207.36
Previous Month	6,456.81	5,618.26	380.38	225.82	6,224.46
Movement	23.79	-59.57	20.39	56.28	17.10

1. Month 1 Financial Position Highlights

Executive Summary Income and Expenditure – Month 1

	Month 1		
	Plan £000	Actual £000	Variance £000
Income	**-40,297**	**-39,506**	**791**
Pay			
Substantive Pay	25,122	22,789	-2,334
Bank	43	1,529	1,486
Agency	259	1,688	1,430
Recharges and Reserves	1,505	1,394	-112
Total Pay	**26,929**	**27,399**	**471**
Non-Pay			
Drugs	897	863	-34
Non-PbR Drugs	1,822	1,856	34
Clinical Supplies & Services	3,047	2,885	-163
Depreciation and Amortisation	1,153	1,149	-4
Other Costs (including Reserves)	6,749	5,851	-897
Recharges	1,446	1,627	181
Total Non-Pay	**15,115**	**14,231**	**-884**
Financing Costs, Profit on Sale of Assets & Donated Assets	**552**	**432**	**-119**
(Surplus)/Deficit Position as at Month 1	**2,298**	**2,556**	**258**

Please note this is a high level report reflecting that this is Month 1 reporting, with no full reporting due to NHSI/E and the ICB until Month 2 (depending on plan resubmissions).

The Trust's reported financial position for month 1 was a deficit of £2.6m, which was £258k adverse to plan. The Trust's in month adverse position against plan was mainly driven by:

- **Clinical Income:** £0.8m adverse to plan, mainly caused by the Trust not achieving the ERF income in month (£0.8m) due to activity targets not being met, plus a risk of £0.1m on the Bassetlaw CCG contract relating to changes notified recently in the allocation of growth funding for 22/23. These are offset by a £0.1 favourable variance on drugs and devices.

- **Non-Clinical Income:** on plan, with recharges favourable to plan by £0.2m and testing income (£0.1m) and education CPD income (£0.1m) adverse to plan, all of which have offsetting increases/reductions in expenditure.

- **Pay:** £0.5m adverse to plan, with the variance mainly driven by Medical and Nursing spend in Medicine, Surgery and Children and Families Divisions. Agency spend remains high at £1.7m in month, mainly on Medical and Nursing staff.

- **Non-Pay**: £0.9m favourable to plan in month, mainly due to a £0.6m favourable variance on independent sector, linked to the elective recovery plan, a £0.2m favourable variance on consumables and other non-recurrent items of £0.1m.

Further detail

Income

Clinical income in month 1 has been aligned to the contract values submitted in the final plan on the 28th of April, with the exception of the risk adjustment on Bassetlaw CCG following subsequent receipt of their contract offer. ERF income has been excluded from the position in month 1 based on the Trust and the expectation that the system will not have achieved the targets in month. The ERF position is not confirmed at this point with the Trust awaiting further guidance from the ICB.

Non-clinical income was on plan in month, with a number of key variances to note:

- £0.2m favourable variance on recharges (mainly associated with WOS) which is offset with a corresponding increase in expenditure.
- £0.1m under achievement on testing income which is offset with an underspend on expenditure.
- £0.1m under achievement on Education Continuing Professional Development (CPD) income which is offset with an underspend on expenditure.

Pay

Pay expenditure was £0.5m adverse to plan in month and was mainly driven by Medical and Nursing spend in Medicine, Surgery and Children and Families Divisions. They key areas to notes are:

- Medicine are overspent on Medical pay by £0.2m and on Nursing pay by £0.4m – due to agency backfill for junior doctors mainly within ED, and agency and bank usage for nursing within ED, Acute Medicine and Care of the Elderly.
- Surgery are overspent on Medical pay by £0.2m and on Nursing pay by £0.1m – due to agency backfill for junior doctors gaps mainly within T&O, and agency and bank usage for nursing due to covid sickness and supernumerary international nurses.
- Children and Families Division are overspent on Medical pay by £0.1m and on Nursing by £0.1m – due to covid absence, maternity and long term sickness, along with nursing and midwifery pressures due to increased premiums for bank and agency backfill.

Agency spend remains high at £1.7m in month, mainly on Medical staff (£0.8m) and Nursing staff (£0.7m). The table below sets out the agency spend by type for quarter 4 of 2021/22 and month 1 of 2022/23, demonstrating the continued agency spend on Medical and Nursing staff. This level of spend is c.£0.8m more than pre-pandemic levels. The Finance team is leading a piece of work to further analyse and understand the Trust's temporary staffing spend especially against pre-pandemic levels of spend.

Total agency spend by category	Jan-22	Feb-22	Mar-22	Apr-22
Administration and estates	42	55	33	63
HCA and other support staff	82	64	82	26
Medical and dental	760	722	886	805
Non Medical Non Clinical	43	37	78	64
Nursing & midwifery	380	418	755	702
Scientific, therapeutic and tech	31	25	40	28
Total	**1,338**	**1,321**	**1,874**	**1,688**

Non-pay

Non-pay was £0.9m favourable to plan in month. Key variances include:

- Independent sector, linked to the elective recovery plan, was £0.6m favourable to plan in month.

- There was a favourable variance of £0.2m on consumables, mainly on prostheses (linked to lower elective activity than planned)
- The Trust benefitted from a non-recurrent profit on sale of assets of £0.1m in month.
- There were other non-recurrent favourable variances of £0.1m.

Capital

Capital expenditure in month 1 was £537k against the plan of £739k (£202k behind plan). Included within the YTD actuals is £1k of donated assets. Key variances to plan are underspends on Estates of £136k and Medical Equipment of £83k. The capital plan for medical equipment has now been agreed at Execs (Appendix 1).

Cash

The cash balance at the end of April was £33.4m (March: £46.4m). Cash has decreased by c £13m compared to month 12 largely as a result of a deficit position in month, payment of capital invoices totalling c £4.5m, which relate to 2021/22 and increased revenue spend f c.£6m, again, which mainly relates to year end creditors.

The cash plan for the month was for cash to be £30.7m, but the favourable performance against this plan is due to remaining capital creditors that were not paid in April. As such, the cash position is expected to fall again in May and throughout the year.

Financial Plan 22/23

Following submission of the 22/23 financial plans in April, the Trust has been notified by the ICB that there will be a national financial plan resubmission process (expected from Mid-May – Mid-June) reflecting that systems have not achieved financial balance within 22/23 plans. A verbal update will be provided to the Trust Board and Finance and Performance Committee, with further information expected from NHSI/E and the ICB in the w/c 16th May.

2. Recommendations

The Board is asked to note:

- The Trust's deficit for month 1 (April 2022) was £2.6m, which was adverse to plan by £258k.
- There will be a 22/23 financial plan resubmission.

The Board is asked to approve:

- Delegated authority for the Audit and Risk Committee (ARC) to sign off the annual accounts, annual report and annual governance statement.
- The Medical Equipment Capital Plan.

3. Appendix

Appendix 1 – Medical Equipment Approved Plan

Medical Equipment - 22-23 Final Plan - App

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	24 May 2022	**Agenda Reference:**	E3		
Report Title:	**Annual Accounts - Going Concern**				
Sponsor:	Alex Crickmar – Acting Director of Finance				
Author:	Matthew Bancroft – Head of Financial Control				
Appendices:	N/A				
Report Summary					
Purpose of report:	Following an initial Going Concern assessment that was presented at the March meeting, the following paper updates the assessment with regards to the Going Concern status of the Trust, to assist with the preparation of the 2021/22 annual accounts.				
Summary of key issues/positive highlights:	Whilst the Trust is expected to report a surplus position for 2021/22 and have a considerable cash position at 31 March 2022, the planning for 2022/23 indicates a significant deficit position. As such, the paper outlines the cash profile, as well as other areas of support that the Trust has, in order to confirm its Going Concern status. Further to the previous paper, the cash profile has been revised, and extended to May 2023, in part as the assessment has to cover 12 months from the accounts sign-off date.				
Recommendation:	The Trust Board is asked to agree the following: • The Trust should be considered a going concern for accounts preparation purposes. • The Trust should prepare its annual accounts for the year 2021/22 and balance sheet as at 31st March 2022 on that basis. • The annual report should clearly state this assessment whilst also outlining the risks facing the trust.				
Action Require:	Approval	~~Information~~	~~Discussion~~	~~Assurance~~	~~Review~~
Link to True North Objectives:	**TN SA1:** *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 impact.				

Report Title: Annual Accounts - Going Concern
Author: Matthew Bancroft

Corporate risk register:	N/A		
Regulation:	Requirement to produce annual financial statements		
Legal:	Requirement to produce annual financial statements		
Resources:	No Issues		
Assurance Route			
Previously considered by:	N/A		
Date:		**Decision:**	
Next Steps:			
Previously circulated reports to supplement this paper:			

Report Title: Annual Accounts - Going Concern
Author: Matthew Bancroft

Going Concern Assessment

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

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

Guidance

The 'Group Accounting Manual 2021-22' published by the Department of Health contains the following guidance:

4.20 A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up.

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

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

4.23 While an entity will disclose its demise in various areas of its Annual Report and Accounts such as in the Performance Report and cross reference this in its going concern disclosure, this event does not prevent the accounts being prepared on a going concern basis or give rise to a material uncertainty in relation to the going concern of the entity.

4.24 DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity.

4.25 Where a DHSC group body is aware of material uncertainties in respect of events or conditions that may bring into question the going concern ability of the entity, these uncertainties must be disclosed.

4.26 As the continued provision of service approach, per paragraph 4.22, applies to DHSC group bodies, material uncertainties requiring disclosure, will only arise in very exceptional circumstances.

4.27 Should a DHSC group body have concerns about its "going concern" status (and this will only be the case if there is a prospect of services ceasing altogether), or whether a material uncertainty is required to be disclosed (which will only arise in exceptional circumstances), it must raise the issue with its sponsor division or relevant national body as soon as possible

4.28 Consideration of risks to the financial sustainability of the organisation is a separate matter to the application of the going concern concept. Determining the financial sustainability of the organisation requires an assessment of its anticipated resources in the medium term. Any identified significant risk to financial sustainability is likely to form part of the risks disclosures included in the wider performance report, but is a separate matter from the going concern assessment.

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

Assessment

Despite the strong guidance identified above the Board of Directors must still satisfy themselves that the trust remains a going concern.

In previous years, the Trust had significant levels of borrowings. However, during 2020/21, the DoH converted revenue loans to PDC Dividend (equity funding). This was significant as previously, the high value of these loans and the uncertainty as to whether these loans would be repaid by the Trust caused auditors to review the Going Concern opinion of the Trust. However, as these loans have been converted, the level of risk has reduced substantially.

The ICS has also supported the Trust in making the redevelopment of the Doncaster Trust Site. However, there is a level of risk around the financial costs of maintaining the current site, as well as the reputational and safety risks associated with the current state of the Doncaster Trust site.

The going concern status is also supported by the healthy cash position that the Trust has, going into 2022/23. The Trust had a cash balance of £46.4m at 31st March 2022, although capital creditors are £11.5m at March 2022. With a significant deficit expected in 22/23 (c. £25m), the cash position deteriorates throughout 2022/23, although it is expected that cash will remain positive throughout the year, with the low point being the year end cash figure, as seen in Appendix A.

It is important to note a number of key assumptions in this forecast, including:

- Income to continue on a Block arrangement and will have a tariff inflation of 2.8% with efficiency of -1.1%.
- Expenditure will have an inflationary uplift of 2.8%
- Capital expenditure for 2022/23 will be £34m and has been phased appropriately
- Capital expenditure funded through PDC, and the associated PDC income have been included. The PDC income is expected to be £31.1m

Appendix A then rolls forward a further 2 months to May 2023 and shows a cash position of £9.2m at May 2023, which is the low point in this additional 2 month period. This projection is highly judgemental and is based on the following key assumptions:

- A straight-line projection of the 2022/23 deficit continuing into 2023/24
- Capital expenditure being limited to the level of depreciation incurred during the 2-month period and occurring on a straight line basis
- There is no PDC income (revenue or capital) to support the cash balance.
- No cash management techniques have been performed
- No movement in the capital creditors figure between March 2023 and May 2023.

It is important to note that if the Trust failed to receive any income in 2022/23, cash would run out in mid-May 2022. However, given the consistent nature of the income streams, and financial stability of the Trust's customers (CCG's backed by Central Government through NHS England/DHSC), this is deemed to be an extremely unlikely situation. This judgement has been proved to be true as the Trust received regular cash flows in April 2022 from commissioners, even though contracts haven't been signed and at the point of receiving the cash, final 2022/23 plans had not been submitted.

The cash flow projections do not factor in any mitigations to manage the cash balance. As such, it can be seen to be a reasonably prudent position. There are a number of tools available to the Trust, which including extending payment days to suppliers (e.g. 10 days would release an additional £4m of cash) and central PDC support which could support the cash position of the Trust.

Conclusion

Therefore, the following supports the assessment of the Trust being treated as a going concern for the 12 months following sign-off of the 2021/22 accounts:

- Continuing support from local commissioners and the ICB
- Services will still need to be provided for people in the locations which the Trust serves with no indication from regulators or others this won't be the case.
- The Trust ended the 2021/22 year with £46.4m cash in the bank
- Positive cash forecast in 12 months time from the date of signing the accounts of c£9m.
- There are no licence conditions in place on the Trust from its regulatory body.

Therefore, it is considered appropriate for the trust to continue to prepare its financial statements on a going concern basis and to make the necessary declarations as part of its annual report and annual accounts. However, the continued risks, particularly around the financial plan for 2022/23 will also be clearly stated in the 2021/22 annual report.

Report Title: Annual Accounts - Going Concern
Author: Matthew Bancroft

Appendix A

	12 months to 31/3/2023	Pro-rata - 2 months to 31/5/2023
In year Deficit	(25,479)	(4,247)
Movement in Capital creditors	(8,236)	
Movement in Capital additions	(34,190)	(2,148)
Depreciation	12,885	2,148
Interest paid	(272)	(45)
Interest expense	312	52
Loan payments	(1,826)	(304)
Annual Leave accrual	(4,700)	
PDC in	31,128	
Cash c/f	13,744	9,199

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Operational Plan Update- data as at 4 May 2022

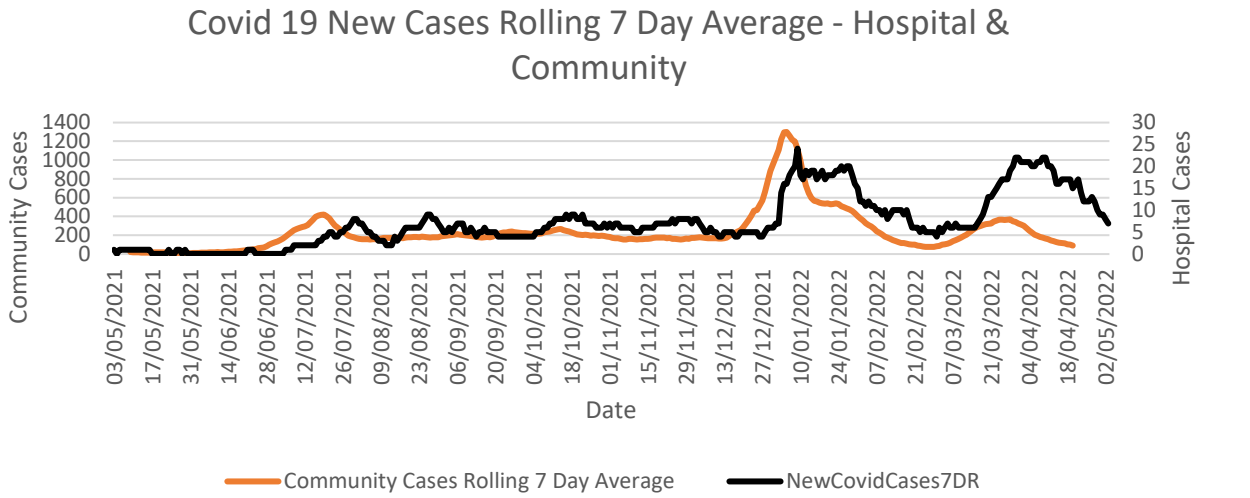
C19 Infection & Admission

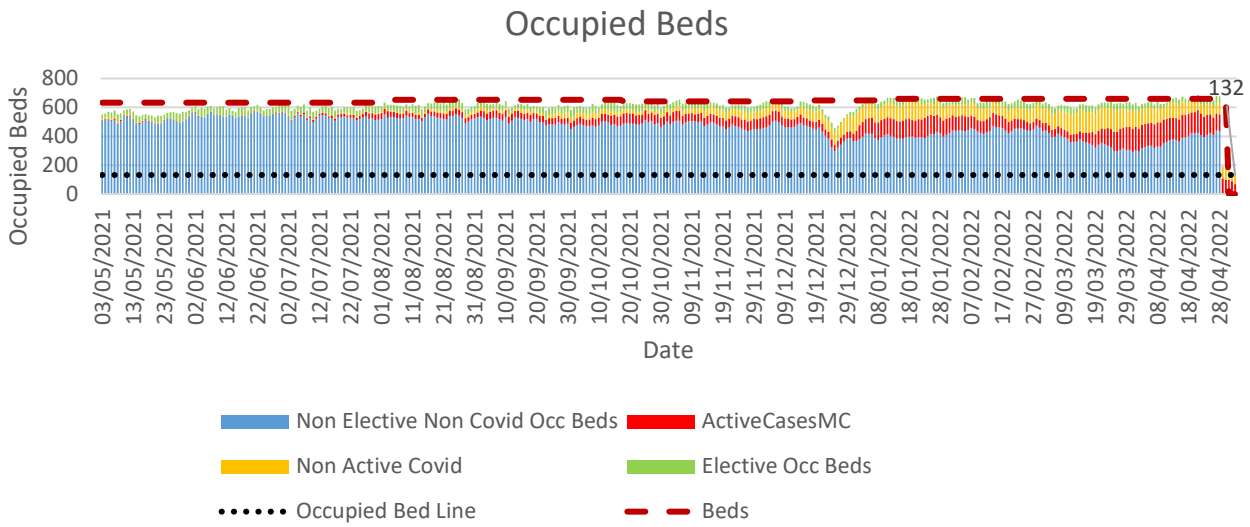
- COVID numbers high through April 22 and now reducing again.

- Total COVID occupancy peak in April c200
- Active case occupancy c140

- Threat from COVID settling again through May.

- High overall occupancy c 96%. Running at particularly high level of occupancy

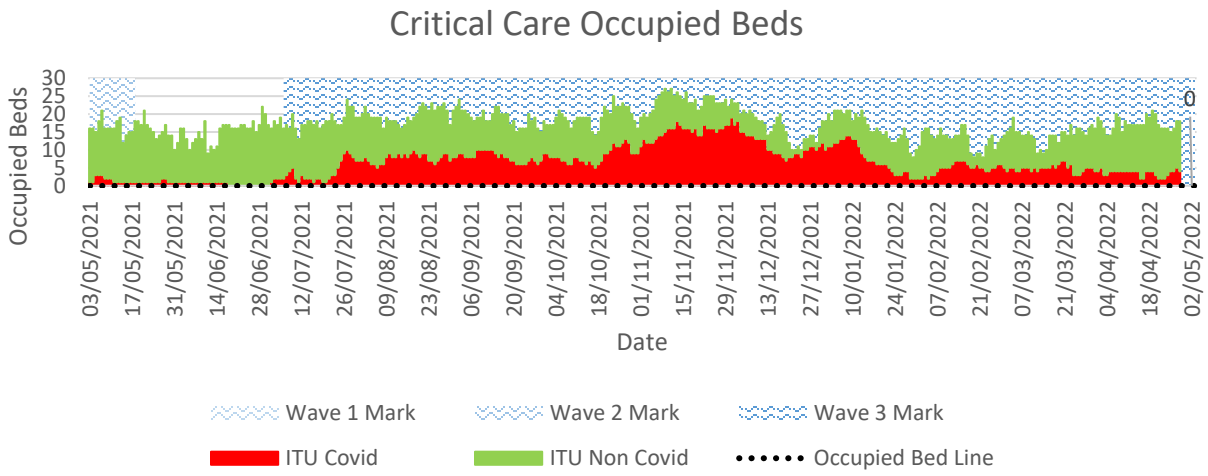




Critical Care

- Critical care occupancy stable. COVID causing less critical care admissions.

- Elective activity able to access Critical Care.



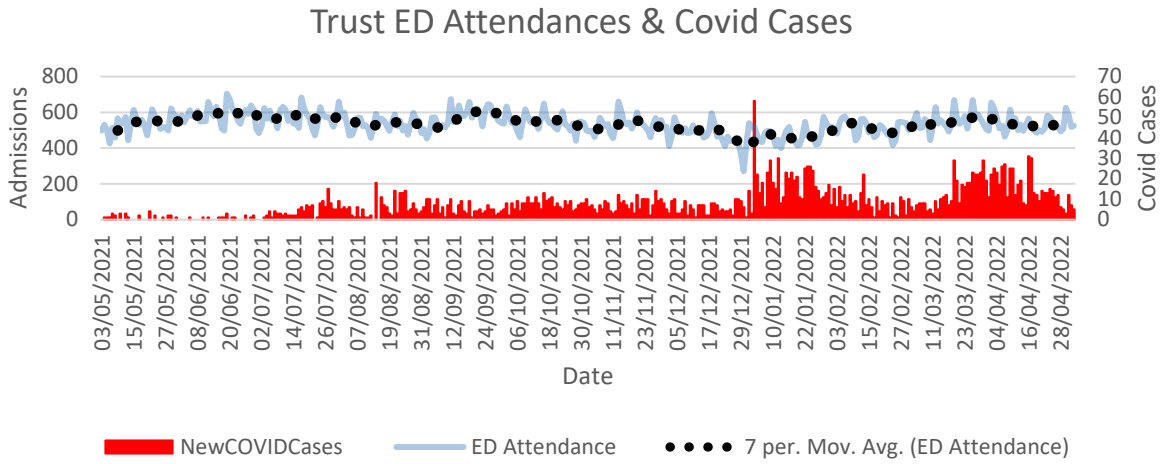
Emergency Flow

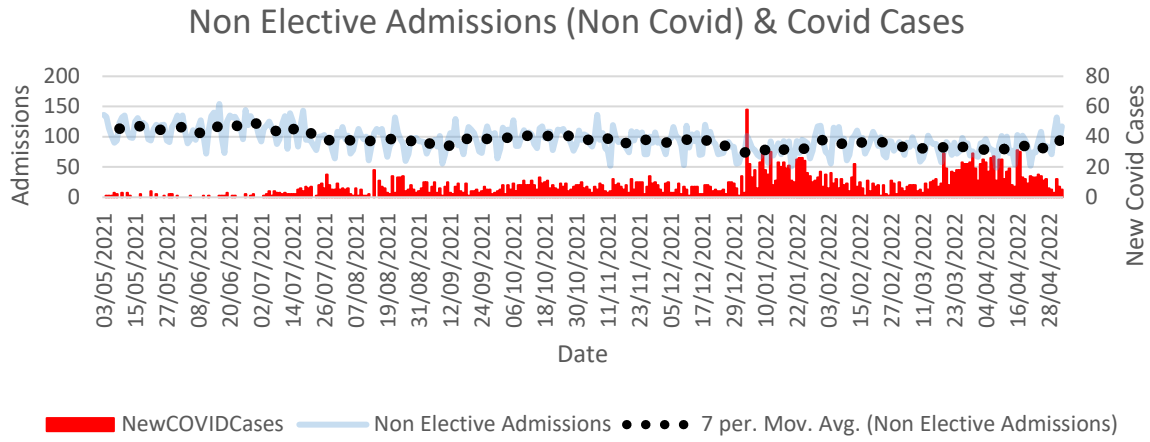
ED attendance levels remain higher than the same time than any of previous 4 years, with significant numbers of COVID cases.

Ambulance handover delays continued to be a challenge. YAS direct access to SDEC implemented in April.

Significant delays due to exit block and waiting to be seen by Doctor.

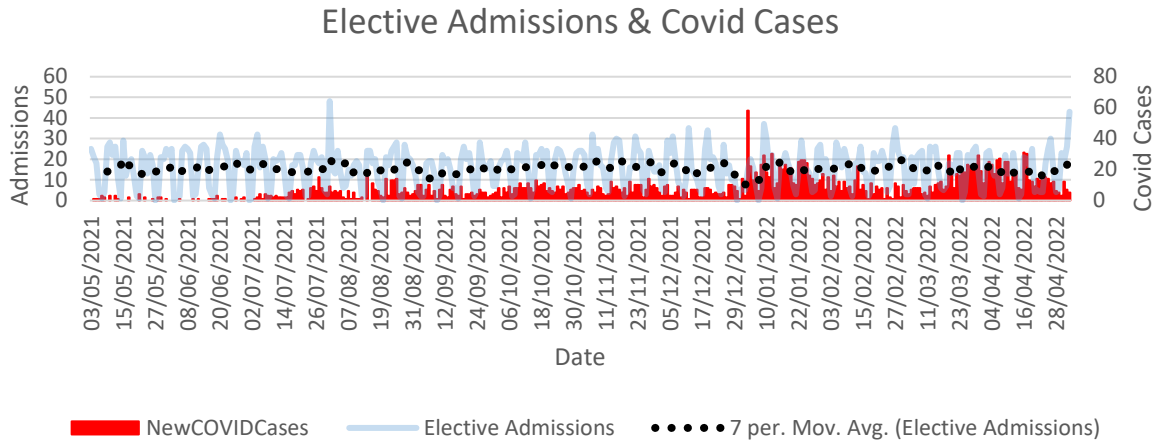
SAFER implementation work continues on wards, with an improving position of data capture on nerve centre.

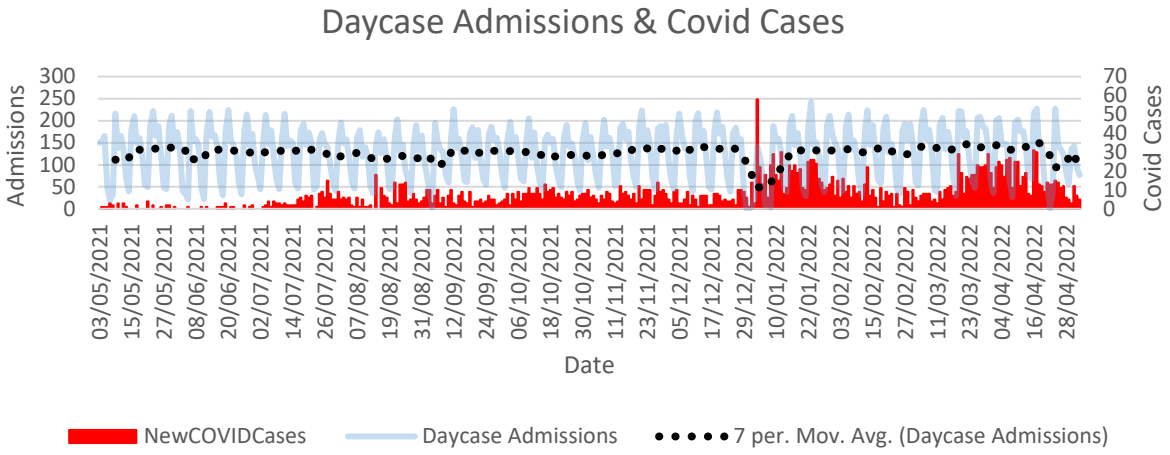




Elective

- Return to full theatre timetable from beginning of April
- The Outstanding Theatres programme has been reinstated which has resulted in delivery of 90% of the planned elective surgery (against target). This is against a backdrop of flow pressures across the organisation and reduced working days in April
- Listing Priority 1 & 2 patients together with the long waiting P3 and P4 patient groups
- Covid continued to have an impact on elective performance during April with yet another spike in infections, impacting on the surgical bed base for both elective and emergency admissions
- Some elective cancellations due to lack of kit and equipment – particularly ophthalmology cataract lists as there is an international shortage of phaco trays (cancelled 26 procedures in 1 week alone). Working closely with Procurement to maximise elective throughput in line with other SYB partners
- Work continues to maximise the use of all theatre lists and booking and scheduling continues to be a focus





Radiology

MRI

- 1548 patients imaged in April 2022 compared with 1359 in April 2021 (growth of 13.9%).
- Three fixed scanners were in use plus 17 mobile scanner days including 9 mobile scanner days funded as part of the Community Diagnostic Centre development.
- Waiting list of 1077 at the end of April compared with 843 at the end of March.
- Waits in excess of six months of 166 compared with 210 at the end of March.

Non Obstetric Ultrasound

- 3683 patients imaged in April compared with 4749 in April 2021.
- Additional sessions undertaken in April by sonographers and radiologists providing 224 scans to partially offset the effect of vacancies. Outsourced and locum activity funded by the Accelerator programme ceased at the end of March.
- Waiting list of 7359 at the end of April compared with 6572 at the end of March.
- Waits in excess of 6 months of 3843 compared with 3023 at the end of March.
- British Medical Ultrasound Guidelines being used to determine eligibility for scans and contain demand with effect from May.

CT

- 6512 patients imaged in April compared with 6099 in April 2021 (growth of 6.8%)
- Significant ongoing growth in demand for emergency and elective CT scans, which is being analysed to inform demand containment plans.
- Waiting list of 3049 at the end of April compared with 2966 at the end of March.

Elective Programme Next Steps 22/23

- Continue to build upon Outstanding Theatres improvements
- Revised Dashboards to be rolled out widely to ensure all involved in the elective programme are sighted on the absolute detail
- Monthly and in month monitoring of performance against targets at specialty level
- Incorporate specialty admin teams into the weekly performance management meetings to secure their engagement and engender a sense of ownership for staff who book the lists
- Reduce late starts and early finishes/the number of cancelled lists – backward and prospective review of actual delivery
- Work specifically with Ophthalmology, ENT and Orthopaedics to increase throughput on lists
- SYB improvement support started with Ophthalmology and ENT being the primary focus across the system, understanding how each provider can be part of an SBY solution to reducing backlogs

COVID Plan

- COVID related staffing issues causing impact on trust & community capacity.
- OPEL Escalation framework & partnership arrangements in place.
- Plan for COVID in place and daily review with triggers for exceptional actions.
- Horizon scanning of COVID numbers and activity continues weekly.
- Moving toward COVID as BAU.

Overall Operational Plan – Next Steps

- Continue to build on **urgent and emergency care improvement plan**
- Significant focus on **ambulance handovers** in line with NHS E requirement
- Continue focus on **“hotspots”** to improve performance
- **Good progress on elective new standards** and focus on key risk areas

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	24 May 2022	**Agenda Reference:**	E5
Report Title:	**INTEGRATED QUALITY & PERFORMANCE REPORT (IQPR) / Performance Exception Report (March 2022)**		
Sponsor:	Gill Marsden –Deputy Chief Operating Officer (elective) Debbie Pook – Deputy Chief Operating Officer (non-elective)		
Author:	Laura Fawcett-Hall – Head of Performance		
Appendices:			
Purpose of report:	The overall integrated performance report aims to: • Deliver an executive summary – summarising the operational context, performance headlines and the forward plan. • Share the full performance metrics through the IQPR at a glance charts. • Provide the full Performance Exception report for the headline metrics.		
Summary of key issues:	**1. <u>Operational Context – Headlines of Data Trend Analysis</u>** a. The Trust continued to see a high level of Covid patients through April 2022, an increase from the February 2022 and March 2022 position. Critical care demand continues to be low for this cohort of patients. b. Staff absence due to Covid 19 continued to cause significant pressure during April 2022 which has impacted on service delivery in all areas. c. ED attendance reduced compared to peaks over summer months, but still higher than last 4 years. d. In common with all Trusts, emergency demand and staffing pressures have impacted on elective delivery, however, the Trust maintained a programme of elective work through April 2022. e. The performance report for April 2022 is presented in this operational context. **2. <u>Headlines from Integrated Performance Report (April 2022)</u>** *Emergency* a. **4 Hour Access** – in April 2022 the Trust delivered 71.49% achievement against national target of 95%, which was a slight improvement on March 2022 and included the Easter period. Performance for the month benchmarks "in the pack" across Northeast and Yorkshire. A wide-ranging action plan is in place. b. **12 Hour Waits -**The Trust are reporting 197 12-hour trolley breaches in April 2022. The Trust continues to experience patient flow challenges. 137 at DRI and 60 BDGH The Trust are reporting 3.6% (577) 12 hour waits from time of arrival. c. **Ambulance Delays -** There are continued challenges on the Doncaster site and a full action plan has been developed to address this quality issue for patients with support from NHSE / ICS. An exception report is provided & the Trust remains an outlier although an improving position is showing. d. **Emergency Care Bundle –** The new standards and are now live and being reported. e. **Length of Stay** slightly increased for elective patients but we saw a slight decrease for non-elective admissions during April 2022 as in March 2022. A partnership patient focused Wednesday Walkaround continues with focus on patients with a 7 day + length of stay		

ensuring all patients have a discharge plan in place. Red to Green roll out continues with an improving data capture showing reason codes, supporting improved discharge processes.

Elective

a. **Activity** - Overall, the Trust was not on plan for April 2022 and had lower activity levels compared to 19/20 – (96.5% of 19/20 day case activity, 82.5% of IP activity, 81.7% of new outpatients and 81.6% of 19/20 follow ups).

b. **52 Week Breaches** – in April 2022 the Trust reported 1285 breaches due to Covid 19 delays, an increase from last month.

c. **104 week waits** – At the end of April 2022, there were 5 patients waiting over 104 weeks, all were either patient choice or had been affected by Covid delays in their pathway.

d. **Referral To Treatment (RTT)** - in April 2022 the Trust delivered 68.1% performance within 18 weeks, below the 92% standard. This position has improved from last month (67.5%) but is still affected by covid bed and staffing constraints. Performance continues to be better than the most recent peer and national benchmark.

e. **The total waiting list** increased slightly during April 2022 to 44961 – slightly above year-end target by 344 patients.

f. **Diagnostics** – in April 2022 the Trust achieved 55.42 % against a target of 99%. This is a decrease from last month. Performance continues to be well below the national and peer benchmark.

Cancer

a. **Faster Diagnosis Standard –** In March 2022 the Trust achieved the FSD standard with 76.2% against the performance target of 75%.

b. **31 Day Standard** – in March 2022 2 out of 3 nationally reported measures were achieved.

c. **62 Day Standard –** in March 2022 0 out of 2 nationally reported measures were achieved.

d. The Trust is off track with all recovery trajectories to reach the required reduction in over 62-day open pathways improvement on cancer pathways.

e. **Open Pathways over 104 Days –** in March 2022 the number of open pathways were 4

f. Cancer performance still performs well compared to peers

Next Steps on Performance & The Operational Plan

For elective and cancer performance, the key next steps are:

a. Recruit to operationalise increased elective surgical bed base

b. Develop recovery plans to mitigate plan revisions for the modular theatre and rapidly mobilise plan for ring-fenced orthopaedic hub and theatre on the DRI site in H2.

c. To expand capacity to deal with backlogs and reduce waiting times

d. Increase productivity, more patients per list (eg ophthalmology), work to high volume low complexity principles

e. Extend referral triage and explore options for community care as a viable alternative to secondary care

f. Work with SYB colleagues to develop best practice opportunities (pre-habilitation and waiting well initiatives)

From an emergency perspective, the key next steps are:

a. Work continues with patients without criteria to reside with the continued implementation of red to green working with partners

	b. Continue to focus on Urgent & Emergency care recovery, extending the frailty pilot. c. The Trust continues to experience significant operational challenges and will continue to focus on safety and sustainability and supporting its teams, people and patients.				
	The Committee is asked to note and comment as appropriate on the attached.				
Action Require:	Approval	Information	Discussion	Assurance X	Review

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:	Changes made to SA1 and COVID 19 addition to SA1 to reflect risk and related to winter planning & also planning mitigation
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:			
Date:		**Decision:**	
Next Steps:	Agreement of 2022/23 performance trajectories to be monitored via new IQPR & related documentation		
Previously circulated reports to supplement this paper:			

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	24 May 2022	**Agenda Reference:**	E6
Report Title:	**Patients waiting less than 15 minutes for ambulance handover from time of arrival**		
Sponsor:	Debbie Pook, Deputy Chief Operating officer		
Author:	Andrea Squires, Divisional Director of Operations for Urgent & Emergency Care		
Appendices:	Supporting graphs		
Report Summary			
Purpose of report:	To provide information and assurance in relation to actions ongoing to improve the number of patients waiting more than 15 minutes for ambulance handover from time of arrival		
Summary of key issues/positive highlights:	• NHSE (2020) guidance states that ambulance handovers should reliably be completed within 15 minutes and that a handover escalation process should be enacted where time to handover exceeds or is likely to exceed 30 minutes • The current national standards state that all patients should be handed over within 15 minutes with none waiting over 60 minutes for handover • The month of April was a challenging period with an increase of ambulances attendances vs March where the trend was decreasing. • Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trusts (DBTH) April performance for patients waiting less than 15 minutes for ambulance handover increased from 40.2% to 41.69%, with decrease from 14.69% to 14.33% of patients waiting over 60 minutes. There was a slight increase from 46.58% to 49.95% at Doncaster Royal Infirmary for patients waiting less than 15 minutes for ambulance handover in April. • Performance improvement has been affected by bed waits specifically on 12th & 19th April, which 19th saw the longest wait of 9:70hrs • Doncaster Royal Infirmary (DRI) in April are the 3rd highest reporting Trust for 60-minute ambulance handover breaches in Yorkshire. • Actions started – Ambulance direct referrals at DRI & BDGH, Early Senior Assessment reconfiguration to improve triage and ED Streaming, 2hrly online ED escalation tools for immediate support as Opel levels increase. Regular meetings with YAS/EMAS focusing on early notice of patient acuity prior to arrival, continued development of Consultant Connect for ED streaming. • Key actions continue to be implemented to ensure ambulance handover times across DBTH are in accordance with national guidance and ensures patients receive safe and high quality care • Further work around pathways such as Same Day Emergency Care is also being completed to improve ambulance handover times as part of the UEC Recovery and Transformation programme • The month of April has seen a reduction in the number of patients waiting more than 60 minutes for ambulance handover from 14.62% to 14.33% however this remains an improvement on January's 16.53% as a result of this ongoing work		

	• This paper will provide a monthly update against national standards and highlight improvements moving forwards				
Recommendation:	For information/assurance purposes only				
Action Required:	~~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:	*Changes made to SA1 and COVID 19 addition to SA1 to reflect risk and related to winter planning & also planning mitigation*
Corporate risk register:	*Report regards Risks ID 6 and 2349 on the Risk Register - F&P 6* • *Failure to achieve compliance with performance and delivery aspects of the SOF, CQC and other regulatory standards* *Report outlines actions plan to make progress on this specific requirement related to ambulance handovers, no change to risks on CRR*
Regulation:	NHS England (2020) Reducing Ambulance Handover Delays: key lines of enquiry
Legal:	N/A
Resources:	N/A

Assurance Route			
Previously considered by:	Divisional Management Board for Medicine		
Date:	27/04/22	**Decision:**	TBC
Next Steps:	Continued monitoring of recovery and associated action plans at Divisional Management Board for Medicine, Finance & Performance Committee and monthly escalation to Board. Work forms part of Urgent and Emergency Care Programme.		
Previously circulated reports to supplement this paper:	N/A		

Doncaster Summary: Patients waiting less than 15 minutes for ambulance handover from time of arrival

Problem Statement: Performance against the Ambulance handover within 15 minutes standard is currently 49.95% for Doncaster.

Current Trend: Performance against the Ambulance handover within 15 minutes improved over the month of April, with 49.95% compared to 46.58% in March.

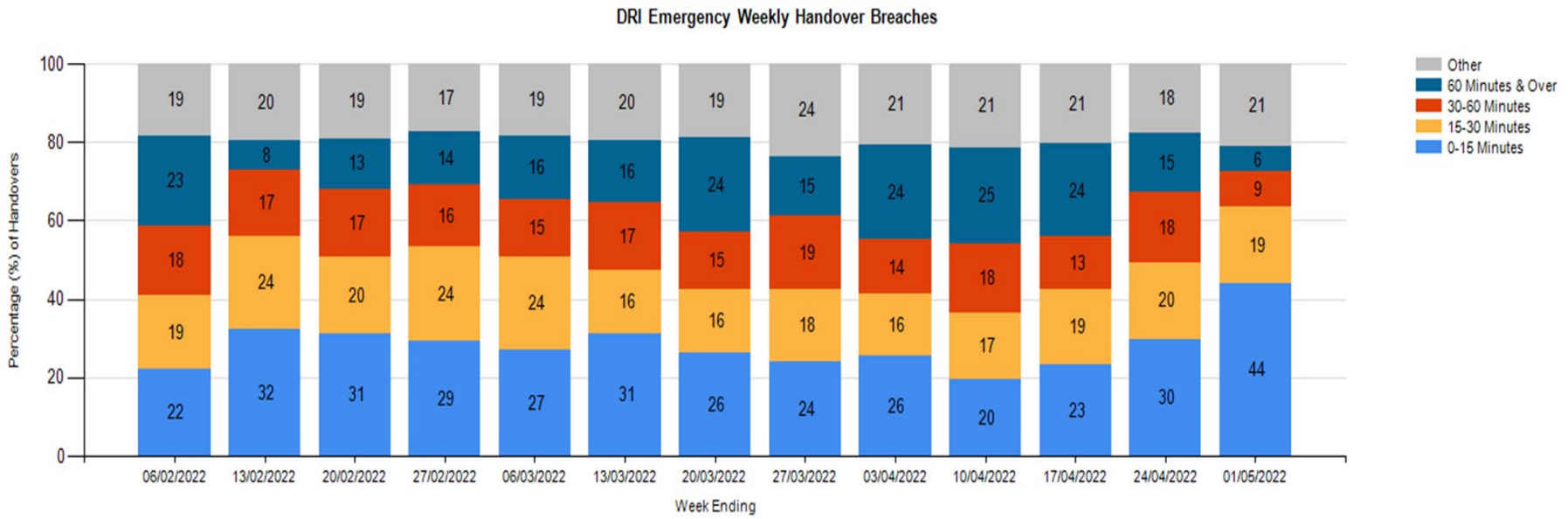
Metric Owner: Divisional Director of Operations (DDO) for Urgent & Emergency Care

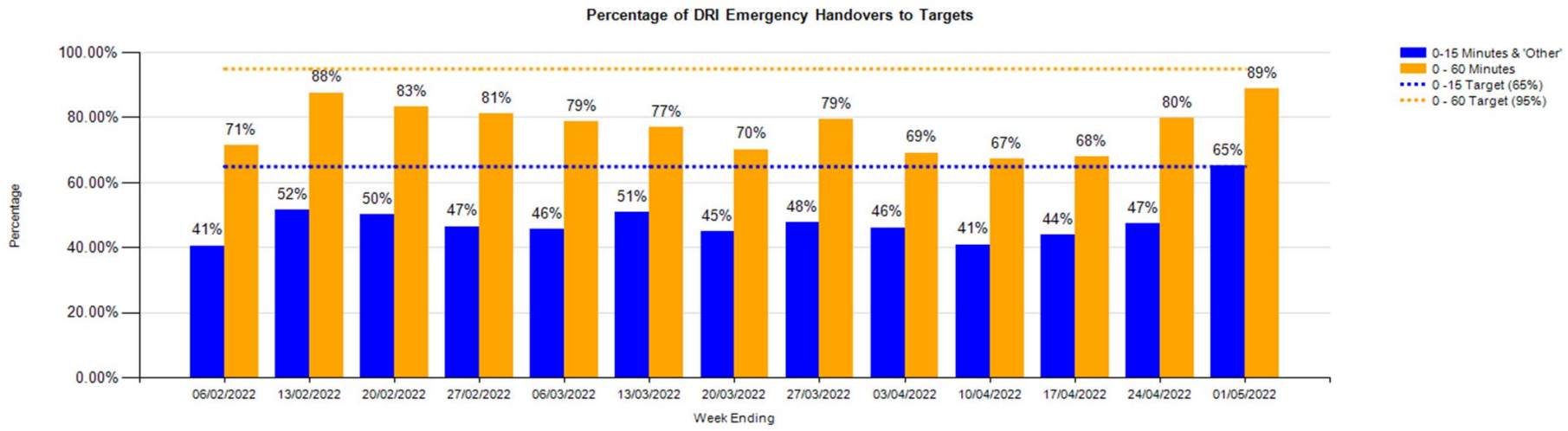
Metric: Ambulance Handover Time: Ambulance handover within 15 minutes – with none over 30 minutes

Desired Trend:

April Performance:

Month	Hospital	No of Arrivals	% less than 15 minutes	% between 15 & 30 minutes	% over 60 minutes	Longest Wait (hrs & minutes)
Apr 2022	Doncaster	1876	49.95%	18.55%	17.38%	09:27:38
	Bassetlaw	748	20.99%	51.74%	6.68%	04:35:18
	Trust	**2624**	**41.69%**	**28.01%**	**14.33%**	**N/A**





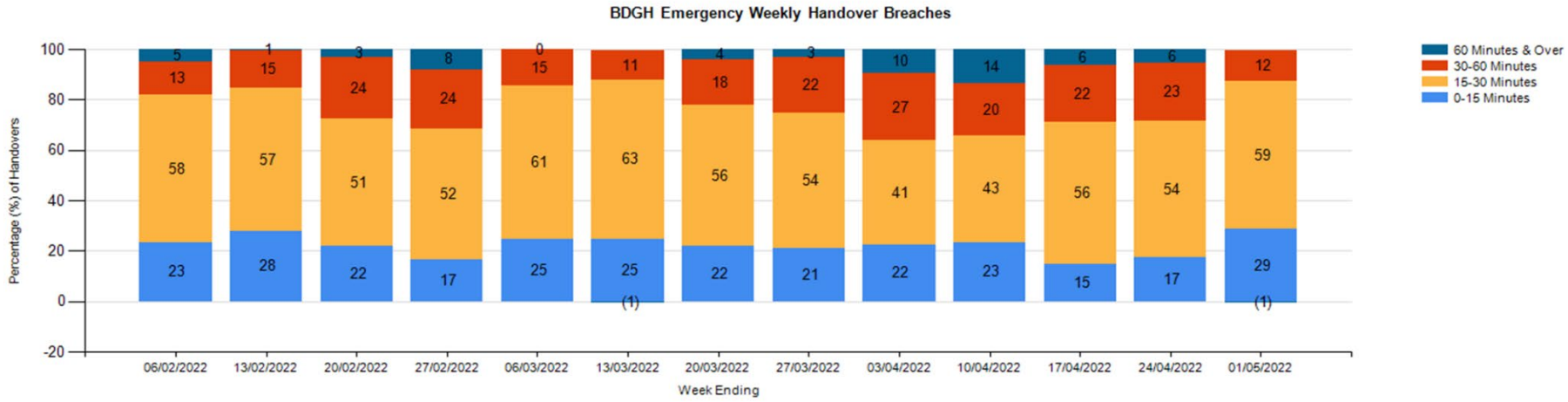
Key associated metrics that also support the standard:	
>15 minutes Time To Initial Assessment (TTIA)	April performance was 36.87% against the 5% target. This is a slight increase from the 36.85% reported in March. Delays are ongoing following the winter period due to high Covid rates and a UEC recovery action plan is in place to improve delays at the ED front door. In May, ESA improvement pilot is being run to improve Triage times
Average Length of Stay (LoS) in ED	Average time in department for April was 203 minutes against the 240 minute target. This is a reduction from 219 minutes reported in March. The department is prone to availability of beds.
>12 hours in ED from Arrival	April performance was 4.7% which remains slightly above the national standard of 5% target. This is a reduction from 4.87% reported in March. Delays continue to be impacted by a current Trust bed occupancy of 94.1%. The Patient Flow Steering Group continue to focus on reducing LoS.

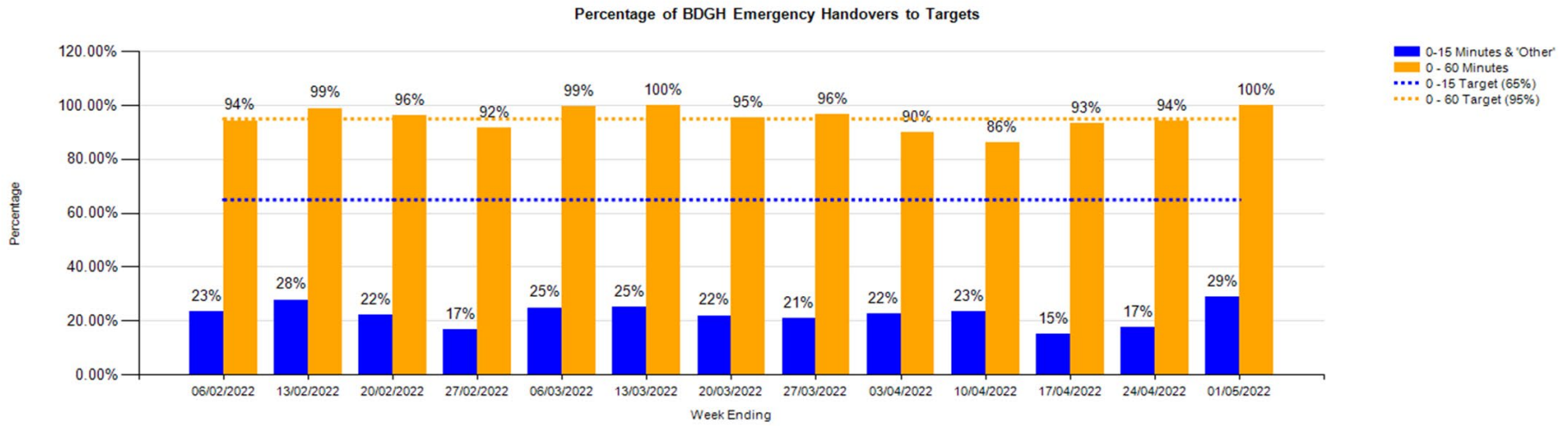
Bassetlaw Summary: Patients waiting less than 15 minutes for ambulance handover from time of arrival

Problem Statement: Performance against the Ambulance handover within 15 minutes standard is currently 20.99% for Bassetlaw. **Current Trend:** Performance against the Ambulance handover within 15 minutes has worsened over the month of April with 20.99% compared to 23.17% in March. This was due to diverts as the longest wait 4th April due to 21 bed waits	**Metric Owner**: Divisional Director of Operations (DDO) for Urgent & Emergency Care **Metric**: Ambulance Handover Time: Ambulance handover within 15 minutes – with none over 30 minutes **Desired Trend**: ⇧

April Performance:

Month	Hospital	No of Arrivals	% less than 15 minutes	% between 15 & 30 minutes	% over 60 minutes	Longest Wait (hrs & minutes)
Apr 2022	**Doncaster**	1876	49.95%	18.55%	17.38%	09:27:38
	Bassetlaw	748	20.99%	51.74%	6.68%	04:35:18
	Trust	**2624**	**41.69%**	**28.01%**	**14.33%**	**N/A**





Key associated metrics that also support the standard:	
>15 minutes Time To Initial Assessment (TTIA)	April performance was 36.8% against the 5% target. This is a slight improvement from the 36.97% reported in March. Delays are ongoing following the winter period due to high Covid rates and a UEC recovery action plan is in place to improve delays at the ED front door.
Average Length of Stay (LoS) in ED	Average time in department for March was 168 minutes against the 240 minute target. This is slight improvement from the 171 minutes reported in March yet remains above the national standard.
>12 hours in ED from Arrival	April performance was 2.28% which is better than the national standard of 5% target. This is a slight increase from the 1.76% reported in March. Delays continue to be impacted by a current Trust bed occupancy of 96.6%. The Patient Flow Steering Group continues to focus on reducing LoS.

Key Summary & Actions: Patients waiting less than 15 minutes for ambulance handover from time of arrival

Top contributor	Potential Root Cause	Countermeasure	Owner	Status
Pre-hospital / Front Door Issues	• Difficulty accessing primary care services for advice and guidance • Difficulty accessing assessment services for advice and guidance • Difficulty accessing community response services	• Additional GP hours in urgent primary care to support ambulance crews where discussion needed with GP • Extend Same Day Health Centre offer to YAS and South Yorkshire Police for patients that need minor injuries support • Extended pilot with new geriatrician at DRI to support conveyance avoidance particularly around frailty • Work underway to promote the Rapid Response service with ambulance crews • YAS direct pathway to medical and surgical same day emergency care services now implemented, to be duplicated at Bassetlaw • Single point of access for GPs to facilitate direct admission to medical and surgical same day emergency care services • Early senior review in ambulance bay to identify patients suitable for medical and surgical same day emergency care services and fit to sit • Implement Screening and Redirection tool, supported by signposting away and early senior review	Fylde Coast Medical Services (FCMS) FCMS DDO for UEC / Care of the Elderly Consultant CCG DDO for UEC / Clinical Director (CD) DDO for UEC / CD DDO for UEC / CD DDO for UEC / CD	Monitoring Monitoring Monitoring Monitoring Monitoring Monitoring Delivery Delivery
Patient Flow issues	• Current Trust bed occupancy of 98% resulting in lack of available beds to move patients into from ED • Increased LoS across the Trust (7, 14 and 21 days) • Lack of available beds in	• Re-configuration of acute medicine to include re-location of 12 beds to existing Early Assessment unit in ED to become an Acute Medical Decisions Unit resulting in an additional 12 beds for Care of the Elderly and General Medicine • Additional 10 beds to be opened on Ward 22 for respiratory patients	DDO for UEC / CD DDO for UEC / CD	Monitoring Paused

	community	• A full review of the Discharge Lounge to increase capacity to support decompression of ED in a morning has been completed • Implementation of Criteria to Reside, Red to Green, and MDT Long Stay Wednesday walk-arounds aim to reduce LoS and increase discharges • Mutual aid is also in aid at Place and across SYB • Partnership winter plans to identify additional community bedded capacity and increased care homes and domiciliary care capacity	DDN for Medicine DDNO (new post) Chief Operating Officer (COO) COO	Delivery Delivery Monitoring Delivery
Operational Grip and Escalation	• Lack of awareness of new clinical national standards for emergency care • Lack of awareness of Trust position for ED and on call teams • Delays in escalation process within and outside of ED • Process delay issues impacting on handover efficiency	• Trust wide roadshow to share new clinical standards for emergency care • Development of new Inter-professional standards for emergency care • Development of Clinical Harm Review for patients waiting longer than 60 minutes for ambulance handover • Fully revised Emergency Care Escalation Protocol incorporating an Ambulance Handover Escalation Protocol • Fully revised Trust OPEL policy • Development of guidance and training for all on call managers • Time In Motion Study to be support by QI Team to identify any delay in handover processes	DDO for UEC DDO for UEC DDO for UEC DDO for UEC COO COO DDO for UEC	Monitoring Monitoring Closed Delivery Delivery Delivery Monitoring
Improving accuracy of handover data between YAS / DBTH	• Delays in entering handover pin to confirm handover has been completed due to competing other tasks • Previous 'double pinning' system	• Daily validation of ambulance handovers to re-commence with a monthly report to highlight any difference in handover time recorded • 'Double pinning' system to be re-commenced to ensure crews pin out prior to leaving the	DDO for UEC YAS/DDO	Monitoring Monitoring

	stopped pre-Covid as automatic system was being trialed. This was never implemented due to Covid-19 pandemic • Internal daily validation was stood down as a result of the above	department and DBTH staff also pin out to confirm handover time. Supporting Protocol to be developed • YAS to share data and investigate why the time stamp is no longer visible on the Electronic Patient Record Form (EPRF) • Monthly meetings to be held with YAS/DBTH operational teams • NHS England and Emergency Care Intensive Support Team to undertake site visits across South Yorkshire and Bassetlaw to ensure consistent approach	DDO for UEC YAS DDO for UEC	Monitoring Monitoring Closed

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	May 2022	**Agenda Reference:**	E7		
Report Title:	**Recovery, Innovation & Transformation Update**				
Sponsor:	Jon Sargeant, Director of Recovery, Innovation & Transformation (RIT)				
Author:	Jon Sargeant, Director of Recovery, Innovation & Transformation (RIT)				
Appendices:	None				
Executive Summary					
Purpose of report:	To provide an update on the changes underway in the Recovery, Innovation and Transformation Directorate and two key projects currently being undertaken.				
Summary of key issues:	This report lays out where we are with setting up the new directorate including progress with bringing the teams together and working towards a way forward with the leaders to reconfiguring the teams within the new directorate. The Trust governance regime is outlined and updates on the Mexborough and Clinical Strategy work are also provided. The report is broken into the following sections: • Recovery, Innovation and Transformation Directorate • Trust Governance Structure • Performance and Project Management • Mexborough Elective Orthopaedic Centre • Service Line Review/Clinical Strategy.				
Recommendation:	The Board are asked to note the content of the 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 our vision*	*Team DBTH feels valued and 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:	All
Corporate risk register:	N/A
Regulation:	None
Legal:	The essential standards of quality and safety consist of 28 regulations (and associated outcomes) that are set out in two pieces of legislation: the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.
Resources:	None

RIT Update Author: **Jon Sargeant** Report Date: **May 2022**

Assurance Route			
Previously considered by:	N/A		
Date:	**N/a**	**Decision:**	None
Next Steps:	N/A		
Previously circulated reports to supplement this paper:	Standard update for Board.		

RIT Update Author: **Jon Sargeant** Report Date: **May 2022**

1. INTRODUCTION

This report outlines progress in the work of the Directorate of Recovery, Innovation and Transformation (DRIT).

2. DIRECTORATE UPDATE

The Directorate is now taking shape, with facilitated team events planned to integrate the services in the new directorate. These events are aimed at bringing the teams together to work though how they will merge and deliver synergies to support the Trust in the recovery and restoration of services on the route to becoming an outstanding Trust.

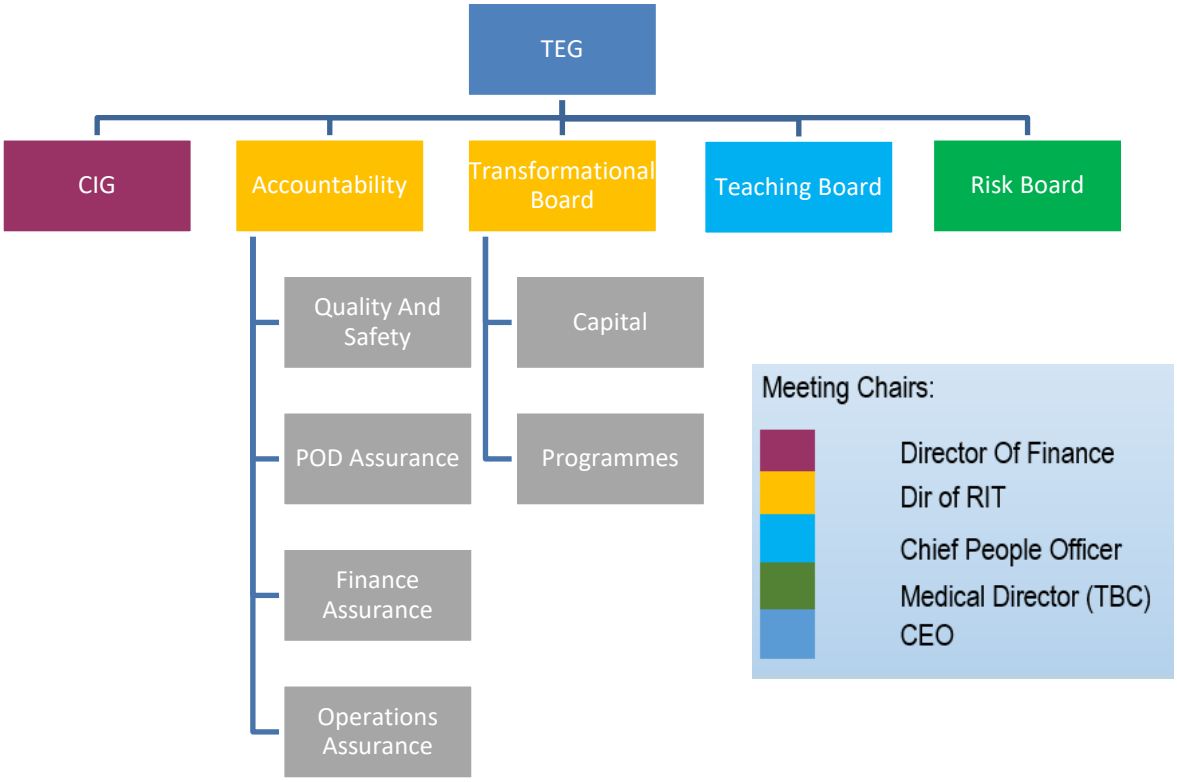
Kirsty Edmondson-Jones (Director of Estates and Facilities) is being seconded as my deputy to support me in this process. The final structure will be agreed though the facilitated work. Kirsty is transitioning into this role and we are both meeting with the Director of Finance to formalise handover in the next week. I will report back to the Board on our final structure once the development work is completed over the next month. However, the work of the directorate will cover the following areas:

- Innovation and continuous improvement
- Strategy and Partnerships/Commissioning
- Performance, Planning and PMO
- Capital Schemes
- IT and Information.

Currently the departments that have come together have significant overlap in duties and it is the aim of the team events to work through these so that these issues are clarified, and roles and responsibilities are made clearer, to avoid duplication and free up resource.

3. GOVERNANCE STRUCTURES

Following a discussion at the last TEG meeting the proposed meeting structure, which has previously been discussed, has been agreed and is currently being implemented, as outlined below:



The terms of reference for each of these meeting are in the process of being prepared. It is proposed that the scheduling of meetings is reviewed to ensure that clinical staff can be in attendance without clashes to their clinical timetables. I am in discussion with the Medical Director about this with the intention that we review the 'traditional' slots for these meetings to ensure that we get full regular attendance. This process will take a little time, so we will book meetings as per the 'traditional slots' to get the process started whilst this review takes place.

4. PERFORMANCE AND PROJECT MANAGEMENT

Laura Fawcett-Hall has taken up the post of Head of Performance, replacing Julie Thornton, who has taken up a role as a Locality Director with RDASH.

Work is underway to implement a standard approach to project management, including a standardised project management software tool called Monday.com. The detailed approach is being fully drafted and shared with executive colleagues, but will involve:

- A prioritisation matrix for approving projects through the Transformation board or Senior Management Team depending on project size/importance.
- Clear project gateways
- A clear change control process for projects
- Standardised project paperwork and reporting standards
- Clear reporting through Transformation Board to TEG and the Board.

All projects e.g., operational improvements, capital projects, digital projects etc. will use the same processes and all projects will be monitored through Monday.com. We have trialled Monday.com in the urgent and emergency care improvement programme where it has proved to be a useful tool and integrates well with the Trust's data warehouse. Paul Mapley, Director of Efficiency, is currently working with colleagues in the departments listed above to finalise this procedure and agree the implementation plan. Once completed this process will be taken through the Finance and Performance Committee. My target is to have this being rolled out from June so we are using it from second quarter of the new financial year.

5. MEXBOROUGH ELECTIVE ORTHOPAEDIC CENTRE

The Mexborough Elective Orthopaedic Centre (MEOC) is a joint bid for elective recovery funding by Barnsley Hospital FT, The Rotherham NHS FT and DBTH to provide dedicated elective facilities for routine Orthopaedic operations (including hips and knees). The proposal is that this facility will include 2 laminar flow theatres and have 24 beds. The unit would be staffed by existing staff from each trust, with capacity for other specialities being freed up at each respective hospital when the orthopaedic work moves to Mexborough.

The Scheme involves a £15m investment in the Montague site, potentially linked to the Rehab unit and sets Montague Hospital up to be a key asset for the South Yorkshire ICB. It is the intention to use a modular build as the Trust did after the Maternity fire in 2021, and work is well underway with the design.

There is a project group set up meeting weekly with representatives from each Trust, chaired by DBTH and the work is currently going well in true partnership.

Clinical involvement has been good from our Orthopaedic team and there is a joint meeting between teams from each organisation being planned for the early summer.

Currently a draft Memorandum of Understanding (MoU) is being discussed by the project team, however the basic assumption is that each trust will be a partner in the unit, with no trust being disadvantaged by entering the partnership, although benefit and risks will be equally shared between partners on an equitable basis. This will all be laid out in the MoU.

The Project is on the agenda for the Finance and Performance Committee in May for a deep dive. The Business case will be completed by the end of June with internal approvals during July. The case can then be submitted to NHSE/I with expected approval in November 2022. On this basis the unit would become operational in July 2023.

6. SERVICE LINE REVIEW/CLINICAL STRATEGY

The detailed work on the service line review continues, with 33 specialty meetings now completed and 'bottom-up' pack being produced. These meetings are then being followed up with further work to outline a service clinical model and strategy of which 19 are now complete. All initial specialty reviews are scheduled to be completed by the end of May and subject to all meetings taking place the follow up clinical model work will be completed by July.

In parallel with the bottom-up work, the project team has started a top- down review of services. Sessions with the Executive team and TEG on service configuration by site to deliver sustainability and best patient outcomes were run in the last month. This work and the bottom-up work will be brought together to present to the Trust Board for further development later in the year.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	24 May 2022	**Agenda Reference:**	F1		
Report Title:	**Corporate Objectives 2021/2022**				
Sponsor:	Richard Parker OBE, Chief Executive Officer				
Author:	Jon Sargeant, Interim Director of Recovery, Innovation & Transformation				
Appendices:	Appendix 1				
Report Summary					
Purpose of report:	This report updates the Board of Directors on delivery of the 2021/ 2022 True North and Breakthrough objectives. Progress reflects the challenges of the on-going pandemic and demands of the elective recovery programme.				
Summary of key issues/positive highlights:	• The updates identify that despite the ongoing operational pressures and the additional demands of the recovery from the impact of the pandemic the commitment to the delivery of the Trust Values, Strategic Objectives and True North remain and that progress towards the delivery of the objectives is being maintained				
Recommendation:	The Board of Directors is asked to note the contents of the updates. The objectives for the 2022/23 year will be presented to the Board of Directors at the July meeting after being discussed as sub-committees of the Board as agreed at the April Board meeting.				
Action Required:	Approval **X**	Information	Discussion **X**	Assurance **X**	Review

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

Implications	
Board assurance framework:	The Corporate objectives reflect the work needed to deliver the Board of Directors strategic direction and mitigate known and reasonably foreseeable risks.
Corporate risk register:	Delivery of the Corporate Objectives for 2021/2022 will support the reduction in known and reasonably foreseeable risks.
Regulation:	The Corporate Objectives for 2021/2022 identify actions which will be taken to maintain, ideally improve, the Trusts CQC Good rating at the next assessment by demonstrating compliance with the standards expected to be achieved for a Good rating in the Safe Domain and an Outstanding rating in the Caring Domain.

Legal:			The Corporate Objectives for 2021/2022 aim to maintain the Trusts progress.
Resources:			The resources required to deliver the Corporate Objectives for 2021/2022 are identified as part of the planning processes for 2021/2022.
Assurance Route			
Previously considered by:			Executive Team, Board of Directors
Date:		**Decision:**	To be presented to the Board of Directors
Next Steps:			Objectives will be reviewed at Board Sub Committees with overall progress reported to the Board of Directors on a quarterly
Previously circulated reports to supplement this paper:			True North and Breakthrough Objectives, Board of Directors Papers. Q3 Update – Board of Directors 22 February 2022

1. INTRODUCTION

This paper updates the Board of Directors (BoD) on the progress which has been made by the Executive Team towards the delivery of the Corporate Objectives. It is clear that the anticipated impact of the Covid pandemic on the Trusts patients and staff has materialised and the Trusts performance, and the Trusts ability to deliver the Strategic aims and objectives and the True North vision had been slower than originally anticipated.

Measures and actions to mitigate the risks and restore the Trust progress towards the 'True North' are being taken through the new Directorate; Recovery, Innovation and Transformation. The Directorate brings together the Trusts established expertise with the aim of concentrating dedicated time and resources on the key elements of recovery which are likely to have the greatest impact on the quality, safety, and sustainability of the Trust services within PLACE and the Integrated Care Board (ICB) :

- Strategy and Improvement
- Digital information
- Information and informatics
- Programme management; and
- Contracting and planning
- Management of Capital programme

This enables the Trusts Operational Teams to concentrate on the delivery of the Trusts operational and plans.

2. BACKGROUND

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

However, during 2021/ 2022 progress on the revitalisation of previous programmes of work and delivery have been impacted by the sustained pressures within the South Yorkshire and Bassetlaw system related to the ongoing Covid pandemic, and the significant challenges in recovering from the extended waits for diagnostic and elective services. In addition, the Trust has lost significant capacity because of the damage to the Women and Children's Hospital which has created additional demands.

The Directors remained focused on the delivery of the Breakthrough and Corporate Objectives for 2021/2022 and took additional steps to better support staff to recover previous performance levels and restore services and learn lessons from the innovation and transformation which has occurred through the pandemic.

3. CORPORATE OBJECTIVES

The contributions each Director has made at the end of quarter 4 towards the delivery of the Breakthrough Objectives in 2021/ 2022 are identified in appendix 1. Board sub-committees undertake assurance on the delivery of the specific elements of the objectives and on the delivery of the Trusts performance.

4. RECOMMENDATIONS

The BoD is asked to discuss the contents of this paper, noting the position against objectives at the end of the financial year. Objectives for the new financial year will be taken through Board sub-committees and brought back to the July's Trust Board , as agreed in April.

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

DIRECTOR	OBJECTVIES IN SUPPORT OF THE DELIVERY OF THE TRUSTS TRUE NORTH AND BREAKTHORUGH OBJECTIVES	EXPECTED COMPLETION DATES AND BOD UPDATES	EXPECTED OUTCOMES	Q2 UPDATE - September 2021	Q3 UPDATE - February 2022	Q4 UPDATE - April 2022
Chief Nurse/ Deputy Chief Executive	Working with the Executive Medical Director and Director of Strategy and Improvement develop a 'Quality Framework' define the characteristics and evidence that will define and support the Trust to be 'Outstanding in all that we do.'	Quarter 3	A quality Framework will be presented to the BOD for use across the Trust	Framework developed and shared at Trust Executive Group. Being trailed in Education and Research and Children and Families Division.	Framework updated, forms part of the Trusts new Quality Strategy.	Quality Strategy draft completed which is underpinned by the quality framework. Shared at the Quality and Effectiveness Committee.
	Demonstrate evidence of compliance with the standards expected to achieve Outstanding in the CQC Caring domain	Quarter 4	Compliance will be assessed by our internal CQC assessment	CQC key lines of Enquiry shared with divisions and the requirements for outstanding in care. Shared Governance being piloted in 3 areas to support.	CQC oversight group set up to review compliance with Key lines of enquiry against Caring	Shared Governance oversight group re-established. CQC compliance group re focussed to meet the requirements of outstanding for caring.
	With the Executive Medical Director ensure that the Trust is able to demonstrate evidence of compliance with the standards expected to achieve Good in the Safe CQC Safe domain	Quarter 4	Compliance will be assessed by our internal CQC assessment and evidenced in CQC Acute Insights	Key lines of Enquiry shared with divisions. Compliance Committee set up to review actions identified from mock inspections. Repository of evidence being developed	Mock inspections delayed due to Covid 19, planning now in place to recommence	CQC compliance group focussed on the key elements to increase safe to good.
	Deliver a reduction of 20% in falls causing medium-severe harm by a quality improvement framework, in the 10 high falls risk areas.	Quarter 4	The reduction in falls is demonstrated in the performance and assurance reports	Quality Improvement approach taken to the reduction of falls. Holistic Care team developed to pull together the key staff who are specialists in falls.	Learning from Falls, is shared across the Trust through the falls accreditation programme. The wards involved in the QI project have seen a reduction in falls.	Holistic care team have led the quality improvements across the Trust. Focused on falls prevention and learning from falls. Pilot areas have seen reduction in falls with harm.
	Reduce perinatal mortality rate through compliance with the National Perinatal Framework and Ockenden recommendations	Quarter 4	Delivery is evidenced in the Maternity Safety reports	Ockenden evidence updated at planned time. Action plans in place against the 7 key outcomes. Perinatal Framework reviewed at Board of Directors monthly. Need to be cognisant of the impact of Covid on maternity outcomes.	Feedback from the Ockenden report has been received. Action plans in place to address in ternal elements. A dedicated piece of work is being progressed to review safety culture within maternity.	Ockenden external visit conducted by the LMNS, with excellent feedback on the progress made at the Trust.
	Ensure the patient/carer voice is listened to by delivering increasing evidence of co-produced outcomes	Quarter 2, 3 and 4	Confirmed by evidence of delivery and direct feedback from patients	Feedback from patients and carers being used to identify learning.	Documented evidence of learning from complaints is now clear on Datix. Work on accessible standards is progressing with some work to support the deaf community following feedback from the public.	Feedback from complaints now shared amongst staff to ensure appropriate learning.
	Ensure safe and benchmarked staffing levels through the Trust	Quarter 2 and 4	Evidenced in the safe staffing and Human resource reports	Safer Nursing Care Tool reviewed in June. Safe care being introduced from December across the Trust.	Board Assurance on Safe Staffing reported to Board. SNCT being renewed in February to include ED. HCSW vacancies appointed to, waiting for start dates. International recruitment continues to be successful. Birthrate plus being repeated in March, international recruitment pilot for midwifery commenced.	Safer Nursing Care Tool, being undertaken across the Trust. Due to feedback in Quarter 1. Safecare roll out delayed due to covid. Dedicated staff now in place to ensure successful implementation.
	Continue to develop and implement the Research and Education Strategy as a vehicle for improvements in care, recruitment and retention and achieving a surplus for additional investments in patient care.	Quarter 4	Evidenced in the Research and Education updates	Teaching Hospital Board established developing the strategy for both education and research but enhancing the widening participation agenda. Professor of Nursing commenced in post, enhancing the non-medical research offer. 3 large scale nursing/midwifery research projects being led by the Trust.	Teaching Board working well, good engagement from partners. Successful Health Foundation bid to expand Health Academy. Non medical research trials increased.	Research strategy now completed and shared at the March Teaching Board. Continues to be great engagement from partners to ensure widening participation
	Celebrate, share and promote good practice	Quarter 4	Evidenced through local, regional and national recognition for the Trust, Teams and Individual members of staff.	Sharing How We Care continues to promote learning across the Trust.	A number of applications for awards are being prepared to highlight both individual and teams across the Trust.	A number of awards have been applied for. Sharing of good practice is undertaken through sharing how we care.
Director of Finance	Implement the 2021/ 2022 Performance and Assurance Framework	Quarter1	The 2021/ 2022 Performance and Assurance Framework is in place and informing successful delivery of objectives and identifying risks to delivery	Accountability meetings running from Q1, Framework updated and presented to F&P, with plans to review in last quarter. Framework, milestone plans and trajectory plans linked to board objectives and monitored by the Performance Team and PMO. Head of Performance post permanently recruited too. Information scorecards now automating some of the reporting in real time, with plans in place and resource identified to produce further scorecards.	Set up and working. Focus and delivery meetings now in place. Scorecards produced. IQPR currently now in dashboard format. Operational performance report updated	As q3, governance arrangements for 22/23 agreed and taken through executive and TEG
	Work with the Corporate and Divisional Directors to ensure the delivery of the Trust revenue plan	Quarter 4	Activity is delivered with the agreed budgets	The Trust has broken even in H1 and H2 plans are agreed. Forecast yearend position is a breakeven. Additional income negotiated with DCCG to cover H2 risks.	On track to deliver H2 plan. The forecast year end position is at least at break even income and expenditure position.	Year End Surplus Position (before technical adjustments for impariments etc) is £2.6m and therefore the Trust has delivered against its break even financial plan. Currently the year end accounts are under review by External Audit and therefore this position is draft until this is completed.
	Work with the Corporate and Divisional Directors to ensure the delivery of the Trusts Capital Plan	Quarter 4	The capital programme is delivered on time and within the allocated budgets	Currently Capital plan on budget, substantial work carried out with the ICS to ensure funding identified for the £12.4m additional costs from the Women's and Children's incident. All major projects except the Bassetlaw Emergency Village on plan and budget.	Currently capital is forecast to deliver on plan (c£35m). All funding secured for capital schemes and all major projects on plan and budget except the Emergency village.	Year end capital position was delivered on plan. With all funding secured for major projects.
	Complete the work on the New Hospital Strategic Outline Business Case	Quarter 2	The options for the future of the DRI site are set out within a strategic Outline Business Case	Work on the OBC is nearing completion, the case for change, the clinical mode and initial design work largely finished. There have been some slight delays and the work on the EOI diverted resource from the project, however the target of Jan 2022 sign off and submission to the NE&Y NHSE/I team should be met.	Strategic OBC sent to NHSEI agreed by board and submitted as per target.	No announce from National Hospital Programme at the time of writing but the objective was met in q2
	Ensure the delivery of the Digital Information Strategy	Quarter 1	The Digital Information Strategy is approved by the Board of Directors	Strategy shared with the board and approved. In addition significant work undertaken on the bid for the EPR programme with the Trust being successful in joining the aspirant cohort for central EPR funding.	Delivered	Delivered
	Complete implementation of Divisional Information Officers	Quarter 1	Divisional Information Officers are in place in each Division and a process from assuring the quality of information is established.	Divisional Information Partners are in place, and we are working with that system now. We do still have some vacancies that are being actively recruited to.	Complete. Currently recruiting to vacancy.	All posts now appointed to.
	Maximise the benefits and opportunities of the WOS	Quarter 4	The WOS is making an increasing contribution to the Trusts plans	The WOS continues to look at new business ventures, and has taken on the marketing and commercial aspects of the QMET on behalf of the Trust, has bid for work at various other NHS Trusts. The WOS is also working commercially with SMARTER. The WOS remains in surplus at the end of Q2 for 2021.	The WOS continues to look at new business ventures, and has taken on the marketing and commercial aspects of the QMET on behalf of the Trust, has bid for work at various other NHS Trusts. The WOS is also working commercially with SMARTER. The WOS remains in surplus at the end of Q2 for 2021.	The WoS has delivered a surplus for the year end and has met its objecctives interms of commercialising the Smart ER project and the QMET work
	Agree and ensure the delivery of local efficiency and effectiveness targets	Quarter 1	The Trusts 2021/ 2022 Efficiency and Effectiveness programme is achieved	Some schemes implemented and the Trust has broken even for H1, however the delivery of efficiency and effectiveness has not been a top priority in Q1 and Q2.	Some schemes implemented and the Trust is forecast to break even for the financial year. As a direct impact of the Covid pandemic any CIP requirement has been offset, and mitigated by additional non-recurrent income in year.	Some schemes were implemented in year and the Trust delivered its plan for the financial year. As a direct impact of the Covid pandemic any CIP requirement has been offset, and mitigated by additional non-recurrent income in year.
Executive Medical Director	Complete the recruitment and selection process for the Executive Medical Directors Team to support the delivery of the Trust objectives, performance and transformation	Quarter 1	Recruitment to the Executive Medical Directors structure will be completed in Quarter 1	Complete		
	With the Chief Nurse ensure that the Trust is able to demonstrate evidence of compliance with the standards expected to achieve Good in the Safe CQC Safe domain	Quarter 2	Compliance will be assessed by our internal CQC assessment and evidenced in CQC Acute Insights	Ongoing	Ongoing	Ongoing
	Ensure robust arrangements are in place within the Medical Examiner Teams to maintain, and improve HSMR/ SHMI	Quarter 2	Learning from Death Reviews and lessons learnt will be used to maintain and improve outcomes and reduce HSMR and SHMI	In place with 100% of all hospital deaths assessed. HSMR presented to the BOD each month and SHMI reporting will be reintroduced from November 2021		
	Demonstrate Improvements in the efficiency and effectiveness of clinical services	Quarter 4	Evidence of Improvement will be demonstrated in internal and external reports; GIRFT, Model Hospital, National Benchmarking	Ongoing	Ongoing	Ongoing - Medical Director engaged with specialties and involved in Service Strategy Meetings and GIRFT reviews to support services' improvement plans.
	Ensure safe and appropriate medical staffing and job plans are in place in all areas	Quarter 4	Actions from the Internal Audit Review of Job Planning are completed.	Internal Audit actions in train with many complete	Ongoing	Programme of activities continuing from the action plan, a number of actions now complete. Continuing internal monitoring through monthly project meetings and ongoing dialogue with 360 Assurance on progress.

DIRECTOR	OBJECTVIES IN SUPPORT OF THE DELIVERY OF THE TRUSTS TRUE NORTH AND BREAKTHORUGH OBJECTIVES	EXPECTED COMPLETION DATES AND BOD UPDATES	EXPECTED OUTCOMES	Q2 UPDATE - September 2021	Q3 UPDATE - February 2022	Q4 UPDATE - April 2022
	Review the Corporate, Divisional and Directorate Governance arrangements to inform the future structure and arrangements for the Trust Governance Team	Quarter 3	The current Governance Arrangements will be reviewed to ensure lessons learnt from the pandemic are incorporated into systems and process to strengthen the delivery of safe and sustainable care	ooo	Reviewed, consultation complete on proposed new structure and TOR. Discussed at CGC and QEC, and presented at Board of Directors	New governance structure approved - action complete. Awaiting completion of external review prior to implementation. Objective for 2022/23 to embed the revised governance framework and supporting arrangements
	Complete the implementation of the Medical Advisory Committee as the fist step in improving communication and engagement with senior medical staff	Quarter 1	Direct and Indirect information, including the staff survey results are demonstrating appropriate progress	Medical Advisory Committee in place and meetings held monthly during 2021 with good feedback.		
	Ensure that training and development programmes are in place in each Division and Directorate to support current medical leaders and encourage and prepare future leaders	Quarter 3	Direct and Indirect information, including the staff survey results are demonstrating appropriate progress	ooo	Actions relating to previous staff survey results are ongoing. 2021 staff survey results are expected in Q4.	Leading to Outstanding Programme developed in collaboration with POD to include relevant medical leadership elements. Medical colleagues will be encouraged to engage with the programme using allocated study leave allowance.
Director of People and Organisational Development	Improve performance across the full range of Human Resource services	Quarter 4	The 2021/ 2022 Performance and Assurance Framework is demonstrating improving performance	A sickness absence and casework system is currently being introduced which will facilitate an improved approach to the management of casework and sickness absence in support of line managers.	QI process review underway in relation to casework processes. One planned for the absence reporting processes which will use same electronic system. Go live of system delayed due to onset of Omicron. Review of recruitment processes planned with options around use of automation being included (part of RPA business case)	Qi Process focused on Casework management and process is underway, new HR Database being rolled out currently, aimed to be complete end June 22, improved use of technology, improved system and process management, improved MI data. Automation options under review.
	Ensure the delivery of a refreshed recruitment and retention strategy to drive towards zero vacancies in all areas.	Quarter 2	The 2021/ 2022 Performance and Assurance Framework is demonstrating improving performance	An international recruitment campaign is currently underway in respect of adult nursing with discussions taking place with regard to midwifery and medical imaging.	50 nurses have joined the Trust from overseas. Overseas recruitment underway in relation to midwifery. A further bid has been accepted for a further cohort of RGNs in 2022/23. A recruitment campaign is in train in respect of HCAs. Draft workforce plan considered by Executive Team and Workforce Planning committee. Due to commence NHSI stay and thrive programme in relation to overseas nurses (slight delay due to recent covid pressures)	Significant recruitment activity undertaken in Q4 in relation to HCW recruitment, successful appointments over 60 HCW, new starters either in place or going through the on boarding process currently. Increase in international recruitment for Midwives, paediatric nurses, radiographers. Workforce planning process undertaken in conjunction with annual business planning process. Implementation of new workforce planning tool in conjunction with KMPG underway.
	Ensure the successful Transfer of Payroll and Pension Service	Quarter 3	Direct and Indirect information and feedback is demonstrating successful delivery and staff satisfaction	Our payroll and pension service transferred to Victoria Pay Services at Sheffield Teaching Hospitals on 1 June following a tender exercise. Staff appear to be experiencing an improved service. A survey will be undertaken during Q3.	Survey moved to Q4 with operational pressures.	Payroll survey completed and results analysed. Analysis due for submission at July People Committee. Results on whole positive and indicate more positive staff experience and attitudes towards new payroll provider
	Undertake a skills gap analysis to inform the development and implementation of an enhanced training and development programme to support current and future leaders	Quarter 2	Direct and Indirect information and feedback is demonstrating successful delivery and staff satisfaction	A development programme has been crafted for divisional leadership teams which will run in the new year following the recruitment to the Clinical Director posts.	Leading to Outstanding and Senior Doctors programmes have been shared across DBTH and bookings being taken. Timing planned to align with CD recruitment. Delivery continues for leadership development programmes with the Develop, Belong and Thrive programme . Soundbites are on offer on a range of topics with good uptake. Leadership development prospectus for 22/23 being finalised.	Leading To Outstanding Programme and suite of leadership training offers across the Trust published. Concerns over lack of confirmed bookings for the courses, P&OD linking with Medical Directors Office with regard to approaches to increase bookings. Discussed with Chair and suggest Leading To Outstanding Programme is run on a Board Development Session. Further discussions taking place in relation to mandating training ensuring role specific analysis undertaken
	Maximise the opportunities for learning from 'Speaking Up'	Quarter 2	Direct and Indirect information and feedback is demonstrating successful delivery and staff satisfaction	Feedback from the staff survey indicates that staff have confidence to be able to Speak Up. Feedback from those who raised concerns within ED indicate that the OD programme of work is being seen as successful.	Continued positive feedback from ED colleagues. Awaiting feedback from 2021 annual staff survey. FTSU forum reporting regularly to the People committee. Expanded FTSU champions in place. Soundbites around FTSU included in the Hive during FTSU month.	Freedom to Speak Up Annual Report complete and presented to May People Committee, due to go to May Board, reflects work undertaken in ED. Further meeting scheduled with ED Management Team to review all work undertaken to date, review next steps and associated actions
	Completion of RACE action plan and objectives for 2021/ 2022	Quarter 1 and Quarter 4	Action plan is presented to People Committee and the BOD and objectives are delivered	The Trust was awarded the quality mark for the RACE equality code. Updates against the action plan have been discussed at both the People Committee and the Board of Directors.	Ongoing progress updates to People committee and Board of Directors meetings	Ongoing progress updates to People committee and Board of Directors meetings
	Develop and provide an enhanced wellbeing offer to Team DBTH	Quarter 2	Direct and Indirect information and feedback is demonstrating successful delivery and staff satisfaction	Expansion of the counselling support provided by Vivup has included access to on site counselling support. A range of workshops are being made available via the ICS wellbeing hub. Regular feedback is provided to the People Committee.	Ongoing expansion of wellbeing programme - TLC service, complementary therapies available for all staff , Know Your numbers campaign started roll out. Business case for enhanced team and Garden room developed. Awaiting feedback	Excellent feedback in relation to the complimentary therapies and know your numbers. Introduced a screening service via OH Team based on feedback which is proving popular. Recognition of the Trusts H&W offer by the Doncaster Council. Shortlisted for further H&W award and nominated for National HPMA H&W Award
	Ensure that the recruitment to posts within the COO structure is completed and that staff within the Directorate have the skills and experience to be successful	Quarter 1	Recruitment to the vacant posts will be completed in Quarter 1	Recruitment completed to Deputy COO in November with vacant GM posts now recruited. Series of Away Days underway to support & develop the GM team. 121 development plans completed as part of annual appraisals.	GM posts now changed to Divisional Directors of Operations in line with comparable organisations. Ongoing team and individual development planned with support from P&OD	Posts substantively filled with ongoing investment in the team, both in terms of personal development tailored to the needs of the individual and team work through continuation of support from P&OD/away days.
	Ensure the delivery of the National, ICS and Local standards for Urgent and Emergency Care, Elective Care and cancer care, and diagnostics	Quarter 1, 2, 3 and 4	The 2021/ 2022 Performance and Assurance Framework is demonstrating delivery	Trust demonstrating recovery and now delivery on all H1 cancer standards. Elective position on % activity compared to 1920 delivered in first quarter. Under-performance in 2nd quarter due to increased C19 activity, in common with all Trusts. 52 week position improving, 50% reduction April 2021 to September 2021. Current focus on diagnostic recovery (largely Radiology) to recover outlier position. H2 plan being finalised, and divisions focusing on new standards; OP transformation, cancer and elective recovery. New Urgent and Emergency Care Standards implemented in shadow form. Full roadshow underway in November to ensure full understanding and mobilisation across all services. Focus in Q3 on ambulance waits in particular.	H2 plans completed although delivery compromised by Omicron variant with av. 9% staff sickness. Reduced elective programme continued throughout. 52 week position maintained	Planning for 22/23 now complete. On target to deliver as planned. Sickness 9% at end of Q4 due to high Covid numers. New emergency standard monitoring in pace. Focus on EUC recovery. 52 week position held and maintained. 104 weeks plan was for zero breaches at year end and this was primarily achieved, apart from three patients (two of whom elected to delay their treatment until April (P6's) and one patient who was unable to proceed with surgery in March due to COVID and who then had to wait 7 weeks post-COVID to achieve the best outcome from surgery. COVID and flow continued to impact on elective recovery plans, with staff sickness and annual leave planned. The number of working days in April is reduced due to the Easter break. Supplies were also a problem with procurement unable to secure delivery of a number of key items, notably phaco packs to support the delivery of cataract surgery, resulting in the cancellation of 26 procedures in one week alone. The regional procurement cell are aware and this is one of a number of national issues/shortages. Alternative products continue to be sourced where possible.
	Ensure wherever possible that recovery and restoration plans reduce inequality	Quarter 1, 2, 3 and 4	The 2021/ 2022 Performance and Assurance Framework is demonstrating delivery	Trust working with place partners to develop plans to address inequality and ensure patients from more deprived communities are not disproportionately affected by current waiting times. Specific initiatives by CCG including social prescribing and other work to support patients to receive the right services.	Trust working with place partners to develop plans to address inequality and ensure patients from more deprived communities are not disproportionately affected by current waiting times. Specific initiatives by CCG including social prescribing and other work to support patients to receive the right services.	Data at place level is starting to become more readily available which supports and aids decision making. Discussions at an ICB also working through the opportunities to address inequalities. Senior Nurse now leading on this from an operational perspective in a shared role with RDASH. This dedicated support is key to developing services for patients.

DIRECTOR	OBJECTVIES IN SUPPORT OF THE DELIVERY OF THE TRUSTS TRUE NORTH AND BREAKTHORUGH OBJECTIVES	EXPECTED COMPLETION DATES AND BOD UPDATES	EXPECTED OUTCOMES	Q2 UPDATE - September 2021	Q3 UPDATE - February 2022	Q4 UPDATE - April 2022
Chief Operating Officer	Ensure arrangement are in place to maintain and improve patient flow to maximise efficiency and effectiveness	Quarter 1, 2, 3 and 4	The 2021/ 2022 Performance and Assurance Framework is demonstrating delivery	Plans developed to improve flow through series of winter workshops. Winter plan includes plans such as reconfiguration of medicine (acute physicians to front door), implementation of SAFER and Red to Green, focus on "getting the basics right" in site. Additional investment as part of winter plan to support delivery of these improvements. Dashboards being finalised Nov 21 to improve transparency of metrics. Partnership plans to improve flow and specific pathways as part of winter plan, alongside improved sharing of information & metrics. Urgent and Emergency Care Standards launched in shadow form and widescale work to engage and mobilise all teams (October 21 onwards). "Why Not Home, Why Not Today" week running 8/11 onwards.	COVID & Winter Plan in place. Red 2 Green role out in place and being supported by RWH. Further actions being taken: • Ambulance Handovers o Efficiency study in run first week Feb. o Review of study in Feb. and actions put in place as PDSA cycles o Daily focus on Ambulance handovers and flow into ED • Triage o Clinical Lead reviewing triage model through Feb. o Thoughts are going towards RAT (Rapid Assessment and Treat) at the front door. o Approach and time frames to be agreed. • Huddles o Training in place for EPIC & NIC around ED huddles o Being rolled out and supported • ED Daily Assurance o Template circulated and being adapted for DBTH o ED Governance discussing and approving o Training being rolled out o Pilot (PDSA) next week • Clinical Site Review o Undertaking a full review of the Clinical Site Team Model (in partnership with Abi) o Benchmarking against peers and best practice o Draft Proposal end of Feb o Reviewing and aligning Flow and escalation policies to draft proposal ☑ One reparations to be returned per day (if level 3 or below) ☑ Focus on stepping down ITU patients daily ☑ Focus on plans and Divisional escalations for patients in department reaching 12 hours • Leadership	All winter plans now complete and review underway.
	Ensure that services deliver the required levels of transformation to allow access to enhanced funding	Quarter 2	The 2021/ 2022 Performance and Assurance Framework is demonstrating delivery	Transformation taken place in specific services to support recovery and delivery of H1 standards and partial achievement of Elective Incentive Fund & other funding sources. For example innovative 1 stop cancer pathways, (i.e. prostate), Same Day Emergency Care in Gynae (delivering significant, quantified reduction of patients requiring inpatient stay), cardio-respiratory drive through, virtual clinics (delivering c 27% of all current OP activity), new OP models focused on virtual review and diagnostic first pathway (i.e. gastro), focus on Patient Initiated Follow Up (4 specialties live), Advice and Guidance (highest delivery in ICS) and range of other supporting OP projects through Outstanding Outpatient work (i.e. e-prescribing, Intouch). Continued focus on transformation for H2 - i.e. further focus on OP transformation in Q3 as per required standards & pathway redesign to support elective recovery (i.e. Non Obstetric Ultrasound pathway redesign for shoulders, implementation of new Pre-Op Assessment Model).	Significant programme of elective support planned from Independent Sector in H2, delivery compromised by COVID across all POD's. Outstanding Outpatient programme continued to develop plans, extend PIFU, A&G etc.	Program of elective recovery will continue into 2022/23.
	Develop, agree and implement robust plans to manage winter pressures and enhanced IPC measures	Quarter 2 and 3	The 2021/ 2022 Performance and Assurance Framework is demonstrating delivery	DBTH internal winter plan agreed and funded (£2.5 m) October 2021. Partner actions identified, and being strengthened (November 2021). This will form the place wide winter plan for Bassetlaw and Doncaster. IPC social distancing measures all reviewed Oct/ Nov 2021 in light of new guidance and service implementing increased activity profiles. Yellow / Blue Pathways remain in place and refined on ongoing basis.	Winter & COVID plan in place. Daily monitoring of plan, IPC and staffing issues. Partners actions identified and implemented. Blue & Yellow pathways continue.	Winter and Covid plan compete, contiunous review of Covid plans in place.
	Complete the review of the Trusts clinical and organisational strategy	Quarter 3	The strategies are presented and adopted by the BOD	Service lines reviews are underway. An engagement exercise to inform the strategy has been undertaken reaching 860 patients and public and 1033 staff. Given changes to alignment of Bassetlaw within the ICS structure, the context has changed and it is likely that the strategy will be delivered later in March 2022 to ensure that any implications are understood.	ICS changes are delayed nationally until July however, Bassetlaw CCG has moved into Nottinghamshire. Implications are still being worked through although patient flows remain unchanged. Covid pressures have impacted the pace of the service line review however, this has now been mitigated with additional temporary resource and the programme of work has been reworked to conclude in May to inform the clinical strategy. Other aspects of development of the revised strategy are running in parallel and a completion date of end May is planned.	Service strategies expected completion in early June giving rich 'bottom-up' strategic insight. Engagment with the executive and TEG has begun to agree strategic framing to focus the service strategis and form the overall DBTH trust strategy.
	Drive transformation and improvement opportunities to make services more effective and efficient and where possible reducing the impact of inequality	Quarter 4	Evidence of Improvement will be demonstrated in internal and external reports; GIRFT, Model Hospital, National Benchmarking	Actions taken in line with planning guidance Action plan developed following the strategy engagement with short medium and long term actions Discussion with place partners about capacity and capability development to address health inequalities and business case in development	Health inequalities (HI) plan in development and Anchor Institution development well underway. Capacity and capability building to address HI continues with place HI post (hosted by DBTH) now recruited to and public health consultant appointment ready for advertisement. Data analysis has been undertaken in preparation for Board reporting on waiting list in line with H2 guidance. Board workshop on HI and anchor framework provided. Successful bid for national funding for expanding strengthening participation agenda Various QI supported improvements (11 completed and 13 ongoing) examples include pre-op team have reduced numbers of patients still to book and increased gap between pre-op and TCI date to 16+ days (not including urgent); better use of non-clinical roles to free up clinical time in emergency surgical pathway	Capacity and capability building to address HI continues with place HI post (hosted by DBTH) now recruited and HI project manager now in post. Delays to the recruitment of the public health consultant have resulted in a delay until June with a likely start date in the autumn of 2022. There is a focus on understanding the waiting lists and backlogs, both from a clinical urgency perspective and with a health inequality lens. Various QI improvement projects as of April 2022 with 16 completed and delivering benefits and 36 ongoing. Examples include introduction of new telephone system in Audiology (introduced 22.11.21) over the period 09.08.21- 28.02.22 - Number of calls reduced by 34% from mean of 270 per day to 177 per day (includes battery line calls). - Number of unanswered calls reduced by 86% from mean 149 per day to 21 per day - No complaints received in January
	Complete the Service Line reporting work	Quarter 1, 2, 3 and 4	Progress will be presented to the BOD and the actions included in the clinical strategy	This is progressing but has been slowed by changes in staffing within the department. Clinical and operational engagement will be required to progress the pace with this now	Data packs developed for each speciality - Covid pressures have impacted the pace of the service line review as this requires clinical and operational time. Engagement underway with Medical Directors office and with support of communications & engagement team. S&I capacity pressures have been mitigated with additional temporary resource and the programme of work has been reprofiled to conclude in May to inform the clinical strategy.	Service strategy reviews are nearing completion with 28 of 35 specialties having had a development workshop and the remaing 7 to be completed in May. Service strategies to be completed in June for futher sharing with division and corporate colleagues.

DIRECTOR	OBJECTVIES IN SUPPORT OF THE DELIVERY OF THE TRUSTS TRUE NORTH AND BREAKTHORUGH OBJECTIVES	EXPECTED COMPLETION DATES AND BOD UPDATES	EXPECTED OUTCOMES	Q2 UPDATE - September 2021	Q3 UPDATE - February 2022	Q4 UPDATE - April 2022
Director of Strategy and Improvement	Support the delivery of a robust learning and development programme to maximise the capacity and capability for improvement	Quarter 3	Direct and Indirect information and feedback is demonstrating successful delivery and staff satisfaction	Training delivered to plan. Positive feedback from learners and examples of quality improvements fed back as part of level 2 training	Training numbers - financial year to date Leve 1 = 47 Level 2 = 24 (7 from Rotherham)- these are completed & certified we currently have another 2 cohorts being trained (not in these numbers), 11 ongoing for Q4 General = 247 (General awareness sessions for preceptorship/f1/HCA etc.)	Training numbers - financial year 21/22 Level 1 = 47 Level 2 = 25 (7 from Rotherham)- these are completed & certified we currently have another 2 cohorts being trained (not in these numbers) General = 291 (General awareness sessions for preceptorship/f1/HCA etc.) Training places on our level 2 Qi coaching course have been offered to partner organisations across Place and the ICS with Rotherham and barnsley taking 6 places. Engagement with Universities, whose students are placed at DBTH to deliver Qi training to pre reg nursing cohorts. Qi team members continue to be active participants in the national improvement networks as well.
	Support the Board of Directors to champion Quality Improvement as the vehicle for transformation	Quarter 1, 2, 3, and 4	Direct and Indirect information and feedback is demonstrating successful delivery and staff satisfaction	A Qi approach is applied through many of the "big schemes" e.g. Bassetlaw Emergency Village, Rapid Diagnostics Training and feedback as above QI being incorporated into the revised Quality Strategy with a 5 year plan co-developed with other teams	QI strategy revised and will form part of new quality strategy Training and coaching as above Teams continue to be supported with QI as requested.	As quarter 3
	Once funding has been approved ensure the deliver of the BDGH Emergency Village scheme	TBC	The Emergency Village Scheme is delivered to plan	Good progress towards outline business case, despite workforce challenges. Some delay possible depending on timelines for consultation on children's services model	Significant work undertaken on this. Public consultation on children's model underway aligned with NHSI assurance process. To ensure adequate capacity	Public consultation on the childrens model has completed. Design of front door model is being agreed between DBTH and Notts Healthcare with facilitated session from the QI team. The business case is on track for completition and submission to Board in June
	Engage at Place and ICS to identify transformation and development opportunities which enhance the services for our communities and staff	Quarter 1, 2, 3 and 4	Opportunities are evidenced in the clinical and organisational strategy	The team is supporting development work on Rapid Diagnostic Services and Community Diagnostic Hub development. A successful bit for phase 1 CDH has been agreed and work commenced. Work on Phase 2 is in development. S&I are supporting the COO and operational teams where requested for example Ophthalmology across the ICS. Work is also underway with the Provider Alliance and the DBTH pre-op team on optimisation and Rehabilitation opportunities for patients on the waiting list	Active involvement in development of integration at place (s). DBTH continues to play an active part in developing and implementing the ICS Community Diagnostic Centre (CDC) plans. The Montagu CDC (formerly called Community Diagnostic Hub) phase one is in place and case for phase two is being finalised in line with national and regional timelines - Board agenda item in Feb 22. Support to cancer team to develop successful bids for Cancer Alliance funding and project management support to develop rapid diagnostic pathways - expanding number of specialties covered. QI support to partner trusts in ICS to share methodology and coaching with positive outputs and we are developing a QI academy to strengthen the education and evaluation offer - working closely with education and research colleagues	DBTH continues to play an active part in developing and implementing the ICS Community Diagnostic Centre (CDC) plans. The Montagu CDC phase 2 business case has been finalised and the national team have implemented a rapid assesment process with a turnaround time of 15 days for a decision. Continued engaement with RDASH in the development of joint working opportunities. Ongoing QI support to partner organisations in the ICS as detailed in row 49 above.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	24 May 2022	**Agenda Reference:**	**F2**
Report Title:	**South Yorkshire & Bassetlaw Pathology Partnership Agreement**		
Sponsor:	Richard Parker OBE, Chief Executive		
Author:	Richard Parker OBE, Chief Executive		
Appendices:	SYB Pathology Partnership Agreement		
Report Summary			
Purpose of report:	In April 2018 the Trusts across South Yorkshire and Bassetlaw signed a Memorandum of Understanding to agree to develop a network pathology service and to work together to provide a single pathology service for South Yorkshire and Bassetlaw with the aim of improving sustainability and ensuring that services are as cost effective as possible while maintaining high quality patient care. The Trusts now wish to consolidate pathology services and related services across the South Yorkshire and Bassetlaw Integrated Care System to create a single pathology service. The South Yorkshire and Bassetlaw Clinical Strategy provides a framework and direction for the reconfigured pathology services that will ensure the local region has an innovative and sustainable pathology service, capable of adapting to the changing needs of clinicians and patients. An Outline Business Case that articulated the case for change with a proposed Target Operating Model for Pathology services has been approved by the Boards of the five Trusts within South Yorkshire and Bassetlaw. As a result, a Full Business Case is now in development. The services offered will support the national and local clinical priorities and support the needs of the local population. This will be effected through the establishment of a contractual joint venture, through which the pathology services will be delivered, which is in effect, a Partnership. The Partnership Agreement sets out the arrangements of the pathology network, how the Trusts have agreed to contribute resources, collaborate, work together to optimise benefits and efficiencies across the Trusts, and manage and apportion risk and liability on a proportionate and equitable basis. The Pathology Agreement is the legal underpinning of the agreed Partnership between the Trusts.		
Summary of key issues/positive highlights:	To provide the necessary legal framework to support the operation of a single pathology service.		

Recommendation:	It is recommended that the Board of Directors approve the Partnership Agreement for Trust sign off and in doing so support the decision for the formal establishment of the SYB Pathology Network allowing the network governance arrangements to be operationalised immediately (subject to Board approval being obtained at all the five Acute Trust members), whilst the development of the Full Business is completed.				
Action Require:	**Approval**	~~Information~~	~~Discussion~~	~~Assurance~~	~~Review~~

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

Implications	
Board assurance framework:	
Corporate risk register:	
Regulation:	
Legal:	
Resources:	

Assurance Route			
Previously considered by:	South Yorkshire & Bassetlaw Acute Federation on 4 April 2022 and Trust's Executive Team		
Date:		**Decision:**	
Next Steps:	If supported, by the Board and the other Provider Trust Boards within the South Yorkshire Integrated Care System, the partnership agreement will be operationalised.		
Previously circulated reports to supplement this paper:	South Yorkshire & Bassetlaw Pathology Transformation Outline Business Case – approved by Board of Directors on 21 September 2021		

Dated 2021

(1) Barnsley Hospital NHS Foundation Trust

(2) Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

(3) The Rotherham NHS Foundation Trust

(4) Sheffield Children's NHS Foundation Trust

(5) Sheffield Teaching Hospitals NHS Foundation Trust

SYB Pathology Partnership Agreement

Table of contents

Clause heading and number — Page number

THIS AGREEMENT IS MADE THE [ ] DAY OF 2022

BETWEEN:

1. Barnsley Hospital NHS Foundation Trust of Gawber Road, Barnsley, South Yorkshire, S75 2EP **("BHFT")**

2. Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust of Armthorpe Rd, Doncaster DN2 5LT **("DBTHFT")**

3. The Rotherham NHS Foundation Trust of Rotherham Hospital, Moorgate Road, Rotherham, S60 2UD **("TRTF")**

4. Sheffield Children's NHS Foundation Trust of Western Bank, Sheffield, South Yorkshire, S10 2TH **("SCFT")**; and

5. Sheffield Teaching Hospitals NHS Foundation Trust of Northern General Hospital, Herries Road, Sheffield, South Yorkshire, S5 7AT **("STHFT")**

together the **"Trusts"**

BACKGROUND

(A) Pathology is a fundamental diagnostic and prognostic service that supports every aspect of patient care pathology services across the South Yorkshire and Bassetlaw Integrated Care System ('**SYB**'). SYB provide a wide range of both routine and specialist services, and offer an extensively recognised portfolio of services and expertise, both nationally and internationally.

(B) The NHS Five Year Forward View and the NHS Long Term Plan, have both identified a need to improve efficiency and productivity across the NHS. In recent years there has also been national reports on pathology services, including Lord Carter's Independent Review of NHS Pathology Services in England (2008), and the Review of Unwarranted Variation in Operational Performance and Productivity in English Acute Trusts (2016). These reports advocate the consolidation of pathology services across England as a means of improving both service quality and cost effectiveness.

(C) Following these reports, National Health Service Improvement ('**NHSI'**) recommended the formation of pathology networks across England with pathology services delivered within each of the networks, on a 'hub and spoke' basis and estimated £200m of savings which could be achieved by implementation of this model. NHSI proposed that a 'North 6' network should be established corresponding to the footprint of SYB. There is an expectation that all 29 networks are established and maturing during the 2024/25 financial year.

(D) In April 2018 the Trusts signed a Memorandum of Understanding to agree to develop a network pathology service and to work together to provide a single pathology service for SYB with the aim of improving sustainability and ensuring that services are as cost effective as possible while maintaining high quality patient care. An appropriate governance structure and expert reference groups were established to consider the model and other possible options for service delivery across SYB. A shared vision was agreed as well as guiding principles against which to evaluate reconfiguration options and a number of key enablers were identified which are critical dependencies for reconfiguration.

(E) A number of options were considered for the organisational form of the SYB network. In January 2020, after seeking legal advice, the Trust decided that STHFT will act as the Host Trust. This organisational form was perceived to be the most cost efficient model from a tax perspective, and would allow staff to remain within the NHS. The expert reference groups have considered the

options for service delivery and have recommended a target operating model with an associated workforce model.

(F) The Trusts now wish to consolidate pathology services and related services across the South Yorkshire and Bassetlaw Integrated Care System to create a single pathology service. The SYB Clinical Strategy provides a framework and direction for the reconfigured pathology services that will ensure the local region has an innovative and sustainable pathology service, capable of adapting to the changing needs of clinicians and patients. The services offered will support the national and local clinical priorities and support the needs of the local population. This will be effected through the establishment of a contractual joint venture, through which the pathology services will be delivered (known as the "**Partnership**").

(G) The Partnership will be hosted by the Partnership Host on behalf of the Trusts. The Trusts shall share control of the Partnership fairly.

(H) This Agreement sets out the Partnership arrangements of the pathology network, how the Trusts have agreed to contribute resources, collaborate, work together to optimise benefits and efficiencies across the Trusts, and manage and apportion risk and liability on a proportionate and equitable basis. This Pathology Agreement is the legal underpinning of the agreed Partnership between the Trusts.

(I) As at the date of this Agreement, the Trusts are preparing to participate in a collaborative Procurement Processes for pathology services and related services, including a pan pathology Managed Service Contract (MSC), a single Laboratory Information Management System (LIMS), Digital Pathology, and logistics services to support the delivery of the Partnership.

(J) The Trusts vision for pathology is to improve lives and safeguard best clinical outcomes by delivering high-quality, innovative laboratory medicine solutions. The agreed guiding principles include making the best use of taxpayers money and to deliver efficiencies from economies of scale and scope.

(K) The Trusts acknowledge and confirm that the way in which the collaboration is to be structured, establishes a cooperation between the Trusts pursuant to Regulation 12(7) of the Public Contracts Regulations 2015 ("PCR") and the Trusts will adhere to the conditions of Regulation 12(7) PCR throughout the term of this Agreement.

IT IS HEREBY AGREED as follows:

1. **DEFINITIONS**

1.1 In this Agreement, the words and expressions defined in Schedule 1 shall have the meanings attached thereto.

1.2 This Agreement shall be interpreted in accordance with the following provisions unless the context requires a different meaning:

1.2.1 unless otherwise specified, references to Clauses and Schedules are to the Clauses of and Schedules to this Agreement;

1.2.2 the Schedules to this Agreement are an integral part of this Agreement and any reference to this Agreement includes a reference to the Schedules; and

1.2.3 where the context requires, words importing the singular shall be construed as importing the plural and vice versa and words importing the masculine shall be construed as importing the feminine or the neuter or vice versa.

1.3 In relation to any conflict and/or inconsistency relating to the provisions of this Agreement, the following shall apply:

1.3.1 for any conflict and/or inconsistency between the Clauses and the Schedules to this Agreement, the Clauses shall take precedence;

1.3.2 for any conflict and/or inconsistency between the Schedules, the following order of precedence shall apply:

(a) this Agreement;

(b) Schedule 2 (Terms of Reference and Trust Delegations);

(c) Schedule 3 (Procurement Resources and Project Delivery Costs)

(d) Schedule 4 (Hosting Obligations and Hosting Standards); and

(e) the order in which all subsequent schedules appear.

2. STATUS AND PURPOSE OF THIS AGREEMENT

2.1 This Agreement sets out the Trusts' intentions to work together during the Term.

2.2 The Trusts acknowledge that this Agreement is between NHS Foundation Trusts and is intended to be legally binding.

2.3 The Trusts confirm to each other that they have and will continue to have all relevant and necessary authority and permissions to participate in this Agreement and any associated documentation in due course.

2.4 The Trusts acknowledge and agree that, as at the date of this Agreement, each Trust has obtained approval in accordance with its internal governance arrangements to enter into this Agreement.

3. TERM

3.1 This Agreement will commence on the Commencement Date and shall continue for the Initial Term unless terminated earlier in accordance with this Agreement.

3.2 On the expiry of the Initial Term this Agreement will expire automatically without notice unless, no later than 12 months before the end of the Initial Term, the Trusts agree in writing that the term of this Agreement will be extended for a further term to be agreed between them (the "**Extended Term**").

4. PARTNERSHIP ARRANGEMENTS

4.1 The Trusts shall work together to deliver:

4.1.1 the Target Operating Model;

4.1.2 each Procurement Process; and

4.1.3 the Pathology Services.

4.2 The Trusts have established the SYB Pathology Partnership Board with representation from each Trust which, subject to Clause 8 and Schedule 2, shall be responsible for the:

4.2.1 oversight and control of the Partnership, including the Project, the Pathology Services, the Partnership Business and this Agreement;

4.2.2 making decisions relating to the Partnership, including but not limited to decisions regarding SYB Pathology Partnership Board Reserved Matters;

4.2.3 appointment of members to and oversight of the SYB Pathology Network Operational Management Team; and

4.2.4 reporting to the Acute Federation Collaborative at a frequency which is to be agreed by the Trusts.

4.3 Each Trust shall provide to the Partnership Host a complete list of Transferring Employees and all information set out in Schedule 8 within the timeframes specified and in any event before the relevant contract Commencement Date.

4.4 During the first six (6) months following the Commencement Date, the Trusts shall develop an agreed list and content of the Partnership Policies in accordance with Clause 8.7.

4.5 The Trusts agree that:

4.5.1 the Transferring Assets and Equipment will transfer to the Partnership Host in accordance with Part 1 of Schedule 7;

4.5.2 the Retained Assets and Equipment will be retained by the Trusts and made available to the Partnership Host in accordance with Part 2 of Schedule 7;

4.5.3 the Transferring Employees will transfer from the Trusts to the Partnership Host in accordance with Schedule 8;

5. THE PARTNERSHIP HOST

5.1 The Trusts agree that STHFT shall be the host of the Partnership (**"Partnership Host"**).

5.2 Subject to Clause 5.3, the Partnership Host shall carry out the Hosting Obligations in accordance with the Hosting Standards.

5.3 Notwithstanding Clause 5.2, the Partnership Host shall not be obliged to carry out or perform any act (or omission) that it reasonably considers:

5.3.1 would conflict with legislation, regulations, the Partnership Host's constitutional documents, the standing orders and standing financial instructions governing the Partnership Host from time to time; or

5.3.2 would put the Partnership Host's business or assets or reputation at risk.

5.4 The costs incurred in fulfilling the Hosting Obligations shall be:

5.4.1 calculated; and

5.4.2 paid;

in accordance with Schedule 4 and any deviation therefrom is a SYB Pathology Partnership Board Reserved Matter and shall require approval by the SYB Pathology Partnership Board.

5.5 STHFT shall remain the Partnership Host until the expiry or early termination of this Agreement unless or until STHFT is unable or unwilling to comply with the requirements or recommendations of a regulatory body in relation to the performance of its obligations as Partnership Host.

5.6 Where STHFT can no longer fulfil its obligations as the Partnership Host, in accordance with Clause 5.5, the remaining Trusts shall agree a replacement Partnership Host which shall provide the Hosting Obligations in accordance with the Hosting Standards from the leaving date of STHFT until this Agreement is terminated in accordance with Clause 3.

6. PROCUREMENT PROCESS

6.1 Each Trust commits to funding its share of the Project Delivery Costs, and providing the Procurement Resources required to successfully deliver each Procurement Process in accordance with Schedule 3.

6.2 The Partnership Host shall manage each Procurement Process on behalf of the Trusts. Each other Trust shall provide such information and assistance to the Partnership Host as may be required by the Partnership Host in order to fulfil its obligations under this Clause 6.2, Clause 5 and Schedule 3. The Partnership Host shall bill the Project Delivery Costs based on actual costs incurred and shall issue invoices to the Trusts on a quarterly basis accompanied by a reconciliation of current Project Delivery Costs. Any significant variance in actual Project Delivery Costs against estimated Project Delivery Costs, which could lead to cost pressures, will be notified to Trusts following discussion at SYB Pathology Partnership Board to assess mitigation options. Any deviation from the Project Delivery Costs is a SYB Pathology Partnership Board Reserved Matter and shall require approval by the SYB Pathology Partnership Board.

6.3 Any other costs relating to each Procurement Process shall be borne by each Trust as they are incurred unless otherwise expressly provided otherwise in this Agreement or otherwise agreed in advance in writing by all Trusts.

7. CONTRACT RESOURCE PROVISION AND CONTRACT COSTS

7.1 Each Trust commits to funding its share of the Contract Costs, and providing the Contract Resources required to ensure compliance with the Partnership Host's obligations under each Contract.

7.2 The Partnership Host shall bill the Contract Costs based on invoices received from the relevant Contract Provider and in accordance with the procedure for invoicing at Schedule 4.

7.3 Each Trust shall ensure that the Contract Costs are paid to the Partnership Host in a timely manner and in accordance with the procedure for payment as set out in Schedule 4.

7.4 Any other costs relating to each Contract shall be borne by each Trust as they are incurred unless otherwise expressly provided otherwise in this Agreement or otherwise agreed in advance in writing by all Trusts.

8. MANAGEMENT AND GOVERNANCE OF THE PARTNERSHIP

8.1 The SYB Pathology Partnership Board is responsible for oversight, control and decision making of the Partnership in accordance with Clause 4.2.

8.2 The SYB Pathology Network Operational Management Team shall report to the SYB Pathology Partnership Board in accordance with Schedule 2.

8.3 Each Trust shall fully support the SYB Pathology Partnership Board and the SYB Pathology Operational Management Team in their roles which are set out in Schedule 2 including:

8.3.1 by way of approval of the OBC/FBC and execution of this Agreement, confirmation that it authorises the SYB Pathology Partnership Board and the SYB Pathology Operational Management Team under their respective Terms of Reference;

8.3.2 participation in the decision making process via each Trust's Board in a timely (as referenced in Schedule 2, Governance Structure, of this Agreement) and appropriate manner in line with the SYB Pathology Partnership Board's, and the SYB Pathology Operational Management Team's requirements. Each Trust has agreed that at the Commencement Date the delegation at Part 3 of Schedule 2 shall be made to Chair/CEO on behalf of Trust Boards of the relevant organisation to enable parallel decision making;

8.3.3 establishment of its own Trust specific project team (as required) to manage the Trust's participation in each Procurement Process and the implementation and transition of the Trust's relevant existing contract during the final phase of the relevant Procurement Process and the commencement of the relevant Contract;

8.3.4 active participation in each Procurement Process when identified by the SYB Pathology Partnership Board or the SYB Pathology Network Operational Management Team as necessary;

8.3.5 adherence to principles of openness and transparency in relation to each Trust;

8.3.6 thorough reviews and checks of final draft documents prior to publication as may be notified as required by the Programme and Project Managers, the SYB Pathology Partnership Board, or the SYB Pathology Operational Management Team;

8.3.7 use of reasonable endeavours to co-operate with and provide assistance to each Trust as requested by the SYB Pathology Partnership Board or the SYB Pathology Operational Management Team;

8.3.8 confirmation of the provisions relating to decision making, quorum and dispute resolution as set out in Schedule 2 and Clause 23 respectively;

8.3.9 confirmation of its support (and any required participation) in respect of the Deliverables (as required by the SYB Pathology Partnership Board or the SYB Pathology Operational Management Team), including but not limited to:

(a) ensuring the SYB Pathology Partnership Board and the SYB Pathology Operational Management Team are fully aware of any relevant policies and procedures with which they must comply;

(b) co-operating and participating in the approval process required by the SYB Pathology Partnership Board or the SYB Pathology Operational Management Team in a timely and transparent manner;

8.3.10 the set up and confirmation of all internal governance procedures; and

8.3.11 ensuring that appointments to the SYB Pathology Partnership Board and the SYB Pathology Operational Management Team are made openly and transparently.

8.4 The Trusts agree that:

8.4.1 neither the SYB Pathology Partnership Board nor the SYB Pathology Operational Management Team shall have any delegated statutory powers or functions of the Trusts;

8.4.2 SYB Pathology Operational Management Team is not a committee of any Trust's board. The SYB Pathology Partnership Board members will be made up of Executive and/or Corporate Directors of the Trusts with delegations as set out at Clause 8.3.2;

8.4.3 nothing in this Agreement shall be construed as a delegation of its statutory powers by any of the Trusts to the SYB Pathology Partnership Board or the SYB Pathology Operational Management Team and nor shall any Trust be deemed to have delegated any powers to the SYB Pathology Partnership Board or the SYB Pathology Operational Management Team;

8.4.4 the operation and decision making of the SYB Pathology Partnership Board and the SYB Pathology Operational Management Team shall be governed by the principles of contract law and not public law;

8.4.5 nothing in this Agreement shall be construed as fettering the statutory powers of the Trusts;

8.4.6 acts and decisions in relation to the Partnership Business shall be taken or made (as the case may be) in the manner described in Schedule 2 and, when a decision has been made in accordance with Schedule 2, then such decision shall bind the Trusts under contract law;

8.4.7 if the Partnership Host fails to act in accordance with the decisions of the SYB Pathology Partnership Board or the SYB Pathology Operational Management Team (in circumstances where such decisions have been made in accordance with Schedule 2), then the Partnership Host shall be in breach of the contractual terms of this Agreement; and

~~8.4.8~~ actions of the Partnership will be taken by the Partnership Host acting on behalf of the Partnership.

8.5 In this Agreement, any reference to a decision or resolution of the SYB Pathology Partnership Board or the SYB Pathology Operational Management Team shall be taken in accordance with Schedule 2 and/or this Agreement (as the context so requires).

8.6 The Trusts acknowledge and agree that they shall comply with all Partnership Host Policies in place from time to time. A list and copies of the Partnership Host Policies that are in place at the Commencement Date have been provided by STHFT to the Trusts prior to the date of this Agreement.

8.7 During the first twelve (12) months following the Commencement Date, the Trusts will develop a list and the content of relevant operational policies that are specific to the Partnership (the "**Partnership Policies**"). The Partnership Policies:

8.7.1 are subject to ratification by the [Policy Ratification Group] (or any equivalent committee or group) of the Partnership Host;

8.7.2 may not contradict the Partnership Host Policies;

8.7.3 shall supplement but not replace the Partnership Host Policies; and

8.7.4 shall include but are not limited to innovation, quality improvement and education and research policies.

8.8 All changes to the Partnership Policies shall be implemented by the SYB Pathology Partnership Board and the SYB Pathology Operational Management Team.

8.9 The SYB Pathology Operational Management Team shall develop an annual Business Plan which shall be approved by the SYB Pathology Partnership Board, The Business Plan will be annexed to this Agreement at each annual review and shall include:

8.9.1 the proposed annual activity (and details of service/pathway developments and how they may be managed) for SYB Pathology;

8.9.2 a financial assessment of the Partnership, including financial modelling assumptions;

8.9.3 agreeing the pricing strategy and the apportionment of costs relating to the Partnership, including any changes to the Project Delivery Costs, the Contract Costs, and the Risk and Gain Share Principles;

8.9.4 financial monitoring and management accounting of the Partnership;

8.9.5 annual planning, schemes of delegation and accounting principles that will apply to the Partnership;

8.9.6 efficiency targets applicable to the Partnership;

8.9.7 quality and improvement targets applicable to the Partnership and any processes required to ensure compliance with these;

8.9.8 contract monitoring arrangements;

8.9.9 facilities and estates arrangements relating to the Partnership;

8.9.10 the purchase of new and/or transfer of existing assets and equipment for use by the Partnership and the management of the assets and equipment used by the Partnership;

8.9.11 arrangements and approvals for the bidding and delivery of additional pathology services to non-Trust organisations;

8.9.12 additional funding or investments (including capital investments) relating to the Partnership; and

8.9.13 requirements and arrangements for the delivery of corporate services relating to the Partnership.

8.10 The Business Plan for the first Financial Year has been adopted by the SYB Pathology Partnership Board.

8.11 Any variations to the Business Plan shall be approved and adopted in writing by the SYB Pathology Partnership Board before 1 April of the Financial Year to which it applies.

8.12 To the extent that a Business Plan is not approved and adopted in any Financial Year, the Business Plan for the preceding Financial Year shall be rolled forward, subject to updating the costs detailed in such Business Plan to reflect indexation by reference to national NHS guidance.

9. REVIEW AND AUDIT OF THE AGREEMENT

9.1 This Agreement shall be reviewed annually by the SYB Pathology Partnership Board.

9.2 The purpose of each review undertaken pursuant to Clause 9.1 is to ensure that the arrangements detailed within this Agreement are operating as envisaged and that each Trust can raise any issues through the SYB Pathology Partnership Board.

9.3 Any proposed changes to this Agreement must be agreed by all Partnership Trust Boards in writing.

10. RESPONSIBILITIES

10.1 Each Trust shall:

10.1.1 at all times, act in good faith towards the other Trusts;

10.1.2 act in a timely manner (including by paying any costs within [30 days] of production of a valid invoice issued by the Partnership Host);

10.1.3 generally do all things necessary, where reasonable and practical to do so, to give effect to the terms of this Agreement and each Contract;

10.1.4 take all reasonable steps to ensure, so far as it is able, that any meeting of the SYB Pathology Partnership Board has the necessary quorum throughout;

10.1.5 share information, experience, skills and work collaboratively with each other to identify solutions, eliminate duplication of effort, mitigate risk and reduce costs; and

10.1.6 adhere to statutory requirements and best practice.

11. LIABILITY

11.1 No Trust limits its liability for:

11.1.1 death or personal injury caused by its negligence;

11.1.2 fraudulent misrepresentation; or

11.1.3 any other liability which cannot be excluded or limited by Applicable Law.

11.2 In consideration of the Hosting Obligations of the Partnership Host the Trusts agree that:

11.2.1 save in the case of the Partnership Host's fraud or wilful default, irrespective of the subject matter (whether in breach of contract, under any indemnity in any agreement, contracts (including each Contract) or arrangements, tort, breach of statute or otherwise), all losses, liabilities, expenses, costs and claims, including liabilities incurred in the event of a termination of any Contract incurred by the Partnership Host in carrying out its role as Partnership Host ("**Liabilities**") should be borne by all Trusts divided by the Trusts in the proportions equivalent to the agreed shares determined by the SYB Pathology Partnership Board as at the date such Liabilities were incurred;

11.2.2 they hereby indemnify and keep indemnified the Partnership Host from and against all unavoidable Liabilities whatsoever resulting from or in connection with its role as Partnership Host, including for the avoidance of doubt, its liability under any Contract; and

11.2.3 each Trust shall, upon request to do so by the Partnership Host in writing, meet its share of any and all unavoidable Liabilities or reimburse the Partnership Host if it has already met such unavoidable Liabilities on demand.

11.3 Subject to Clauses 11.4 and 11.5, each Trust shall be severally liable for costs and/or losses incurred by one or more of the other Trusts to the extent that they arise or result from that Trust's deliberate or negligent acts or omissions and/or breach of this Agreement except to the extent that such costs and/or losses have been caused by any deliberate or negligent act or omission by, or on behalf of, or in accordance with the instructions of the SYB Pathology Partnership Board or the Trust claiming costs and/or losses.

11.4 No Trust shall be liable under Clause 11.3 to the extent that the costs are already covered in the Contract Costs.

11.5 No Trust shall be liable for any Indirect Losses.

11.6 It is agreed that each Trust has reviewed and agreed to the terms of each Contract prior to the Partnership Host entering into each Contract on behalf of the Trusts.

12. **TERMINATION**

12.1 This Agreement shall terminate:

12.1.1 where a material dispute cannot be resolved pursuant to Clause 23 and all Trusts agree to its termination;

12.1.2 upon the termination of each and every Contract; or

12.1.3 during the Term, if:

(a) a Trust fails to obtain or loses any regulatory consent, licence or approval necessary for its compliance to this Agreement and/or the continuation of this Agreement or incurs any other restriction, the effect of which might reasonably be considered to have a material adverse impact on the continuance of this Agreement;

(b) a Trust commits an illegal act which is relevant to or connected with this Agreement;

(c) a Trust causes significant reputational damage to any other Trust due to a material breach (whether or not capable of remedy); or

(d) a Trust is deemed to be incapable of carrying on its business by a relevant regulatory or professional body, or substantially the whole of its business, including in relation to its ability to award and/or enter into a Contract;

then the other Trusts shall be entitled to immediately terminate the relevant Trust's participation in the Agreement by joint written notice. Such decision by the Trusts shall be approved by the SYB Pathology Partnership Board.

12.2 Where this Agreement is terminated pursuant to Clause 12.1.1 or Clause 12.1.2 then the Trusts shall pay any outstanding proportion of the Project Delivery Costs and any other costs (not included in the foregoing) directly arising pursuant to Clause 12.1.1 or 12.1.2. Each Trust shall be responsible for any outstanding proportion of the Contract Costs owed by it at the time of the Termination as identified by the Partnership Host. Any Dispute between the Trusts regarding whether any such costs should be apportioned shall be referred to the Dispute Resolution Procedure (Clause 23) for resolution without prejudice to the Trusts' obligations to make payments of Contract Costs accrued to the date of termination or expiry as well as any termination payments payable under the relevant Contract on demand by the Partnership Host. Subject to the foregoing, each Trust shall bear their own costs where they fall due.

12.3 If notice is served pursuant to Clause 12.1.3, then the Trust that is in default or that wishes to withdraw or otherwise leaves the Agreement shall pay any outstanding proportion of the Project Delivery Costs and any other costs (not included in the foregoing) directly arising pursuant to Clause 12.1.3. The Trust that is in default or that wishes to withdraw or otherwise leaves the Agreement shall be responsible for any outstanding proportion of the Contract Costs owed by it at the time of the Termination as identified by the Partnership Host. Any Dispute between the Trusts regarding whether any such costs should be apportioned shall be referred to the Dispute Resolution Procedure (Clause 23) for resolution without prejudice to the Trusts' obligations to make payments of Contract Costs accrued to the date of termination or expiry as well as any termination payments payable under the relevant Contract on demand by the Partnership Host. Subject to the foregoing, each Trust shall bear their own costs where they fall due.

12.4 Where the Partnership Host is the Trust that is the subject of Clause 12.1.3 (a) to (e), then the outstanding proportion of the Contract Costs owed at the time of the Termination shall be calculated by the Partnership Host and approved by the SYB Pathology Partnership Board.

13. CONSEQUENCES OF TERMINATION

13.1 On termination of this Agreement, the following Clauses shall continue in force: Responsibilities (Clause 10), Clause 12 (Termination), this Clause 13 (Consequence of Termination), Clause 14 (Confidentiality), Clause 15 (Information Governance and Sharing of Data), Clause 16 (Data Protection), Clause 18 (Bribery and Corruption), Clause 23 (Dispute Resolution), Clause 25 (Status of Agreement), Schedule 1 (Definitions and Interpretation) and Schedule 3 (Procurement Resources and Project Delivery Costs).

13.2 Termination of this Agreement shall not affect any rights, remedies, obligations or liabilities of the Trusts that have accrued up to the date of termination.

13.3 Each Trust shall act reasonably and in good faith with regards to mitigating any adverse consequences on each other to the extent it is reasonable and within the control of each Trust to do so.

14. CONFIDENTIALITY

14.1 Each Trust:

14.1.1 shall treat all Confidential Information belonging to any other Trust or any Contract Provider as confidential and safeguard it accordingly; and

14.1.2 shall not disclose any Confidential Information belonging to any other Trust or any Contract Provider to any other person without the prior written consent of the other Trust or the relevant Contract Provider, except to such persons and to such extent as may be necessary for the performance of this Agreement or except where disclosure is otherwise expressly permitted by the provisions of this Agreement including Applicable Law.

14.2 Each Trust shall take all necessary precautions to ensure that all Confidential Information obtained from any other Trust under or in connection with this Agreement:

14.2.1 is given only to such of the employees and professional advisers or consultants engaged to advise it in connection with this Agreement and as is strictly necessary for the performance of this Agreement;

14.2.2 is, if it is Special Category Data or Personal Data, kept secure in accordance with the requirements of the Data Protection Legislation and only used in accordance with the disclosing Trust's instructions;

14.2.3 is treated as confidential and not disclosed (without written prior consent) or used by any employees or professional advisers or consultants otherwise than for the purposes of performing its obligations under this Agreement.

14.3 The provisions of Clauses 14.1 to 14.3 (inclusive) shall not apply to any Confidential Information received by one Trust from the other which:

14.3.1 is or becomes public knowledge (otherwise than by breach of this Clause 14 or through act of default on the part of the receiving Trust or the receiving Trust's agents or employees);

14.3.2 the receiving Trust lawfully obtained from a third party who:

(a) lawfully acquired it;

(b) did not derive it directly or indirectly from the disclosing Trust; and

(c) is under no obligation restricting its disclosure;

14.3.3 must be disclosed pursuant to a statutory, legal or parliamentary obligation placed upon the Trust making the disclosure, including any requirements for disclosure pursuant to Clause 15, or otherwise in accordance with a court order, or the recommendation, notice or decision of a competent authority.

14.4 On termination of this Agreement or the participation of a Trust, each Trust (or in the event that the Agreement is terminated in relation to one Trust, that Trust) shall:

14.4.1 Subject to the Public Records Act 1958 as amended, destroy or return to the other Trusts, as applicable, all documents and materials (and any copies) containing, reflecting, incorporating or based on the other Trusts' Confidential Information;

14.4.2 erase all Confidential Information belonging to the other Trusts from computer and communications systems and devices used by it, including such systems and data storage services provided by third parties (to the extent technically and legally practicable); and

14.4.3 certify in writing to the other Trusts that it has complied with the requirements of this Clause and any relevant provision of each Contract notified to it by the Partnership Host, provided that a recipient Trust may retain documents and materials containing, reflecting, incorporating or based on the Confidential Information of the other Trusts to the extent required by Applicable Laws or any applicable governmental or regulatory authority.

14.5 Except as expressly stated in this Agreement, no Trust makes any express or implied warranty or representation concerning its Confidential Information.

14.6 The Trusts agree that the provisions of this Clause 14 shall continue following expiry or termination for any reason of this Agreement for a period of three (3) years.

15. INFORMATION GOVERNANCE AND SHARING OF DATA

15.1 The Trusts acknowledge that they are subject to the requirements of the FOIA, the EIRs and the Data Protection Legislation and the Trusts shall assist and co-operate with each other to enable them to comply with these requirements.

15.2 The Trusts shall procure that any of their agreed sub-contractors shall:

15.2.1 transfer any Request for Information to the relevant Trust which is the subject of the Request for Information (the "**Disclosing Trust**") as the case may be as soon as practicable after receipt and in any event within two (2) Working Days of receiving that Request for Information;

15.2.2 provide the Disclosing Trust with a copy of all Information in its possession or power in the form that the Disclosing Trust requires as soon as practicable and in any event within five (5) Working Days (or such other period as the Disclosing Trust may specify) of the Disclosing Trust requesting that Information; and

15.2.3 provide all necessary assistance as reasonably requested by the Disclosing Trust to enable it to respond to a Request for Information within the time for compliance set out in the FOIA and regulation 5 of the EIRs.

15.3 Each Trust shall maintain an adequate records management system to enable it to retrieve the Information within the time limits prescribed in the FOIA and/or EIRs as applicable.

15.4 In considering whether Information is exempt from disclosure, the Disclosing Trust shall reasonably consider the nature of such Information and in particular whether any information has been identified by the other Trust as being commercially sensitive; however, for the avoidance of doubt, the Disclosing Trust shall be responsible for determining in its absolute discretion whether the Information should be disclosed in response to a Request for Information.

15.5 Each Trust acknowledges that the other Trusts may, acting in accordance with the Secretary of State for Constitutional Affairs' Code of Practice on the discharge of public authorities' functions under Part 1 of FOIA (issued under section 45 of the FOIA, November 2004), be obliged under the FOIA or the EIR to disclose Information:

15.5.1 without consulting with the other Trusts, or

15.5.2 following consultation with the other Trusts and having taken their views into account.

15.6 The Disclosing Trust agrees to keep the other Trusts fully informed of any FOIA requests received and processed in relation to this Agreement.

15.7 The Trusts shall ensure that all Information produced in the course of this Agreement or relating to this Agreement is retained for disclosure and each Trust shall permit the other to inspect such Information and documents and records containing such Information as that other Trusts may reasonably request from time to time.

15.8 It is agreed that SYB Pathology Partnership Board and any SYB Pathology Operational Management Team minutes and any documents related to each Procurement Process and each Contract may contain commercially sensitive information, and that the Disclosing Trust shall, where reasonably practicable and appropriate, seek the other Trusts' opinion on whether such information is exempt from disclosure in accordance with the provisions of the FOIA or the EIRs save that the decision on disclosure shall remain the sole responsibility of the Disclosing Trust.

15.9 Any costs charged for FOIA requests received and processed in relation to this Agreement will be split proportionately between the Trusts.

16. DATA PROTECTION

16.1 Each Trust shall comply with the Data Protection Legislation. Without prejudice to the foregoing, when a Trust (the "**Processing Trust**") is acting as a Processor by Processing Personal Data on behalf of another Trust (the "**Controlling Trust**") under or in connection with this Agreement, the Processing Trust shall:

16.1.1 only Process Agreement Data in accordance with the instructions of the Controlling Trust as set out in this Agreement or as provided in writing by the Controlling Trust to the Processing Trust from time to time;

16.1.2 not transfer data outside of the UK; and

16.1.3 assist and fully co-operate with the Controlling Trust as requested by the Controlling Trust from time to time to ensure the Controlling Trust's compliance with its obligations under the Data Protection Legislation which shall include, but not be limited to:

(a) completing and reviewing data protection impact assessments;

(b) implementing measures to mitigate against any data protection risks; and

(c) implementing such technical and organisational measures to enable the Controlling Trust to respond to requests from Data Subjects exercising their rights under the Data Protection Legislation.

16.2 The Processing Trust shall notify the Controlling Trust promptly (but in any event within 24 hours) should it:

16.2.1 be under a legal obligation to Process the Agreement Data, other than under the instructions of the Controlling Trust, in which case it shall inform the Controlling Trust of the legal obligation, unless the law prohibits such information being shared on important grounds of public interest; and

16.2.2 become aware that in following the instructions of the Controlling Trust, it shall be breaching Data Protection Legislation.

16.3 When Processing Agreement Data under this Agreement the Processing Trust shall take all necessary technical and organisational precautions and measures to preserve the confidentiality and integrity of Agreement Data and prevent any unlawful Processing or disclosure, taking into account the state of the art, the costs of implementation, the nature, scope, context and purposes of Processing as well as the risk of varying likelihood and severity for the rights and freedoms of the Data Subjects. These shall include, but not be limited to:

16.3.1 encrypting the Agreement Data stored on any mobile media or transmitted over public or wireless networks;

16.3.2 implementing and maintaining business continuity, disaster recovery and other relevant policies and procedures to ensure:

(a) the confidentiality, integrity, availability and resilience of Processing systems and services;

(b) the availability and access to Agreement Data in a timely manner in the event of a physical or technical incident;

(c) that all employees and contractors who are involved in the Processing of Agreement Data are trained in the policies and procedures set out in Clause 16.3 and are under contractual or statutory obligations of confidentiality concerning Agreement Data; and

16.3.3 pseudonymising the Agreement Data on request by the Controlling Trust,

(the "**Security Measures**").

16.4 The Security Measures shall be regularly tested by the Processing Trust to assess the effectiveness of the measures in ensuring the security, confidentiality, integrity, availability and resilience of the Agreement Data and shall maintain records of the testing.

16.5 The Processing Trust shall notify the Controlling Trust promptly (and in any event no later than 24 hours of discovery) if it becomes aware of any actual, suspected or threatened unauthorised exposure, access, disclosure, Processing, use, communication, deletion, revision, encryption, reproduction or transmission of any component of the Agreement Data, unauthorised access or attempted access or apparent attempted access (physical or otherwise) to the Agreement Data or any loss of, damage to, corruption of or destruction of such Personal Data ("**Security Incident**").

16.6 The notification in Clause 16.5 shall include:

16.6.1 the nature of the breach, including the categories and approximate number of Data Subjects and records concerned;

16.6.2 the contact at the Processing Trust who will liaise with the Controlling Trust concerning the breach; and

16.6.3 the remediation measures being taken to mitigate and contain the breach.

16.7 The Processing Trust shall not provide any third party with access to Agreement Data or sub-contract any of its obligations under this Agreement without the prior written approval of the Controlling Trust. Where approval has been granted by the Controlling Trust to the Processing Trust pursuant to this Clause 16.7, the Processing Trust shall:

16.7.1 undertake due diligence on the sub-contractor equivalent to the due diligence undertaken on the Processing Trust by the Controlling Trust under this Agreement;

16.7.2 put in place contractual data processing provisions equivalent to those in place between the Processing Trust and the Controlling Trust under this Agreement; and

16.7.3 remain liable for the Processing activities of such sub-contractor.

16.8 The Processing Trust shall provide all necessary information and assistance to the Controlling Trust in order for the Controlling Trust to verify the Processing Trust's compliance with its obligations under this Agreement and the Data Protection Legislation including:

16.8.1 allowing the Controlling Trust and its advisors to inspect and make copies of the records required under this Clause 16.8; and

16.8.2 allowing access to Processing Trust premises on reasonable notice and provide all reasonable assistance to the Controlling Trust to enable the Controlling Trust to audit the Processing Trust's compliance with the Security Measures.

16.9 Unless required by law, the Processing Trust shall, upon termination or earlier expiry of the Agreement for whatever reason, at the option of the Controlling Trust, either securely delete or return all Agreement Data to the Controlling Trust. If required by law to retain a copy, the Processing Trust shall inform the Controlling Trust what it is retaining and the legal reason why it needs to be retained.

16.10 The Trusts agree to use all reasonable efforts to assist each other to comply with the Data Protection Legislation. This includes (but is not limited to) the Trusts providing each other with reasonable assistance in complying with Data Subject access requests served on an Trust under the Data Protection Legislation and always consulting with each other prior to the disclosure by any Trust of any Personal Data in relation to such requests.

16.11 The provisions of this Clause shall apply during the continuance of the Agreement and indefinitely after its expiry or termination.

Agency under each Contract

16.12 The Trusts acknowledge that the Partnership Host will act as an agent on behalf of the Trusts under each Contract in respect of their obligations as Controllers. In recognition of this arrangement the Trusts agree to follow the provisions of Schedule 5.

16.13 In the event that the agency position is deemed unlawful by a competent authority, the Trusts will, without undue delay, and as soon as reasonably practicable, enter into data

processing agreements with the relevant Contract Provider [on the same terms as those set out in the relevant Contract.]

17. **FORCE MAJEURE**

17.1 If an Event of Force Majeure occurs, the affected Trust must:

17.1.1 take all reasonable steps to mitigate the consequences of that event;

17.1.2 resume performance of its obligations as soon as practicable; and

17.1.3 use all reasonable efforts to remedy its failure to perform its obligations under this Agreement.

17.2 The affected Trust must notify the other Trusts immediately when it becomes aware of the Event of Force Majeure, giving detail of the Event of Force Majeure and its likely impact on the delivery of its obligations in accordance with this Agreement.

17.3 If it has complied with its obligations under Clause 17.1 and Clause 17.2, the affected Trust will be relieved from liability under this Contract if and to the extent that it is not able to perform its obligations under this Agreement due to the Event of Force Majeure.

18. **BRIBERY AND CORRUPTION**

18.1 For the purposes of this Clause 18 the expressions "**adequate procedures**" and "**associated with**" shall be construed in accordance with the Bribery Laws.

18.2 Each Trust shall ensure that it does not, by any act or omission, place any other in breach of any Bribery Laws. Each Trust shall comply with all applicable Bribery Laws and ensure that they have in place adequate procedures to prevent any breach of this Clause 18 and ensure that no Trust shall make or receive any bribe (which term shall be construed in accordance with the Bribery Laws) or other improper payment or advantage, or allow any such to be made or received on its behalf, either in the United Kingdom or elsewhere, and will implement and maintain adequate procedures to ensure that such bribes or improper payments or advantages are not made or received directly or indirectly on its behalf.

18.3 Each Trust shall immediately notify the other Trusts, the SYB Pathology Partnership Board and the SYB Pathology Operational Management Team as soon as they become aware of a breach or possible breach of any of the requirements in this Clause 18.

19. **EQUALITY ACT**

19.1 Each Trust shall not unlawfully discriminate within the meaning and scope of the provisions of the Equality Act 2010 or any statutory modification or re-enactment of that Act or analogous legislation which has been, or may be, enacted from time to time relating to discrimination in employment or discrimination in the delivery of public services.

19.2 Each Trust shall take all reasonable steps to secure that all their servants, employees or agents and all sub-contractors employed in the performance of the sub-contract do not unlawfully discriminate as set out in Clause 19.1.

20. **SUB-CONTRACTING AND ASSIGNMENT**

20.1 No Trust shall be entitled to sub-contract or assign its rights or obligations under this Agreement without the consent of each of the other Trusts, such consent not to be unreasonably withheld or delayed unless such assignment, sub-contracting, novation or transfer is to a statutory successor in which case no consent shall be required.

21. **INTELLECTUAL PROPERTY RIGHTS**

21.1 All existing Intellectual Property of each Trust that is used by the Trusts in connection with this Agreement shall remain the exclusive property of the Trust that owned such Intellectual Property on the commencement of this Agreement. Each Trust hereby grants to each other a non-exclusive, royalty free licence to use any such existing Intellectual Property solely for the purposes of participating in the relevant Procurement Process.

21.2 Any Intellectual Property created by a Trust as part of or arising out of this Agreement shall belong to the Trust who created it (the "**Owning Trust**"). The Owning Trust hereby grants to the other Trusts a non-exclusive, royalty free licence to use any such new Intellectual Property for the purposes of collaborating in relation to this Agreement.

21.3 Where Intellectual Property is developed jointly by the Parties and there is no single clear developer, the Trusts will jointly own any such Intellectual Property and no Trust will be entitled to independently use such Intellectual Property other than in conjunction with the relevant Procurement Process without the written consent of the other Trusts.

21.4 The Trusts hereby agree that any benefit accruing to any Trust in relation to the exploitation of the Intellectual Property arising under Clause 21.2 and/or 21.3 shall be shared between the Parties on terms to be agreed by the SYB Pathology Partnership Board.

21.5 Any dispute as to the ownership of any Intellectual Property shall be determined in accordance with Clause 23 (Dispute Resolution Procedure).]

22. NOTICES

22.1 Any notice required to be given under this Agreement may be delivered personally or sent by first class post, courier or transmitted by email to the Chief Executive (or equivalent) of each other Trust at the address given at the beginning of this Agreement, or such other addresses as may be notified in accordance with this Clause 22 from time to time.

22.2 Any notice so sent shall be deemed to have been duly given if sent by:

22.2.1 personal delivery or courier – on delivery at the address of the relevant Trust; or

22.2.2 prepaid first class post – five (5) days after the date of posting; or

22.2.3 transmitted by email – when able to be read as received on recipient's email server.

22.3 This Clause does not apply to the service of any proceedings or other documents in any legal action or, where applicable, any arbitration or other method of dispute resolution.

23. DISPUTE RESOLUTION PROCEDURE

23.1 In the event of any dispute arising in relation to this Agreement ("**Dispute**"), the matter shall first be considered by the SYB Pathology Operational Management Team. In the event that the SYB Pathology Operational Management Team is not able to resolve the dispute within ten (10) Working Days of the matter arising, the SYB Pathology Operational Management Team shall escalate the matter by referring it (in the first instance), to the SYB Pathology Partnership Board.

23.2 In the event that the SYB Pathology Partnership Board is unable to settle the dispute within ten (10) Working Days of referral to it detailed in Clause 23.1, they shall within five (5) Working Days after the end of that negotiation period submit the dispute for consideration by the Acute Federation Collaborative.

23.3 In the event that the Acute Federation Collaborative is unable to settle the dispute within ten (10) Working Days of referral to it detailed in Clause 23.2, they shall within five (5)

Working Days after the end of that negotiation period submit the dispute to mediation by a mediator to be agreed between the Trusts.

23.4 If the matter is not resolved following the process referred to in Clauses 23.1 to 23.3, the Trusts shall attempt to settle it by mediation in accordance with Centre for Effective Dispute Resolution ("**CEDR**") Model Mediation Procedure. To initiate a mediation, a Trust may give notice in writing ("**Mediation Notice**") to the others requesting mediation of the dispute and shall send a copy thereof to CEDR asking CEDR to nominate a mediator. The mediation shall commence within 28 days of the Mediation Notice being served. No Trust will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one hour or one Trust has failed to participate in the mediation process. No Trust will commence legal proceedings against the other until thirty (30) days after such mediation of the dispute in question has failed to resolve the dispute. The Trusts shall co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay the mediator's costs, as the mediator shall determine or in the absence of such determination such costs shall be shared equally.

23.5 During the mediation phase and in advance of the mediation session, each Trust must submit to the mediator within five (5) Working Days of the mediator's request a signed position statement describing the precise points on which the Trusts disagree, and describing its own solution to the dispute.

23.6 No Trust may commence any court proceedings in relation to any Dispute arising out of this Agreement until it has attempted to settle the Dispute by mediation and either the mediation has terminated or the other Trust has failed to participate in the mediation, provided that the right to issue proceedings is not prejudiced by a delay.

23.7 Nothing in this Agreement shall prevent a Trust seeking from any court any interim or provisional relief that may be necessary to protect the rights or property of that Trust or the security of Confidential Information, pending resolution of the relevant dispute in accordance with the process set out in this Clause 23.

24. GENERAL

24.1 No variation of this Agreement or the Terms of Reference shall be effective unless it is in writing and signed by each Trust.

24.2 Failure of any Trust to enforce or exercise, at any time or for any period, any term of this Agreement does not constitute, and shall not be construed as, a waiver of any term and shall not affect the right to enforce such term, or any other term contained in this Agreement, at a later date.

24.3 Nothing in this Agreement shall constitute, or be deemed to constitute, a legal partnership between the Trusts, or shall constitute any Trust as the agent, employee or representative of the other(s).

24.4 The Trusts hereby agree that this Agreement shall be binding on any successors in title.

24.5 No one other than a party to this Agreement, their successors and/or permitted assignees, shall have any right to enforce any of its terms whether by virtue of the Contracts (Rights of Third Parties) Act 1999 or otherwise.

24.6 If any part of this Agreement is declared invalid or otherwise unenforceable, it shall be severed from this Agreement and the Trusts shall work together to agree a variation to this Agreement to ensure their continuation and achieve so far as possible their original intent. In the event that the Trusts cannot agree an appropriate variation, any Trust may terminate its participation from this Agreement with immediate effect.

24.7 No publicity or advertising regarding the relationship between the Trusts concerning any Procurement Process, any Contract or this Agreement shall be released by any Trust without the prior written approval of the other Trusts, which shall not be unreasonably withheld.

24.8 The Trusts shall do and execute all such further acts and things as are reasonably required to give full effect to the rights given and the matters contemplated by this Agreement.

24.9 This Agreement may be executed and delivered in any number of counterparts, each of which is an original and which, together, have the same effect as if each Trust had signed the same document.

24.10 This Agreement constitutes the entire agreement and understanding between the Trusts with respect to the subject matter of this Agreement and supersedes any prior agreement, understanding or arrangement between the Trusts with respect to the subject matter of this Agreement, whether oral or in writing.

25. STATUS OF AGREEMENT

This Agreement is governed in accordance with this Clause 25.

25.1 This Agreement and any dispute or claim arising out of, or in connection with, it, its subject matter or formation (including non-contractual disputes or claims) shall be governed by, and construed in accordance with, the laws of England.

25.2 The Trusts irrevocably agree that the Courts of England and Wales shall have exclusive jurisdiction to settle any dispute or claim arising out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

SCHEDULE 1

Definitions

Acute Federation Collaborative	means the collaboration of Chief Executives and Chairs of all SYB Acute Trusts with a common aim of improving quality, safety, sustainability of services and the patient experience by sharing collective expertise and collaborating on specific projects;
Agreement	means this agreement, including its Schedules;
Agreement Data	means Personal Data and/or Special Category Data Processed by a Processing Trust on behalf of the Controlling Trust under or in connection with this Agreement;
Applicable Laws	all laws, rules, regulations, codes of practice, research governance or ethical guidelines or other requirements of regulatory authorities, as amended from time to time;
Bribery Laws	means the Bribery Act 2010 and associated guidance published by the Secretary of State for Justice under the Bribery Act 2010 and all other applicable United Kingdom laws, legislation, statutory instruments and regulations in relation to bribery or corruption;
Business Plan	means [insert];
Commencement Date	means [insert date];
Confidential Information	means information, the disclosure of which would constitute an actionable breach of confidence, which has either been designated as confidential by an Trust in writing or that ought to be considered as confidential (however it is conveyed or on whatever media it is stored), including commercially sensitive information, information which relates to the finances, business, affairs, properties, assets, trading practices, goods/services, developments, trade secrets, Intellectual Property rights, know-how, employees and other workers, customers and suppliers of an Trust and all Personal Data and Special Category Data.;
Contract	means each contract for the provision of the different elements of the Pathology Services entered into by the Partnership Host with each Selected Supplier for the delivery of the Pathology Services;
Contract Award Criteria	means the agreed contract award criteria applied during each Procurement Process;
Contract Commencement Date	means the commencement date of the relevant Contract;
Contract Costs	means the costs payable under or in connection with the Contracts, including any such costs arising on termination or expiry of the Contracts, however that arises, to be apportioned between the Trusts as set out in Schedule [3 OR x];

Contract Manager	means [an individual appointed by the Partnership Host in accordance with paragraph 2 of Schedule 4 of the Agreement];
Contract Provider	means [insert for each of the Contracts];
Contract Resources	means the human resources that must be supplied by each Trust as set out in Schedule [3 OR x] (Contract Resources and Project Delivery Costs);
Contract Term	means the period of time equivalent to the duration of the relevant Contract as set out and determined therein;
Controller	has the meaning given in the Data Protection Legislation;
Controlling Trust	has the meaning given in Clause 16.1;
Data Protection Legislation	means all applicable data protection and privacy legislation, regulations and guidance, including: the General Data Protection Regulation (Regulation (EU) 2016/679), as incorporated into UK legislation by way of the European Union (Withdrawal Agreement) Act 2020 and as amended by the Data Protection, Privacy and Electronic Communications (Amendments etc) (EU Exit) Regulations 2019 ; the Data Protection Act 2018; and the Privacy and Electronic Communications (EC Directive) Regulations 2003;
Data Subject	has the meaning given in the Data Protection Legislation;
Deliverables	means deliverables set out in Schedule 2;
Direct Losses	means amounts recoverable under Clause 11.3 or any Project Delivery Costs, excluding Indirect Losses;
Dispute Resolution Procedure	means the procedure set out in Clause 23 of this Agreement;
EIRs	means the Environmental Information Regulations 2004 together with any code of practice made pursuant to those Regulations and any related guidance issued by the Secretary of State for the Department for Environment, Food and Rural Affairs, the Information Commissioner or the Secretary of State for the Department of Constitutional Affairs;
Evaluation Process	means the process identified as such in Schedule 3 (Evaluation Process Compliance);
Event of Force Majeure Event	an event or circumstance which is beyond the reasonable control of the Trust claiming relief under Clause 17, including war, civil war, armed conflict or terrorism, strikes or lock outs, riot, fire, flood or earthquake, and which directly causes that Trust to be unable to comply with all or a material part of its obligations under this Agreement;
Expiry Date	means [insert];

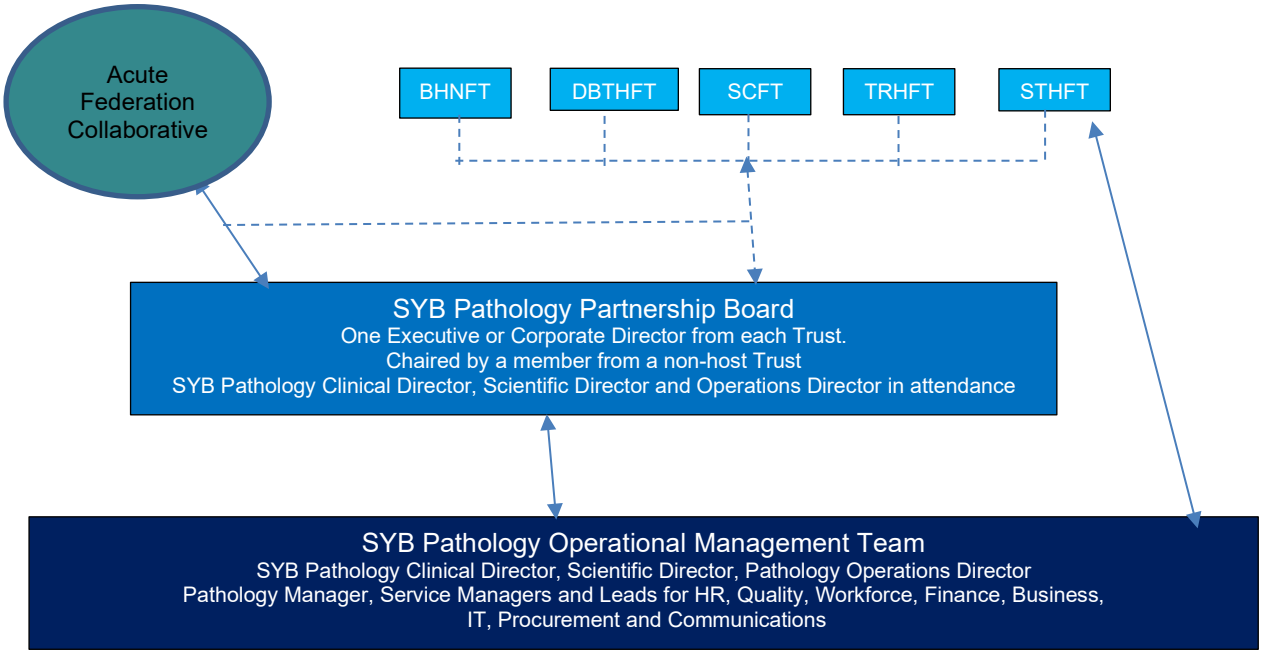
Financial Year	the period starting on the Commencement Date and ending on the following 31 March and each subsequent period of 12 calendar months starting on 1 April, provided that the final Financial Year will be the period starting on the relevant 1 April and ending on the Expiry Date or date of earlier termination of this Agreement;
FOIA	means the Freedom of Information Act 2000 and any subordinate legislation (as defined in the Interpretation Act 1978), but excluding the EIRs, as amended modified or re-enacted from time to time, together with all codes of practice made pursuant to that Act or pursuant to that subordinate legislation from time to time, and together with any related guidance issued by the Information Commissioner or the Secretary of State for the Department of Constitutional Affairs;
Full Business Case or **FBC**	means the full business case that has been approved in relation to the Project;
Health Service Body	has the meaning set out at section 9(4) of the NHS Act 2006;
Hosting Obligations	means the obligations set out in Schedule 4;
Hosting Standards	means the standards set out in Schedule 4;
Indirect Losses	means any loss of profits, loss of business or loss of business opportunity (whether such losses arise directly or indirectly) and any other consequential or indirect loss of any nature, but excluding Direct Losses;
Initial Term	means a period from the date of this Agreement until the Expiry of the Contract Term of each Contract unless terminated earlier in accordance with Clause 12 (Termination) or extended in accordance with Clause 3.2 (Term);
Information	shall have the meaning given under section 84 of the Freedom of Information Act 2000 including but not limited to environmental information as defined in regulation 2 of the EIRs and Personal Data and data as defined in the Data Protection Legislation;
Intellectual Property	means any patents, rights to inventions, registered designs, copyright and related rights, database rights, design rights, topography rights, trademarks, service marks, trade names and domain names, trade secrets, rights in unpatented know-how, rights of confidence and any other intellectual or industrial property rights of any nature, including all applications (or rights to apply) for and renewals or extensions of such rights and all similar or equivalent rights or forms of protection which subsist or will subsist now or in the future in any part of the world;
NHS Act 2006	means the National Health Service Act 2006;
NHS Contract	shall have the meaning set out in section 9 of the NHS Act 2006;
Outline Business Case or **OBC**	means the outline business case that has been approved in relation to the Project;
Partnership	means the contractual joint venture established pursuant to this

	Agreement between the Trusts for the provision of the Pathology Services which the Trusts agree will be collaborative and inclusive venture;
Partnership Business	means [the arrangements set out in the Business Plan];
Partnership Host	has the meaning set out in Clause 5.1;
Partnership Host Policies	means [insert a list of Partnership Host policies];
Partnership Policies	has the meaning set out in Clause 8.7;
Pathology Services	[means the pathology services and related services, including a single laboratory information management system, transport services to support the delivery of the pathology services, and digital pathology [services and equipment], procured in accordance with the relevant Procurement Process and set out within the relevant Contract;
Personal Data	has the meaning given in the Data Protection Legislation;
Process	has the meaning given in the Data Protection Legislation (and **"Processed"** and **"Processing"** shall be construed accordingly);
Processing Trust	has the meaning given in Clause 16.1;
Processor	has the meaning given in the Data Protection Legislation;
Procurement Decision Making Group	means the group made up of members of each Trust and governed in accordance with its agreed terms of reference;
Procurement Process	means each of the procurement processes as more particularly set out in Schedule 3;
Procurement Resources	means the human resources that must be supplied by each Trust as set out in Schedule 3 (Procurement Resources and Project Delivery Costs);
Procurement Timetable	means the timetable included in Schedule 3 (Procurement Timetable) as the same may be amended from time to time by the SYB Pathology Partnership Board;
Project	means the project for the provision of the pathology laboratory services, a laboratory information management system, transport services, and digital pathology [services and equipment] that are required by each Trust and which are being provided or procured pursuant to each Procurement Process;
Project Delivery Costs	means the project delivery costs to be incurred by the Trusts and apportioned as set out in Schedule 3;
Request for Information	shall have the meaning set out in FOIA;
Retained Assets and Equipment	means the assets and equipment listed in Part 2 of Schedule 7;

Risk and Gain Share Principles	means the risk and gain share principles set out in Schedule 4;
Selected Supplier	means the supplier (or suppliers, if applicable, on the basis of multiple lots) appointed by the Trusts pursuant to the application of the Contract Award Criteria during each Procurement Process;
Special Category Data	has the meaning given in the Data Protection Legislation;
SYB Pathology Operational Management Team	means the SYB Pathology Operational Management Team established in accordance with the SYB Pathology Operational Management Team Terms of Reference at Part 2 of Schedule 2;
SYB Pathology Operational Management Team Terms of Reference	means the terms of reference that govern the set-up, management, roles and responsibilities of the SYB Pathology Operational Management Team (as updated from time to time), a copy of which (as at the date of this Agreement) is set out in Part 2 of Schedule 2;
SYB Pathology Partnership Board	means the SYB Pathology Partnership Board established in accordance with the SYB Pathology Partnership Board Terms of Reference at Part 1 of Schedule 2;
SYB Pathology Partnership Board Reserved Matter	means matters reserved for decision by the SYB Pathology Partnership Board as set out at Part 2 or Schedule 2;
SYB Pathology Partnership Board Terms of Reference	means the terms of reference that govern the set-up, management, roles and responsibilities of the SYB Pathology Partnership Board (as updated from time to time), a copy of which (as at the date of this Agreement) is set out in Part 1 of Schedule 2;
SYB Pathology Workforce Group	means the group made up of members of each Trust and governed in accordance with its agreed terms of reference;
Target Operating Model or TOM	means the target operating model set out in Schedule 6;
Term	means the Initial Term of this Agreement plus any Extended Term(s) agreed between the Trusts;
Transferring Assets and Equipment	means the assets and equipment listed in Part 1 of Schedule 7;
Trust(s)	means each and any or all (as the context so requires) of the organisations listed at the start of this Agreement (numbers 1 to 6);
Working Day	means any day other than a Saturday, a Sunday, Christmas Day, Good Friday or a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in any part of the United Kingdom and "**Working Days**" shall be construed accordingly.

SCHEDULE 2

Terms of Reference and Trust Delegations



SCHEDULE 2

Terms of Reference and Trust Delegations

Part 1

South Yorkshire and Bassetlaw (SYB)

Pathology Partnership Board (PPB)

Terms of Reference

NAME OF GROUP:	SYB Pathology Partnership Board
ACCOUNTABLE TO:	Chairs and Chief Executives - Acute Federation Collaborative
REPORTING THROUGH:	Chief Executives – Acute Federation Collaborative
PRIMARY PURPOSE:	To oversee delivery of, and maximise the sustainability, safety and efficiency, of the Partnership. The vision is to improve lives and safeguard the best clinical outcomes by delivering high quality, innovative laboratory medicine solutions making best use of taxpayers money to deliver efficiencies form economies of scale and scope.
COMPOSITION OF GROUP/ MEMBERSHIP:	A non-host Chief Executive will act as the Chair of the SYB Pathology Partnership Board. The membership of the Partnership Board will comprise one of each of the following:- • Executive or Corporate Director (Barnsley Hospital NHS FT) • Executive or Corporate Director (Doncaster & Bassetlaw Teaching Hospitals NHS FT) • Executive or Corporate Director (Sheffield Children's NHS FT) • Executive or Corporate Director (Sheffield Teaching Hospitals NHS FT) • Executive or Corporate Director (The Rotherham Hospital NHS FT) In appointing individuals to the SYB Pathology Partnership Board, the participating Trusts will act with a view to ensuring that the makeup of the board reflects the breadth of the provision across both general and specialist care, with an appropriate mix of skills and expertise.
IN ATTENDANCE	• SYB Pathology Clinical Director • SYB Pathology Scientific Director • SYB Pathology Operations Director Attendance by other relevant officers outside of the Membership will be agreed in advance of each meeting.

RESPONSIBILITIES OF PARTNERSHIP BOARD MEMBERS	1. To review the Agreement on an annual basis with any variations to be approved by each Trust Board in writing. 2. To provide leadership, create a culture of collaboration across the Partnership and effectively manage any challenges that arise in an open and constructive way. 3. To ensure appropriate governance and management arrangements are in place across the Partnership. 4. To agree the overall strategy for the Partnerships on behalf of the Trusts and report to the Acute Federation Collaborative and Trust Boards as required. 5. To provide oversight to annual planning, tenders and business case processes including planning, delivery of milestones, and risk and issue management. 6. To approve the annual Business Plan and to oversee its implementation. 7. To agree plans ensuring that measurable outcome criteria are in place for each initiative / project. 8. On an annual basis, to agree the contribution to the running of the Partnership to be made by the Trusts and the outcomes and benefits that are required as a result from that investment. 9. To ensure the principles of this Agreement are adhered to by all of the participating Trusts. 10. To ensure successful delivery and implementation of the Full Business Case for the Partnership. 11. To review and endorse any proposed changes to the agreed Target Operating Model, ensuring operational, clinical and financial sustainability of such changes prior to approval by all Trust Boards. 12. To refer any Reserved Matters, as defined in this Agreement, to individual Trust Boards. 13. To agree the structure and objectives of the SYB Pathology Operational Management Team. 14. To provide oversight and direction to the SYB Pathology Operational Management Team, holding the Clinical Director and team accountable for service delivery and performance. 15. On behalf of the Trusts, and customers, assure the delivery of the agreed outcomes. 16. To monitor delivery and performance of the expected outcomes, agreeing mitigations and corrective actions with the SYB Pathology Operational Management Team. 17. To make business case recommendations to individual Trust Boards and approve business cases and plans within the limits of the Hosts SFIs. 18. To receive, review and approve the annual accounts as provided by the Host Department of Finance. 19. To have oversight of all relevant external contracts. 20. To abide by the agreed guiding principles including making the best use of taxpayers money and to deliver efficiencies from economies of scale and scope. 21. To agree any financial implications for the Partnership as a result of the annual Business Plan e.g. fluctuations to test pricing, expected annual Cost Improvement Plan.

	22. To provide effective support in the identification and mitigation of the Partnership's risks and issues. 23. To agree and support the Partnership's communication and engagement plans at system and local level. 24. To ensure appropriate communication and engagement with stakeholders across the Integrated Care System, acting as points of contact for local teams and services. 25. To hold any external advisors to account for their performance against agreed objectives and in accordance with any contract. 26. To undertake any other duties required of it by the Trust Boards. 27. To ensure that organisational, professional or personal conflicts of interest are effectively managed in an open and constructive way 28. To seek to resolve any disputes between the Trusts in accordance with Clause 23 of this Agreement.
SERVICED BY:	SYB Pathology Operations Director
FREQUENCY OF MEETINGS:	Monthly for the first 12 months and then as agreed by the Partnership Board
REQUIRED ATTENDANCE:	Attendance of the Director representative from each participating Trust at scheduled meetings will be critical to successful delivery of the SYB Pathology Network. Therefore, notwithstanding the quoracy requirements below, each Trust will endeavour to have representation at each meeting. A nominated executive or corporate deputy may represent Trusts where necessary.
QUORACY:	In line with this Agreement, each of the five Trusts will have equal participation in this forum. Meetings will be quorate based on attendance of Executive representatives from three out of five Trusts. Proposed decisions will be shared with any participating Trust not represented within a week of the meeting to enable feedback from that Trust. Where a unanimous agreement cannot be reached, the proposal will be discussed via email and at the next meeting. Each Trust must be present at the meeting where a material decision is required.
MINUTES CIRCULATED TO:	Acute Federation Collaborative Trust Boards SYB Pathology Operational Team Other Groups as required
REVIEW DATE:	April 2023
DATE APPROVED:	

SCHEDULE 2

Terms of Reference and Trust Delegations

Part 2

South Yorkshire and Bassetlaw (SYB)

Pathology Operational Management Team (OMT)

Terms of Reference

NAME OF GROUP:	SYB Pathology Operational Management Team
ACCOUNTABLE TO:	Acute Federation Collaborative
REPORTING THROUGH:	SYB Pathology Partnership Board (PPB)
PRIMARY PURPOSE:	To oversee the general pathology service delivery and to maximise sustainability, safety and efficiency of the Partnership. The vision is to improve lives and safeguard the best clinical outcomes by delivering high quality, innovative laboratory medicine solutions making best use of taxpayers money to deliver efficiencies form economies of scale and scope.
COMPOSITION OF GROUP/ MEMBERSHIP:	• SYB Clinical Director (CD) • SYB Scientific Director (SD) • SYB Operations Director (OD) • SYB Pathology Manager • Pathology Clinical Lead for each Pathology Discipline • Pathology Laboratory Manager for each Pathology Discipline • Quality Lead • Workforce Lead • Business Lead • Finance Lead • Procurement Lead • IT Lead • HR Business Partner • Communications Lead The SYB Clinical Director will act as Chair of the Pathology Operational Team. The Clinical Lead and Laboratory Manager Lead representation for each discipline must ensure that all partner Trusts are adequately represented.
IN ATTENDANCE	NHSI North of England regional lead for diagnostic transformation programmes. Other relevant officers outside of the Membership will be agreed in advance of each meeting.

RESPONSIBILITIES OF SYB PATHOLOGY OPERATIONAL MANAGEMENT TEAM MEMBERS	1. To develop and recommend the overall strategy for the Partnership and provide medical, scientific, technical and support expertise to the SYB Pathology Partnership Board. 2. To develop the annual Business Plan for the Partnership, including measurable outcomes, for recommendation to the SYB PPB. 3. To prepare associated business cases, procurement plans and other and projects for recommendation to the SYB PPB, and individual Trust Boards where required. 4. To support the successful delivery of the business cases or projects arising from the annual Business Plan, monitoring and leading on any corrective action needed to deliver the agreed outcome/success criteria including delivery of milestones and risk and issue management. 5. To report the measurable outcome criteria to the PPB on a monthly basis. 6. To establish and monitor an agreed set of KPIs across SYB Pathology, reporting compliance by exception to the PPB on a monthly basis. 7. To provide effective support in the identification and mitigation of SYB Pathology risks and issues. 8. To take action to ensure the Trusts compliance with the principles of this Agreement including tenders, investment and recruitment decisions. 9. To provide leadership in driving a collaborative culture across the Partnership. 10. To provide oversight and direction to working teams. 11. To provide oversight to the recruitment of posts. 12. To provide support to the Host finance and business teams to enable a common pricing strategy which can be implemented across the Partnership. 13. To monitor activity and income of all external contracts. 14. To ensure appropriate communication and engagement with stakeholders across the Integrated Care System, acting as points of contact for local teams and services. 15. To recommend SYB Pathology communication to the PPB and support engagement plans at both system and local level. 16. To ensure that organisational, professional or personal, conflicts of interest are effectively managed in an open and constructive way. 17. To ensure appropriate governance and management arrangements are in place. 18. To undertake any other duties required of it by the PPB and Trust Boards.
SERVICED BY:	SYB Pathology Manager

FREQUENCY OF MEETINGS:	Monthly
REQUIRED ATTENDANCE:	It is expected that, as a minimum, two members of the SYB Senior Management Team (CD, SD or OD) will be in attendance. It is expected that the Clinical Lead and / or Laboratory Manager from each Pathology Discipline (Automated Blood Sciences, Specialist Blood Sciences, Histology, Microbiology) will attend each meeting such that all partner sites are adequately represented. Senior nominated deputies may represent Disciplines and Sites where necessary.
QUORACY:	Meetings will be quorate based on attendance of representatives from three out of the four Pathology Disciplines (Automated Blood Sciences, Specialist Blood Sciences, Histology, Microbiology) with adequate representation of 3 out of the 5 partner Trusts. Recommendations will be shared with any discipline and Trust not present within a week of the meeting to enable feedback, from that Trust. Where a unanimous agreement cannot be reached the proposal will be discussed via email and at the next meeting.
MINUTES CIRCULATED TO:	Pathology Partnership Board Other Groups as required Minutes to be communicated to all SYB Pathology staff via agreed communication channels.
REVIEW DATE:	April 2023
DATE APPROVED:	

SCHEDULE 2

Terms of Reference and Trust Delegations

Part 3

Trust Delegations

Trust Boards will not delegate their statutory responsibilities to the SYB Pathology Partnership Board.

Any proposed changes to this Agreement must be approved by all Trust Boards in writing.

Any proposed changes to Terms of Reference must be approved by all Trust Boards in writing.

Pathology Board Reserved Matters are any changes to the agreed Target Operating Model and Workforce Models which must be approved by the Trust Boards with consideration by the Acute Federation Collaborative.

Reserved Matters as at the Commencement Date include:

- Changes to the Partnership Agreement
- Changes to the Target Operating Model
- Financial decisions in line with Host SFIs
- Changes to the Workforce Model

SCHEDULE 3

Procurement Resources and Project Delivery Cost

All procurements undertaken in accordance with this Agreement will be in accordance with:

- procurement legislation;
- the Partnership Host Standing Financial Instructions, Standing Orders and Procurement Policy; and
- the Pathology Network Outline Business Case ('OBC') and when agreed, the Full Business Case ('FBC');

Any procurement requiring competition, not included in the Pathology Network OBC or FBC, may be recommended by the SYB Pathology Operational Management Team and approved by the SYB Pathology Partnership Board.

A) Procurement Process – General Compliance

In order for the Partnership Host to carry out the Procurement Processes on behalf of the Partnership that are both, compliant with the relevant legislative framework and minimise the risk of a challenge being brought, the below process will be adhered to (in accordance with the relevant Host decision making process, for each Procurement Process);

The SYB Operational Management Team will:

- Establish a Procurement Decision Making Group. For larger projects this will require a project board with a representative from each Trust;
- Establish a Pathology Project Lead/Manager;
- Establish a lead for the development of the OBC and FBC (if required);
- Agree the overall timetable of the procurement;
- Agree the procurement route and put the recommendation forward to the Procurement Decision Making Group;
- Draft the tender documentation;
- Agree the contract award criteria (this will include adherence to the evaluation guidance as provided and directed by STHFT as the Partnership Host) and make a recommendation to the Procurement Decision Making Group;
- Carry out the commitments in the OBC and FBC;
- Provide support to the team leading the Procurement Process on their behalf;
- Make contract recommendations to the Procurement Decision Making Group and where required the SYB Pathology Partnership Board; and
- Approve the Regulation 84 Procurement Report.

The Partnership Host will, in conjunction with the SYB Pathology Operational Management Team, provide advice via the SYB Pathology Partnership Board to ensure all Trusts, as a collective group, mitigate the risk of non-compliance and supplier challenge. Any deviation from the advice may compromise the process, therefore all Trusts must raise any potential issues including potential conflicts of interest to the SYB Pathology Partnership Board and the SYB Pathology Operational Management Team as soon as they are aware of the issues or conflicts.

B) Contract Award and Contract Management

The Partnership Host will enter into all the contracts with the supplier on behalf of the Trusts.

The Partnership Host will be responsible for the contract management of all contracts with the supplier awarded on behalf of the Partnership.

C) Finances

The Partnership Host will deal with the financial elements of the contracts following contract award and costs will be recovered from the Trusts via a routine monthly/quarterly recharge (TBC). The authorised 'risk and gain share' document will be used as the default principle for distributing costs and income between the Trusts. Costs will be signed off by the SYB Pathology Partnership Board and will reflect the values in each Outline Business Case.

Where any procurements exceed the scope of this Agreement, these would be considered on an individual basis. When the Target Operating Model is reached, Trusts will be recharged on an equalised cost per unit basis. Unit costs will include the costs of any procurement.

D) Slippage and Delays

The project timelines will be managed by the SYB Pathology Operational Management Team and any delays that have a financial impact will be reported to the Pathology Partnership Board. Any delays that cause a financial risk to a Trust(s) will be shared proportionally between all Trusts in accordance with the agreed risk and gain share arrangement.

SCHEDULE 4

Hosting Obligations and Hosting Standards

Part 1

1. GENERAL OBLIGATIONS

1.1 The Partnership Host shall:

1.1.1 comply with Schedule 8 (TUPE), employ the staff of the Partnership in accordance with Schedule 4 Part 2) (Hosting Standards) and ensure there are no compulsory redundancies;

1.1.2 in all matters regarding legal personality act on behalf of the Partnership, including, without limitation, entering into all contracts, agreements and arrangements (including each Contract) in relation to the Partnership;

1.1.3 be responsible for all regulatory matters including:

(a) registration with the Care Quality Commission (or its successor body);

(b) registration with the Medicines and Healthcare products Regulatory Agency (or its successor body);

(c) registration with the Human Tissue Authority and registration with the Clinical Pathology Accreditation UK Limited;

(d) meeting the requirements of NHS Improvement and any relevant Clinical Commissioning Groups and any other commissioning organisations; and

(e) any relevant UKAS accreditation;

1.1.4 set up separate accounting records in relation to the Partnership including maintaining accurate and complete statements and records of all transactions in relation to the Partnership;

1.1.5 prepare financial reports and accounts for the Partnership records for each year in accordance with the requirements of all Applicable Laws and generally accepted accounting practices applicable in the United Kingdom in relation to this Agreement;

1.1.6 supply each Trust with the financial and other information necessary to keep the party informed about how effectively the business of the Partnership is performing and in particular shall supply each Partner with:

(f) a copy of each year's Business Plan for approval in accordance with Clause 8.9;

(g) monthly income and expenditure accounts of the Partnership to be supplied within fifteen (15) Working Days of the end of the Month to which they relate (the first Working Day being the first Working Day of the following month) and the accounts shall include activity report, a surplus and loss account, a balance sheet and a cashflow statement;

1.1.7 promptly notify the SYB Pathology Partnership Board and the SYB Pathology Operational Management Team of any liabilities which it considers it is entitled

to seek indemnity protection or reimbursement from the other Trusts under this Agreement such notice to include:

(a) the quantum and nature of such liability;

(b) details of the circumstances causing such liability;

(c) any steps it has taken to minimise such liability (to the extent that such steps are appropriate) acknowledging the Partnership Host acts in accordance with the terms of this Agreement and the decisions of the SYB Pathology Partnership Board and the SYB Pathology Operational Management Team; and

(d) other details regarding the liability, including details of any litigation;

1.1.8 operate the Partnership as the legal host on behalf of the Trusts in accordance with the decisions of and directions of the SYB Pathology Partnership Board and the SYB Pathology Operational Management Team;

1.1.9 must put into place and maintain in force appropriate insurance (or membership of an NHS Resolution risk sharing scheme) in respect of:

(a) employers liability;

(b) clinical negligence, where the provision or non-provision of any part of the Services to be provided from time to time pursuant to the relevant Contract may result in a clinical negligence claim;

(c) public liability; and

(d) professional negligence; and

1.1.10 on a Trust's request, produce both the insurance certificate giving details of cover and the receipt for the current year's premium in respect of each insurance; and

1.1.11 perform the Hosting Obligations to the Hosting Standards (as applicable).

2. CONTRACT MANAGEMENT

2.1 The Partnership Host shall be responsible for managing each Contract under the terms of the relevant Contract.

2.2 [The Partnership Host has appointed a Contract Manager who will act as the representative of the Partnership in connection with each Contract. The role description of the Contract Manager will be agreed between the Trusts through the SYB Pathology Partnership Board. The Contract Manager will, notwithstanding that he/she is employed by the Partnership Host, be expected to act equally in the best interests of all of the Trusts and in accordance with their joint instructions through the SYB Pathology Partnership Board and the SYB Pathology Operational Management Team. Where any Trust has concerns that the Contract Manager is not acting in their best interests the matter shall be referred to the dispute resolution procedure.]

SCHEDULE 4

Hosting Obligations and Hosting Standards

Part 2

Hosting Standards

1. HOSTING STANDARDS

1.1 In its performance of the Hosting Obligations, the Partnership Host shall:

1.1.1 comply with all instructions of the SYB Pathology Partnership Board and the SYB Pathology Operational Management Team in relation to the Partnership Business;

1.1.2 perform the Hosting Obligations with the best care, skill and diligence in accordance with best practice in the supplier's industry, profession or trade;

1.1.3 use personnel who are suitably skilled and experienced to perform tasks assigned to them, and in sufficient number to ensure that the Hosting Obligations are fulfilled in accordance with this Agreement;

1.1.4 ensure that the Hosting Obligations conform with all descriptions and specifications set out in any reasonable written specification provided by the SYB Pathology Partnership Board or the SYB Pathology Operational Management Team;

1.1.5 provide all equipment, tools and vehicles and such other items as are required to perform the relevant Hosting Obligations;

1.1.6 use the best value goods, materials, standards and techniques, and ensure that all goods and materials supplied and used will be free from defects in workmanship, installation and design;

1.1.7 obtain and at all times maintain all necessary licences and consents, and comply with all applicable laws and regulations, in respect of the Hosting Obligations;

1.1.8 observe all health and safety rules and regulations and any other security requirements that apply at any of the premises from which the Pathology Services or the Hosting Obligations are provided; and

1.1.9 not do or omit to do anything which may cause any Trust to lose any licence, authority, consent or permission on which it relies for the purposes of conducting its business.

SCHEDULE 4

Hosting Obligations and Hosting Standards

Part 3

Contract and Costs Management

Risk and Gain Share

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 SYB Directors of Finance at their meeting on 22nd April 2021.

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 will be used to distribute savings / surplus income within the Partnership as a consequence of implementing the Full Business Case.

Risk and Gain Share Proposals 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.

SCHEDULE 5

Agency Arrangements

Text only to be included if agency arrangements apply.

SCHEDULE 6

Target Operating Model

Recommended SYB Pathology TOM - August 2021

Hospital Site	Type of Lab	Range of Services
Northern General Hospital, Sheffield	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
Royal Hallamshire Hospital, Sheffield	ESL * Sp **	ESL for Blood Sciences Specialist centre for Haematology and Coagulation Specialist centre or Gestational Trophoblastic Disease Frozen sections POCT
Sheffield Children's	ESL * Sp Paediatric PM **	ESL for Blood Sciences Specialist centre for paediatric biochemistry Paediatric PM Frozen sections Brain smears POCT
Doncaster Royal Infirmary	Ext ESL Mini CSL	Extended ESL for Blood Sciences Secondary lab for Microbiology (not 24/7) Frozen sections Andrology POCT
Rotherham Hospital	ESL	ESL for Blood Sciences Frozen sections Andrology POCT
Barnsley Hospital	ESL	ESL for blood sciences POCT
Bassetlaw Hospital	ESL	ESL for Blood Sciences POCT
Chesterfield Royal Infirmary		Frozen sections

* A quality impact assessment is being completed to understand whether, to meet all of the critical Requirements, an ESL is required at both the RHH and SCH sites.

** Two sites (Royal Hallamshire Hospital and Sheffield Children's) are being evaluated for the site of a single Histopathology CSL.

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	Ext ESL for Blood Sciences plus a secondary Microbiology Laboratory
Sp	Specialist Centre

SCHEDULE 7

Assets and Equipment

Part 1

Transferring Assets and Equipment

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 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.

Trust Asset Lists

Trust asset lists are attached. These lists are accurate as of 1st Jan 2022 but are subject to continual review and update.

SCHEDULE 7

Assets and Equipment

Part 2

Retained Assets and Equipment

Details of any assets and equipment that will not transfer to the Partnership Host but will be made available by the Trusts for use by the Partnership Host are be inserted once finalised and confirmed. This should also include details of any charges for making such assets and equipment available as required.

SCHEDULE 8

Transferring Partnership Employees

Part 1

1. INTERPRETATION

1.1 The definitions in this paragraph apply in this Schedule.

Directive: the Council of the European Union Directive 2001/23/EC;

Employee Liability Information: the employee liability information to be provided pursuant to regulation 11 of the Transfer Regulations;

Losses: all losses, claims, actions, costs, liabilities, damages or expenses, (including all reasonable legal and professional costs and expenses), proceedings, demands and charges whether arising under statute, contract or at common law but excluding loss of profits, loss of use, loss of production, loss of business, loss of business opportunity, or any claim for consequential loss or for indirect loss of any nature but excluding any of the same that relate to loss of revenue;

Resource Transfer Date means the date the Partnership Host takes responsibility for the provision of the Services or any part of the Services and the resources relating to the Services or any part of the Services are transferred to it by a Trust.

Redundancy Costs means notice pay (including any payment in lieu of notice), redundancy payments payable on termination of employment pursuant to any arrangement (including voluntary redundancy) whether contractual or statutory, any entitlement to early benefits on redundancy or early retirement benefits pursuant to the employee's terms and conditions of employment, any increased employment costs arising due to the application of a relevant pay protection policy and any employer national insurance liabilities associated with such payments and costs;

Relevant Transfer: a relevant transfer for purposes of the Transfer Regulations;

Services: means the Pathology Services as defined in Schedule 1

Transferring Employees: the persons employed by BHFT, DBTHFT, TRTF, SCFT (or a supplier or sub-contractor of the same) who are wholly or mainly engaged in the activities of the Services immediately before the Resource Transfer Date.

Transferor Trusts means BHFT, DBTHFT, TRTF, and/ or SCFT, as the context determines;

Transfer Regulations: the Transfer of Undertakings (Protection of Employment) Regulations 2006.

2. RELEVANT TRANSFERS

2.1 The parties anticipate that the transfer of the Services to the Partnership Host will constitute a Relevant Transfer and that the contracts of employment (together with any collective agreements) of the Transferring Employees shall have effect (subject to Regulation 4(7) of the Transfer Regulations) thereafter as if originally made between the Transferring Employees and the Partnership Host except insofar as such contracts relate to any benefits for old age, invalidity or survivors under any occupational pension scheme (save as required under sections 257 and 258 of the Pensions Act 2004), however staff who are eligible to participate in, or who immediately before such Relevant Transfer are participating

in, the NHS Pension Scheme shall continue to be provided with access or continued membership in the NHS Pension Scheme. On the occasion of a Relevant Transfer to any sub-contractor or supplier the Partnership Host shall procure that the former and any new sub-contractor or supplier shall comply with their obligations under the Transfer Regulations and with the provisions of Fair Deal for staff pensions: staff transfer from central government (October 2013).

3. EMPLOYEE LIABILITY INFORMATION AND MEASURES

3.1 Each Transferor Trust shall promptly respond to any reasonable requests from the Partnership Host for information about the workforce and working arrangements for purposes of determining the number and job titles of the individuals assigned to the Services for purposes of the Transfer Regulations and details of all unfilled vacancies in the Services and details of all roles currently filled by agency or bank staff working in the Services.

3.2 Each Transferor Trust has supplied to the Partnership Host the Employee Liability Information as at the date of this Agreement, which is contained in Part 2 of this Schedule 8, relating to each of those employees of the respective Transferor Trust who it is expected, if they remain in the employment of the relevant Transferor Trust or its sub-contractor or supplier until immediately before the Resource Transfer Date, would be Transferring Employees.

3.3 Each Transferor Trust warrants that the information it has supplied is accurate and complete. Each Transferor Trust shall severally indemnify and keep indemnified the Partnership Host in respect of any Losses:

3.3.1 which the Partnership Host incurs and which are reasonably attributable to a breach of this warranty, including but not limited to where the incompleteness or inaccuracies in such information resulted in the Partnership Host agreeing a lower fee or payment from the Transferor Trusts under this Agreement; and

3.3.2 arising from any claim by any party as a result of the Transferor Trust (or sub-contractor or supplier) failing to provide or promptly provide the Partnership Host where requested by the Partnership Host, the Employee Liability Information or to provide full Employee Liability Information or as a result of any material inaccuracy in, or omission, from the Employee Liability Information.

3.4 Without prejudice to their obligations under this Schedule, the Transferor Trusts will provide the Employee Liability Information to the Partnership Host at such time or times as are required by the Transfer Regulations and update the Employee Liability Information to take account of any changes as required by the Transfer Regulations.

3.5 The parties agree to take all reasonable steps, including co-operation with reasonable requests for information to ensure that the Relevant Transfer takes place smoothly with the least possible disruption to the Services and to the Transferring Employees.

3.6 The Partnership Host shall immediately and in any event within five (5) Working Days following a written request by a Transferor Trust, provide to the relevant Transferor Trust details of any measures which the Partnership Host or any sub-contractor or supplier envisages it or they will take in relation to any Transferring Employees who are or who will be the subject of a Relevant Transfer, and if there are no measures, confirmation of that fact.

4. INDEMNITIES

4.1 The Transferor Trusts shall severally indemnify and keep indemnified in full the Partnership Host against all Losses incurred by the Partnership Host in connection with or as a result of any claim or demand by (i) a Transferring Employee of the Transferor Trust or by (ii) any

trade union or staff association or employee representative in respect of all or any of the Transferring Employees, in either case that arises out of the employment or termination of the employment of any Transferring Employee of the Transferor Trust or its sub-contractor or supplier, provided that this arises from any act, fault or omission of the relevant Transferor Trust or its sub-contractor or supplier in relation to such employee prior to the Resource Transfer Date.

4.2 The Transferor Trusts shall remain (and procure that any sub-contractor or supplier shall remain) responsible for all their (or as relevant, sub-contractor's or supplier's) employees (other than the Transferring Employees) on or after the Resource Transfer Date and shall severally indemnify and keep indemnified the Partnership Host against all Losses incurred by the Partnership Host resulting from any allegation or claim whatsoever, whether arising before on or after the Resource Transfer Date by or on behalf of any of the relevant Transferor Trust's employees or sub-contractor's or supplier's employees or persons engaged by the Transferor Trust or its sub-contractor or supplier who do not constitute the Transferring Employees.

4.3 Where any liability in relation to any of the Transferring Employees or former employee of the Transferor Trust or its sub-contractor or supplier in respect of their employment or its termination by the relevant Transferor Trust or its sub-contractor or supplier which transfers in accordance with the Transfer Regulations arises partly as a result of an act or omission occurring before the Resource Transfer Date and partly as a result of an act or omission occurring after the Resource Transfer Date, the relevant Transferor Trust shall severally indemnify and keep indemnified in full the Partnership Host against only such part of the Losses sustained by the Partnership Host as is reasonably attributable to an act fault or omission of the relevant Transferor Trust or its sub-contractor or supplier prior to the Resource Transfer Date.

4.4 The indemnities contained in paragraphs 4.1 shall apply as if references in that paragraph to any act, fault or omission of the Transferor Trust also included a reference to a sub-contractor or supplier employer of any Transferring Employee prior to the Resource Transfer Date.

4.5 The Partnership Host shall indemnify and keep indemnified in full the Transferor Trusts against:

4.5.1 all Losses incurred by a Transferor Trust in connection with or as a result of any claim or demand against a Transferor Trust by (i) any person who is, or has been, employed or engaged by the Partnership Host or any sub-contractor or supplier in connection with the provision of the Services or (ii) any trade union or staff association or employee representative in respect of such person, in either case where such claim arises as a result of any act, fault or omission of the Partnership Host or any sub-contractor or supplier on or after the Resource Transfer Date;

4.5.2 all Losses incurred by the Transferor Trusts in connection with, or as a result of, any claim by any employee, trade union or staff association or employee representative (whether or not recognised by the Partnership Host or any relevant sub-contractor or supplier in respect of all or any of the Transferring Employees) arising from, or connected with any failure by the Partnership Host and/or any sub-contractor or supplier to comply with any legal obligation to such trade union, staff association or other employee representative whether under Regulation 13 of the Transfer Regulations, under the Directive or otherwise and, whether any such claim arises or has its origin before on or after the Resource Transfer Date.

4.6 The Trusts agree to jointly and severally indemnify each other against all Losses incurred by the Transferor Trusts in connection with or as a result of:

4.6.1 any claim by any Transferring Employee that any proposed or actual substantial change by the Partnership Host to the Transferring Employees' working conditions, or any proposed measures of the Partnership Host or any relevant sub-contractor or supplier are to that employee's material detriment or to the material detriment of any person who would have been a Transferring Employee but for their resignation (or decision to treat their employment as terminated under Regulation 4(9) of the Transfer Regulations) whether such claim arises before on or after the Resource Transfer Date; and

4.6.2 any claim arising out of any misrepresentation or mis-statement made by the Partnership Host or any sub-contractor or supplier (except where the Partnership Host is negligent) to the Transferring Employees or their representatives whether before, on or after the Resource Transfer Date and whether liability for any such claim arises before on or after the Resource Transfer Date.

5. PAY AND BENEFITS (INCLUDING REDUNDANCY PAY)

5.1 Each Trust shall and shall procure that its sub-contractor or supplier shall be responsible for all remuneration, benefits, entitlements and outgoings in respect of its Transferring Employees, including without limitation all wages, holiday pay, bonuses, commission, payment of PAYE, national insurance contributions, pension contributions, statutory redundancy payments, contractual redundancy payments, payments on early retirement and otherwise, prior to the Resource Transfer Date.

5.2 The Partnership Host shall be responsible or shall procure that any relevant sub-contractor or supplier is responsible, for all remuneration, benefits, entitlements and outgoings in respect of the Transferring Employees and any other person who is or will be employed or engaged by the Partnership Host or any sub-contractor or supplier in connection with the provision of the Services, including without limitation all wages, holiday pay, bonuses, commission, payment of PAYE, national insurance contributions, pension contributions, payments on early retirement and otherwise, on or after the Resource Transfer Date.

5.3 The Trusts agree to jointly and severally indemnify the Partnership Host for any and all Redundancy Costs arising from a redundancy of any Transferring Employee on or after the Resource Transfer Date. For the avoidance of doubt, each Trust including the Partnership Host will pay an equal share of the Redundancy Costs. No redundancies will be made without the agreement of the SYB Pathology Partnership Board.

6. OFFER OF EMPLOYMENT TO OBJECTING EMPLOYEES

6.1 If any Transferring Employee objects to the transfer, the Trusts will take all necessary steps to offer employment to such employees and will seek to preserve continuity of employment. The Transferor Trust which employs the relevant Transferring Employee will take primary responsibility for searching for alternative employment, however, all Trusts must cooperate to search for employment and offer employment on the same terms as the relevant Transferring Employee was afforded immediately prior to the Resource Transfer Date.

7. CLAIMS AND GRIEVANCES

7.1 The Trusts agree to take all reasonable steps to conclude internal grievance, disciplinary and appeal processes prior to the Resource Transfer Date.

7.2 In the event that any of the Transferring Employees bring or raise claims, grievances or appeals on or after the Resource Transfer Date that relate in whole or in part to their employment prior to the Resource Transfer Date, the Trusts agree to cooperate with the Partnership Host and to promptly comply with all reasonable requests for information and to afford the Partnership Host access to any of their employees who may be relevant

witnesses in order to assist the Partnership Host in defending, responding to and investigating any such claims, grievances or appeals.

8. **RECRUITMENT**

8.1 Between the date of this Agreement and transfer of the Services under TUPE the Trusts agree:

8.1.1 not to appoint to any existing vacancy within the Services without the agreement of the SYB Pathology Partnership Board;

8.1.2 not to advertise any new vacancy within the Services without the agreement of the SYB Pathology Partnership Board; and

8.1.3 to undertake all approved recruitment to the Services in accordance with the SYB Pathology Workforce Group vacancy control procedure.

9. **EXIT ARRANGEMENTS**

9.1 In the event of a change of Partnership Host, termination of the Partnership, or any other event giving rise to a subsequent transfer under TUPE, the Trusts will agree exit terms and arrangements via the SYB Pathology Partnership Board at least two months in advance of the subsequent transfer of the Services (or as soon as reasonably practicable where two months is not possible).

Part 2

Employee Liability Information

Each Transferor Trust will supply the Partnership Host the Employee Liability Information as soon as finalised and confirmed. This is Information relating to each of those employees of the respective Transferor Trust who it is expected, if they remain in the employment of the relevant Transferor Trust or its sub-contractor or supplier until immediately before the Resource Transfer Date, would be Transferring Employees.

SIGNATURE PAGE

SIGNED by ....
(Signature)

(Role) ……..
.....
for and on behalf of (Date)

Barnsley Hospital NHS Foundation Trust

SIGNED by ....
(Signature)

(Role) ……..
.....
for and on behalf of (Date)
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

SIGNED by ....
(Signature)

(Role) ……..
for and on behalf of .....
The Rotherham NHS Foundation Trust (Date)

SIGNED by ....
(Signature)

(Role) ……..
.....
for and on behalf of (Date)
Sheffield Children's NHS Foundation Trust

SIGNED by ....

(Signature)

(Role) ……..

.....

for and on behalf of *(Date)*

Sheffield Teaching Hospitals NHS Foundation Trust

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	24 May 2022	**Agenda Reference:**	F3		
Report Title:	**Nottingham & Nottinghamshire Integrated Care Board Provider Representative**				
Sponsor:	Jon Sargeant, Director of Recovery, Innovation & Transformation (RIT)				
Author:	Jon Sargeant, Director of Recovery, Innovation & Transformation (RIT)				
Appendices:	None				
Executive Summary					
Purpose of report:	To provide an update on the nomination for the Partner Members of the NHS Nottingham and Nottinghamshire Integrated Care Board.				
Summary of key issues/positive highlights:	The ICB is required to appoint partner members to its unitary Board. These partner members will be critical to the ICB, bringing their knowledge and a perspective from their sectors to the work of the Board, and playing a key role in establishing new ways of working across the system to meet the needs of our citizens. Following discussion with local partners, it was agreed that the Board of NHS Nottingham and Nottinghamshire ICB will include five of these partner members including two from our local NHS Trusts and NHS Foundation Trusts: • One to bring a perspective of hospital, urgent and emergency care services; and • One to bring a perspective of mental health, intellectual disability and community services. As members of the ICB Board, the partner members will be accountable to the ICB Chair and alongside other members of the Board, they will have collective and corporate accountability for the delivery of the ICB's functions and statutory duties. The process for appointing to the partner members is set out in the ICB's Constitution in line with legislative requirements. For the NHS Trust and NHS Foundation Trust roles, individuals are to be jointly nominated by the following organisations that have been collectively agreed as formal partners of the ICB: • Sherwood Forest Hospitals NHS Foundation Trust • Nottinghamshire Healthcare NHS Foundation Trust • Nottingham University Hospitals NHS Trust • East Midlands Ambulance Service NHS Trust • Doncaster and Bassetlaw Hospitals NHS Foundation Trust. The partner joint nominations are: **Representing hospital, urgent and emergency care services is:** Paul Robinson, Chief Executive of Sherwood Forest Hospitals NHS Foundation Trust. **Representing mental health, intellectual disability and community services is:** Dr. John Brewin, Chief Executive of Nottinghamshire Healthcare NHS Foundation Trust				
Recommendation:	Members are asked to receive this report.				
Action Required:	Approval	**Information**	Discussion	Assurance	Review

NN Partner Members Nominations Author: **Jon Sargeant** Report Date: **May 2022**

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 our vision*	*Team DBTH feels valued and feedback from staff and learners is in the top 10% in the UK*	*The Trust is in recurrent surplus to invest in improving patient care*

Implications			
Board assurance framework:			
Corporate risk register:			
Regulation:			
Legal:			
Resources:			
Assurance Route			
Previously considered by:			
Date:		**Decision:**	
Next Steps:			
Previously circulated reports to supplement this paper:			

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	24 May 2022	**Agenda Reference:**	**G1**
Report Title:	**Corporate Risk Register**		
Sponsor:	Jon Sargeant - Interim Director of Recovery, Innovation & Transformation		
Author:	Fiona Dunn, Deputy Director Corporate Governance/Company Secretary		
Appendices:	CRR MAY 2022		

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:	<u>Key changes to the CRR this period:</u> • No new corporate risks rated 15+have been added or escalated from Management Board • Currently there are 94 risks logged rated 15+ across the Trust and were tabled at the May 9th Trust Executive Group (TEG) for review • 12 of these risks are currently monitored via Corporate Risk register (CRR) • Risk ID2472 – (COVID1) - World-wide pandemic of Coronavirus-management. Risk rating decreased from 20 to 15 (5Cx3L). Rationale for decrease: visiting being reinstated as current infection rates reduced and "return to living with COVID" guidance being implemented. Elective work slowly recovering. Bed occupancy with COVID reduced. <u>Action required</u> • Continuous review of existing risks and identification of new or altering risks through improving processes. • Ensure link to key strategic objectives indicated within the Board Assurance Framework. • To help identify further management actions to improve the current risk management processes, the Trust has commissioned, and external review of the risk management processes which is in progress now, with a draft report due for review. Recommendations to be considered and outcomes shared and monitored via proposed governance structure facilitated by Interim Director of Recovery, Innovation & Transformation
Recommendation:	The Committee is asked to note the Corporate Risk Register information and the acknowledgement of the further review being undertaken which should improve and strengthen the Trusts risk management processes.

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:	TEG & Executive Team – (15+ risks)		
Date:	TEG 9 th May 2022	**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 9/5/2022		

Appendix 4 (Level 4 detail)

Corporate Risk Register Summary May 17 2022

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**	30/05/2022	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 - Knock on disruption of procurement and logistics teams sometimes delaying response Updated: 18/12/2020 Trust has been explicitly instructed by NHS E & DoH not to take no 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 -	Wilson, Rachel	**Dec/21** -Covid 19 pandemic related supply issues have now eased but national allocation arrangements remain in place for some key medicines. EU exit impact has been minimal to date but medicines shortages continue due to a combination of other issues. (A Barker). Trust has been explicitly instructed by NHS E & DoH not to take no 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.	Extreme Risk	15	High Risk	Apr-22	⟺
2664	**PEO3**	01/03/2022	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	**30/11/21** Risk grading decreased from 20 to 16 with new controls in place. Full action plan in place. Substantive consultant appointed and commenced in post(dec2021). Locum post appointed for 12 months and starting early 2022. Mutual aid secured from STH from January 2022. Second offer of mutual aid being explored. Full set of wider actions focusing on short-term workforce, environment, and longer term training and workforce model.Some support from general anaesthetists and external locums. **7/5/21** Mutual from Sheffield commenced (covers approx. 5 shifts per	Extreme Risk	16	High Risk	Nov-21	⟺
2472	**COVID1**	17/08/2022	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	Trainer, Abigail	**17/5/22** risk reduced. visiting reinstated as current infection rates reduced and "return to living with COVID" guidance. Elective work slowly recovering. Bed occupancy with COVID reduced (AT) **20/3/22** existing controls in place and recovery plans monitored via COO and delivered to F&P & Board. New IPC guidance in place to allow 1mrule to support elective recovery. Updates regularly to CQC via engagement meetings.ay	Extreme Risk	15	High Risk	May-22	↓
11	**F&P1**	24/05/2022	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	Alex Crickmar	**24/3/22** full discussionre new plans to F&P 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	Mar-22	⟺
7	**F&P6**	31/05/2022	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	Debbie Pook,Gill Marsden	**30/11/21 -** Controls still applicable as in March. Refreshed board performance report in progress to reflect H2 priorities and to improve transparency of performance against key metrics. Improved benchmarking approach in place using data from NHSE/I, nationally published data and dashboards. Trust wide engagement approach with consultants/SAS and Divisional leaders regarding H2 requirements including UEC roadshow.[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	Extreme Risk	16	High Risk	Mar-22	⟺

Appendix 4 (Level 4 detail) **Corporate Risk Register Summary May 17 2022**

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
19	PEO1 (Q&E1)	02/05/2022	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	Anthony Jones	**2/12/21** -Regular updates provided to Partnership Forum and JLNC in respect of service and Trust level changes being planned. Deputy Director of P&OD has weekly meetings with staff side chair and secretary and attends the staff side meetings and the Director of P&OD meets regularly with the LNC Chair. The Communications team share regular updates using Facebook, general and targeted emails and posting on the Trust website and The Hive to ensure all colleagues in the Trust are updated on key issues - recent examples include during the Covid pandemic. In addition the monthly team brief sessions have moved on line with a recording of the Chief Executive being posted on facebook and The Hive. The Executive Team meets weekly with the Head of Communications in attendance; in addition there are monthly Trust Executive Group meetings and quarterly senior leadership meeting with the Chief Executive. The Chief Executive holds regular listening events with all Divisions and directorates virtually to which all staff are invited.[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	12	Moderate Risk	Feb-22	⟺
12	F&P4	29/10/2022	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	Howard Timms	**[29/03/2022** Howard Timms] Implementation of Maintenance Strategy Review (7 Point Plan) FY 22/23 £16.7 Million Capital Investment identified for 22/23 Project Team working on Development of new Hospital Build for Doncaster. **[16/11/2020** 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	Mar-22	⟺
1410	F&P11	22/08/2022	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 (4) Disaster recovery and business continuity testing (5) Control of device (not user) access to the network (6) Configuration management and process documentation) (7) Backup management and storage capacity (8) Logging and retention of log information (infrastructure) (9) Failure to wholly implement patch management (10) Visibility of networked devices and systems as they relate to notified vulnerabilities (e.g. CareCERT advisories) As a result the above could lead to temporary closure of systems access, infection of key software and/or related operational issues. This would need significant remedial work and might require forensic response that would need to be funded from cyber liability insurance. Negative press coverage would follow and investigation by national bodies would be likely.	Anderson, Ken	**7/2/22** -Updated ordering of risks to reflect work done on patching, asset management and log retention and analysis, which has reduced risk in these areas. More work remains on those points, but other risks now have a greater priority. Work is ongoing to update unsupported software in the organisation, with further investment requested in 22/23 to continue the work needed. Investment has also been requested in the top 2 risk areas and other identified areas of risk identified.**[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	Extreme Risk	15	Moderate Risk	Feb-22	⟺

Appendix 4 (Level 4 detail) **Corporate Risk Register Summary May 17 2022**

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
16	PEO2 (F&P8)	02/05/2022	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	Anthony Jones	**02/12/2021** - Regular reports to the People Committee in relation to vacancy levels and training plans. Refreshed Trust level workforce plan being developed detailing hot spot areas and planned actions. Electronic workforce planning tool being investigated to support divisional/specialty workforce planning. Workforce planning forms part of business planning process. Apprenticeship group in place which reports through the Training and Education committee to the People Committee. Workforce Planning committee now in place with representation from divisions and key staff groups to explore how we maximise our recruitment and training opportunities.**[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	Feb-22	⟺
1807	F&P20 / Q&E12	28/10/2022	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	Howard Timms	[**29/03/2022** Howard Timms] Lift Refurbishment Programme delayed due to COVID. Lift Refurbishment Project for EWB Lift 3 and 7 commenced March 22. Further Lift Refurbishment Planned 22/23 including South Block Lifts 3 and 4, W and C Lifts 1 and 2 and Mexborough Pain Management. [**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	Mar-22	⟺
1412	F&P12	29/10/2022	Estates and Facilities	Not Applicable (Non-clinical Directorate)	**Risk of fire to Estate**	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	Howard Timms	[**29/03/2022** Howard Timms] EWB and W&C Block Fire Enforcement Notices Rescinded and replaced with Fire Action Plans Fire Improvements W&C investment 21/22 £4.1 million Further Fire Improvement Works scheduled investment 22/23 £3.0 million **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	Mar-22	⟺
13	ARC01	29/07/2022	Directorate of Finance, Information and Procurement	Not Applicable (Non-clinical Directorate)	**Risk of econmic crime against the Trust by not complying with Government Counter Fraud Functional Standard GovS 013**	Risk of econmic crime against the Trust by not complying with the Government Counter Fraud Functional Standard GovS 013 – Counter Fraud leading to (i) Impact on Trust's finance (ii)Negative impact on reputation (iii)action from Cabinet Office re failure to comply with standard	Alex Crickmar	[**04/04/2022]** Regular communication via ARC and Trust Counter Fraud champion and CF Specialists. Trust assessed against the standards and documented for compliance in (LOCAL FRAUD RISK ASSESSMENT Version 11 (Valid from 1st April 2022 until 31st March 2023. Submitted and approved at ARC via the Counter Fraud Operational Plan 24th March 2022. Individual risk assesment attached to risk. Actions added to individual risk owners. 12 is highest risk attahced to Bank madate fraud (i) Local Counter Fraud Specialist work plan and investigations (ii) Fraud awareness training. (iii) DH Counter-Fraud regime and oversight (iv) Liaison with DOF and Chair of ANCR (v) Staff fraud questionnaire. (vi) Board level awareness, October 2018.	Extreme Risk	12	High Risk	Apr-22	⟺

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	24 May 2022	**Agenda Reference:**	G2
Report Title:	**Use of Trust Seal**		
Sponsor:	Fiona Dunn, Deputy Director of Corporate Governance / Company Secretary		
Author:	Fiona Dunn, Deputy Director of Corporate Governance / Company Secretary		
Appendices:	None		

Report Summary				
Purpose of report:	The purpose of this report is to confirm use of the Trust Seal, in accordance with Section 14 of the Trust's Standing Orders.			
Summary of key issues/positive highlights:	Seal No 129	Description Supplemental Deed- adults weight management service. Service Contract between Doncaster Metropolitan Borough Council and Doncaster & Bassetlaw Teaching Hospitals NHS FT	Signed Richard Parker OBE Chief Executive Alex Crickmar Interim Director of Finance	Date of sealing 27 April 2022

Recommendation:	The Board is requested to approve the use of the Trust Seal				
Action Require:	**Approval**	**Information**	~~Discussion~~	~~Assurance~~	~~Review~~

Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**

Implications	
Board assurance framework:	n/a
Corporate risk register:	n/a
Regulation:	Board of Directors Standing Orders
Legal:	
Resources:	none

Assurance Route			
Previously considered by:	Executive Team		
Date:	20/4/2022	**Decision:**	Approved
Next Steps:	none		
Previously circulated reports to supplement this paper:			

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	24 May 2022	**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 March 2022'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

April's Board meeting was a shorter, check-in meeting, updates included a report from the Remuneration Committee, in respect of organisational pay awards and the Chief Executive and Directors report.

A virtual Spring Governor Workshop took place on 11 April, when the Governor Support Team provided an update in respect of support and training opportunities, we heard a national perspective on topical governor issues, from Finn O'Dwyer-Cunliffe, Senior Policy Manager and governors were supported to share good practice and current challenges. Finally, a presentation was delivered by NHSE/I on the upcoming consulation on the addendum to the Guide for Governors. Peter Abell, Bassetlaw Public Governor has very kindly agreed to deliver a workshop on what this may mean for governors at the Trust at 4pm on 19 July 2022.

Finally, as Chair of NHS Providers Governors Conference on 6 July and the non-executive director induction programme on 14 July I have joined a number of planning calls to ensure events runs smoothly on the day.

Governors

On 8 April we welcomed 8 new Doncaster and Bassetlaw public governors and saw David Northwood, Vivek Panikkar and Kay Brown re-elected. We also said goodbye to those governors who had chosen not to stand or were not re-elected, and I have shared with them all special thanks for their contribution during their terms of office.

Newly elected governors were invited to attend an induction with myself, the Chief Executive and Company Secretary on 19 April, as part of this session the governors heard about the Trust, including its various sites, population, workforce and Board of Directors. They were appraised on the role of a Foundation Trust, the Trust's vision and values and a broad overview of the role of the governors.
Hazel Brand, former Lead Governor, also joined the session to share how the governors are involved in the Trust business, use of their collective skills, knowledge and experience, the governor's code of conduct and the various ways to stay up to date with trust news. A separate meeting with the Company Secretary to run through role requirements in more detail took place later that same week.

Since my last Board report the governors have had the opportunity to attend a governor development and briefing session on Foundation Schools in Health, supported by Kelly Turkhud, Vocational Education Manager, Sarah Pinder, Project Manager and hosted by Mark Bailey, Non-executive Director. The next planned session will take place on 14 June and Ruby Faruqi, Stay and Thrive Matron, will provide an oversight of her new role and the initiatives taken by the Trust to enhance retention and development opportunities of nursing colleagues.

Finally, on 28 April the Council of Governors met, the non-executive directors were able to share their committee updates and members of the executive team were on hand to handle those operational questions. The Council received a timeline of the appraisal process for myself and non-executive directors and had been involved in feeding into the process for my appraisal, via the Interim Deputy Lead Governor.

1:1s & Introductory Meetings

In addition to my regular meetings with the Chief Executive, I have taken part in 1:1 discussions with the Non-executive Directors, Interim Deputy Lead Governor and Company Secretary. I have also met with the Deputy Chief Executive, Acting Director of People & Organisational Development, the Director of Nursing, and the Interim Director of Recovery, Innovation and Transformation.

Following a number of introductory meetings across the organisation I was also able to meet with Zoe Lintin, our soon to be Chief People Officer; Zoe shared her reflections to date and her ambitions for her new role.

I also took the opportunity to meet with George Briggs, who following his retirement from the Rotherham NHS Foundations Trust will commence in post as Interim Chief Operating Officer. George will offer support to the Trust whilst we undertake the recruitment of a substantive post holder. George brings with him a wealth of experience gained throughout his 40 years of NHS service and we look forward to welcoming him on board in mid-June.

Recruitment

Further to my last Board report and as confirmed at the extra-ordinary meeting of the Council of Governors on 28 March I am delighted to welcome Mark Day, Non-executive Director to the Board. Mark officially commenced in post on 1 May and has been undertaking a range of corporate and team induction meetings since that time. We welcome Mark to his first Board meeting today and look forward to his involvement at the sub-committees of Board in due course. We continue to recruit for the remaining NED vacancy and following the recent announcement that Sheena McDonnell has successfully been appointed to the Chair of the Board at Barnsley Hospital, an additional candidate will be sought. The recruitment campaign is being managed with the support of Odgers Berndtson, recruitment advisors. In order to offer support during this transition period Sheena has kindly given a commitment to remain in post at DBTH until 30 June. In view of the change in non-executive directors the Company Secretary will be undertaking a review of their attendance at Committees to ensure appropriate cover is maintained.

In respect of recruitment to the post of Chief Operating Officer, I have met with Odgers Berndtson to review the longlist of applicants and where required have participated in pre-application discussions. Interviews for this post will take place on 9 and 10 June 2022.

Other meetings and events

I was delighted to be invited to the opening of the North Notts Nectar Trail in the Canch at Worksop, where a number of bee sculptures decorated by talented locals have been located. I was joined at the event by the Chair and Chief Executive of North Nottinghamshire Business Improvement District, a representative from Bassetlaw District Council and sponsors from Go Green and Stagecoach. The displays will remain in place across the district until September, with the aim of celebrating positive character traits, the natural environment and increasing footfall. All proceeds raised through sculpture sponsorship and auction will be generously donated to the Trust's charity.

Following the retirement of Pat Drake at the end of March, I chaired the April meeting of the Quality & Effectiveness Committee; Kath Smart will assume responsibility as committee chair until a clinical non-executive appointment has been made. I have also observed the Finance & Performance Committee.

I have attended development sessions relating to the Integrated Care Board and South Yorkshire & Bassetlaw Acute Federation, the latter session took place on 16 May and was facilitated by Adele Coulthard, NHSE/I's Head of System Improvement (North region). This allowed wider Trust Board members the opportunity to consider the purpose and priorities of the Acute Federation.

The Trust continues to actively participate in South Yorkshire & Bassetlaw Integrated Care System meetings and a regular monthly meeting of Chairs now takes place with Pearse Butler, Independent Chair and Chair Designate of the South Yorkshire Integrated Care Board. The Chief Executive and I also continue to meet with the Designate Chair and Chief Executive of Nottingham & Nottinghamshire Integrated Care Board. The Trust is also represented at the Nottingham & Nottinghamshire Chair and Chief Executive Provider Collaborative and Chair and Elected Members forums.

Finally, as part of the celebrations of International Day of the Midwife, Nurse and Operating Department Practitioners, I joined senior nursing colleagues on ward visits to share my thanks for all colleagues do each and every day, but to recognise them specifically on the International Day of the Nurse. Colleagues were able to enjoy a drink, a biscuit and received a trust branded travel mug as a sign of our appreciation. I also joined Dr Sam Debbage, Deputy Director of Education & Research to close day one of the conference Nurses a Voice to Lead: Invest in Nursing and Respect to Secure Global Health.

NED Reports

Mark Bailey

Since the last Board report, Mark has participated in the Board Committees for Finance & Performance, Quality & Effectiveness, People and Audit & Risk.

Assurance and 'buddy' meetings have been held on-site and virtually with executive colleagues and members of their teams. Specific areas covered include nursing, maternity, digital transformation, performance, restoration and recovery, research, health and well-being and charitable funding.

Acting as the interim NED Safety Champion for Maternity, Mark also supported part of the regional Ockenden assurance visit of our maternity services.

Mark has supported the Surgery and Cancer Division with the appointment of an Orthodontist Consultant and along with the Chair held a welcome meeting with our latest cohort of International Nurse.

Individual 'buddy' calls with Governors continue along with attendance and presentation of the development of our Charity at the Council of Governors.

Kath Smart

Kath has attended her regular committee meetings including Board, Finance & Performance Committee, People Committee and Charitable Funds. She also presented at the recent Council of Governors.

Chairing both March and April's Audit & Risk Committee, and also meeting with both Internal Audit and the Local Counter Fraud Officer as part of her role as Audit Chair. Kath has also met with KPMG who are supporting the Trust with risk management work.

She has chaired consultant interviews and was pleased to appoint consultants in both Dermatology and Haematology services within the Trust.

Finally, Kath had 1:1's with Suzy Brain England and Mark Day, newly appointed non-executive director. She has led the Quality & Effectiveness Committee agenda planning session in preparation for the June meeting and attended the South Yorkshire & Bassetlaw Acute Federation development session.

Sheena McDonnell

This month Sheena has continued to focus on developing her skills and knowledge as a non-executive in the NHS and has participated in a stronger communities event and equality, diversity, and inclusion briefings. Sheena has also participated in a board development workshop on risk appetite.

Sheena has attended the Quality and Effectiveness Committee and in her newly appointed Senior Independent Director role commenced the arrangements for the appraisal process for the Chair of the Board, including having carried out the appraisal meeting with the Chair. This will subsequently be recorded and returned to NHSE/I as per their expectations.

Sheena has also attended and presented at the Council of Governors and prepared for and chaired the People Committee. As the new Chief People Officer is soon to commence in post, Sheena has been involved in some handover discussions with Zoe Lintin, who also attended and observed the People Committee. Sheena has participated in a HR appeal panel and along with other NED colleagues has attended an Acute Federation development workshop. She has also attended a walk through of the accounts, ahead of the Audit & Risk Committee and met with newly appointed non-executive director, Mark Day as part of his induction.

Neil Rhodes

Since the last Board meeting Neil has attended the Council of Governors, sharing an overview of Trust annual financial outturn and plans for the year ahead. He has held a meeting with key executives to agree the agenda for the next Finance and Performance Committee and had separate business meetings with the Chair, Suzy Brain England, Interim Chief Operating Officer, George Briggs, Interim Director of Recovery, Innovation & Transformation, Jon Sargeant and Executive Medical Director, Dr Tim Noble.

Prior to the next Board meeting Neil is also scheduled to chair a meeting of the Nottingham & Nottinghamshire Provider Collaborative Chair & Chief Executives at Bassetlaw Hospital, have an introductory meeting with new non-executive director, Mark Day and a walkthrough of final accounts with Director of Finance, Alex Crickmar. On 23 May he will also attend the Nottinghamshire and Nottingham ICB Chairs and Chief Executives meeting.

Mark Day

Mark commenced in post of 1 May, he has attended the Trust's corporate induction programme and has commenced introductory meetings as part of his local induction. Mark has joined the South Yorkshire & Bassetlaw Acute Federation development session which was a helpful insight to bring him up to speed with progress to date.

Mark will be on site at Doncaster Royal Infirmary on Friday 20th May when he will be able to complete some housekeeping matters, arrange for an official photograph and have the opportunity to meet with some colleagues face to face.

Chief Executive's Report
May 2022

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

An update on the Trust's response to COVID-19

Like many trusts across the region, throughout March and April we saw instances of COVID-19 amongst our patients increase substantially. From an average of around 45 each day, this peaked at 180 in early April, increasing the pressures faced by colleagues.

This was further compounded by transmission amongst colleagues and the need subsequent need for a period of isolation, as per our infection, prevention, and control measures. Suffice to say, we've had a tricky number of weeks, however I am pleased to report that we appear to be on the climb down from this spike in coronavirus-related activity.

In response to heightened rates of COVID-19 within our communities, we took the difficult decision to restrict visiting.

Thankfully, we have been able to recover our position since then, and at the time of writing the number of patients with us with active coronavirus is just 41. As such, we have been able to rescind our visiting restrictions once again, more details of which can be found further on within this report.

As ever, I share my thanks with colleagues who have worked exceptionally hard throughout this challenging period and hopefully we have some better weeks and months ahead.

Visiting restrictions eased at the Trust

The refreshed rules mean that the majority of adult inpatients can have up to two visitors at any one time between the hours of 11am and 8pm – however individuals are asked to call ahead before attending, as well as wear a mask throughout.

Non-COVID patients:

A general visiting period between 11am and 8pm will be adopted (to avoid overcrowding). Patients will be allowed up to two visitors at any one time. We will ask families to coordinate this as best as they can and reduce the number of people coming into the hospital. We will also ask staff to manage as best as they can to avoid any crowding within bay areas.

As usual, visitors will be asked to wear a mask, and should be asked if they are experiencing any symptoms of COVID-19 before entry.

COVID-19 patients:

To reduce any potential for further outbreaks, COVID-19 positive patients will be allowed one nominated visitor whenever they are still testing positive for the illness – again between the hours of 11am and 8pm.

Visitors will be asked to wear a mask at all times. If the patient is undergoing any aerosol generating procedures, they should be provided with, and ask to wear, a hood.

Elective surgery:

We do continue with some restrictions for those undergoing planned inpatient surgery and ask families and friends to stay in touch via electronic means where possible. We are supporting two visitors per patient per day between 11am and 8pm. Visitors must remember that many patients undergoing planned surgery are clinically vulnerable and at high risk should they develop covid in the postoperative period. We would ask that if visitors have any symptoms of COVID, feel generally unwell or have been in contact with someone who has COVID or has symptoms of COVID, that they don't attend as a visitor to the elective wards.

Post-surgery

Two visitors per patient for each patient between hours of 11am to 8pm, however we would ask visits to be kept as short as possible. Visitors are asked to Lateral Flow Test if possible.

Outpatient, diagnostic services and Emergency Department:

Patients attending for appointments, or an emergency visit can be accompanied by one other person. As usual visitors will be asked to wear a mask.

Complex needs patients:

Two visitors at any one time, however, open access for two nominated carers of patients with complex needs, those on palliative care, have learning disabilities, dementia, autism or a mental health need, beyond the normal hours of 11am to 8pm.

End of life care:

Two visitors at the bedside at any one time, however this can be rotated, open visiting beyond the hours of 11am and 8pm.

Children and siblings:

Can visit where two visitors are permitted and must be accompanied by an adult.

Paediatric and maternity:

Visit remains as outlined here: https://www.dbth.nhs.uk/patients-visitors/

Over 2,500 scans completed at Montagu Hospital, as Community Diagnostic Centre completes 'phase one'

Following the installation of MRI and CT suites at Montagu Hospital, over 1,000 and 1,600 respective scans have been completed, significantly reducing Doncaster and Bassetlaw Teaching Hospitals (DBTH) backlog of patients waiting for important diagnostic tests.

Late last year, Montagu Hospital was selected to host one of a pair of 'Community Diagnostic Centres' (CDC) within South Yorkshire, following a £3 million investment from the South Yorkshire and Bassetlaw Integrated Care System (ICS), of which Doncaster and Bassetlaw Teaching Hospitals (DBTH) has received around £230,000 of capital funding so far.

Managed as part of five year project, the first step was completed in January, as mobile MRI and CT units were placed on site, following the construction of suitable foundation pads by the Trust's Estates and Facilities teams. Since that time, the scanners were working throughout the latter parts of winter and into spring, providing a suitable alternative for local residents, and particularly those

that reside within the Dearne Valley, to receive crucial hospital care within a community setting that is convenient for them.

Unfortunately, there are around 367,000 new cancer cases in Britain each year, which works out at around 1,000 detected daily. With restrictions imposed as a result of the COVID-19 pandemic, cancer waiting lists have increased, as has the backlog of individuals awaiting diagnostic tests, a crucial component to the fight against the illness, as early detection often leads to better outcomes. As such, colleagues at DBTH, along with partners, are doing all they can reduce any delays locally.

The first part of the CDC is now complete, plans have been developed by the Trust's Strategy and Improvement team with clinical leads to take the project forward. The 'Phase 2 Business Case' will be submitted in the coming months, and colleagues are hopeful that it will receive the approval necessary from the regional and national team for further funding.

The Trust intends to communicate further about upcoming plans as and when it is able to, and in the meantime is looking for local people to get involved with future projects and developments such as the Community Diagnostic Centre, sharing their views and helping to shape healthcare in the area. If you wish to be involved, please email dbth.comms@nhs.net

Funding for the CDC has been secured as part of a national programme to help the NHS further accelerate diagnostic activity and recover services from the impact of the COVID-19 pandemic as quickly as possible. It is a share of a £350m national pot to create 40 new centres and was announced by the Government and NHS on Friday 1 October 2021. These new one-stop-shops for checks, scans and tests will provide a combined 2.8 million scans in their first full year of operation, of which the Montagu service will play its part.

Marking two years since completion of our first in-house COVID-19 test

Polymerase chain reaction (PCR) tests work by analysing samples taken through the insertion of a long cotton bud into the nose and around the back of the throat of an individual. Trained experts then extract the viral nucleic acid from the specific sample, amplify it, and then finally analyse it, establishing whether or not the someone has COVID 19.

As the pandemic began in March 2020, the Microbiology team, which is housed at Doncaster Royal Infirmary, initially sent tests to their counterparts at Sheffield Teaching Hospitals who kindly undertook limited screening on behalf of the Trust. However, given challenges to capacity at the time, and increasing numbers of patients presenting with symptoms of the novel illness, this only allowed for around 50 swabs to be checked per day, and as cases rose so did the pressure on the testing systems.

In a bid to increase the number of PCR samples that could be analysed for patients at Doncaster Royal Infirmary, Bassetlaw Hospital and Montagu Hospital, Michael Leng, Head Biomedical Scientist in Microbiology at DBTH, began exploring the possibility of setting up an in-house solution rather than sending their tests away. Within a few days, and with the successful procurement of cutting-edge technology, the very first test for coronavirus took place on site on Thursday 9 April 2020.

Since that time, the Microbiology team have tested more than 243,000 samples for COVID-19, with colleagues testing more than 700 samples a day during peaks of activity.

The service continued to innovate throughout the pandemic, with colleagues able to utilise in-house testing for the illness, enabling them to return to work quicker if a negative result was achieved.

Additionally, the team began to work with Abbott in January 2021 to install rapid testing stations, creating extra screening capacity with results returning in around 13 minutes.

The Trust continues to routinely screen both staff and patients for COVID-19 upon entry to the hospital, with all health professionals asked to undertake twice-weekly lateral flow tests.

An update on the Hearts for Doncaster sculpture

To date we have raised £12,556 and have sold 570 hearts for the sculpture – an incredible achievement.

The funds raised will be directly reinvested into patient care and services within our local hospitals, and, again, we want to take this opportunity to share our thanks for your kind support. There are still many hearts which require sponsoring and dedication, but we hope that over time each will be adorned with a loving message and tribute.

Due to several factors, it has taken us longer than we had initially planned for the sculpture to be placed within community and for this we want to apologise for the delay.

As you will understand, it is incredibly important to find a location where the sculpture will be safe and secure, as well as easily accessible for our supporters to go and sit for a while enjoying the piece.

We are now delighted to say that, working closely with Doncaster Council, we have secured the perfect location, however you will have to wait just a little bit longer until we can officially reveal where this is going to be, as we finalise the appropriate details. What we can say however is that it will be within a central and accessible location in Doncaster.
When we can reveal the location and the grand opening date (which we hope will be in the next few months), we will have a special event opening the accompanying garden where it is going to be placed.

A similar project has been undertaken elsewhere in the country, and below you can see what the completed sculpture will look like, minus the attached hearts which will give it its memorable colours and distinctive presence.

If you do have any questions please do not hesitate to get in touch by emailing: dbth.charity@nhs.net and if you have friends, family or loved ones who wish to sponsor a heart, they can do so by heading to: https://dbthcharity.co.uk/hearts-for-doncaster/

Special graduation ceremony for international recruits

Since 2020, the Trust has recruited around 50 individuals from overseas, supporting them to gain official accreditations as well as settle within the country. All of them are fully trained and registered within their country of origin and have been appointed to take up roles across a variety of specialities including renal medicine, diabetes and endocrinology and general nursing.

In total, 10 cohorts of nurses have helped to bolster the ranks at Doncaster Royal Infirmary, Bassetlaw Hospital and Montagu Hospital. In order to fully practice without supervision, each recruit has had had to complete the OSCE. This is a practical accreditation overseen by the Nursing and Midwifery Council (NMC) which enables international candidates to gain practice clinically within the UK.

The graduation ceremony was organised as an alternative to similar events organised by universities when students graduate from their respective studies. Acknowledging the hard work, dedication and

commitment of the newly appointed staff, particularly as they have contended with the additional challenges of settling into a new country and working environment and all in the midst of a pandemic.

Taking place in Doncaster Royal Infirmary's Lecture Theatre in mid-February, each of the successful nurses was presented with a certificate detailing their accreditation, with the Trust's Chief Nurse, David Purdue, and Non-Executive Directors, Pat Drake and Mark Bailey, also in attendance and on hand to share their thanks and congratulations.

Of the 50 or so recruits, 38 successful passed the OSCE and will now join the full-time establishment of the relevant wards and services as Registered Nurses. A further 12 will take their exam shortly and are currently being supported by colleagues at the Trust.

Fluoroscopy room opens at Doncaster Royal Infirmary

A brand new fluoroscopy room has been opened at Doncaster Royal Infirmary, following investment of more than £410,000.

Fluoroscopy is a medical procedure that makes a real-time video of the movements inside a part of the body by passing x-rays through it over a period of time. Fluoroscopy is commonly used to check how a patient's stomach and intestines are working for example if food is being properly swallowed, amongst many other investigations and examinations.

The new suite at DRI features a Siemens Luminos Lotus Max, a two-in-one fluoroscopy and radiography machine, which will enable the Trust's radiology team to undertake digital film imaging, as well as the aforementioned procedure.

Now in operation, the service supports crucial diagnostics within endoscopy, speech and language therapy, as well as barium studies and urology and Gynaecology dynamic studies, to name a few.

The hybrid nature of the Fluoroscopy room allows staff to use it for all plain film imaging from any source, improving waiting times and accessibility for all. The room is particular useful for those with complex needs, disabled as well as paediatric patients due to the extra adjustability of the equipment to accommodate individual requirements. For example, the table goes low enough for children to get on unassisted, the table can go vertically with the patient on it, so helping moving and handling. For patients who cannot lie flat, the team can X-ray spines and knees standing whilst they are fully and safely supported from behind.

While much of the budget of the project was assigned to the procurement of the specific technology required, the team were also keen to ensure that the clinical environment was calming for those undergoing examinations, and featured warm colours and mood lighting.

Appointment of first Professional Nurse Advocate to support mental health of staff

The Professional Nurse Advocate Training Programme is a clinical development scheme for registered nurses and was introduced in response and recognition of the effects that the pandemic has had on NHS staff.

PNAs offer something known 'restorative clinical supervisions' – the means placing an emphasis on strengthening an individual's ability to cope by providing a safe psychological space for them to discuss how they are feeling, how their profession impacts on this and how it can affect their

professionalism. It was created to address challenges within Critical Care, such as supporting nurses who may be at risk of burning out and in turn could have a negative effect on patient safety, quality of care, staff wellbeing, and absence rates.

Jenny Hunt was one of the first 400 individuals in the country to receive training and has subsequently been successfully appointed into a Lead Professional Nurse Advocate at the Trust through a joint appointment with the University of Sheffield.

Jenny has been seconded into the role and will work to develop a network of trained PNA's at DBTH, in conjunction with the University of Sheffield who deliver the PNA academic programme locally. The PNA role provides a model of supervision which supports a continuous improvement process that builds personal and professional resilience, enhances quality of care, and supports preparedness for appraisal and revalidation.

Currently there are three qualified PNAs, including Jenny, across the Trust and a further 21 who are either in training, or shall be going into training shortly. The vision, in line with the national strategy, is for the Trust to have one PNA to every 60 nurses by the end of this year. By the following year this will hopefully increase to one PNA to every 40 nurses, and by 2025 they hope to have one PNA to every 20 nurses. The programme is driven by Ruth May, the Chief Nurse at NHS England, and is currently only open to Registered Nurses, but will hopefully be extended to other Allied Healthcare Professionals and other NMC registrants in the future.

Joint Advisory Group (JAG) on Gastrointestinal Endoscopy

Our Endoscopy have submitted the necessary paperwork as part of our annual JAG review to maintain against this accreditation.

JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the criteria set out in the JAG standards.

I want to thank colleagues for their hard work in ensuring this work was completed before the deadline, particularly as it came at such a challenging time for the Trust.

Appointments and departures

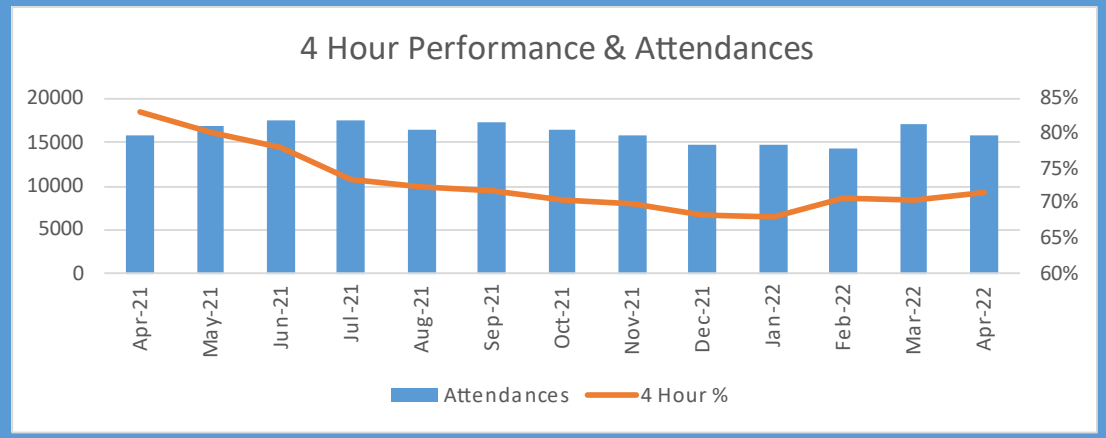
- **Rebecca Joyce**, Chief Operating Officer, has departed the Trust. A recruitment process is currently underway to appoint a successor.
- **George Briggs**, has been appointed Interim Chief Operating Officer and will join the team in the coming weeks.
- **David Purdue**, Chief Nurse, will depart the Trust in the coming weeks to take up a post at NHS England and Improvement. Abigail Trainer, Director of Nursing, will act into the vacant position until a recruitment process is completed in the summer.
- **Jon Sargeant**, Director of Executive Director of Restoration, Innovation and Transformation, has been named Deputy Chief Executive following David's depature.
- **Andrea Bliss**, Divisional Director for Children and Neonates, has stepped down and retired.
- **Laura Chrum** has been appointed as Director of Nursing for Paediatrics and will join the Trust on Monday 16 May.
- **Pat Drake**, Clinical Non-Executive Director, has retired following 52 years within the NHS. A recruitment process is currently underway to appoint to two vacant Non-Executive Director positions.
- **Mr Ray Cuschieri**, Deputy Medical Director, has retired following 33 years at the Trust. Ray is succeeded in post by an expanded Medical Director office.

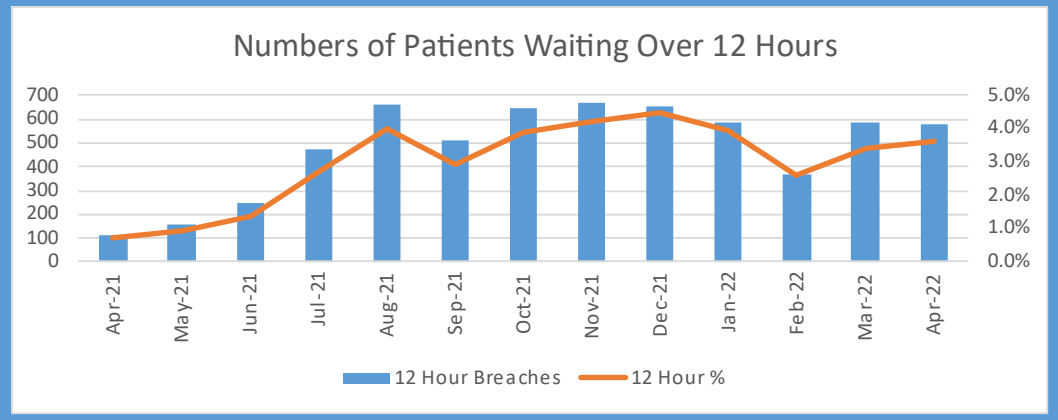
- **Marie Purdue**, Director of Strategy and Transformation, has left the Trust to take up the new role of Managing Director (Interim) for the South Yorkshire Mental Health, Learning Disability and Autism Alliance.
- **Andrew Barker**, has retired following 31 years at DBTH as Chief Pharmacist. Andrew's deputy, Rachel Wilson, has been appointed to the vacant position.
- **Dr Anurag Agrawal**, has been named Divisional Director of Medicine.
- **Dr Naushad Khan**, has been named Clinical Director for Emergency Medicine.
- **Miss Kathryn Rigby** has been appointed as Clinical Director for Breast, Vascular, Urology and Gastrointestinal
- **Mr Tomas Barani** has been appointed as Clinical Director for Obstetrics and Gynaecology
- **Dr Shivani Dewan** has been appointed as Clinical Director for General Medicine

Trust Integrated Exception Performance Report – April 2022

1. Urgent and Emergency Care – 4 hour standard and new standards
2. Urgent and Emergency Care – Ambulance Standards
3. Urgent and Emergency Care – Length of Stay
4. Urgent and Emergency Care – Length of Stay (Discharge)
5. Elective – Activity
6. Elective – Waiting List and Long Waiters
7. Elective – Outpatients
8. Diagnostic Waits
9. Cancer – Referral to Diagnosis
10. Cancer – Treatment
11. Health Inequalities
12. Performance – The Forward View

1. Urgent and Emergency Care: 4 hour performance and 12-hour standards





Key issues:

- 4 hour performance ↑ 71.49% for Trust. Main breach reasons continue to be doctor and bed waits
- COVID patients continue to affect discharges, flow and Infection Control challenge in April
- Attendance levels remain higher than any of previous four years, with main increase across Minors pathway
- Increase in ambulances at peak periods
- Significant sickness and staff absence due to Covid isolation continues
- Significant exit block impacting on flow due to delays in discharging patients into community
- Closure of community beds due to infection outbreaks impacting on flow

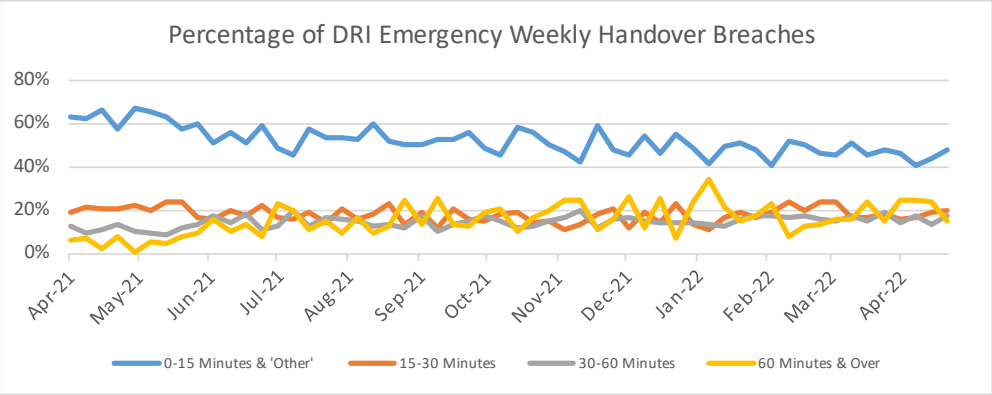
Key actions:

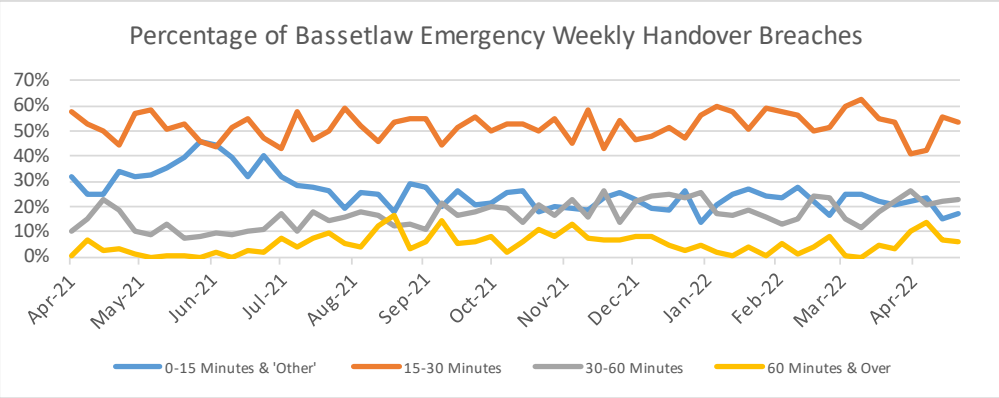
- Acute Medical Unit re-located to ED, focused on admission avoidance and short turnaround at front door
- Reviewing Early Assessment Unit model options
- Re-establishment of Early Senior Assessment model at Front Door
- Additional ED capacity now in place in Out Patient Department 2 to support escalation as required
- Frailty In-reach pilot commenced 21 March 2022
- Focus on Length of Stay, Flow and Discharge (Ongoing)
- Daily assurance template training and PDSA through now moved to monitoring.
- Refresh of training and implementation of operational huddles and escalation process work continues to embed
- Review of staffing models Feb - March 2022.

April 2022 Performance

Hospital	4 Hour % Achieved	Attendances	Breaches	%Streamed From FDASS
Bassetlaw	79.18%	4793	998	6.63%
Doncaster	63.09%	9521	3514	20.51%
Montagu	99.80%	1523	3	0.07%
Trust	71.49%	15837	4515	14.35%

2. Urgent and Emergency Care: Ambulance waits





Key issues:

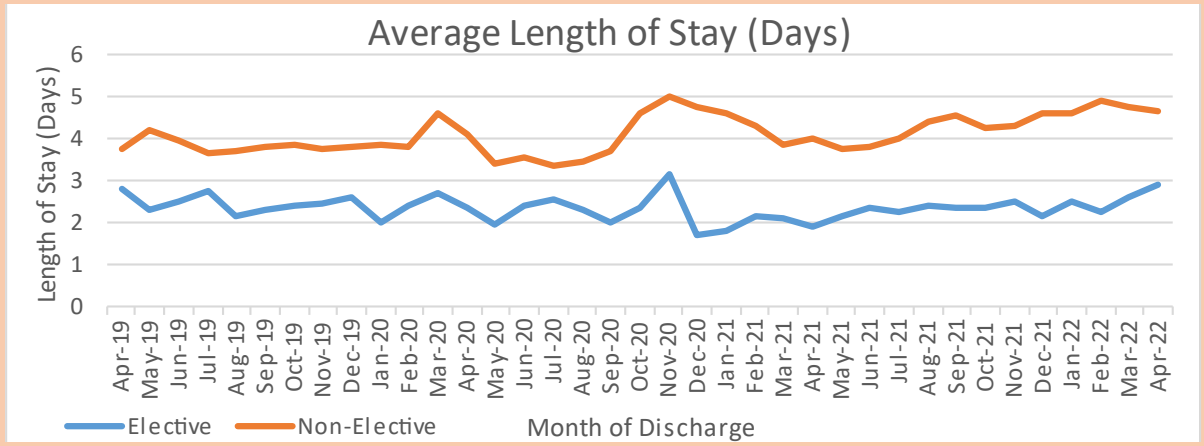
- Ambulance handover performance position challenging in April 2022 across Easter BH.
- High levels of ambulances continue in the Doncaster & Bassetlaw area.
- Further increase in COVID patients in April caused an ongoing exit block from ED increasing challenges to flow of ambulances coming into and the receiving of handovers.
- Issues relate to flow out of ED & wider trust continue to cause delays.
- Medical Director supporting engagement work with specialties to support flow out of the department.
- Divisional Director supporting work with ED teams to improves flow.

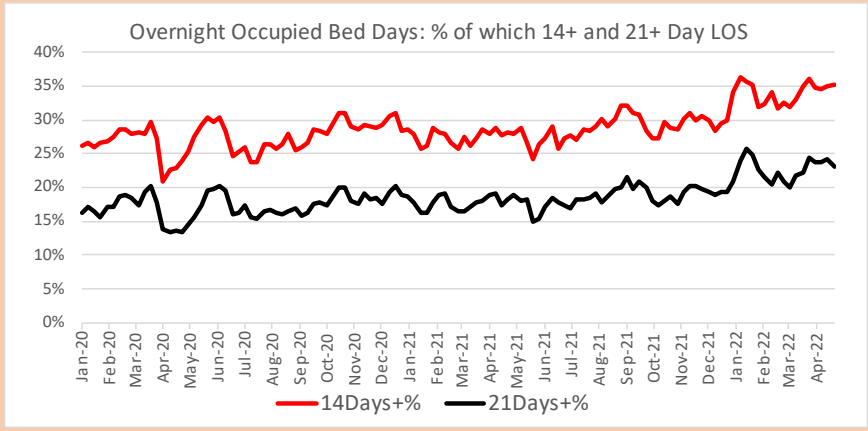
Key actions:

- Direct pathways for YAS to Medical Same Day Emergency Care (SDEC) and Surgical SDEC implemented Nov 21. Direct pathways for Community Response Team being scoped (June 2022)
- Direct pathways for EMAS to Medical Same Day Emergency Care (SDEC) at BDGH currently being implemented
- Same Day Emergency Care full review – to include review of Directory of Services now complete
- Reviewing referral criteria for surgical and medical SDEC pathways
- Length of Stay work stream key enabler
- Improvements to handover process to improve accuracy of data now complete
- See full Board Deep Dive Report for April 2022

Month	Hospital	Total Arrivals	%<15 Minutes	% 15-30 Minutes	% >30 Minutes	Longest Wait
Apr-22	Bassetlaw Hospital	748	20.99%	38.37%	27.27%	04:35
Apr-22	Doncaster Royal Infirmary	1876	49.95%	18.55%	31.50%	09:27
Apr-22	Trust	2624	41.69%	24.20%	30.30%	09:27

3. Urgent and Emergency Care: Length of Stay (LoS)





Key issues:

- Ongoing work to improve use of data on Length of Stay and Discharge Practice for internal teams – linking in with Data Scientist
- SAFER, Red 2 Green & Good Board Round Practice not consistently implemented on all wards.
- EDD on assessment units not consistent.
- Discharge update information on nerve-centre being reviewed
- Ongoing review of site management processes
- Challenges with patients who no longer have 'right to reside
- Implementation of Hospital and Community Discharge Policy across all area's
- Discharge pathway information within nerve centre to review

Key actions:

- Continue with 'Walkaround Wednesday's with focus on patients with 7 day + length of stay, ensuring all patients have a plan
- Red 2 Green team to continue with focus on supporting areas with lower compliance & engaging with wider multi-disciplinary team
- Red2 Green delay data added to patient safety huddle boards on pilot wards in partnership with QIi
- Partnership working to continues twice daily to review patients who no longer have a right to reside.
- Monitoring of discharge pathway v actual discharge pathway.
- Urgent and Emergency Care Programme continues with Real World Health consultancy

4. Urgent and Emergency Care: Length of Stay (Same Day Emergency Care - SDEC)

Discharges by Time of Day (Excluding Day case)

Discharge Time	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Before Noon	13.8%	14.9%	14.2%	13.1%	14.9%	15.4%	14.1%	13.5%	12.0%	14.1%
Before 4PM	45.6%	46.7%	46.1%	45.8%	48.2%	47.6%	47.0%	46.5%	42.9%	46.8%
After 4PM	53.9%	53.0%	53.5%	53.8%	51.3%	51.7%	52.7%	53.1%	56.8%	53.1%

Key issues:

- Not currently co-located with other SDEC areas (surgery/gynae) or ED – deters direct referrals
- Current staffing shortfalls - both ACP and medical for medical SDEC (ACU)
- Increase in overall attendances and reduced space in ED – opportunity identified for streaming to SDEC
- Issues for DBTH relate to flow into ED and into wider Trust
- Referral criteria pathways focused which reduces opportunities

Key actions:

- Work ongoing developing plans for SDEC co-location with support from Real World.
- SDEC Pathways with surgical and acute medicine being reviewed to access additional opportunity.
- Exploring potential combined Urgent Treatment Centre with new Co-located SDEC to provide new Front Door Model which will also release existing UTC space for Minor Injuries
- Direct referral pathways in place for YAS and EMAS to SDEC – moving into monitoring stage
- Working with ICS SDEC Transformation group to make further improvements
- Reviewing Early Senior Assessment model to improve streaming to SDEC from arriving ambulances
- Single point of access now in place via Consultant Connect

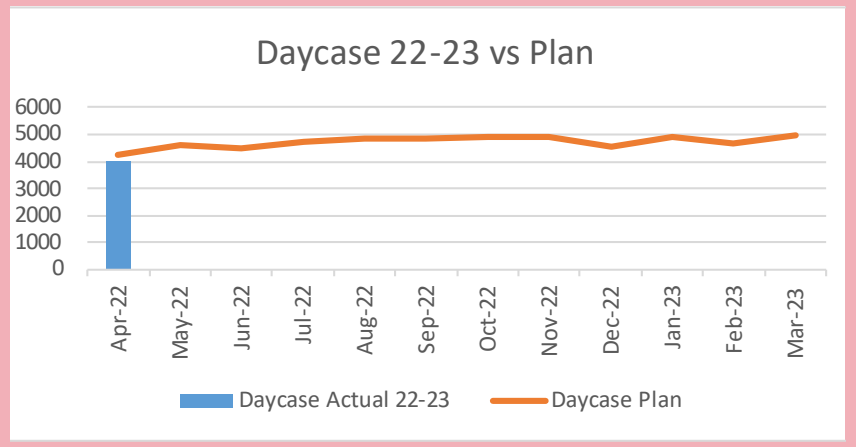
% of all Non-Elective Admissions to an SDEC Ward

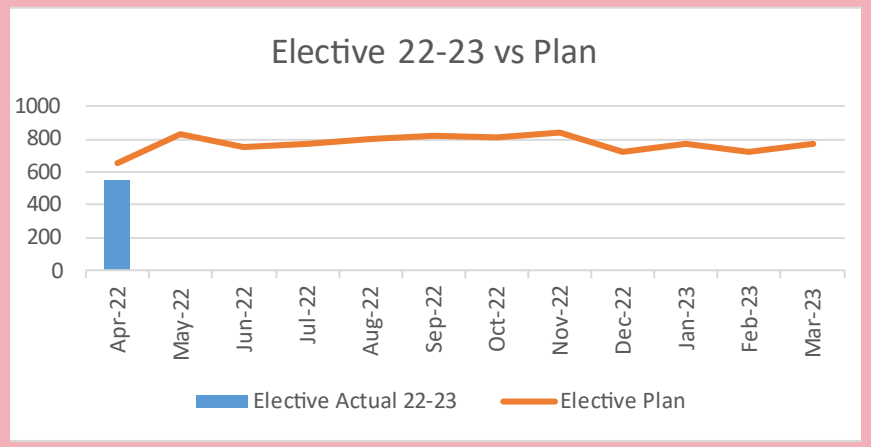
Ward	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
ACUTE MEDICINE DECISIONS UNIT									3.2%	5.2%	4.5%	4.0%	3.2%
AMBULATORY CARE UNIT - DONCASTER	7.0%	7.2%	8.8%	8.0%	7.7%	8.0%	8.1%	8.4%	7.5%	8.9%	8.8%	10.1%	9.2%
EMERGENCY SURGICAL AMBULATORY CARE	4.0%	3.7%	3.4%	4.4%	4.8%	4.3%	4.3%	4.7%	5.2%	6.3%	5.0%	5.0%	5.2%
GYNAE SAME DAY EMERGENCY CARE					0.2%	0.3%	0.4%	0.4%	0.4%	0.3%	0.2%	0.1%	0.0%
Grand Total	11.0%	10.9%	12.2%	12.4%	12.7%	12.6%	12.9%	13.5%	16.3%	20.8%	18.6%	19.3%	17.6%

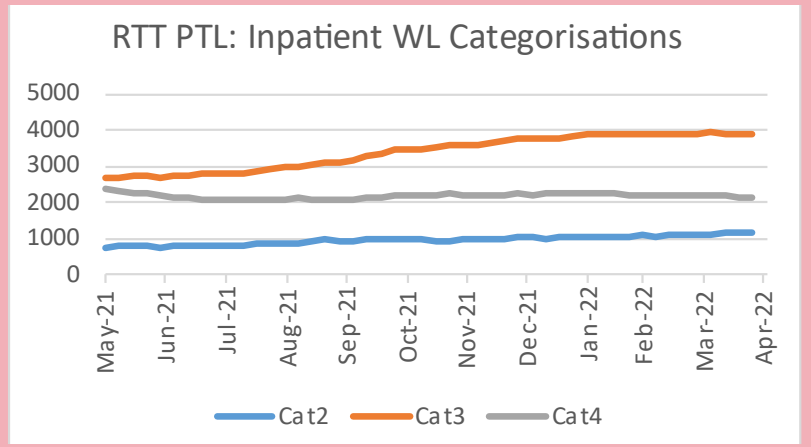
Number of Non-Elective Admissions to an SDEC Ward

Ward	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
ACUTE MEDICINE DECISIONS UNIT									142	219	178	175	133
AMBULATORY CARE UNIT - DONCASTER	338	355	428	377	345	356	377	372	330	375	347	442	389
EMERGENCY SURGICAL AMBULATORY CARE	195	183	167	207	214	191	202	206	231	264	198	219	220
GYNAE SAME DAY EMERGENCY CARE					8	13	19	18	18	13	7	4	1
Grand Total	533	538	595	584	567	560	598	596	721	871	730	840	743

5. Elective: Daycase and Inpatient Elective







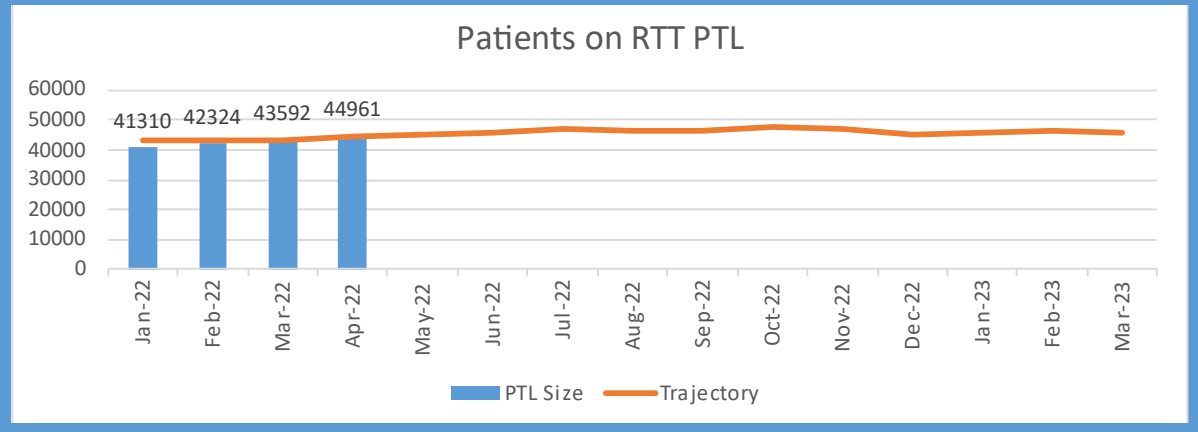
Key issues:

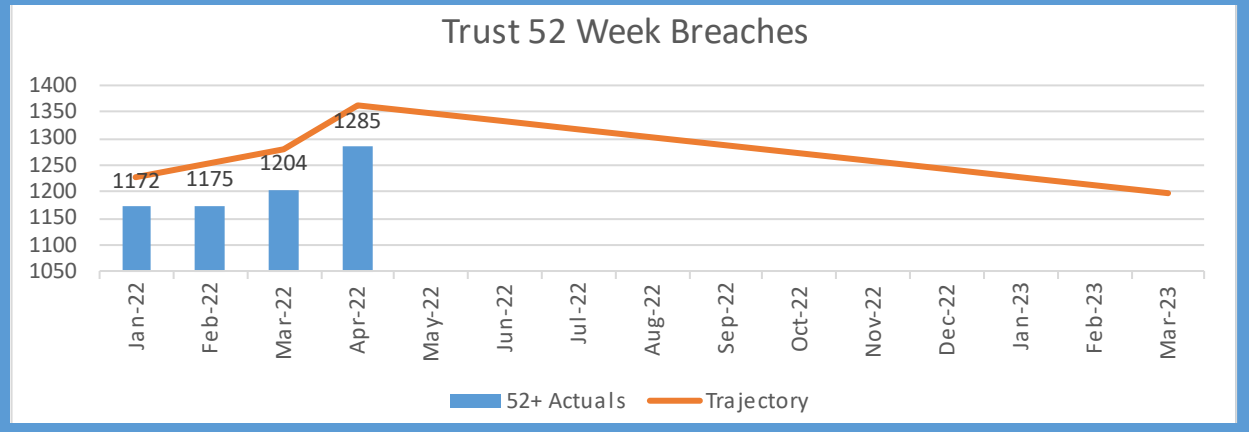
- Day case - Trust delivered 95.5% of plan & 96.5% of 19/20 activity
- Inpatients - Trust delivered 83.8% of plan 82.5% of 19/20 activity
- All patients are listed on the basis of clinical prioritisation and longest waiting times
- There is a steady and continued increase in elective throughput although comparing to 19/20 we note that COVID stopped elective activity during Q1 of that base year
- Slight increase in patient cancellations due to C19
- Staffing pressures continue due to C19 particularly medical staff
- Bed pressures continued to be an issue for elective and emergency surgery activity
- Trust delivered 86% of clock stop activity (target 89% v April 2019) in April 2022 .

Key actions:

- Continue to list all patients, prioritising Cat 2's and the longest waiting Cat 3's & 4's
- Critical Care capacity available to support elective programme
- Beds at Parkhill used tactically to support DRI bed base (ongoing)
- Outsourcing continues and is front loaded into the first 6 months of the year to maximise flexibility going forwards
- Maximising surgical activity at Doncaster, Bassetlaw and Mexborough to maintain elective programme
- Ongoing clinical review & challenge of categorisation at DBTH in line with the ICS led group (ongoing) – also known as Harm Minimisation approach
- Conversion of inpatients to day case wherever possible
- Maximising use of theatre lists/sharing lists to ensure best use of theatre, surgeon, anaesthetic resources (ongoing)
- Ensure the Outstanding Theatres programme supports approach
- Increasing the number of patients of patients booked onto all lists

6. Elective: Patient Tracking List and Long-Waiters





Key issues:

- 52 week wait position relatively stable at 1285 at end April (1204 at end of March) and ahead of target of 1364
- Total Patient tracking List slightly increasing to 44,961 in April Target <44,617 for April, so a breach of target by 344.
- Trust delivered 68.1% Incomplete pathways which is slightly lower than March 2022 which was 68.3%.

Key actions:

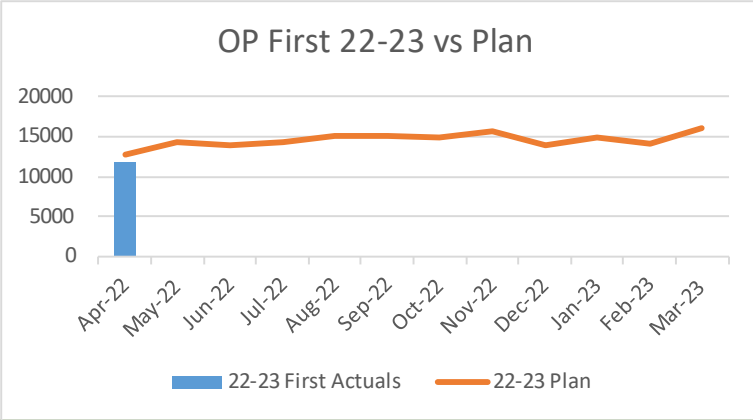
- Weekly PTL meetings maintained to ensure consistent approach across Trust to managing long waiters, both for outpatient and inpatient activity
- RTT Audits being rolled out across all clinical service areas to identify opportunities for improvement/training
- Maintained focus on 104 week waiters with weekly external reporting to NHSEI
- All 90 ww patient pathways man-marked and tracked
- Ongoing focus on validation
- KPMG supporting Outstanding Outpatient and Theatres work-streams to identify opportunities for 22/23 underway

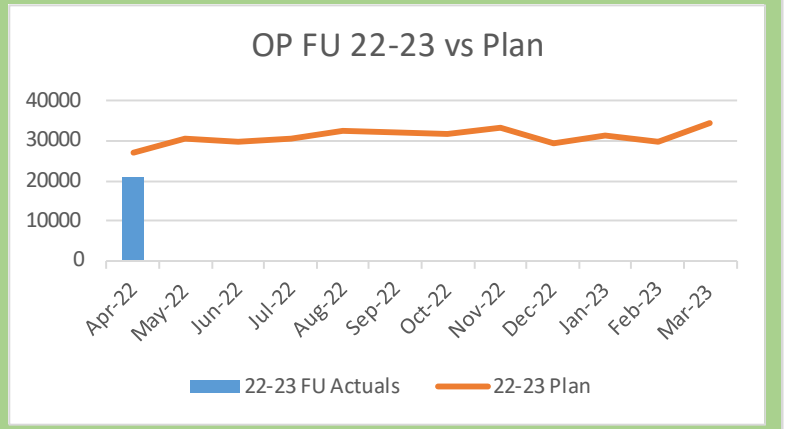
CCG	Values	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
NHS Bassetlaw CCG	Total Waiters	9391	9475	9440	9269	8936	8848	9014	9334	9601
	% Under 18 Weeks	70%	70%	69%	70%	67%	66%	66%	67%	67%
NHS Doncaster CCG	Total Waiters	26566	26793	26942	26526	26083	25967	26589	27380	28196
	% Under 18 Weeks	71%	70%	71%	71%	68%	67%	67%	68%	68%
Trust	Total Waiters	42790	43125	43156	42372	41503	41310	42324	43592	44961
	% Under 18 Weeks	70%	70%	70%	70%	67%	67%	67%	68%	68%

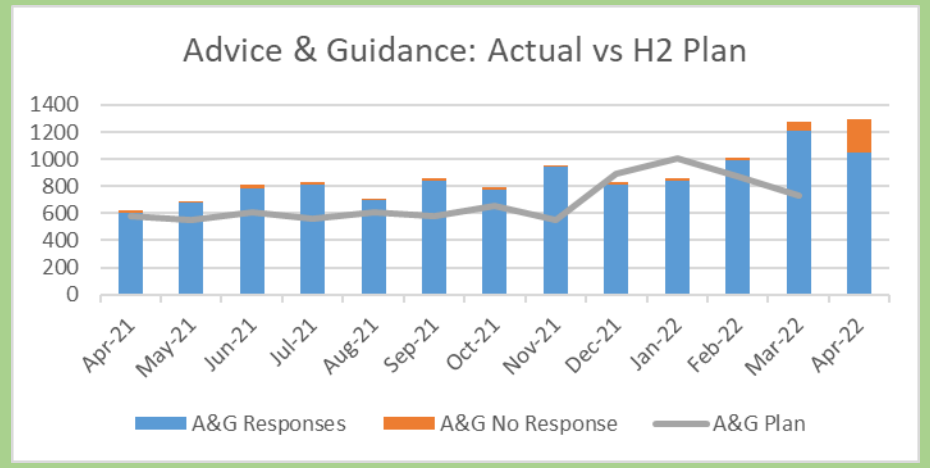
Reported 52+ Weeks: Top 6 Specialties

Specialty	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
TRAUMA & ORTHOPAEDICS	599	582	618	622	561	564	555	540	532	616
OPHTHALMOLOGY	153	193	230	252	239	275	279	287	321	317
ENT	131	114	106	111	107	108	119	112	96	91
UROLOGY	72	89	192	81	67	92	91	92	103	88
GENERAL SURGERY	63	56	53	39	28	34	39	34	21	12
ORAL SURGERY	36	26	18	20	26	24	21	20	17	20
Grand Total	1054	1060	1217	1125	1028	1097	1104	1085	1090	1144

7. Elective: Outpatients





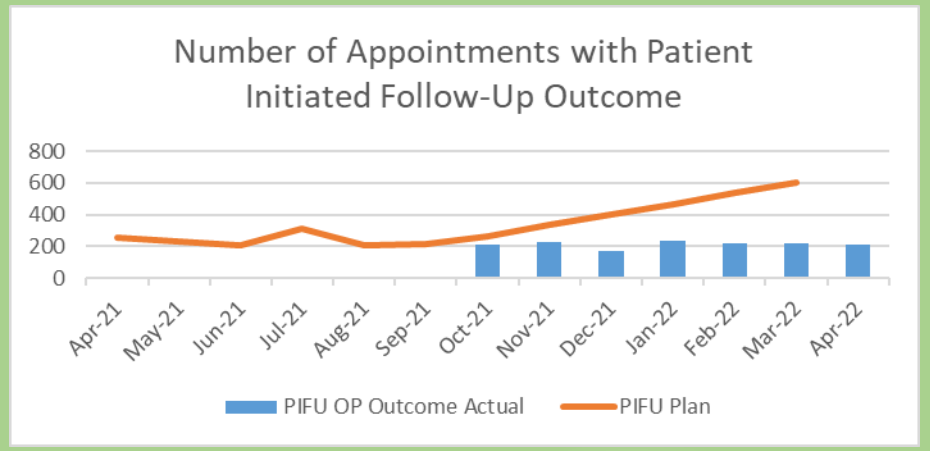


Key issues:

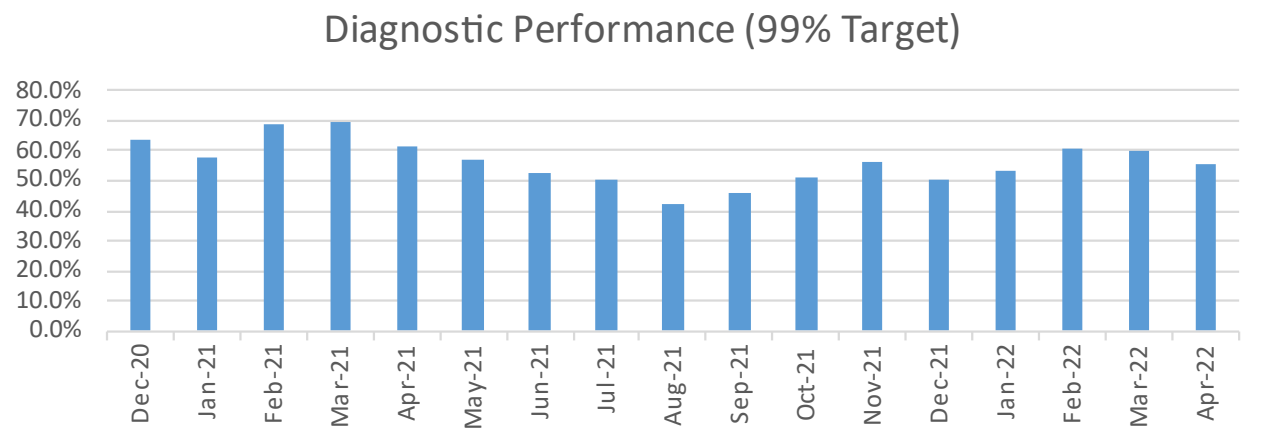
- First outpatient appointments the Trust delivered 91.9% of plan and 81.7% of 19/20 activity
- Follow-up outpatient appointments the Trust delivered 77.1% of plan and 81.6% of 19/20 activity.
- Some activity stood down due to sickness, but also due to planned annual leave
- Patient Initiated Follow Up (PIFU) activity being rolled out in 5 more specialties
- Plans being developed to address large numbers of historic open appointments across Divisions
- Need to maintain outpatient access to ensure timely flow through patient pathways

Key actions:

- Look for opportunities to increase capacity, deal with the backlog and reduce waiting times for patients
- Improve patient information, targeted support and self-management eg My Planned Care
- Increase A&G (16 per 100OPFA by March 23)
- Embed PIFU (5% of all OP attends by March 23) across specialties
- Promote use of revised DERICK dashboards to support monitoring / improvement work
- Outstanding Outpatient work with KPMG progressing well
- Continued focus on validating open appointments by specialty



8. Diagnostic waits



	Waiters <6W	Waiters >=6W	Total	Performance
Trust	8818	7092	15910	55.42%
NHS Doncaster	5860	4770	10630	55.13%
NHS Bassetlaw	2212	1703	3915	56.50%

Key issues:

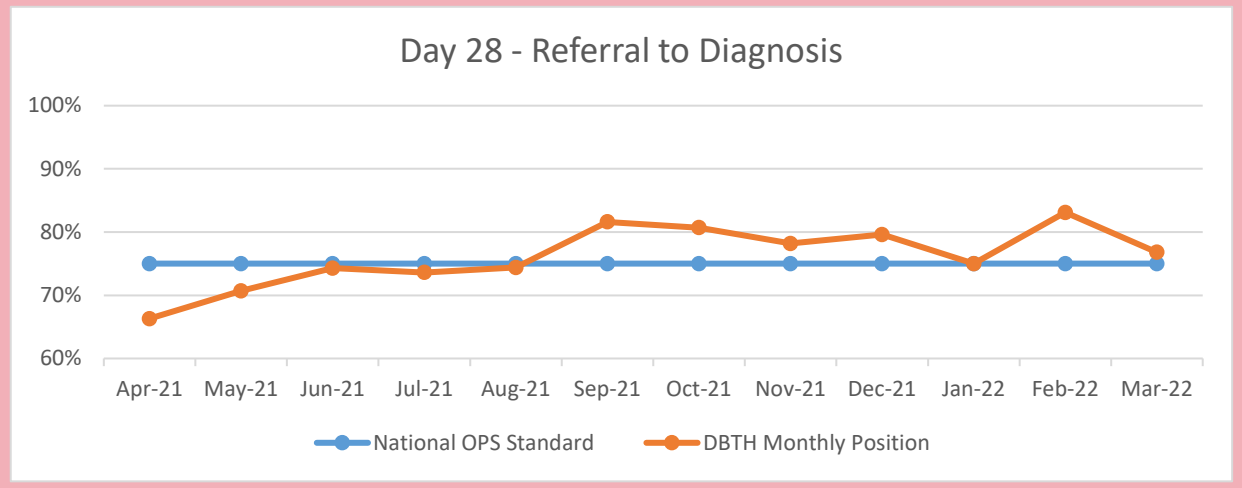
- Performance against the 6-week target declined to 55.42% compared with 59.79% in March.
- The decline in 6-week performance was greatest in CT with a reduction to 63.96% from 73.54 % the prior month.
- Performance of 100% was achieved for colonoscopy and gastroscopy.
- The number of 6-week waits for investigations increased to 7092, the highest number since January.

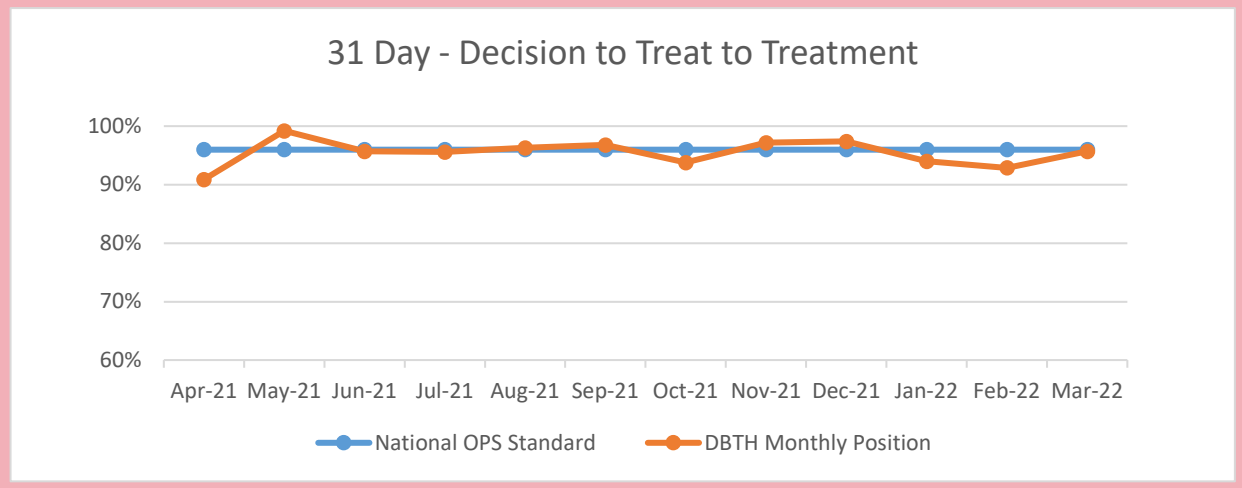
Key actions:

- Potential options are being explored to further increase CT capacity at DRI.
- Discussions ongoing regarding establishment and application of guidelines for referral for emergency CT imaging.
- Additional mobile CT and MRI capacity at Montagu Hospital has been funded nationally as part of the Community Diagnostic Centre program. The MRI capacity commenced in April with CT capacity scheduled for August.
- British Medical Ultrasound Society guidance to reduce unnecessary ultrasound referrals implemented with effect from 2 May 2022

Exam Type	<6W	>=6W	Total	Performance	Longest Waits
MRI	911	166	1077	84.59%	46
CT	1950	1099	3049	63.96%	60
Non-Obstetric Ultrasound	3516	3843	7359	47.78%	80
Barium Enema	0	0	0	0	0
DEXA	390	837	1227	31.78%	36
Audiology	273	665	938	29.10%	47
Echo	628	248	876	71.69%	12
Nerve Conduction	120	188	308	38.96%	41
Sleep Study	12	0	12	100.00%	2
Urodynamic	57	35	92	61.96%	109
Colonoscopy	250	0	250	100.00%	5
Flexible Sigmoidoscopy	81	0	81	100.00%	5
Cystoscopy	281	11	292	96.23%	7
Gastroscopy	349	0	349	100.00%	5
Total	**8818**	**7092**	**15910**	**55.42%**	**109**

9. Cancer: Referral to Diagnosis (Faster Diagnosis Standard & Diagnosis)





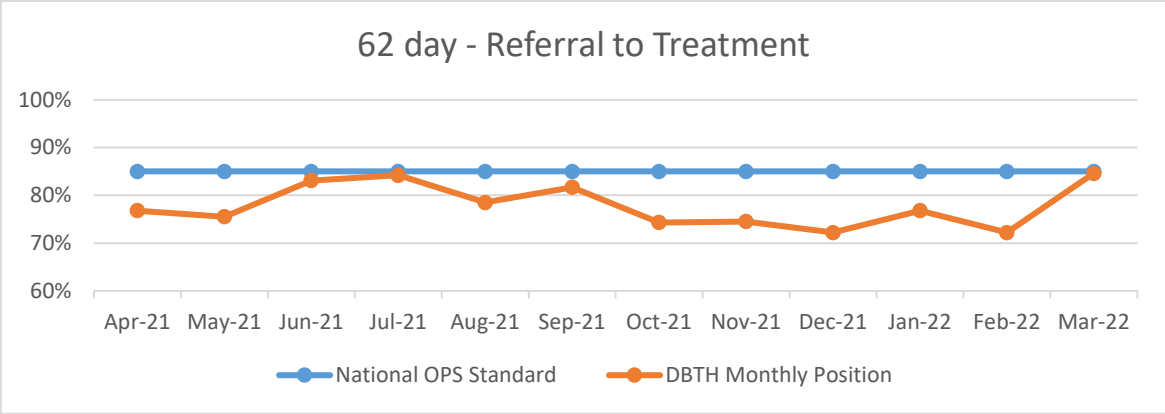
Key issues:

- Trust FDS standard compliant for March and overall Year End position (76.2%) – but variability in percentage linked to core staffing resource month on month
- Management of individual diagnostic waits within the Day 28 time line impacting on individual tumour groups achieving Best Practice Time Pathway milestone events
- Capacity pressures for IP diagnostic procedures
- Reporting and review of diagnostic results attribute to significant percentage of administrative breaches within individual tumour groups
- Key staffing pressure in Histopathology from June likely to impact on turnaround times for reporting and significantly impact on all Cancer Services

Key actions:

- Continue to review position on a 3 monthly rolling model till year end to establish key themes and pinch points regarding medical and clinical resources
- Establishing a quarterly improvement trajectory for each individual tumour groups for the FDS standard, based on 2021/22 compliance utilising activity, breach reasons, performance against to standard and overlay BPTP guidance.
- Histopathology pathways and transfer models linked across the wider ICS are now being reviewed

10. Cancer - Treatment



Mar-22	31 Day Classic	31 Day 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)*
Trust	95.5%	95.7%	100.0%	84.6%	88.9%	64.6%
Doncaster CCG	94.7%	100.0%	100.0%	83.3%	80.0%	67.6%
Bassetlaw CCG	96.6%	100.0%		92.9%	100.0%	44.4%

Key issues:

- Complexity of pathways either based on clinical findings or Genomic testing resulting in delayed pathways
- Capacity pressures for IP diagnostic procedures
- Challenges in pathway flow linked to internal transfer between tumour sites – on going work between Skin and ENT.
- Compliance linked to Day 38 IPT impacting on Tertiary Care compliance, some of these issues can be linked to Day 28 compliance for certain tumour groups

Key actions:

- Establishing a quarterly improvement trajectory for each individual tumour groups for the 62 day standard, based on 2021/22 compliance utilising activity, breach reasons, performance against to standard. Potential to improve on Day 38 IPT transfers delays
- Reduce the number of 104 day referral to treatment breaches on classic 62 day pathway
- Patient Navigator posts established in in 6 services although funded from external funding - Business case required to ensure substantive funding n place.

11. Health Inequalities

Ethnic Category	Doncaster Population %	Bassetlaw Population %	Doncaster and Bassetlaw Combined %	Waiting List Ethnicity Breakdown: Apr-22
Asian/Asian British	2.5%	1.1%	**2.1%**	1.5%
Black/African/Caribbean/Black British	0.8%	0.5%	**0.7%**	0.6%
Mixed/multiple ethnic groups	1.1%	1.1%	**1.1%**	0.8%
Other ethnic group	0.4%	0.6%	**0.4%**	0.9%
White *	95.3%	96.7%	**95.7%**	84.0%
Not stated /Not known / NULL	0.0%	0.0%	**0.0%**	12.2%

Index of Multiple Deprivation (IMD) Decile (where 1 is most deprived 10%)	Doncaster Population %	Bassetlaw Population %	Doncaster and Bassetlaw Combined %	Waiting List IMD Breakdown: May-22
1	25.3%	8.3%	**20.5%**	19.7%
2	16.0%	13.2%	**15.2%**	15.5%
3	11.9%	12.6%	**12.1%**	12.7%
4	9.2%	8.5%	**9.0%**	9.1%
5	6.8%	9.2%	**7.5%**	7.6%
6	10.0%	13.4%	**11.0%**	10.8%
7	7.4%	12.3%	**8.8%**	8.9%
8	6.8%	14.0%	**8.8%**	8.7%
9	5.1%	8.4%	**6.0%**	6.0%
10	1.5%	0.0%	**1.1%**	1.0%
Unknown	0.0%	0.0%	**0.0%**	0.0%

*Based on 16/05/22 Data

Key issues:

- Waiting list data analysis still in development
- Levels categorised as Not stated/Not known/NULL requires focussed piece of work to understand reasons for this and required actions

Key actions:

- Recruitment of Consultant in Public Health (joint funded with partners) underway interviews June 2022
- DBTH Project Manager with special interest in health inequalities - Richard Woodhouse started 25.4.22 and has been meeting key stakeholders to understand HI issues and improvements relating to DBTH three tier approach for HI - prevention, partnership working and role as Anchor Institution designing the DBTH action plan.
- Collaborative working as a network with new HI Lead, Mandy Espey for Place is underway and was discussed at Horizon, Planning and Design group 10.5.22
- Deep dive into reasons for Not stated/Not known/NULL both from a clinical urgency perspective and with a health inequality lens - May/June 2022
- HI forum being convened to share good practice

12. Performance – The Forward Look – April 2022

Urgent and Emergency Care

- Work continues with patients without criteria to reside with the continued implementation of red to green working with partners
- Continue to focus on Urgent & Emergency care recovery, extending the frailty pilot.
- The Trust continues to experience significant operational challenges and will continue to focus on safety and sustainability and supporting its teams, people and patients.

Elective

- To expand capacity to deal with backlogs and reduce waiting times
- Increase productivity, more patients per list (eg ophthalmology), work to high volume low complexity principles
- Extend referral triage and explore options for community care as a viable alternative to secondary care
- Work with SYB colleagues to develop best practice opportunities (pre-habilitation and waiting well initiatives)
- The 6-4-2 weekly monitoring process in theatres using the new dashboard is demonstrating an ongoing increase in listing patients – to continue to strengthen approach going forwards and for this to become “BAU”
- Develop recovery plans to mitigate plan revisions for the modular theatre and rapidly mobilise plan for ring-fenced orthopaedic hub and theatre on the DRI site in H2.
- Maintained focus on long waiting patients to ensure there are zero patients waiting 104 weeks by July, although Trust keen to reduce all waits for all patients wherever possible
- Weekly PTL meetings continue, focussing down to 30 weeks in many specialties, to ensure that all plans for both outpatient and inpatient elective pathways are optimised and waits are reduced wherever possible
- Further develop and build upon the opportunities being identified by KPMG for theatres and outpatients
- Monitoring in place to ensure no 104 week breaches after the end of May 2022

Cancer

- The Trust remains focussed on recovering its 62 day position and returning to pre-COVID performance

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

FINANCE AND PERFORMANCE COMMITTEE

Minutes of the meeting of the Finance and Performance Committee
Held on Wednesday 19 January 2022 at 14:00 via Microsoft Teams

Present:	Neil Rhodes, Non-Executive Director (Chair) Mark Bailey, Non- Executive Director Alex Crickmar, Interim Director of Finance Pat Drake, Non-Executive Director Jon Sargeant, Director of Recovery, Innovation and Transformation Kath Smart, Non-Executive Director
In attendance:	Ken Anderson, Chief Information Officer Suzy Brain-England, Chair of the Board Kirsty Edmondson-Jones, Director of Estates and Facilities Claudia Gammon, Secretarial Support Officer (Minutes) Sheena McDonnell, Non-Executive Director James Nicholls, Project Director Dr Tim Noble, Medical Director Richard Parker, Chief Executive David Purdue, Chief Nurse Marie Purdue, Director of Strategy and Improvement Jodie Roberts, Director of Allied Health Professionals Dan Simmons, Shared Agenda Claire Stewart, Head of Income and Contracting Ian Stott, Speciality Medicine CD
To Observe:	No governors present to observe
Apologies	Fiona Dunn, Deputy Director Corporate Governance/Company Secretary Rebecca Joyce, Chief Operating Officer

		ACTION
FP22/01/ A1	**Welcome, Apologies for Absence and declarations of interest (Verbal)**	
	The Chair welcomed members and those in attendance. No declarations of interest were declared.	
FP22/01/ A2	**Requests for any other business (Verbal)**	
	None.	
FP22/01/ B1	***Discussion on SOC for the New Build*** The Chair introduced the Director of Recovery, Innovation and Transformation to the meeting. It was then asked if an overview could be given of what was being asked of the Finance and Performance committee.	

	The Director of Recovery, Innovation and Transformation explained that the finalised SOC was now ready and would be presented to board on the 25th January. After this it would be submitted for acceptance and approval on the 31st January to NHEI. An outline business proposal would be discussed at the next Finance and Performance meeting to discuss expressions of interest ahead of the National Hospital Project. A next step would be to contact the MP's for a consultation and engagement meeting also for Doncaster council to sign off the use of the Basin site. The Director of Recovery, Innovation and Transformation introduced the Project Team made up of the following: Jon Sargeant – Senior Responsible Officer James Nicholls – Project Director Kirsty Edmondson Jones – Estates and Strategy Lead Ian Stott – Lead Clinician Jodie Roberts – Clinical Lead Ken Anderson – IT & Digital Lead Claire Stewart – Finance, Economics and Commercial Lead After the incident that occurred in April 2021 the building was now in a fragile state and had an impact on both staff and patients. The following was discussed about why Doncaster needed a new hospital: - Infrastructure – ventilation, lift issues, electric failures and problems with windows. As time goes on these would increase. - Capacity – equipment was being used more and more however there isn't enough space for everything. - Configuration – poor clinical and adjacency flows as the hospital had grown but would never be market leading - Stakeholders directly and indirectly support the change with this and require the hospital to be efficient. A new hospital would achieve the following: - Performance, quality, experience and outcomes - Statutory and regulatory compliance - Adaptable, flexible, digitally enabled - Affordable and value for money - Wider social and economic benefits. The Director of Recovery, Innovation and Transformation gave an outline of each of the five options and introduced the Project Director: **Business as Usual** • Which delivers minimum compliance and quality requirements only • Refurbishment of the whole site • 12 phases • 24 years to build • 103,294 m2 of refurbished space	

	• £16,531 cost/m2 • £1,707,563,375 inflated price • £1,011,908,857 April 21 prices • New parking, FM hub and energy centre to be added **Business as Usual +** • Which meets some critical success factors and spending objectives • Refurbishment and extension of the existing DRI estate. • 11 phases • 21 years to build • 120,105 m2 • £18,181 cost/m2 • £2,183,683,790 inflated price • £1,324,854,061 April 21 prices • Emergency services, Women & Children's, distribution centre, multi-story car park, energy centre and FM hub to be added **Do Minimum** • Which meets the critical success factors and spending objectives • Build and refurbishment on different sites (emergency & W&Cs on basin site and elective on current DRI site) • 6 phases • 10 years to build • 109,581 m2 • £14,131 cost/m2 • £1,548,461,590 inflated price • £1,189,764,479 April 21 prices • Refurbish ambulatory and elective services at DRI and vacate main building • Basin site would have women & children's and emergency departments **Preferred Way Forward** • Which meets the critical success factors and spending objectives • New build on a single new site, delivered in a single phase with accommodation • 1 phase • 6 years to build • 99,098 m2 • £13,798 cost/m2 • £1,367,341,088 inflated price • £1,082,330,410 April 21 price **Preferred Way Forward +** • Which meets the critical success factors and spending objectives • New build on a new site delivered in multiple phases, including accommodation • Firstly moves the Women & Children's and the Emergency department to the basin site • Then the Elective Surgery would move • 3 phases • 10 years to build • 108,353 m2 – larger in size • £14,253 cost/m2 • £1,544,317,096 inflated price	

	• £1,142,896,355 April 21 prices Timescales have been developed by the construction advisors that have worked alongside the architects and costed by the advisors RLB. The Project Director introduced the Head of Income and Contracting who explained that economic analysis had been reviewed in order to achieve the best option and value for money. The analysis used was from the Comprehensive Investment Appraisal Model which highlighted that the Preferred way forward ranked 1 overall with: Incremental Costs of £139.1m Incremental Benefits of £1,187.6m Risk adjusted Net Present Social Value of £1,048.7m Benefit Cost Ratio of 8.54 Two tests took place in order to create the above figure – firstly a New Social Value test and Secondly a Benefit Cost Ratio test. The option with the best Benefit Cost Ratio was then ranked one. The Head of Income and Contracting introduced the Speciality Medicine CD to explain the models of care which had been put together both nationally and regionally for a long term NHS plan and how that develops within the ICS. The Clinical Model was made up of four areas: • Prevention – keeping a healthy population • Out of hospital care – routes in, urgent treatment, virtual wards and elective care • System Wide Support – frailty and long term care • Hospital Care – new ways of working and digital infrastructure The Speciality Medicine CD introduced the Director of Allied Healthcare Professionals to explain further about the model of care and that it was high level and would benefit the residence of Doncaster. Improving care pathways and care within the community. The new build would allow easier patient flow with staff being supportive and positive of the changes. It was important for recruitment and the retention of staff to develop care pathways and host them in the future. The Director of Estates and Facilities gave an outline of the estates case including that 40 sites were assessed for site selection which was then narrowed down to the Basin site. Although the basin site required significant remediation, Doncaster Council had been awarded funding in order to have the ground ready for building. The following had all been taken into consideration: • Site Selection – Location and risk/benefit • Design Overview – Flexibility and adaptability • Enabling & Phasing – Constraints and Operations • Environment – Flooding and energy • Planning – Footprint and Parking • Compliance – Fire & Building Research Establishment' Environmental Assessment Method • Delivery – Modern Methods of Construction The Chief Information Officer explained that it would be digital by default, a future proofed and smart build. All networks and equipment had been tried and tested to give best practice for	

	electronic patient records. This would allow the delivery of real time data and alerts to ensure patient flow was maximised. All systems would be created and then moved as part of the integrated care systems. Digital represented people, process, technology, fully integrated, faster, secure and cyber security mitigations providing care and quality to patients. The OBC would follow the route of the Commercial and Management case, this included the following sections: • Professional Services – Architects, Engineers and Real Advice • IT & Digital – Hardware Solutions, Training and Testing • Equipment – IT & Digital, Clinical and Infrastructure • Construction – Demolition, Decant Space and Site Management • Land – Site Sale, Site Purchase and Remediation • Procurement – Frameworks and Procure 22/23 The Director of Recovery, Innovation and Transformation discussed the management case and that instead of a steering board committee the case had been raised within Finance and Performance, Executive team meeting and Board papers. Once this was at the stage of OBC a steering board would be created. There were two timelines, one a realistic timeline and the other an accelerator timeline. The realistic had an expectation of the 1st September 2029 dependent on Expression of Interest approval. This also depended on if the DRI were one of the 8 hospitals selected for new build. A proposal would be raised next year this would include the present team keeping together. The Director of Estates and Facilities gave a summary: • Explore Opportunity • Regional Priority • Political Support • Strong Strategic Fit with Doncaster • Strong Case works Economically and Financially But • NHP was the only route for funding • Timing and Delays would be an issue • Capital Costs were significant and maybe a blocker The next steps were explained by the Director of Recovery, Innovation and Transformation as the following: • Recommendations – presented at 19th January F&P • Presented at Board on 25th January • Submission to NHSEI on 31st January • Initial EOI short-list announcement on 31st January • Potentially intensive Q&A from NHP • Final 8 NHP schemes approved 31st July • Consultation and engagement – promotion of the scheme • Arrangements with Doncaster Council, MP visit then back to F&P • OBC development Following questions from The Chair of the Board regarding funding from partnerships such as Doncaster Council and the Private Sector and if other funding had been researched. It was answered that raising cash to support the capital build had been reviewed and support was	

	limited from the ICS/ICB. Only way to receive this approval was from the treasury in order to spend the capital. The Chair of the Board also queried if the preferred sites remediation's funding pledge timelines controlling when the land preparations were complete and when we can build upon the land. It was confirmed that the council would have a full survey with an engineering report to provide clarity ahead of the full business case. Following a further question from the Chair of the Board regarding the timeline and could some assurance be provided that this would either be met or we would be ahead of this. It was confirmed that a lot was managed by the central build team with a national team of experts. The Chair commended the team with the presentation and observed that there were three items that were required to be reviewed. 1) To have the proposal in a great position and keep it there 2) Stay alert with the central process management team 3) Work system with our key stakeholders and key opinion formers to ensure that our hospital was one to be selected. It was felt that the team on the project should be kept together, a concern was regarding the flooding on the site however this was answered by the raising of the ground. The keeping of relationships and information updated was important throughout the process. Mark Bailey commented that the alignment of current projects was important along with the maximising of resources. It was asked if we were confident in the build and the capacity was enough. The Project Director confirmed that although the square footage was reduced there was a larger capacity, including more beds, equipment and theatres making it a larger hospital. Following a question from Kath Smart regarding the bed capacity within the new build of 770 for the future it was answered that the workload had been looked at including the growth capacity within the new building. The flexibility and adaptability of the new build was important and that it responded to change based on National Standards. The figures were from the Public Health team using their expertise to assist with demographic models changes. The Chair asked that the following 4 proposals were understood and support and approval was given: • Recommend approval to the Board on the 25th January 2022 • Asked that the Senior Responsible Officer was asked to submit the proposal for funding for the next phase and maintain momentum. • Note the memorandum of understanding with Doncaster Council to govern collaboration. • Acknowledge and support the need for reinvigorated external engagement and communications particularly with and through local MP's to progress. The Chair concluded by asking for assurance and support on the 4 propositions, this was given by all.	
	The Committee: - **Noted, supported and gave assurance from the plan for the SOC for the New Build**	
	<u>Date and time of next meeting (Verbal)</u>	

	Date: Thursday 24 February 2022 **Time:** 09:00 **Venue:** Microsoft Teams	
	<u>Meeting Close</u> Meeting closed at 15:25PM	

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 24th February 2022 at 09:00 via Microsoft Teams

Present:	Neil Rhodes, Non-Executive Director (Chair) Mark Bailey, Non- Executive Director Pat Drake, Non-Executive Director Kath Smart, Non-Executive Director Alex Crickmar, Acting Director of Finance Jon Sargeant, Director of Recovery, Innovation and Transformation	
In attendance:	Ken Anderson, Chief Information Officer Fiona Dunn, Deputy Director Corporate Governance/Company Secretary Joseph John, Medical Director for Operational Stability and Optimisation Jenny Marsh, Deputy Director of Finance Gillian Marsden, Deputy Chief Operating Officer – Elective Debbie Pook, Deputy Chief Operating Officer – Non-Elective Marie Purdue, Director of Strategy, and Improvement	
To Observe:	Lynne Schuller, Public Governor	
Apologies	Rebecca Joyce, Chief Operating Officer Mary Spencer, Public Governor	
		ACTION
FP22/02/A1	**Welcome, Apologies for Absence and declarations of interest (Verbal)**	
	The Chair welcomed members and those in attendance. No declarations of interest were declared.	
FP22/02/A2	**Requests for any other business (Verbal)**	
	None.	
FP22/02/A3	**Action Notes from Previous Meeting (Enclosure A3)** Updates were provided on the below actions: **Action 1: Patients wait time Report** Further update and 'My Pathway' website to be presented in March **Action 2: Radiology Recovery plan** Further update to be given in March **Action 3: Governance Opportunities – Major Schemes & Estates & Facilities updates**	

	Further update to be given in April **<u>Action 4: Datix position paper & timeline</u>** Project plan to be presented in March	
	The Committee: - ***Noted the updates and agreed, as above, which actions would be closed.***	
	<u>Action</u>: Claudia Gammon would update the Action Log.	
FP22/02/ B1	**<u>Operational and Business Plan Update (Enclosure B1)</u>** The Director of Recovery, Innovation and Transformation explained the target was for 104% and that the National Submission timelines were: - Draft plan to be submitted to the ICS by the 9th of March - Draft plan to be submitted nationally by the 17th of March - Meeting with the ICS early March to discuss progression - Final submission to the ICS on the 20th of April - Final submission nationally on the 28th of April The plan would be presented at Executive Team, Trust Executive Group, Finance and Performance and Board in the future. Workshops were to be completed by the 25th of February to discuss bed plan, theatre, elective capacity, and workforce plan for each area. There would be a lot of work involved to reach the 104% target and changes would be required to be made around Orthopaedics and Ophthalmology. The Deputy Chief Operating Officer - Non-Elective gave an update that the outpatient workshop had been successful, discussing a way in which to reduce follow up appointments by 20%. Contact had been made with Rotherham to discuss the reduction of wait times within Podiatry. Theatre workshops had also been used to discuss a way of learning from challenges and issues. Bed plan had highlighted key areas and allowed a way forward to change ways for the future. The Director of Recovery, Innovation and Transformation referenced that all details were required to be captured via templates that were developed for each area. The Acting Director of Finance explained the planning guidance and that although the business plan was in draft form it was still being used. The main part of the Financial Framework for 2022/23 was the ICS progress allocation where the majority was for revenue funding. A baseline adjustment would incorporate the removal of back-pay and Service Development Funds. The Net growth uplift would reflect on demographic and non-demographic activity requirements, inflationary pressures, and a requirement of 1.1%. Convergence adjustment was from current funding levels where the path during Covid-19 was significantly higher than spend review fund levels. It was an additional efficiency requirement to bring system and organisations back down to within a long-term financial plan. This was just under 1.1% for Doncaster and Bassetlaw. Elective Recovery funding money was £2.3billion to support for 2022/23 and the support systems to reach the 104% 2019/20 target levels. Broken down this was 100% of core allocations for 2019/20 plus the 4% activity levels funded through Elective Recovery Funds. Where systems deliver above the target an additional 75% of tariff would be earned however, if this was not delivered then the 75% of tariff would not be earned. The ICS Covid-19 allocation had been significantly reduced by 57% for South Yorkshire which equates to £7. 8million.This	

	was broadly in line with other systems. Non-NHS income sources such as car parking would be required to be recovered, this was at £300,000 pre pandemic. Contracts were to be reintroduced for NHS and Non-NHS Providers with CCG contracts with the ICS to be set up for 3months later. Contracts would be aligned with providers and commissioners. Initial allocations for 2022/23 were on a draft basis with clinical income based on ICB allocations and non-clinical income based on current run rate of income received and adjusted for any non-recurrent items. Pay was based on current establishment and rotas that the divisions were working to. A high-level review had the clinical capacity for 2019/20, the aim was to get back to pre-pandemic levels of activity. Non-pay was adjusted by insourcing, outsourcing and material known cost pressures including utilities and clinical negligence schemes for Trusts. Central set of reserves including: - Pay inflation based on national plan guidance - Non-pay inflation based on national planning guidance – excluding utilities - Contingency reserve of £1.5 million - Elective Recovery Fund reserve – offsetting income of £11million. Budget Setting includes: - Alignment to workforce plans - Alignment to bed plan - Alignment to activity plans - Cost Pressures When adding tariff efficiency of 1.1%, convergence of 0.94% and 57% Covid-19 reduction it totals £13.9million. 2022/23 ICB allocation v's first draft budget leaves a £34.8 million gap. Energy cost pressures were 60-70% higher than previous £2.8million. Historically our Trust had achieved a maximum of £13 million of cost improvement programmes within a year. Several steps would be taken to finalise the budget with options of how to reduce the gap looking at bed plan and the workforce plans from divisions with the draft budget pay being £7 million more than current levels of spend. Activity/productivity plans for the Elective Recovery funds currently stands at £11million, if 100% of cost was delivered this could reduce part of the gap. High levels of agency/bank staff were currently used, if reduced this could support and close part of the financial gap. A revised plan would be presented at the next Finance and Performance meeting then to be sited at Board. Operational Capital was the replacement of equipment, Primary Care, Diagnostics and Digital all make up the Capital Allocations. The system capital for 2022/2023 - 2024/2025: - 2021/22 – Operational Capital of £105,394 - 2022/23 – Operational Capital of £110,067 - 2023/24 – Operational Capital - £91,778 - 2024/25 – Operational Capital - £91,778 £105 million capital for elective recovery (Targeted Investment Fund TIF) for the Northeast and Yorkshire. Schemes should all be above £5 million and only for significant cases. A bid had been put in for Montague Orthopaedic hub which was currently moving through the process with an update next month. £2.4 million capital for primary care with £17.9 million for diagnostics in 2022/23 including £17.5 million for community diagnostic centres and £0.4 million for	

	endoscopy. There would be £12.4 million for digital in 2022/23, £6.2 million for levelling up, £5.8 million for front line digitalisation and £0.3 million critical cybersecurity. Doncaster had an operational pot of £30.982 million which include £10.3 million, this was £18.995 million in 2021/22. All other organisations within the area of Doncaster and Bassetlaw had lost money where Doncaster had gained. Following a question from Mark Bailey regarding planning and would there be an example by area of what the gap is to show the capacity against demand by area. The Director of Recovery, Innovation and Transformation answered that beds would be looked at alongside KPMG. A push would also be made to get to the 100% baseline before looking at other plans. With growth and TIF money creating a reserve. There was also a challenge around the beds and longer lengths of stay. Following a question from Kath Smart about whether our Trust was in a better position for audits. The Director of Recovery, Innovation and Transformation answered that work was currently being carried out to address the audit items and to standardise an approach. This was progressing with better engagement from the clinical teams. More meetings and catch ups were assisting with the progression. The Director of Recovery, Innovation and Transformation explained that the next steps for capital and demand would be that the targets would come back with information on the progression with the ICS. Bringing back trajectories and where we should be, apply for performance framework specifically looking at productivity and managing other work.	
	The Committee: - **Noted and gave assurance from the Operational and Business Plan Update**	
FP22/02/ C1	**<u>Integrated Performance Report (Including Ambulance Handover</u>** Deputy Chief Operating Officer for Non-Elective gave a performance update for January: • Peak of Omicron in January impacted on pressures. • Critical Care did reduce which allowed assistance within elective activity. • Staff absence was high in January • Emergency Department attendance had reduced although still higher than in previous years • 4 hr target in January was 95% however our Trust only achieved 68% • 78 patients were on 12 hr trolley breach – all patients were put on to bed at 8 hrs. No harms incurred. • Both East Midlands and Yorkshire Ambulance services had significant delays. • Length of stays over 7 days were being scrutinised. • Support from Real World Health. Deputy Chief Operating Officer for Elective also gave a performance update for January: • Staffing gaps still a concern • All urgent and category 2 patients for elective activity had been completed in January. • Category 3 & 4 post surgery critical care support wasn't listed until beginning February, this had been brough forward to the end of January 2022. • Hoping to have no 104-week waiters by the end of March – weekly meetings were in place to discuss this. • In December 2021 18-week performance was at 70% and was currently at 66%. • 80% of 80-week waiters have a care plan in place.	

	• Ophthalmology, Orthopaedics and Ear, Nose & Throat were being assessed to look at the differences and number of procedures upheld in a day. • 52-week breaches were at 11,073 with a target of 12,059 – below what was declared. • Target for virtual outpatient appointments was 25% however at the end of January our Trust was at 26.1% • Patient navigators were now in post to look at future pathways and a way forward. • Less diagnostics for the elderly on Cancer pathways • By the end of March there would be 8 104-day patients on complex pathways these were those who have been difficult to diagnose. Following a question from Pat Drake regarding digital appointments and how patients do we require individually. The Deputy Chief Operating Officer for Elective activity explained that we needed to be mindful as not all patients have access to digital media. Communications played a big part in this, and more graphics were required in our letters to assist the understanding of them. It was all about having the right balance and delivering a clinical service to access when to see the patients. Following a further question from Pat Drake regarding what our confidence levels were at the front door of the Emergency Department and whether any admissions could be avoided. Also, what was the wider community implementing to support this. Deputy Chief Operating Officer for Non- Elective answered that front door was working alongside the Yorkshire Ambulance Service to look at a clinical advisory role. They would access the patient and decide the next steps. CCGs were also involved. A large improvement with ambulance delays had been made since January with the delays moving to 4 and a half hours recently. Pat Drake commented on the amount of CT scans being carried out and were they always necessary. The Medical Director for Operational Stability and Optimisation replied that the guidelines set needed to be followed and that most of the scans carried out were because of abdominal issues. The process should be that a clinical assessment was carried out then within 15 minutes a consultant was contacted to review and discuss with the patient if a scan was required. Director of Recovery, Innovation and Transformation explained that Real Word and the Governance were the same piece of work, and everything was to be checked to ensure alignment. All projects for Urgent and Emergency Care Board were put together as an overarching Board for Elective with them all being imbedded within the annual plan. Kath Smart observed that it was good to see the red to green and perfect week. Ambulance handover trajectories were used to measure improvements from 68% to 95% they required explanations on and a way forward. The Deputy Chief Operating Officer for non-elective confirmed that trajectories and a way forward were being discussed. Looking at the peak times, creating an action plan and what improvements had been made throughout February. Further work was continuing with East Midlands and Yorkshire ambulance services. The Chair agreed that any senior leadership issues would be highlighted and raised at People Committee.	
	The Committee: - ***Noted and took assurance from the Integrated Performance Report***	

FP22/02/ C2	**<u>Corporate Directorate Update</u>** i. Granger Report Update ii. Bassetlaw Emergency Village Project Board Terms of Reference Service Line Review Catering Update The Director of Recovery, Innovation and Transformation explained that the Sodexo contract had now been agreed. Sodexo have agreed to make changes which included: • Variations in the menu • Changing the opening hours to match the footfall • Provide hot vended food. • Click and collect service for Costa and Subway • Reopen the pop-up coffee cart at A&E • Spend £200,000 on the upgrade of Bassetlaw • Catering in Women and Children's • Delivery service from Subway/restaurant to the West Side of the hospital, being trialled Following a comment from Kath Smart regarding the Health and Well Being benefits in providing nutrition to staff and that it was important to gain staff's feedback. The Director of Recovery, Innovation and Transformation replied that a trial would take place for staff to receive a 20% discount across all menu choices. This was instead of the low-cost option currently available. A survey would then be sent to staff to comment on both choices offered. Kath Smart commented about the Granger Report and that the Estates risks appeared to be out of date with Board being sited on Fire, Lifts, and Infrastructure. This requires the risks updating on the risk register. Following a question from Mark Bailey about how our Trust gains resource into all areas. It was answered that this had been escalated to Urgent Care Board who were looking at governance and focussing on delivery meetings. Understanding the gaps, prioritising, considering resource and value for money. Pat Drake questioned the Health and Safety report and did it feature on another committee. Patient incidents were reported via Quality and Effectiveness committee and staff incidents were reported via Health and Safety Committee however, there was no further action taken. This will be reviewed further through the revision of Sub Committee terms of reference and NED Champion roles. The Bassetlaw Emergency Village Terms of Reference were agreed at Executive Team meeting with the remainder of the report being taken as read.	
	<u>Action:</u> - ***Further update on the Sodexo plans***	**JS**
	<u>The Committee:</u> - ***Noted and took assurance from the Corporate Directorate Update***	

FP22/02/ C3	**<u>Omicron Planning & Delivery</u>** This item was not discussed within the meeting	
	The Committee:	
FP22/02/ D1	**<u>Financial Performance & Forecast</u>** The Chair invited the committee members to raise any concerns on the report that weren't raised previously at Board. This was accepted and nothing further was raised.	
	<u>The Committee:</u> - ***Noted the Financial Performance & Forecast Update***	
FP22/02/ D2	**<u>National Cost Report – Annual</u>** The Chair invited the committee members to raise any concerns and to note the report. Kath Smart requested for this to be deferred until the next meeting	
	<u>The Committee:</u> - ***Noted the National Cost Report***	
FP22/02/ D3	**<u>Bad Debts Review – Annual</u>** The Chair invited the committee members to raise any concerns and to note the report.	
	<u>The Committee:</u> - ***Noted the Bad Debts Annual Review***	
FP22/02/ E1	**<u>Board Assurance Framework SA1 and SA4 (Enclosure E1)</u>** The Company Secretary confirmed that there had been no changes since this was presented at Board 2 days ago. All challenges previously recorded via board minutes .	
	The Committee: - ***Noted and took assurance from the Board Assurance Framework***	
FP22/02/ E2	**<u>Corporate Risk Register (Verbal)</u>** The Company Secretary confirmed that this was the same risk register that was raised at Board with the Estates risks that relate to Finance and Performance being answered at Board. No further updates were raised.	
	<u>The Committee:</u> - ***Noted and took assurance from the Corporate Risk Register***	
FP22/02/ E3	**<u>Bassetlaw Emergency Village</u>** Report had been read and with no further questions being raised	
	<u>The Committee:</u> - **<u>Noted and took assurance from the Bassetlaw Emergency Village Update</u>**	

FP22/02/ E4	**<u>Montague Community Diagnostic Centre Business Case</u>** Following questions from the Chair regarding the date changes, why was it urgent as it was presented at Board prior to F&P, where was the money being funded from, future milestones and what were the next steps. The Director of Strategy and Improvement explained that phase 1 was proposed in 2021 with a skeleton idea for phase 2 also being put forward. The timescales were national, our own governance, ICS governance, regional then nationally must be finalised with a deadline of the 11th of March. Discussions with the CCG's must be made as they have received the outline case for phase 1. The capital funds stand at £8.6 million with the revenue at £4million. CT and MRI scanners were both within phase 1 and would continue into phase 2. Ultrasounds would commence in Q3 of 2022 with Endoscopy in Q1 of 2023. Cancer pathways and screening would also be queried. The Acting Director of Finance added that the capital funds were taken from the capital diagnostic section of money at £17 million. The money would be used for both our Trust and Barnsley as they also have a Community Diagnostic Centre bid in. The revenue money was at £410 million which was to support the CDCs without the CCG's. Kath Smart asked if the case would go ahead if the revenue wasn't approved and would they still proceed at risk. This was confirmed as it would be possible to retract part of the business case if required. The Director of Recovery, Innovation and Transformation confirmed that they wouldn't be able to proceed without the capital funds and that if received it would be unlikely that our Trust wouldn't receive the revenue funds.	
	<u>The Committee:</u> - ***Noted and took assurance from the Montague Community Diagnostic Centre Business Case update***	
FP22/02/ E5	**<u>EPR Emergency Case</u>** The Chair asked the Chief Information Officer to explain the preferred pathway, understand the route to funding and what would be delivered. Chief Information Officer gave a detailed presentation of the Electronic Patient Record business case to the committee. Approval was to be sourced as part of the national programme and was sponsored by NHS Digital. Approval for the Strategic Business Case was for the end of February 2022, then moving to the Outline Business Case mid-April. £250,000 would be provided to assist with the Outline Business Case. Digital Strategy Aspirations: • Digitise Patient Interactions • Improved User Experience • Deliver Enabling Technology • Provide Relevant Tools for the role • Accurate and timely data at the point of care • Fully digitised end to end process • Data sharing and interoperability Electronic Patient Record Covers: • Patient Safety • Paperless • Outpatient Paperless • Electronic Prescribing Systems • Patient Flow	

	• Patient Administration System There maybe an impact on current projects: • Suspended • Non-essential upgrade on existing systems would cease • Non-essential capital work would be paused in 2023/24 to reduce burden of business changes on the divisions. Pre-requisites: • Infrastructure analysis (e.g., Network analysis – potential upgrade) • Data analysis and architecture Clinical engagement and safety were crucial along with working alongside the Director of Recovery, Innovation and Transformation. Live environment would only be accessible once passed the test and training sites. Key Risks are: • Unexpected Costs • Solution does not support complex pathways • Supplier does not meet required deadlines • Implementation had an adverse impact on Business as Usual • Need for substantial additional change activity • Poor stakeholder by in/engagement • Staff capability/capacity/recruitment and training. However, the Key benefits from the EPR are: • Improved Patient Safety • Improved Patient Experience • Improvements in Quality Care • Increased Productivity and Efficiency • Improve Staff Experience • Improved Data Quality for Clinical Audit and Research There would be an on-site implementation team that would have role specific training, have flexibility in managing trusts starting points, support and give guidance on data migration and quality assurance. Four options were provided and ranked in order: 1) Preferred Option – Net present social value £60,566 2) Do Maximum – Net present social value £57,738 3) Do Minimum – Net present social value -£11,923 4) Business as Usual – Net present social value -£14,142 The Chair asked why the preferred option was ranked top alongside procurement. The Chief Information Officer answered that it was a national programme working with the centre's framework. Suppliers had offered support with conducted pre-market programmes and benchmarking. This was standard practice across the NHS. Following a question from Mark Bailey about why we can't source another trusts EPR to accommodate. It was answered that several years ago the NHS tried to have a national standard however, this failed to work. The idea was for all trusts to be inline and use best practice.	

	The Acting Director of Finance added that any trust requiring the EPR system would receive £6 million to support, the remainder would be funded by our Trust. DBTH have an additional £6 million that can also be used. However, it was unsure if this also came with Capital Departmental Expenditure Limit (CDEL). This shouldn't any affect on the Outline Business Case. Kath Smart asked the following questions, were the ICS supporting any other trusts who have presented a business case? And why was there a large difference in the £43 million capital and the £10 million revenue? The Chief Information Officer replied that the preferred option had been investigated in depth as it was cloud based and that the subscription on revenue was to be reviewed. Pat Drake queried the routes to public/patient engagement sharing connectivity with primary care. Also, how maternity notes linked in. The Chief Information Officer answered that there were to be no closed systems, working on integrated care records and how electronic data feeds in.	
	The Committee: - ***Noted and took assurance from the EPR Emergency Case Update***	
FP22/02/ E6	**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.***	
FP22/02/ F1	**Governor Observations** No governor observations	
FP22/02/ G1	**Any Other Business** There were no items for any other business	
FP22/02/ G2	**Performance Report Appendixes**	
	The Committee - ***Noted the Performance Report Appendixes***	
FP22/02/ G3	**Minutes of the Sub – Committee Meetings (Enclosure)** ***The Committee noted:*** - ***Capital Committee – 16 September & 18 November 2021***	

FP22/02/ G4	**Minutes of the meeting held on 26th October 2021** - ***The Committee approved the minutes of the meeting held on 18 November & 17 December 2021***	
FP22/02/ G5	**Date and time of next meeting (Verbal)**	
	Date: Wednesday 23rd March 2022 **Time:** 14:00 **Venue:** Microsoft Teams	
	Meeting Close: Meeting closed at 12:55pm	

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 23rd March 2022 at 14:00 via Microsoft Teams

Present:	Neil Rhodes, Non-Executive Director (Chair) Mark Bailey, Non- Executive Director Kath Smart, Non-Executive Director Alex Crickmar, Acting Director of Finance Jon Sargeant, Director of Restoration, Innovation and Transformation	
In attendance:	Fiona Dunn, Deputy Director Corporate Governance/Company Secretary Bridget Harrison, Senior Performance Project Manager Joseph John, Medical Director for Operational Stability and Optimisation Gillian Marsden, Deputy Chief Operating Officer – Elective Debbie Pook, Deputy Chief Operating Officer – Non-Elective Julie Thornton, Head of Performance Kay Khan, Keystream	
To Observe:		
Apologies	Pat Drake, Non-Executive Director Lynne Schuller, Public Governor Mary Spencer, Public Governor	
		ACTION
FP22/03/A1	**Welcome, Apologies for Absence and declarations of interest (Verbal)**	
	The Chair welcomed members and those in attendance. No declarations of interest were declared.	
FP22/03/A2	**Requests for any other business (Verbal)**	
	None.	
FP22/03/A3	**Action Notes from Previous Meeting (Enclosure A3)** Updates were provided on the below actions: **Action 1 – FP21/10/C1 – Patients wait time Reports** Closed – Camis missing patients paper included within the agenda **Action 2 – FP21/11/C2 – Radiology Recovery Plan** Update to be provided at the April 2022 meeting **Action 3 – FP21/11/D4 – Governance Opportunities – Major Schemes & Estates & Facilities Updates**	

	Update to be provided at the April 2022 meeting **<u>Action 4 – FP21/11/G1 – Datix, Complaints and Risk Management position & timeline</u>** Review of timeline to be finalised with a clear plan around complaints, risk management and Datix at the April 2022 meeting. **<u>Action 5 – FP22/02/C2 – Sodexo</u>** Update to be provided at the May 2022 meeting **<u>Action 6 – FP22/02/C2 – Health and Safety Board</u>** Closed – Within JS presentation on the agenda	
	The Committee: • ***Noted the updates and agreed, as above, which actions would be closed.***	
	<u>Action</u>: Claudia Gammon would update the Action Log.	
FP22/03/ B1	**<u>Recovery Update (Verbal)</u>** The Director of Restoration, Innovation and Transformation gave an overview of what was to be discussed in this item. A governance update including the Board Assurance Framework, visibility of data, assessment on the quality of data, project management, how plans were tracked, Integrated Quality & Performance Report (IQPR) and the draft brief management structure would be provided at the next Finance and Performance meeting this would be a paper. The Head of Performance then gave an update on the plans for the infrastructure and data quality dashboards which were now in place. The production of the IQPR and data quality would run alongside kite marking. The Head of Performance introduced Kay Khan from Keystream to provide a demonstration of the dashboard. The Senior Performance Project Manager explained that the project metrics were an end-to-end process map that can be observed at ward level, how the data was produced and how does it filter from ward level to the IQPR. All metrics would be reviewed including performance and workforce metrics included within the IQPR. Kay Khan from Keystream explained about the work she was carrying out within the Trust on the new IQPR dashboards. The new IQPR dashboard allows staff to monitor the different KPI's across finance, performance, people, and patients that then filter into the Trust Health. Completion of the first phase of the IQPR dashboard was for April with everything completed by mid-May. Some areas that can be investigated further would be: • Urgent and Emergency Care including Ambulance Handovers • Emergency Wait Times • Critical Time Standards to include information on performance • People & Safety • Finance Details • Elective Outpatients • Appointment attendances • Non appointment attendances • Post Discharge	

	The Director of Restoration, Innovation and Transformation confirmed that it would be possible to drill down the information within the dashboard. The dashboard can be accessed via a URL or an App on phones, PC, and tablets inside or outside of the Trust. Kay Khan added that she would look at the trends against each KPI and the performance framework. A divisional level review would take place and refreshed daily or weekly. A day-to-day operations tool was also being worked on. The Director of Restoration, Innovation and Transformation commented that there was a task to put external metrics/benchmarks in where possible ahead of the next phase. Some departments had been met with to amend data warehouse and the reporting tool. The Chair asked about the labelling and miss alignment of what the functions were named. Was that something that could be changed? Also, would it work the same at Trust level to Divisional level? The Director of Restoration, Innovation and Transformation answered that this was to be investigated into by the Chief Information Officer. Further to a question from the Medical Director for Operational Stability and Optimisation about whether the dashboard was available for the consultant workforce to enable them to view the performance of their department. He also asked if it was possible to view other hospitals data. The Head of Performance confirmed that it was accessible by consultants, and they would be able to view at trust level and in the future at divisional level. Each metric would be investigated in turn looking at the quality ones first. Senior Performance Project Manager explained that each of the 31 metrics were mapped at ward level and were included within the IQPR. There were questions that were asked around the dashboard about each metric. They were Sign off and Validation, Timely and Complete, Audit and Accuracy, Robust Systems and Data Capture. They were manually inputted into the system dependant on the score it would then show assurance levels. This would then feature within an action plan and sent to the relevant teams. Following a comment from Kath Smart about the kite mark system, she then asked about the receivers of limited or no assurance and how was that to be monitored at Finance and Performance. Also, would the IQPR have indicators in the future. The Senior Performance Project Manager answered that the receivers were welcoming the action plans. The Director of Restoration, Innovation and Transformation added that the Complaints and Risk review had taken place and exceed expectations. The report would be against monthly trajectories, milestones and plan, revised governance rules, stages of projects, timelines, and changes to projects. It was also added that formalisation of how meetings were managed and linked together were to be confirmed. Finance Assurance, Mini Manpower, Mini QEC, Projects, Capital, Risk Board, Teaching Board, Transformational Board, Focus and Delivery, CIG and Operations all filter into Trust Executive Group. Kath Smart observed about the risks and that the strategy risk management challenged the risk scores at Trust Executive Group. The information would then be shared with the other sub-committees.	
	Action:	

	• ***A report was to be created about the coterminosity of information, was it working.***	**JS**
	The Committee: • **Noted and gave assurance from the Recovery Update**	
FP22/03/ C1	**<u>Integrated Performance Report</u>** The Deputy Chief Operating Officer for Non-Elective gave an update on the Urgent and Emergency Care along with the Ambulance Handover: • In February the performance was at 70% and remained the same in March. • Ambulance and walk in attendance within the Emergency Department (ED) was higher • One of the main issues was the exit block out of the ED department. • The 60 minutes ambulance handover had come down from 16% to 11% • 12 hour wait times had reduced in ED but still required further assistance to achieve handover targets. • No harms had come to any patients during ambulance handovers. • Actions were in place to assist with Ambulance handovers in April • Same day emergency care was being piloted at Bassetlaw to help the Yorkshire Ambulance service directly. Doncaster already have this in place. • A HSE visit had taken place with only verbal feedback being received regarding a rise in length of stays and the exit block. A written report would be received shortly. • 96% occupancy with 15% of those patients being in hospital for over 21 days. Of that 6.5% to 7% had no right to reside. The Deputy Chief Operating Officer for Elective gave an update on the 104 week wait and that the target was 0 by the end of March. There were six patients left to be treated to stop them going over the 104 week wait time. An in-depth investigation took place to look at the plus 90 week waits, a plan had been made and reported to NHSE. However, there would be one patient outstanding due to having covid-19, this had been raised with NHSE. Weekly Patient Tracking List meetings took place with the divisional teams with surgery bookings going down 40-50 weeks, however there were some patients that didn't have a date over 70 weeks. Referral to treatment would meet target by the end of the year. Within the last two weeks two elective operations had to be cancelled due to covid-19 spikes within the Trust. The Medical Director for Operational Stability and Optimisation referenced that there were issues nationally with ambulance handovers times. There were two main issues: • Firstly, ensure all patients go via the system by using all resources correctly.	

	• Secondly, that system partners have GP's support so less patients were seen via the Emergency Department. The discharging of patients was difficult over the weekend especially if a care package was required. Following a question from Kath Smart regarding the rise in CT scans the Medical Director for Operational Stability and Optimisation answered that Radiology were currently investigating this and had regular two weekly meetings. Non-Obstetric Ultrasound numbers had reduced. CT scans were also being investigated with the acute CT's numbers being the first to investigate then to reduce the numbers. The Deputy Chief Operating Officer for Non-Elective concluded that the partners meet regularly and patients that were of concern. The amount of right to reside patients had decreased however, exit block, waiting for a bed and staffing issues were still a concern. When occupancy was down to 85% - 90% then beds would be more available.	
	The Committee: • ***Noted and took assurance from the Integrated Performance Report***	
FP22/03/ C2	**Ambulance Handover** This item was included within the Integrated Performance Report	
	The Committee: • ***Noted and took assurance from the Ambulance Handover Update***	
FP22/03/ D1	**Financial Performance & Forecast** The Acting Director of Finance gave a breakdown of the month 11 financial position: • The Trust position for month 11 was £792k (£827k in month 10) • **Year to date** a surplus of £2.5m driven by accelerator funds, winter funds and Emergency Recovery Funds (ERF) being underspent. • **Clinical Income** - £0.9m variable - £0.4m relates to release of accelerator/ERF monies • **Non-Clinical Income** - £0.6m adverse variance to plan - £0.3m was driven by the insurance monies relating to the Women & Children's incident. • **Pay Position** - £0.3m underspend on accelerator schemes and £0.4m underspend on winter plans. Agency spend remained high at £1.3m/£1.4m, prior to covid-19 this was at £0.9m. • **Sickness levels** were the highest in the region at 9%, prior to covid-19 this was 5%. 4% was covid-19 related sickness. • **Non-Pay Position** – £0.4m underspend on the accelerator schemes - £0.3m related to higher prices on utilities	

	• **<u>Year end</u>** – the Trust was expecting to deliver at least a break-even financial position. At month 9 a forecast detailed taken by the Trust indicated that they would deliver a £2.8m surplus at year end. **<u>There were several variables that would factor into the year-end position:</u>** • Clinical Negligence Scheme for Trusts (CNST) awaiting notification on the maternity rebate of £600k • Annual Leave accrual • Education income position from Health Education England (HEE) • **<u>Capital expenditure</u>** - was £27.2m year to date with a current plan of £24.7m – driven by £2.9m Women's & Children's modular cost, £0.4m Donated Assets and £0.8m offset underspends in Medical Equipment • **<u>Cash balance -</u>** was high at the end of February at £51.8m – increase of £8.9m compared to month 10. Year end cash balance was expected to be £45m with reduction in cash to month 12 driven by capital programmes. Further to a question by the Chair regarding the Capital expenditure on agency staff and the requirement for reassurance that this area was being investigated to ensure all options were explored. The Acting Director of Finance confirmed that more of an understanding was required on agency staff as prior to Covid-19 there was more control on the spend. Agency costs were high and further processes were required moving forward to gain financial assurance. The Director of Restoration, Innovation and Transformation added that this was raised previously in June 2021 and added to the Board Assurance Framework as a risk in July 2021. There had been added pressures of split wards with the Women and Children's incident in 2021 contributing to the requirement for extra staff. Kath Smart requested if an update regarding the various aspects of agency staff could be raised at either Finance and Performance or the next People Committee. The Director of Restoration, Innovation and Transformation confirmed that at Finance and Performance the balance against safety issues would be discussed. A plan would be used to determine the size of the issue.	
	<u>The Committee:</u> • ***Noted the Financial Performance & Forecast Update***	
FP22/03/ D2	**<u>Year-end Update</u>** The Acting Director of Finance highlighted some of the key issues within the Year-end Update and that going concern remained an issue and needed an update with the Cash position. The renumeration report was a high-risk area and information requests had been placed with NHS pensions and received. The issue had also occurred in 2021 with regards to Directors who had opted out of pensions and would be worked upon nationally. It was possible that there would be a qualification from external audit with regards to the issue in 2021. Account preparations were still in place for the end of April 2022. Further to a question from Kath Smart regarding a date for the walkthrough of the accounts. The Acting Director of Finance added that this would either be via Finance and Performance committee or another meeting to look at the accounts step by step.	

	The Committee: • ***Noted the Year-end Update***	
FP22/03/ D3	**Operational Planning Update Major Presentation** The Director of Restoration, Innovation and Transformation gave an update on the progression of the business plan. The timeline was as follows: • Draft submitted to the ICS on the 9th of March • Draft submitted nationally on the 17th of March • Final workforce, capacity, performance, and project development plans completed by the divisions on the 25th of March • Executive review of plans week commencing 28th March • Operational plan final draft on the 8th of April • Final sign off to be presented at Trust Executive Group on the 11th of April • Final submitted to the ICS on the 20th of April • Final submitted nationally on the 28th of April Activity targets were compliant across areas except for outpatients and the requirement for the activity to drop to 85% as per 2019/2020. This was an area of challenge mostly due to follow up appointments. • There was a target that 25% of outpatient consultations would be held virtually however, only 17% were taking place. • Endoscopy was running at 85% this was being investigated • Plan was to deliver 116% of CT scans – this was double the amount as the peers within the area. • Delivery of 120% echocardiography activity had not been met due to work force issues. The Acting Director of Finance explained about the draft financial submissions that had been presented in February to the committee at £34.8 million. This included a CIPS of £13 million to bring the gap down to £21.8 million. Since the first draft the intention of the CCG was not to fund the £17 million income included within the ICS allocations. The £17 million included Winter plan and the accelerator plan. This was £13 million original CIP plan plus £4 million added. The Trust was asked by the ICS to make a further non-recurrent saving of 1%, the gap would then increase to £51.1 million. The revenue next steps: • Align financial assumptions with workforce plans, bed plans and activity plans • Contract negotiations with Doncaster CCG to reduce the gap	

	• ICS efficiency ask • Review and sign off cost pressures – received over £20 million worth • Await final guidance • Development of CIP and efficiency plans • Final submissions mid-April • Draft bids had been submitted to relevant capital groups • ICS issued operational capital allocations of £30 million - £1.8 million due to business log maintenance. On top of the of the operational capital there was £105 million for elective recovery, a bid had been proposed and shortlisted for the elective hub at Montagu. The Capital Plan submitted was based on 105% of Capital allocations, it would be investigated which schemes have caused this to go over 100%. Further to a question from the Chair regarding what was required by the committee at this stage in the process. The Acting Director of Finance confirmed that a final plan including an update on the ICB and CCG position would be presented at the meeting in April. The Director of Restoration, Innovation and Transformation summarised that once the plan was finished this would give the committee more assurance. Orthopaedics and Ophthalmology areas needed to increase activity, change productivity, and increase agency staff If required.	
	<u>The Committee:</u> • ***Noted the Operational Planning Update Major Presentation***	
FP22/03/ E1	**<u>Update on Strategic Projects</u>** The Director of Restoration, Innovation and Transformation explained that there were three major schemes at present: <u>Bassetlaw Emergency Village</u> • Work was being carried out on the Outline Business Case (OBC) via governance for June/July • Clinical model was not affordable with prices rising since the case was first written in 2018. • Size requires changing – on going governance structure • Meetings with internal and external capital partners. • Need to work within the costs of the capital scheme or could affect case for the new build. • A way to fund Same Day Emergency Care (SDEC) was required for each site. <u>New Hospital Build</u> • There was no update on the top 30 hospitals – this could be issued after the elections. • Confident on the support provided by the MP's	

	• Final paper including the Outline Business Case would be produced and presented at the committee meeting in April. • James Nichols was to remain on the project until September 2022. • Paper to be presented on the progression of the budget and would be presented at April meeting. <u>Mexborough Programme</u> • Two laminar lead lined theatres had been proposed at the Mexborough site • Including 24 beds and recovery areas. • Doncaster, Barnsley, and Rotherham would be able to use this as an Orthopaedics site • A bid for a similar unit had also been submitted by Sheffield to the ICB. • Bids were to be finished by the 20th of April. • Meeting on the 28th of March would take place to discuss the next steps. • Pulling all resources and monies together to work collaboratively amongst other trusts The prices on the renovations for the Women and Children's had inflated by 15% and was now at £14.9 million, hope was to open the unit in March 2023.	
	The Committee: • ***Noted and took assurance from the Update on Strategic Projects***	
FP22/03/ E2	**<u>Board Assurance Framework SA1 and SA4</u>** The Acting Director of Finance confirmed that the agency year position risk had been noted and had a score of 16.	
	<u>The Committee:</u> • ***Noted the Board Assurance Framework***	
FP22/03/ E3	**<u>Corporate Risk Register</u>** The Company Secretary confirmed that nothing had changed on the risk register and that the structure risk board was in progress and a review including papers would be looked upon in the future.	
	<u>The Committee:</u> • **<u>Noted and took assurance from the Corporate Risk Register</u>**	
FP22/03 /E4	**<u>Assurance Summary (Verbal)</u>** 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.***	

FP22/03/ F1	**Governor Observations** No governor observations as none present	
FP22/03/ G1	**Any Other Business** There were no items for any other business	
FP22/03/ G2	**Performance Report Appendixes**	
	The Committee - ***Noted the Performance Report Appendixes***	
FP22/03/ G3	**Minutes of the Sub – Committee Meetings (Enclosure)** ***The Committee noted:*** - ***Capital Committee –21st December 2021***	
FP22/03/ G4	**Minutes of the meeting held on 24th February 2022** - ***The Committee approved the minutes of the meeting held on 24th February 2022***	
FP22/03/ G5	**Date and time of next meeting (Verbal)**	
	Date: Monday 25th April 2022 **Time:** 09:00 **Venue:** Microsoft Teams	
	Meeting Close: Meeting closed at	

FINAL

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

PEOPLE COMMITTEE

Minutes of the meeting of the People Committee
Held on Tuesday 1st March 2022 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 David Purdue, Deputy Chief Executive & Chief Nurse	
In attendance:	Jayne Collingwood, Head of Leadership and Organisational Development Fiona Dunn, Deputy Director Corporate Governance/Company Secretary Dr Sam Debbage, Deputy Director of Education and Research Claudia Gammon, Corporate Governance Officer (Minutes) Anthony Jones, Acting Director of People and Organisational Development Dr Nick Mallaband, Medical Director for Workforce and Speciality Development Angela O'Mara, Deputy Company Secretary Beccy Vallance, Quality Improvement Clinical Lead	
To Observe:	Mark Bright, Public Governor – Doncaster Kay Brown, Staff Governor Alexis Johnson, Governor	
Apologies:	Dr Tim Noble, Executive Medical Director	
		ACTION
PC22/03/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.	
PC22/03/A2	**Requests for Any Other Business (Verbal)**	
	There were no requests for any other business.	
PC22/03/A3	**Actions from previous meeting (Enclosure A3)** **Action 1** Closed **Action 2** Once framework was circulated this action can be closed and removed **Action 3** Closed	

	Action 4 Closed **Action 5** Agreed to defer item pending the commencement of the new Chief People Officer – due in July 2022 **Action 6** Due in June 2022	
	The Committee: - ***Noted the updates and agreed, as above, which actions would be closed.***	
PC22/03/B 1	**Workforce Planning Tool** Acting Director of People and Organisational Development gave a detailed presentation of the Workforce Planning Tool that had been partnered alongside KPMG. Who would work closely with our Trust to create a strategic workforce model, this would enable our Trust to: - Visualise and better understand existing profiles. - Estimate Requirements - Understand how those requirements and associated costs with growth over the next ten years - Understand changes in demand and how they impact the workforce It would also include a partnership with RDASH, mainly the Allied Health Professional workforce. The model would take our activity, staffing and information from our finance data. Managers would have the ability to forecast alongside scenario forecasting to show the impact that strategic programmes would have on future workforce demand. The Acting Director of People and Organisational Development gave examples of the functions within the dashboard and would be: - Understand current staff levels vs staff required to service demand - Understand cost split by substantive bank and agency staff - Understand activity projections by care setting and organisation - Understand high level retirement and diversity statistics. Current Staffing Requirements – showing current workforce gaps allowing to: - Understand workforce gaps at both specialty and job role level - Understand workforce gaps both in terms of full time equivalent and percentage - Filter by organisation, setting, specialty, job domain and category. Forecast Staffing Requirements – allows you to target a closing of the workforce gap to: - Adjust target number of years - Understand how many staff members need to be hired annually to achieve target - Understand the hiring profiles at job/role level - Filter by organisation, setting, specialty, job domain and category. Scenario Modelling Gap Analysis - allows you to visualise the impact scenarios:	

	- Understand the impact of different schemes and scenarios on workforce and cost across 10 years. - Understand whether cost implications of a scenario were feasible - Understand the impact of running multiple scenarios at once - Filter by organisation, setting, speciality, job domain and category Scenario Modelling Reducing the Gap – allows you to visualise a holistic hiring strategy to close the workforce gap: - Adjust target number of years to close the gap - Across 10 years how many staff were needed - Filter by organisation, setting, speciality, role and band The timeline for the project was 16 weeks. With the next steps being: - Agree project - Source the data - Understand the data Pat Drake observed that the tool would require refreshing every year. Baseline staffing would need to be aligned to projects that were clearly linked to staff engagement and planning. Following a question from Pat Drake regarding the discrepancies within ESR and how they were to be addressed with the tool. The acting Director of People and Organisational Development explained that the data in ESR was currently an issue but would require a 4/5-week data cleansing. KPMG have previously used the tool in other larger organisations. Mark Bailey asked if our Trust were linking in with RDASH and their planning. The Acting Director of People and Organisational Development answered that RDASH were a good pilot as they have triple the amount of workforce. It wasn't only the buying of the tool it also included consultancy time from KPMG. Further to a question from the Deputy Director of Education and Research regarding what support was offered to influence role specific learning from work experience staff to those in their final year. It was answered that information would be used more proactively to help with learning and the support to assist with roles in the future. The system would be able to breakdown the nursing workforce to a role specific level or educational role. Assistance was also being provided by Allied Health Professionals. Alexis Johnson asked what the cost implications were, it was answered that the costing would be £250,000 this would include the workforce tool, KPMG project team and training for line managers with additional help from RDASH. This would also be a one-off fee with an additional license fee that was still in negotiations. The Chair added that forward planning and working with NHSI/E annually would be a benefit, also having monthly updates. Further to a question from Mark Bailey regarding the link to Finance and Performance Committee and whether the process started or was it required to wait 16 weeks. It was answered that this was sited on by the teams and discussions would take place for this to be discussed further at Finance and Performance Committee. The Medical Director for Workforce and Speciality Development asked several questions, the first was about how accurate the data on ESR was. This was answered that it isn't at present	

	and wouldn't be until after it was cleansed. A question was asked if the system was previously validated and had it been used elsewhere? It had been tested in 5 other organisations and considered growth predictions. The Chair gave an overview in that future planning of this would be discussed at People Committee. The tool would be useful in decision making although there were some risks around data challenges.	
	The Committee: - ***Noted the update Workforce Planning Tool***	
PC22/03/B 2	**<u>Staff Survey – Early Results</u>** Head of Leadership and Organisational Development shared information regarding the previous 2021 staff survey taken in October 2021. It saw the biggest change in questions asked for the previous 10 years to ensure alignment with the People Promise. New questions were asked around international recruitment and work progression within our Trust. Over 4000 staff members completed the survey out of a possible 6500 (63%). The results were like those from 2018. Our Trust was 40th out of 60 Trusts overall and 38th out of 60 on overall positive score rate. Among the areas of questions, we scored average on the following themes: - We are Compassionate and Inclusion - Morale - We each have a voice that counts - We are safe and healthy - We are always learning The remaining themes we scored slightly lower: - We are recognised and rewarded - We work flexibly - We are a team - Staff Engagement Following a question from Pat Drake regarding the results and how they would be taken forward. It was answered that this would be by area whichever made the greatest gain and moving forward the quickest to show a significant difference. Kath Smart also asked if the data shown that no trust had made any improvement within our peer group was correct. This was confirmed that it was correct and that all trusts had moved slowly. This would also need to be raised with NHSIE and department of health as prior to Covid-19 our Trust were making a large amount of progression. The Acting Director of People and Organisational Development observed that we need to gain a focus on recruitment, sickness, and traction as we currently don't have enough staff resource. Quality Improvement Clinical Lead suggested that terminology roadshows maybe beneficial as language was very important. The Chair reflected that this all linked back to the staff and the strategic objectives and had the biggest impact.	

	The Committee: - ***Noted and took assurance from the Staff Survey – Early Results***	
PC22/03/C 1	**<u>Board Assurance Framework – True North SA2 & 3</u>** Acting Director of People and Organisational Development explained the framework was a work in progress highlighting the key elements in terms of focus. There were 2 points of feedback from Board 1) Guardians of safe working 2) Reference to previous audits. Discussions have also been had around the pushing back of the appraisal season to the beginning of June, this would allow further preparation time. Communications had created a staff survey to check whether staff understood our Trusts vision. 89% of staff knew and could engage with the vision. The Chief Nurse commented that our Trust need to look at the conversion of trained staff and keeping those that were newly qualified. Kath Smart commended the update on the Board Assurance Framework and confirmed that once this had been updated and refreshed it would then be discussed at the next Board meeting. The Chair praised the update and explained that with it being a live document that it needed to be updated regularly and to be mindful of the operations for people to influence the work they carry out.	
	The Committee: - ***Noted the update from the Board Assurance Framework – True North SA2 & 3***	
PC22/03/C 2	**<u>Workforce Assurance Report</u>** - **Vaccination as a Condition of Deployment Update** - **Nursing Staffing Workforce Plan** Acting Director of People and Organisational Development updated the committee on the vacancies and the workforce gaps/challenges. The recruitment process was being reviewed to ensure it was clear. There were currently challenges around the recruitment of Health Care Assistants with 56 being recruited since September 2001. At present there were four recruitment selections, two were for Health Care Assistants and the remaining two were for trained nurses. Exit interview questionnaires were being used via ESR to help understand any issues that the committee would then be sited on. Sickness rate had lowered but was still high at 7.07%, in January 2022 this was seen at 13.5%. Working alongside Occupational Health to assist with staff getting back to work. An answer on the vaccine deployment was imminent. Following a question from Pat Drake regarding 35 staff vacancies within maternity. It was asked if they should be included within the report. It was agreed that they should be. Long term sickness was also raised as this was a cause for concern. The VCF process looks at past feedback from staff and factors in retention and turnover. Kath Smart referenced the high cost of agency staff and the selling of annual leave. The Acting Director of People and Organisational Development answered that currently there were over	

	350 requests to sell annual leave and that staff must take a minimum amount for Health and Wellbeing. This will also reduces the amount of agency staff required. The Medical Director for Workforce and Speciality Development suggested a different way for staff to take their annual leave. One way would be that as most staff prefer to take their annual leave throughout the summer months. This would mean during the winter months when busier there would be more staff available to work. The Chair referenced that recruitment was the biggest challenge and that we needed to attract a workforce.	
	The Committee: - ***Noted and took assurance from Workforce Assurance Report***	
PC22/03/C 3	**<u>Education Assurance Report (Includes SET)</u>** Deputy Director of Education and Research asked for any questions to be put forward and that the paper would be taken as read. Following questions from Pat Drake about whether there was always someone trained in Newborn Life Support and Paediatrics was confirmed. Pat also commented on the low % of estates and facilities staff that hadn't attended their fire training, this was being investigated by management.	
	The Committee: - ***Noted the update from the Education Assurance Report***	
PC22/03/C 4	**<u>Widening Participation Update Q3</u>** Deputy Director of Education and Research asked for any questions to be put forward and that the paper would be taken as read. Following an observation from Kath Smart regarding apprentices and were they being given the right support. Further workforce planning had been factored in over the next year with managers fully supporting this. If they then stay within the Trust as staff, they were a good investment in the long term. Pat Drake praised that the Cadets were back at the Trust. Pat also put a request in for Organ Donations to be promoted within our Trust. The Deputy Director of Education and Research confirmed that when the 'We Care' event was on a stand could be arranged. A comment was made regarding maximising work experience involvement and it's growth. An investment would be required to grow this with a business paper being presented in the future.	
	The Committee: - ***Noted and took assurance from Widening Participation Update***	
PC22/03/C 5	**<u>Monitoring and Learning Environment Report (HEE)</u>** An overview was given by the Deputy Director of Education and Research prior to any questions asked. The Monitoring and Learning Report was an Annual Multi Educational Learning	

	Assessment that required assurance from the committee. The report was submitted at the beginning of November with a follow up visit at the end of November. All data obtained was a true reflection and covered both nurses and doctors in training. Following a question from Kath Smart about if the learners were able to view the report, it was confirmed that this depends on the learning group. Being proactive, managing expectations, sharing positive feedback amongst staff, and including the team were all important factors.	
	The Committee: - ***Noted and took assurance from the update from the Monitoring and Learning Environment Report***	
PC22/03/E 1	**<u>Leadership Development Offer</u>** The Head of Leadership and Organisational Development highlighted the Learning Development Offer and that it was about bringing leadership together including Leadership Development, Quality Improvement, Some Transactional Management/Processes and HR Processes. It was a work in progress with a comprehensive offer of everything in one place for leaders. New programmes and sound bites sessions were also put forward. Following a question from Pat Drake regarding the alignment with appraisals and were we identifying people needs. It was confirmed that if there was a gap then it would be acknowledged. It was also noted that staff were using the sound bites in their own time. The Chief Nurse added the importance of having the right structures in place to allow staff to develop looking at working with local universities to support graduate training.	
	The Committee: - ***Noted and took assurance from the update for the Leadership Development Offer***	
PC22/03/E 2	**<u>QI Academy Update</u>** A short update was given by the Quality Improvement Clinical Lead in that an ICS meeting had been scheduled for all Trusts in South Yorkshire for their QI Leads. Also, that a National Evaluation Practice was to commence in our Trust. Following a question from the Chair regarding if our Trust had the capacity for the QI work, this was answered that there were now 4 members of staff in the QI team plus 1 secondment role therefore would be possible.	
	The Committee: - ***Noted the update for the QI Academy***	
PC22/03/E 3	**<u>Health and Wellbeing Update</u>** Head of Leadership and Organisational Development thanked the Non-Executive Directors on behalf of the Health and Well-Being team for assisting with the tea trolleys on wards. They were greatly appreciated and positively received. Pat Drake observed that there had been some frustrations among staff at Bassetlaw due to information being received by communications with no indication of the future. Head of Leadership and Organisational Development confirmed that the reasoning behind the tea trolleys was for staff engagement. Work was being carried out with communications to develop more efficient ways to inform staff.	

	Kath Smart thanked the team and that there was work to do around the sickness management/absence to reduce wait times. Kath Smart also asked if we were confident and were able to see and support those that were suffering with anxiety/depression. Seniors' leaders were noticing this. It was answered that it was challenging as some staff self-refer so harder to track. Work on this was in progress. Acting Director of People and Organisational Development added that teams had identified those members of staff that were of a Russian or Ukrainian background to fully support them.	
	The Committee: - ***Noted the Health and Wellbeing Update***	
PC22/03/F 1	**<u>Trauma & Orthopaedics Update</u>** Acting Director of People and Organisational Development explained that the 16 recommendations were being reviewed via 3 days of engagement and timeout sessions with the wider Trauma and Orthopaedics team. Throughout day 1 and half of day 2 single site trauma workshops were to be discussed. The 2nd piece of work would be patient flow and wait lists including support from the QI team. Working collectively was important and in keeping the teams engaged. The first day was the 1st of March, the second would take place mid-March with the final day end of March. Despite progress being made there was still work that was required.	
	The Committee: - ***Noted and took assurance from Trauma and Orthopaedics Update***	
PC22/03/G 1	**<u>Corporate Risk Register</u>** The Company Secretary confirmed that the Corporate Risk Register had not been any updates since Board. The Acting Director of People and Organisational Development then explained that the report showed the 15+ risks within staff shortages and linked in with workforce planning. This would be reviewed further with the Company Secretary. Pat Drake observed that some of the language used in the report needed to be reviewed, this was noted.	
	The Committee: - ***Noted the update on the Corporate Risk Register.***	
PC22/03/H 1	**<u>EDI Plan 2022-25</u>** The EDI plan was for 3 years and provided a strong focus on staff inclusion and developing staff network rates. ESR dated was screened to enable the team to locate Russian and Ukrainian staff members to offer support. The focus was to be on inclusion and staff networks in the future. Pat Drake observed that the report should also demonstrate equality, diversity within patients. Also, to bring Patient experiences in and understanding staff and patients needs. Pat Drake also requested that this was brought back to a future meeting.	
	The Committee: - ***Noted the update on the EDI Plan 2022-25.***	

PC22/03/I1	**Governor Observations (Verbal)** Mark Bright explained to the committee that he would submit any questions as nothing governor specific via email. Alexis Johnson observed that that the engagement with staff was important however difficult throughout the pandemic. Building a strong relationship with local colleges would be beneficial. The Deputy Director of Education and Research confirmed that regular contact was made with the colleges to develop a partnership.	
	The Committee: - ***Thanked the Governors for their observations.***	
PC22/03/ J1	**Minutes of the Sub-Committee Meeting (Enclosure J1)**	
	The Committee noted: i. Teaching Hospital Board - 7 September 2021 ii. Workforce Planning Committee - 1 October 2021 iii. Training & Education Committee - 8 July 2021 iv. Equality, Diversity & Inclusion Committee - 16 August 2021 & 11 October 2021 v. Health & Wellbeing Committee - 9 August 2021 & 1 November 2021 vi. Freedom to Speak Up Forum – 30 September 2021	
PC22/03/K 1	**Any Other Business (Verbal)** There were no items of any other business. The Chair thanked Pat Drake for her time, attendance and contributions to the People Committee.	
PC22/03/K 2	**Minutes of the Meeting held on 2nd November 2021**	
	The Committee: - ***Approved the minutes of the meeting held on 2nd November 2022.***	
PC22/03/K 3	**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	
PC22/03/K 4	**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, with the exception of the staff survey results which would be escalated to the Board for discussion,*** ***- Progress against committee associated Executive's objectives,*** ***- Divisional compliance with the Trust's risk management process.***	
PC22/03/K 5	**<u>Date and time of next meeting (Verbal)</u>**	
	Date: Tuesday 3rd May 2022 **Time: 9.00am** **Venue: Microsoft Teams**	
	Meeting closed at 12:12pm	

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

AUDIT AND RISK COMMITTEE

Minutes of the meeting of the Audit and Risk Committee
Held on Thursday 24th March 2022 at 09:30 via Microsoft Teams

Present:	Kath Smart, Non-Executive Director (Chair) Mark Bailey, Non-Executive Director Sheena McDonnell, Non-Executive Director Neil Rhodes, Non-Executive Director	
In attendance:	Mark Bishop, NHS Accredited Counter Fraud Specialist Laura Brookshaw, 360 Assurance Alex Crickmar, Acting Director of Finance Fiona Dunn, Deputy Director of Corporate Governance/Company Secretary Kirsty Edmondson Jones, Director of Estates and Facilities (AR22/03/F1) Claudia Gammon, Corporate Governance Officer (Minutes) Dan Spiller, Ernst Young Sean Tyler, Head of Compliance (AR22/03/F1) Ruth Vernon, Assistant Director 360 Assurance	
To Observe:	Dennis Atkin, Public Governor Suzy Brain-England, Chair of the Board	
Apologies:	Matthew Bancroft, Head of Financial Services Dr Noble, Executive Medical Director	ACTION
AR22/03/A1	**Welcome, apologies for absence and declarations of interest (Verbal)**	
	Kath Smart welcomed the members and attendees. The apologies for absence were noted.	
AR22/03/A2	**Actions from previous meeting (Enclosure A2)**	
	Updates were provided on the below actions: **Action 1 – ARC21/10/D3** This item would come back to ARC in April 2022 **Action 2 – ARC21/10/C1** Closed – Circulated the guidance within October 2021 minutes **Action 3 – ARC21/10/D1** Closed – As it was on the Board agenda for April 2022	
	The Committee - ***Noted the updates and agreed, as above, which actions would be closed.***	

AR22/03/A3	**Request for any other business (Verbal)**	
	There were no requests for any other business.	
AR23/03/B1	**External Audit Progress Update (Verbal)** Dan Spiller explained as the new auditor that there had been a first meeting with the Acting Director of Finance to discuss planning. Although the audit plan wasn't fully completed at present it would be ready for the Audit and Risk meeting in April. The risk assessments for 2021/22 included fraud risks, IFRS 16 implementation risks, PPE and growing concern which were similar to previous years. The new risk focused areas for this year would be fixed asset register and retained focus around the senior officers renumeration report. The Acting Director of Finance added that there was an issue with the qualification last year for the renumeration report relating to the pension scheme and not receiving the information from NHSBA. This has been raised and is being investigated by NHSE/I. It was likely that we would receive a similar qualification this year to last year due to issues. T Dan Spiller added this year there was a added value for money focus around estates and Women and Children's due to the incident last April. A formal plan would be received at the April ARC meeting. EY also raised that they would also be reviewing a new risk on Executive Capacity. In response to a question from Mark Bailey about if there are triggers and what they were. Dan Spiller confirmed that the triggers were about capacity at Executive Director level with regards to the changes in workforce as this would be a factor but shouldn't change the outcome. The ADoF confirmed that this was expected and as additional capacity had been created at Executive level, then felt this mitigated risk. In response to a question by Kath Smart regarding the IFRS 16 leases and the requirement to delay this for another year. Dan Spiller confirmed that there were currently conversations taking place with local governments to discuss the financial impact and further updates would be released soon. The Acting Director of Finance confirmed that there would be a walk through of the accounts on the 20th May 09:30am – 11:00am	
	The Committee: - ***Received and noted the External Audit Progress Update***	
AR22/03/C1	**Local Counter Fraud Progress Report** The NHS Accredited Counter Fraud Specialist explained that an Operational plan was required to be finalised, it was the same as last years following standards set by the government and counter fraud standards. It had been a second year that the Fraud Prevention Guide Assessment had been a required, it was used to look at the guidance and the impact this had. No changes were required previously within DBTH and no fraud had been detected. Risk areas were identified, reviewed, risk owners contacted, documented and individual risks were scored. An idea for a separate fraud risk register may then be implemented. The Company	

	Secretary added that a plan similarly to the Board Assurance Framework was to be looked at and to include counter fraud. Once complete this would be circulated.	
	Action: - ***Any Comments on the outcome-based metrics (see Section 5.2) to be submitted via email to Mark Bishop***	**All**
	The Committee: - ***Noted the Local Counter Fraud Specialist Progress Report.***	
AR22/03/C2	**<u>Counter Fraud Operation 2022/23</u>** Statutory Central Training for SET was at 97% on fraud which the Committee agreed was positive. More face-to-face training including ad hoc drop-in sessions that would be arranged in the future. The Counter Fraud Return was required for completion by the end-May 2022. Currently there were "amber" rated areas including the new requirement to measure the outcomes. This would need to built on over the next 12months. There were three investigations, five new referrals, two closed, one pending and five cases being pursued. Sheena McDonnell commented about the level of details and communications that was sent out via the Trust newsletter was appreciated. It was also mentioned that it was good to see less cases than normal. The Chair asked about the Counter Fraud Champion webinar that should have taken place last year to explain the requirements of a champion and it was felt this role was still evolving.	
	The Committee: - ***Noted and approved the Counter Fraud Operation 2022/23***	
AR22/03/C3	**<u>CORP/FIN 1(D) – Fraud, Bribery and Corruption Policy & Response Plan Review</u>** The Fraud, Bribery and Corruption Policy & Response Plan Review policy had previously been circulated prior to the meeting with no comments recorded.	
	The Committee: - ***Noted and approved the*** **Fraud, Bribery and Corruption Policy & Response Plan Review Policy**	
AR22/03/D1	**<u>Internal Audit Progress Report and Recommendation Tracker (Enclosure D1)</u>** Ruth Vernon from 360 Assurance gave an update that KPMG had now completed their four pieces of work, and all corresponding actions are in 360 Assurance's action tracking system. 360 have completed general ledger and financial reporting, which received significant assurance and raised four low risk actions. 360 have been working alongside the Chief Nurse regarding the planning for the Patient Safety Incident Response Framework review, and the testing for the data quality and divisional governance reviews remain in progress. The current first follow up position is 29% with an overall implementation rate of 65%. Action owners had met with 360 Assurance to discuss their historic action. There were several actions that could	

	be closed by the 31st of March some of which had not met the organisations deadline. The Acting Director of Finance confirmed that the review had made everything clearer, although there was still work to do everything was heading in the right direction. The Committee raised concern regarding Audit Recommendations Follow up rates - as 29% met by original deadline, with an overall of 65% action completed by revised deadlines – and felt this was not acceptable. Although 360 had carried out good work to chase up outstanding actions and it was assured action owners had met with 360 Assurance to discuss their historic actions, it felt this position was not where the Trust wanted to be and would escalate to the Board. In response to a question from Sheena McDonnell regarding the number of high-risk actions delivered within the time and closed and how did this compare to other Trusts. Ruth Vernon confirmed that ideally after a first follow up, other clients achieved 75% completion rate however, as DBTH Audit contract was started mid-year then there was not yet a full year worth of the new process. It was beneficial for the owners to be open and honest when agreeing deadlines. Prioritising the high-risk actions was important and to ensure senior management were aware of the priority of them. Sheena McDonnell added that focus should be made on the high-risk actions where the dates have been missed these should be explored via Executive team and escalated via Board. In response to a question from the Chair regarding the delays in the patient safety incident response framework (PSIRF) the Acting Director of Finance confirmed this was partly around a wider piece of work on this area. 360 Assurance will work with the Chief Nurse to ensure that work wasn't duplicated, adds value, and aligns with the framework. The Company Secretary added that a risk review (by KPMG) was being undertaken and would review the risk management processes, with the outcome being reported back. The Committee requested that work undertaken was complementary and didn't duplicate other similar work being carried out by	
	The Committee: - ***Noted and took assurance from the Internal Audit Progress Report and Recommendation Tracker;*** - ***Wished to escalate the poor performance of Audit recommendation completion rate to the Board*** - ***Asked for an update on the PSIRF Audit delay to be provided by DoNursing***	
AR22/03/D2	**<u>Stage 1 Head of Internal Audit Opinion</u>** The Stage 1 Head of Internal Audit Opinion had previously been circulated in January 2022 for consideration and members of the Audit Committee had met with 360 Assurance and the ADoF to discuss. It has now been superceded by the Stage 2 HoIA as below	
	The Committee: - ***Noted and took assurance from the Stage 1 of Head of Internal Audit Opinion***	
AR22/03/D3	**<u>Stage 2 Head of Internal Audit Opinion</u>** Ruth Vernon referenced the tight timescales with Audit and Risk committee beingcsited ahead of the interim opinion in April. If 360 assurance were completing the audit opinion within a full	

contract year, the stages would be spread out. First stage in October; second stage January ;and the third stage in March/April ahead of the full opinion. There were three points to the audit opinion:

- Firstly – Strategic Risk Management – 360 review of the Board Assurance Framework and 15+ Risk Register must be considered; this was graded an "Moderate Assurance - AMBER" in 360's present view

- Secondly – Follow up Actions – High level risks and completion of audit recommendations; this was graded a "Limited Assurance - RED" in 360's present opinion

- Thirdly - Internal audit plan outturn – considering reviews completed by KPMG in the first six months of the year, and the reviews 360 have since been undertaking.

The opinion also considers CQC ratings, external audits conclusions, staff surveys and any 3rd party assurances.

Ruth Vernon stated that there were five Internal Audit Opinion Levels:

- Substantial Assurance (Green)
- Significant Assurance (Yellow)
- Moderate Assurance (Amber)
- Limited Assurance (Red)
- Weak Assurance (Black)

At present we are at the following levels:

- Strategic Risk Management – Moderate Assurance
- Individual Assignments – decision to be provided at year-end
- Implementation of Actions - Weak assurance as at 1 October 2021 but this has since improved to Limited; this will be followed through to year end and may improve further.

The Committee expressed concern that this is a deterioration from previous years opinion and was disappointed at the outcome. They agreed not enough progress was being made on Risk Management and Closing of Audit Recommendations, and the reasons for this have been discussed at previous meetings including lack of resources and Covid absence and prioritisation. The Committee felt a "Moderate - Limited Opinion" is not where the Trust would aim to be and would wish to see at least "Significant Opinion" in future years.

Assurances were given by the Company Secretary and the ADoF that the new Audit Recommendations process would improve the rate; the outcome of the KPMG work would identify capacity issues/ gaps in risk management and that the Trust would focus on implementation of the recommendations in the Stage 2 Opinion. The Committee requested the Stage 2 HOIA is escalated to Board, to ensure Board have early sight of the opinion and Board members can provide assurance as to how things will change and improve going forwards.

The Acting Director of Finance confirmed that the Executive Directors and Senior Management fully supported all risk areas. The risk culture required further development across the organisation.

	The Committee: - ***Noted and took assurance from the Stage 2 Head of Internal Audit Opinion;*** - ***Requested this report be escalated to the Trust Board;***	
AR22/03/D4	**<u>Audit Reports Update – KPMG</u>** The two audit reports were: - Backlog Maintenance – - Significant Assurance – This was circulated prior to the meeting with no comments raised and the Committee commended on a positive report. - Medicine Management – Circulated prior to the meeting however no one was present to discuss the report further. This had been added to the Quality and Effectiveness agenda for April along with Audit and Risk Committee on the 19th of April.	
	Action: - ***Discuss Medicines Management audit report as only partial assurance rating after being presented at Aprils Quality and Effectiveness Committee***	**TN**
	The Committee: - ***Noted and took assurance from the Audit Reports Update - KPMG***	
AR22/03/D5	**<u>Internal Audit Plan 2022/23</u>** Ruth Vernon provided an update on next years Internal Audit Plan with it's three stage process including core audits for opinion, risks around Board Assurance Framework and High-Level Audits. These were linked into the trusts strategic aims and was also included was a three-year forward plan and the 360 Assurance Charter for 2022-23 three-year plan and charter. The Chair confirmed this had been sent through previously with any suggestions being amended on the plan	
	The Committee: - ***Noted and approved the Internal Audit Plan 2022/23 and the Charter***	
AR22/03/E1	**<u>Governor Observations (Verbal)</u>** Dennis Atkin made comment that he was glad to see the changes being made with addressing the risks, he questioned if the evidence was available to the Board. The Chair confirmed that written mitigations were to be included in the Corporate Risk Register as per the actions required in the Stage 2 HOIA Report.	
	The Committee - ***Noted the observations provided by the Governors.***	

AR22/03/F1	**<u>Health and Safety Biannual Report</u>** The Chair referenced and commended the Estates and Facilities team on the outcome of the Backlog Maintenance Audit report for receiving significant assurance on it. With processes being put in place from recommendation advised. The Director of Estates and Facilities gave an overview of the report: - The Granger report would also be reviewed again in September 2022 - The power within the Women and Children's area was on track for completion in April 2022. - An update was provided at February at Finance and Performance committee with all 15 outstanding actions now being complete. - Health and Safety had completed 82% of SET training Following a question from the Chair about if there were any policies that were out of date or due, this was confirmed that there weren't any policies that were out of date. However, 3-4 actions were due, and there was a robust process in place to follow up any outstanding policies. The Chair also asked about the staff accommodation and the standards required of them. The Director of Estates and Facilities confirmed that D Block had been newly refurbished with a focus on the newly recruited International Nurses. A walk round had taken place to check other accommodation, and this was seen to be of a good standard. However, Lister Court and B Block were deemed as not fit for purpose and would be demolished. The Chair required an update on the Capital Scheme and the opinion Fire and Rescue service and was given assurances the Fire works (although originally delayed due to Covid) were now on track and being delivered as per plans. DBTH was the only trust within the ICS that deliver their own Capital Programme Schemes. Sheena McDonell asked several questions following the update on the report, firstly what changes had been made as the dates were in the past. For example: Asbestos was dated as November/December 2021. The Director of Estates and Facilities explained that at the time the report was written it was in a timely way however due to meetings being stood down due to Covid-19 number some aspects were out of date. Work was being carried out to complete SET training within the Estates and Facilities as some staff were yet to complete the training. to In response to a question from Sheena McDonnell regarding Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) and if there were any claims relating to. This written update would be sent regarding how RIDDOR feeds into the Quality Improvement Process, which would then be circulated to the committee.	
	The Committee - ***Noted the Health and Safety Bi Annual Report*** - ***Requested an update on SET Training in the EF& Directorate*** - ***Requested information on how RIDDORs are managed in DBTH***	
AR22/03/F2	**<u>Quarter 3 and work plan & 2021/22 Local Security Management Report</u>** The Director of Estates and Facilities provided an update on quarter 3 of the report with the largest piece of work being the control access to mortuaries after receiving an urgent request from NHSE/I to action. Additional works have now taken place and were complete. The Trust	

	have also put a plan together for terrorist incidents. Lone working within the community midwives had improved. A violence and prevention standards overview would be presented at Executive Team meeting within the next few weeks. The Chair raised concerns about the number of community midwives that were subject to verbal abuse and threats and that staff should be supported in reporting these incidents. The Director of Estates and Facilities confirmed that there was support for those staff that was recommended by NHSEI to reduce violence. The Chair also raised that mask wearing within the trust was still a challenge despite no feedback or concerns from Saba security. This would be required to be investigated to provide further assurance. It had also been mentioned about moving the work around lone working and violence and prevention to the People and Organisational Development directorate. In response to a question from Neil Rhodes about the challenges and type of the abuse that the staff were subject to. The Director of Estates and Facilities answered that it was physical abuse and that NHSE/I had published new standards to reduce this. NHSE/I also recommended the change in directorate however, this may be looked at once the new Director of People and Organisational Development was in post. Following a question from Sheena McDonnell regarding two exclusion orders that had been issued to patients and was that a new strategy to reduce violence and aggression. The Director of Estates and Facilities confirmed that this wasn't new, and the Trust usually issue two exclusions per year. The Chair completed the item by asking The Director of Estates and Facilities about the risks on the corporate risk register and if the dates had lapsed and what were the next steps. The Director of Estates and Facilities answered that if dates had passed, they would be investigated and completed as soon as possible.	
	Action: - ***Executive team to decide whether appropriate report and self-assessment to be provided at either People Committee or Audit and Risk Committee for the Violence Prevention Standards.***	**KEJ**
	The Committee - ***Noted the Quarter 3 and work plan & 2 2021/22 Local Security Management Report***	
AR22/03/G1	**<u>Corporate Risk Register</u>** The Company Secretary commented that the overdue risks had previously been highlighted within the meeting and there were no further updates. The Committee expressed concern at the out of date risks which it felt had been pointing out for some meetings now and questioned how DBTH communicates with to the risk owners and tracks actions and responses them via Datix. The Company Secretary confirmed that the risks were tracked via Datix with all risk owners being contacted and messages sent to them regularly for updates and escalated when necessary. The Chair reminded all that the CRR was a public document and it should be up to date and accurate, but felt this was not represented in the document. The Company Secretary gave assurances that reminders would be sent to Risk Owners to ensure out of date risks were updated.	

	The Chair also mentioned the financial risk on the CRR and asked the The Acting Director of Finance to confirm when it was last reviewed, as it seemed out of date. It was confirmed this risk would be updated. Sheena McDonnell also commented that this was a public document and was therefore challenge back to the risk owners to ensure it represented the risks DBTH was facing. The Company Secretary added that an escalation system was agreed and in place.	
	Action: - ***Finance risks to be reviewed and updated via Datix***	**AC**
	Action: - ***Update Estates and Facilities Risks (FP4, FP12 & FP20)***	**KEJ /ST**
	The Committee: - ***Noted the corporate risk register.***	
AR22/03/G2	**<u>BAF – (Full)</u>** The Company Secretary referenced that recommendations had been made by 360 assurance to drive the Board Assurance Framework (BAF) agenda item. The BAF has previous been presented at the individual committees however never seen as a full BAF. Therefore, it had been decided that in the future it would be a complete full BAF that would be presented at Audit and Risk. The Chair added that reading the Board Assurance Framework alongside the Internal Audit Stage 2 Report demonstrated that the BAF needs to be reviewed alongside Committees work plan when creating the agendas. The Company Secretary agreed and confirmed that tying this in amongst the risk boards, actions and level assurances was also important. Ensuring that risks were linked and reviewed amongst other committees risks and work plans. Sheena McDonnel commented on the lack of accuracy in the BAF including inaccurate risk scores, some areas with no corrective actions, inability to see what had changed from the last BAF and changes requested by Committees not being actioned. The ADoF and Company Secretary provided assurances these would be remedied going forward and the next BAF due at Board had corrections made.	
	The Committee: - ***Noted and was assured by the BAF (Full) subject to ongoing development improvements outlined in the Stage 2 HOIA.***	
AR22/03/H1	**<u>Single Tender Waiver Report (Enclosure H1)</u>** The Acting Director of Finance updated that the report was standard to show where we were as a trust. An email had been sent regarding the new financial year to all Senior Leaders instructing them to follow procurement rules, quotes and values, there would be training set around this.	

	The Chair commented about a supplier that was mentioned within the paper and whether they were the sole supplier. This was confirmed and that they had been signed off by procurement to ensure they were inline with regulatory rules before a sign off by finance. The Chair also asked about the air scrubbers and the urgent need to replace or procure them prior to Covid-19. The Acting Director of Finance referenced that this had been a requirement during the Omicron checks as a lesson learnt from the first wave. They had been discussed at Executive level and signed off.	
	The Committee: - ***Noted the Single Tender Waiver Report.***	
AR22/03/H2	**Losses and Compensations (Enclosure H2)** There were no further updates from the Acting Director of Finance. Sheena McDonnell referenced the taking of unauthorised photos and asked if this was staff taking photos of patients as this was within the report. The Acting Director of Finance answered that this would be investigated.	
	Action: - ***This would be investigated, and an update circulated to the members of ARC***	**AC**
	The Committee: - ***Assured and noted the Losses and Compensations Report.***	
AR22/03/II	**Governor Observations (Verbal)** There were no Governor observations	
	The Committee: - ***No observations were made by the Governors.***	
AR22/03/J1	**Health and Safety Committee Minutes – 19/08/2021 & 14/10/2021 (Enclosure J1)**	
	The Committee: - **Noted and approved the Health and Safety Committee Minutes –19th August 2021 & 14th October 2021.**	
AR22/03/J2	**Information Governance Group Minutes – 27/09/2021, 25/10/2021, 22/11/2021 & 24/01/2022 (Enclosure J2)**	
	The Committee: - ***Noted and approved the Information Governance Group Minutes* – 20/09/2021, 25/10/2021, 22/11/2021 & 24/01/2022**	
AR22/03/J3	**Job Planning Report Update – March 2022**	

	(For information only – this would be presented and discussed further at the 19th April)		
AR22/03/K1	**Any Other Business (Verbal)** The Chair of the Board was present for this meeting and wished to add her comments, including it seemed appropriate that DBTH had a return to rigour with reviewing its processes and risks, ensuring triangulation of evidence where appropriate, and 2022 presented an opportunity to return to business as usual in with the rigour and processes to keep patients safe.		
AR22/03/K2	**Minutes of the meeting held on 12th October 2021 (Enclosure K2)**		
	The committee: - ***Noted and approved the minutes of the Audit and Risk Committee –12th October 2021***		
AR22/03/K3	**Issues Escalated From/To (Verbal)**		
	Issues escalated from/to: **i) QEC Sub-Committees** Medicine Management Report **ii) Board Sub-Committees** **iii) Board of Directors** Head of Internal Audit Report for Stage 2		
AR22/03/K4	**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 – Yes - Any new Emerging risks that have been identified from the meeting? – Audit recommendations		
AR22/03/K5	**Date and time of next meeting (Verbal)**		
	Date: Time: Venue:	**Tuesday 19th April 2022** **09:30** **Microsoft Teams**	

FINAL

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

TRUST EXECUTIVE GROUP

Minutes of the meeting of the Trust Executive Group
Held on Monday 13TH December 2021 via Microsoft Teams

Present:	Karen Barnard - Director of People & Organisational Development Fiona Dunn - Deputy Director Corporate Governance / Company Secretary Kirsty Edmondson Jones – Strategic Director of Estates & Facilities Rebecca Joyce - Chief Operating Officer Eki Emovon - Divisional Director - Children and Families Dr Tim Noble - Executive Medical Director Richard Parker - Chief Executive (Chair) Marie Purdue - Director of Strategy and Improvement Jon Sargeant – Interim Director of Recovery, Innovation & Transformation Dr Jochen Seidel - Divisional Director - Clinical Specialities Alasdair Strachan - Director of Education & Research Abigail Trainer - Director of Nursing	
In attendance:	Ken Anderson - Chief Information Officer (AOB) Dr Anurag Agrawal - Acting Divisional Director – Medicine Simon Chiva – Inenco (item B3) Claudia Gammon – Secretarial Support Officer (Minutes) Dr Sudipto Ghosh – Associate Medical Director for Professional Standards and Revalidation Matthew Gleadall – Acting Deputy Director of Estates and Facilities (item B3) Bethany Goodwin – Inenco (item B3) Dr Joseph John - Medical Director for Operational Stability and Optimisation Gill Marsden – Deputy Chief Operating Officer – Elective Howard Timms – Acting Operational Director of Estates & Facilities (Item B3)	
Apologies:	Alex Crickmar - Acting Director of Finance Nick Mallaband – Medical Director for Workforce and Specialty Development David Purdue - Chief Nurse	
		ACTION
TEG21/12/ A1	**Welcome and Apologies for Absence (Verbal)**	
	The Chief Executive welcomed the members and attendees to the meeting. The above apologies for absence were noted.	
TEG21/12/ A2	**Matters Arising / Action Log**	
	Updates were received on actions: **Action 1** – Closed **Action 2 –** Delayed due to Chief Nurse giving apologies for the meeting – to be brought back in January's meeting	

	The Committee: - ***Noted the updates and Claudia Gammon updated the action log***	
TEG21/11/ A3	**<u>Conflict of Interest (Verbal)</u>** No conflicts of interest were declared.	
TEG21/12/ A4	**<u>Requests for any other business (Verbal)</u>** Ken Anderson - Chief Information Officer **<u>Cyber Security</u>**	
	The Committee: - ***Noted and agreed as above.***	
TEG21/12/ A5	**<u>CEO Update</u>**	
	The Chair reported that the major issue at present was the Omicron variant and the impact it has had over the past 3 weeks. The booster vaccinations were progressing well. Omicron appears to be less sensitive to AstraZeneca vaccine. Information coming out of S. Africa suggests that the Astra Zenica vaccine was not providing significant levels of immunity over time whilst the other vaccines were giving 75% efficacy. Evidence suggests that Omicron variant appears to be four times more infectious especially within the first few days and wouldn't always be detected on a lateral flow test. Discussions were being had to ensure the target of 1million doses a day were carried out nationally. Three patient pathways were being considered for hospitals due to the increase of Omicron infectivity: 1) Non-Covid-19 pathway 2) A,B and Delta pathway 3) Omicron pathway Karen Barnard - Director of People & Organisational Development added that the booster programme was to recommence on the 15th December. Inpatients and outpatients face to face appointments were being reviewed as there were 4,500 patients under 50 that were booked for appointments until the end of December that could be offered the vaccination. 460 staff members had yet to receive either their first or second vaccination. Following a question from the Director of Education & Research regarding an update on the flu vaccination uptake, it was answered that the flu numbers were lower than usual and that there was no active flu in the country. Additional guidance at present was that if you can work from home to do so however this wasn't always possible within the Acute hospital setting. Following a question from the Divisional Director - Clinical Specialities about which roles required staff to be mandatory vaccinated and whether it should be mandated uniformly across all trusts. KB responded, that the agreement would be across the integrated health care system. The Chair commented that one version of the policy would be issued across the trusts clinical staff. If staff didn't support this then they would be unlikely to be able to work clinically anywhere else.	

	The Chair confirmed that Pearce Butler was appointed the chair of the ICS, Gavin Boyle was the Chief Executive. The other senior appointment within the system is Ruth Brown who has been acting Chief Executive at Sheffield Children's hospital and was appointed Chief executive for Children substantively. The Acute Federation role for Barnsley, Rotherham, Doncaster, Sheffield Teaching Hospitals and Sheffield Children's was to be reviewed once the ICS & CCG reconfiguration was complete. The Acute Federation will take on the responsibility for delivering the elective recovery program with the service contract between £1billion and £1.5billion. Further to a question from Director of Education & Research regarding an update on the bid for the surgery and recovery capital fund and if it had been successful. The Chair explained this was still to be confirmed with a bid for one Elective Surgical hub at Royal Hallamshire serving Sheffield and the second at Mexborough serving Rotherham, Doncaster and Barnsley. They would both be modular build and would be on top of the Community Diagnostic Hub.	
	The Committee: - ***Noted the CEO Update***	
TEG21/12/ B1	**<u>DBTH Strategy Development and Service Line Review</u>**	
	An update was given by Director of Strategy and Improvement that the data internally and externally was complete for tranche 2 with the others in progress. Work was being carried out alongside the Interim Director of Recovery, Innovation & Transformation team to work alongside partners in order to move forward with the Mexborough build. External company project support will be precured to ensure all opportunities for elective pathways etc are considered. A meeting would commence this week to look at further updates along with engaging with Clinical teams when time and work pressures allow.	
	The Committee: - ***Noted the update on the DBTH Strategy Development and Service Line Review***	
TEG21/12/ B2	**<u>People Strategy and NHS HR & OD</u>**	
	The current People and Organisational Development strategy runs out next year. It was nationally lead by NHSE&I. The Director of People & Organisational Development explained (presentation) that the 2030 vision for HR and OD in the People Plan was: **Looking after our people** People Promise, Staff safety, Staff physical and mental well-being, flexible working **Belonging in the NHS** Promoting inclusivity, ensuring staff have a voice, compassionate and inclusive leadership **Growing for the future** Expanding and developing our workforce, focus on recruitment, staff retention and alignment and collaboration across health and care systems	

	New ways of working and delivering care Make the most of skills in teams, making the most of skills and energy in wider workforce and educating people for the future They were the four people plan chapters/pillars with eight vision statements (sector themes) within the people promise. The DBTH People Strategy lasted 5 years previously with a detailed plan and report to cover all strategies as one that over arches. DBTH People Strategy included the Trust Strategy, Develop, Belong, Thrive, Here and the We Care Values. True North Objectives also tied into the People Strategy. Measures were in place via KPI's in: - New ways of working - Flexible working - Workforce metrics - Education's metrics - Proportions of staff - Staff engagement/experience metrics The National report would be sighted at Board in January 2022 and also in more depth at the People Committee. The slides will be circulated for further review. No comments were received from the group on this presentation. The Chair concluded this section by updating that the Chief People Officer post had been out for recruitment and interviews are scheduled for mid-January with strong quality of applicants.	
	The Committee: - ***Noted the People Strategy***	
TEG21/12/ B3	**<u>Trust Green Plan</u>**	
	The Strategic Director of Estates & Facilities introduced Simon Chiva from Inenco who updated the group with a presentation outlining strategically the plans in achieving a Net Zero status for the Trust by 2045 and delivering sustainable healthcare for the benefit of our patients. This was a 4 year plan until 2026 and had clauses that have to be met. Delivery of a green plan is a legal obligation. Within the plan there were nine areas of focus: **Workforce and System Leadership** Sets out the approach to governance, plus engaging and developing workforce and system partners **Sustainable Models of Care** Sets out the approach to embedding net zero principles across all clinical services	

	Digital Transformation Sets out the links between the digital transformation agenda and net zero NHS **Food and Nutrition** Sets out the approach to reducing the carbon emissions from the food made, processed or served within the organisation **Estates and Facilities** Sets out the approach to reducing the carbon emissions from the operation of the organisations buildings and infrastructure **Adaptation** Sets out the approach to mitigating the risk and effects of climate change **Travel and Transport** Sets out the approach to reducing the carbon emissions arising from the travel and transport **Supply Chain and Procurement** Details how the Trust can use its individual purchasing power and decisions to reduce carbon embedded in its supply chains **Medicines** Details the approach to reducing the carbon emissions from the use of medicines The Strategic Director of Estates & Facilities confirmed that the draft Green Plan had been sent to the directors within the areas above in order to create separate business cases. Simon Chiva continued to explain that within each of the nine focus areas there was dedicated chapters focussing around three areas, Carbon, Contract 18 and Sustainable Development Assessment Tool (SDAT). The next steps for the Green Plan are: - 15th December - Completion of draft Green Plan - 21st December - Presentation of the draft Green Plan to Board for approval and review - 14th January - Finalised plan submitted to the ICS - 31st March – ICS develop a consolidated system wide plan The Chair and the Director of People & Organisational Development left the meeting due to a National briefing. The Interim Director of Recovery, Innovation & Transformation continued as the Chair.	
	The Committee: - ***Noted the NHS HR & OD update***	

TEG21/12/ C1	**<u>Operational Update</u>**	
	An Operational update via presentation, was given by the Chief Operating Officer. Ongoing Covid-19 occupancy of 13.8%, an increase from 10.7% in October. An expected peak was due in January 2022 for hospitalisations. A similar level of pressure was seen in wave 2. Emergency department attendance was reduced yet running at a high rate compared to August/September. 16 paediatric patients were transferred to alternative hospitals in November due to reduced paediatric capacity. Elective activity had been impacted due to Covid-19, unless a patient was category 2 or a long wait then they wouldn't receive any surgery until the 9th January. The 52 week waits PTL list had been reduced to 11, which was beyond the H2 plan. Delivery on theatre work was at 80% slightly lower than planned due to emergency pressures. A full Winter plan had been agreed for both internal and external. Challenges with mobilising some internal schemes due to workforce pressures. The decision around who occupies Ward 22 and to what degree of occupancy is of serious importance and a decision is scheduled for this week. Elective work, the plan is to consolidate to Bassetlaw and to consolidate on day case. Park Hill would also been reviewed as a further protective area. Following a question from the Acting Divisional Director – Medicine regarding students and if it was possible for them to assist, it was confirmed that this would be discussed with the Deans at the universities. Juniors would be able to move from one area to another to assist in other specialties. Virtual outpatient appointments were still to be used due to risk and the national position. The Chair made reference to the issues at present and that national planning guidance was imminent.	
	The Committee: - **Noted the Operational Update.**	
TEG21/12/ C2	**<u>Refreshed OPEL Framework</u>**	
	The Chief Operating Officer gave a brief overview of the refreshed Opel framework. There were clear triggers across the Emergency Department with Opel ranging between 1 and 4. Level 4 being the highest level of escalation. Agreements had been made with partners and worked well with efforts being made to improve Emergency Department policy. Following a question from the Executive Medical Director regarding how many triggers it took to raise to an Opel 4. It was confirmed that 5 triggers were required however if this could also be 4 triggers and judgement was to be used. The Director of Education & Research raised concern about the cancelling of education training for staff and requesting them in clinical areas. The Chief Operating Officer confirmed this would be looked into further.	

	Clinical Directors were required to be aware of the refreshed framework and to read it through.	
	The Committee - ***Noted and approved the UEC Standards & Next Steps***	
TEG21/12/ E1	**<u>Finance Update</u>**	
	No update due to the Acting Director of Finance not in the meeting	
	The Committee: - ***Noted the Finance Update***	
TEG21/12/ E2	**<u>Recovery, Information/Informatics and Transformation</u>**	
	An update was given by the Interim Director of Recovery, Innovation & Transformation informing that a bid had been submitted for the Elective Centre with the hope of opening by September 2022. Plans were put in place to finalise the agendas for both the Winter Plan and Elective Recovery Plan. Support was in place for the urgent care recovery plan for both outpatients and elective care within theatres and surgery. A wider clinical strategy was looked at to overarching governance and introduction of divisional focus groups. A project manager had been appointed to assist with the work at Bassetlaw and would report/record parts of the quality score card for falls/trips. They would also support the Director of Nursing with the SI process and the tracking and monitoring of the coroner reports.	
	The Committee: - ***Noted the Recovery, Information/Informatics and Transformation***	
TEG21/12/ E3	**<u>Consultant Vacancies</u>**	
	The Acting Divisional Director – Medicine discussed the vacancy for the Gastroenterology consultant and that there was a budget for 9.2 consultants and at present there were 7.6 in post. The post holder would be based at Doncaster for Elective and Emergency pathways including rotas, overnights and weekends. They would also be required for outpatient endoscopy and impatient activity. The Executive Medical Director referenced on call and that it would require factoring in. Following a question regarding the in-house process for 7 day bleep service it was confirmed that at present STH support this and have for the past 18 months. The post was agreed by all members	

	The second vacancy was for an Obstetrician and Gynaecologist Consultant following recommendations from the Ockenden report in 2020. This post would be required to be recruited for within the next 7 months due to funding. The post holder would participate in on call. A job plan was required in order to agree this role however on the basis that it would be provided at a later date the members agreed to this.	
TEG21/12/ F1	**<u>Items for escalation to the Corporate Risk Register (Enclosure G1)</u>** i) Review of Risks rated 15+	
	The Company Secretary requested that the risks were to be scrutinised and the grading looked at via Datix then to be escalated to TEG after discussions at Divisional level. Further scrutiny/challenge of risks would happen via Divisional focus to ensure full risk grading validation and appropriate controls and mitigation actions had been identified. Following a question regarding the lifts within South Block and the risks incurred by this, it was answered that the parts had been ordered for lift 4 and were being delivered in January. Once this was repaired then lift 3 could be repaired. A request for communications and the risks to be described in further detail was noted. Ensure that the risk description and fully information was provided within the DATIX system.	
TEG21/12/ G1	**<u>Any other Business (Verbal)</u>** **<u>National Cyber Alert.</u>** The Chief Information Officer gave information on a recently received national Cyber alert with regards to Java script. He confirmed that software was being checked by the team. As firewalls use Java they were also being checked with the perimeters being looked into. Suppliers were providing patches over the next couple of weeks to ensure no harm was made. Chief Information Officer to keep updated.	
TEG21/12/ G2	**<u>Sub-Committee Reports/Minutes (Enclosure G2)</u>**	
	The Committee noted the: i) Corporate Investment Group – September and October 2021 ii) Children's and Families' Board – October 2021	
TEG21/12/ G3	**<u>Minutes of the Trust Executive Group meeting dated Monday 8th November 2021 (Enclosure H3)</u>**	
	The Committee: - ***Noted the amendments required to the minutes of the meeting dated 8th November 2021.***	
TEG21/12/ G4	**<u>Date and time of next meeting (Verbal)</u>**	
	Date: **Monday 10th January 2022** Time: **14:00 – 17:00** Venue: **Via Microsoft Teams**	
	The meeting closed at 16:30pm	

FINAL

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

TRUST EXECUTIVE GROUP

Minutes of the Meeting of the Trust Executive Group
Held on Monday 14th February 2022 via Microsoft Teams

Present:	Ken Anderson - Chief Information Officer (AOB) Dr Anurag Agrawal - Divisional Director – Medicine Alex Crickmar - Acting Director of Finance Fiona Dunn - Deputy Director Corporate Governance / Company Secretary Kirsty Edmondson Jones – Strategic Director of Estates & Facilities Eki Emovon - Divisional Director - Children and Families Anthony Jones Acting Director of People and OD Richard Parker - Chief Executive (Chair) David Purdue - Chief Nurse Marie Purdue - Director of Strategy and Improvement Dr Alasdair Strachan - Director of Education & Research Abigail Trainer - Director of Nursing	
In attendance:	Antonia Durham-Hall – Divisional Director Claudia Gammon – Secretarial Support Officer (Minutes) Dr Joseph John - Medical Director for Operational Stability and Optimisation Gill Marsden – Deputy Chief Operating Officer – Elective Debbie Pook - Deputy Chief Operating Officer – Non-Elective Andrew Potts - Divisional Director of Operations (Clinical Specialities)	
Apologies:	Nick Mallaband – Medical Director for Workforce and Specialty Development Rebecca Joyce - Chief Operating Officer Dr Tim Noble - Executive Medical Director Jon Sargeant – Interim Director of Recovery, Innovation & Transformation Dr Jochen Seidel - Divisional Director - Clinical Specialities	
		ACTION
TEG22/02/ A1	**Welcome and Apologies for Absence (Verbal)**	
	The Chief Executive welcomed the members and attendees to the meeting. The above apologies for absence were noted.	
TEG22/02/ A2	**Matters Arising / Action Log**	
	Updates were received on actions: Action 1: An update would be given by the Director of Recovery, Innovation & Transformation at the next meeting in March 2022	**JS**
	The Committee: - ***Noted the updates and Claudia Gammon updated the action log***	

TEG22/02/ A3	**Conflict of Interest (Verbal)** No conflicts of interest were declared.	
TEG22/02/ A4	**Requests for any other business (Verbal)** No requests for any other business were made	
	The Committee: - ***Noted and agreed as above.***	
TEG22/02/ A5	**CEO Update**	
	The Chair gave an update that the new ICB CEO Gavin Boyle had been appointed with Pearse Butler being appointed as the Chair. The date in April for the ICS to change to the ICB had been pushed back to the 1st of July. Interviews were taking place to form the South Yorkshire Integrated Care System. 4 directors had been appointed with Senior Leadership team posts being advertised. The Acute Federation work alongside the ICS to deliver the Acute business Integrated Care System with South Yorkshire. ICS deliver core services in a shadow format. An interim Managing Director had been appointment short term with a permanent role going to advert. They would work on the Acute Federation programme to ensure care was carried out in a safe and sustainable way and ensure the delivery of National Quality Standards. The Managing Director would have objectives to follow including, formalising, and completing job description/specification, governor structure for committees in common, Board format from April 2022. Regular briefings would be sited at Confidential Board, with the five Boards involved being briefed at the same time. Further to a question from the Acting Director of People and OD about the challenges and does the development impact, for example single site trauma work and can it be accelerated. The Director of Strategy and Improvement explained that there was a link with the Service Line Review work and looking with teams that then feed into the Acute Federation. This would then have an impact on the ICS and Acute Federation after a conversation with partners. The Chair added that the Managing Directors work required the transfer of resources within the Hosted Network in the future. Teams would work together to make sure services were sustainable. Our Trust can ensure the delivery of Elective Hubs for Urology and Orthopaedics as the demand changes. Following a question from the Director of Education & Research regarding the specialist services and how they were commissioned as some were delivered in two hospitals. The Chair confirmed that the two hospitals were Sheffield Teaching Hospitals and Sheffield Children's. The significant risks would require working out for example when Camis service moved to Sheffield Children's what services were required and how they could work together would be part of future discussions. The Government had requested that they wished to see the wait times for over 6million people to be brought down with a further 16million people not receiving all their referrals and treatment required. The system had created two proposals for Elective Surgical Hubs, one at Mexborough which would be a partnership between Rotherham and Barnsley. A second hub for Orthopaedics would be based at Royal Hallamshire. Mexborough would contain modular builds, two operating theatres and 28 extra beds. They have been selected	

	based upon being a Cold site and having no Accident and Emergency department or acute hospital facilities. This would allow the Trust to reduce wait times and would be flexible for other specialties to use. The value of this was £14.5million. There were other business cases that had also been put forward: Elective Surgical Hub, Phase 2 CDH business case, Bassetlaw Emergency Care Village (£17.6million) and the Strategic Outline case for the New Build. Over the next few weeks, the Trust would be informed if they have been selected for the final 30, with the final 8 New Build hospitals then being determined. The Chair referenced that Rotherham and Barnsley would have no patients on the 104 week waits listing after the 31st of March. DRI were moving in the right direction and had lowered their totals. Public Health had informed the Trust that there had been constant Covid-19 figures, and these would remain until the Summer with 80-90 active patients in the hospital. No variants were a concern, vaccination programme was working to decrease the numbers, lower Intensive Care patients and the wearing of masks had contributed to both flu and norovirus figures being lower. There maybe a targeted phase of vaccinations in the Autumn for those who were high risk. Sickness absence within the Trust was at 9% and would not be expected to move due to those having school age children. Vaccinations among staff may not be mandatory and may rely on senior team to encourage their staff to have the vaccine. Non-Executive Director roles have been advertised, one of which must be a with one a clinical NED, due to the retirement of Pat Drake at the end of March. Governor vacancies both staff and public were out at present.	
	The Committee: - ***Noted the CEO Update***	
TEG22/02/ B1	**<u>DBTH Strategy Development and Service Line Review (Verbal)</u>**	
	The Director of Strategy and Improvement confirmed external support had been sourced to allow the service line review to progress at pace. Traunch 1 Clinical Directors have been invited to meetings to go through their data packs. Data packs were to be prepared for the remainder. A discussion had been undertaken with the Medical Directors to ensure they have the Clinical engagement and services and what they wish to do. This would be brought back to the next Board with further updates.	
	The Committee: - ***Noted the update on the DBTH Strategy Development and Service Line Review***	
TEG22/02/ C1	**<u>Operational Update</u>**	
	The Deputy Chief Operating Officer for Non-Elective surgery explained that there had been a peak with Omicron within both the community and hospitals. During the first few weeks of January our Trust saw a maximum occupancy of 150 patients with higher hospitalisations but not within Critical Care. During the peak a maximum of 7 patients were within Critical Care. The Emergency Department was receiving a higher attendance rate in January than last Winter but lower than the summer peak. Real World Care were assisting with ambulance handovers and governance areas and what could be done differently. Yorkshire Ambulance Service was under extreme pressures in December 2021.	

	The Deputy Chief Operating Officer - Elective discussed that it had been arranged that category 3 and 4 patients would not be operated on until end January 2022, however, this was brought forward. 6-4-2 model had been brought back into theatres. All 104-week waits were booked in until the end of March. With them then going down in increments, therefore in 2 weeks our Trust should be at 80 week waits. It had been agreed that the modular theatres would support the elective programme for an Orthopaedics hub. Ward 19 would also be used from the end of February. This put the elective surgery in an improved position since the incident in Women and Children's. The Chair praised the work and noted that the Trust still had work to do to support and improve some wait times along with further work in diagnostics.	
	The Committee: - ***Noted the Operational Update.***	
TEG22/02/ C2	**<u>Recovery, Information/Informatics and Transformation Update</u>**	
	The Director of Recovery, Innovation and Transformation wasn't available to present this item, however, the Chair explained that getting our Trust back to business as usual was about governance, risk, recovery, cancer care and back to a process of working more consistently.	
	The Committee - ***Noted Recovery, Information/Informatics and Transformation Update***	
TEG22/02/ E1	**<u>Finance Update</u>**	
	The Acting Director of Finance gave an update that Paul Mapley was leading the business planning with a first draft to be submitted by the 17th of March and final plan for the end of April. 104% was the key target for delivery based on activity levels of 2019/2020. The revenue position in 2022/2023 was worth £7.4million with H2 plan x2, 57% covid reduction plus 1.1% efficiency and 0.94% convergence adjustments. All added together were a total of £13.9million, if we deliver 104% then we would earn £11.2million. However, if we don't deliver the activity required, we would lose the money at a marginal rate of 50-75%. This would then lead to a £2.7million gap with £2.8million surplus which would have cost impacts and income adjustments. Following a question from the Director of Strategy and Improvement about where the funding was from it was answered that this was part funded and that the ICB were running the allocation live. The Chair added that the system suggested a significant shortfall against costs v's budgets. This was where the Acute Federation were required to review the funding and allocate where it goes. The Divisional Director of Medicine asked about the 104% activity and was it elective or emergency. 104% was based on delivery of elective day cases and outpatients looking at the elective recovery funds and excluded outpatient follow ups. The Chair explained that the baseline data would be sent for each division with the 104% based at system level for South	

	Yorkshire and Bassetlaw with them working together as in 2019/2020. System plans would be required to be put into place if one area under performs and the other over performs due to discrepancies with the money earnt. Following a question from the Divisional Director for Children's and Families about if the trusts don't perform well how and were they able to meet the 104%. The Chair answered that the funding would be fair at 92% and changes would be made to ensure the system works together. The Acting Director of Finance explained that the cost goes up when delivering extra activity for example, 88% activity in 2019/2020 for £27.4million and 100% activity at £31.8million. This was based on high level projection, average unit costs of elective and day case work, cost behaviours identified through fixed, semi fixed and variable costs across our Trust. There had been a 2% increase to 7% since the pandemic. Activity was measured on day case, elective and non-elective with a rise from 10% to 18% since 2019/2020. 2022/2023 was expected to be a very challenging year financially with the £27.4million gap. An increase in productivity and efficiency would allow the Trust to get back to 2019/2020 levels to reduce the financial gap. Financial grip, control and governance were all key to managing spends including a reduction in agency spends which had become unsustainable and unaffordable in 2021/2022. Sickness levels were higher due to the impact of Covid-19, with the summer levels predicted to lower. The Infection Prevention and Control guidance was different for NHS staff. Following a question from the Acting Director of People and Organisational Development regarding agency staff spends. It was confirmed that 90 more Health Care Support workers, 100 International Nurses and students were joining the Trust in a hope to bring down agency costs. One of the priorities was to retain these staff and fully support them. The Chief Nurse added that in 2019/2020 there weren't as many open beds and wards open.	
	The Committee: - ***Noted the Finance Update***	
TEG22/02/ E2	**<u>Consultant Vacancies</u>**	
	There was nothing raised for this item	
TEG22/02/ E3	**<u>Hospital New Build and SOC Update</u>**	
	The Chair explained that the Strategic Outline Case had been presented at Board in January for approval, prior to submission to NHSE/I for consideration. If the Trust was successful in making the final 30 hospitals for the New Build, then extra would be provided. Costs stand at £1.34billion which was consistent with other new hospital bids.	
	The Committee:	

	- ***Noted the Hospital New Build and SOC Update***	
TEG22/02/ F1	**Items for escalation to the Corporate Risk Register (Enclosure G1)** i) Review of Risks rated 15+	
	The Company Secretary confirmed that there were still a considerable number of risks at 15+ without any clear updated actions or review dates. Following a comment from the Divisional Director of Medicine that discussions were happening with Governance and Divisional Leads it was explained that when these occur, and any updates were given they were documented via Datix. The Chair added that we need to learn what was required as when a risk becomes over 15+ it was then presented at Trust Executive Group for discussion.	
TEG22/02/ G1	**Any other Business (Verbal)**	
	No items raised	
TEG22/02/ G2	**Sub-Committee Reports/Minutes (Enclosure G2)**	
	No minutes were received for information due to the decision to stand down due to as meetings were stood down	
TEG22/02/ G3	**Minutes of the Trust Executive Group meeting dated Monday 13th December 2021**	
	The Committee: - ***Noted the amendments required to the minutes of the meeting dated 13th December 2021.***	
TEG22/02/ G4	**Date and time of next meeting (Verbal)**	
	Date: **Monday 14th March 2022** Time: **14:00 – 17:00** Venue: **Via Microsoft Teams**	
	The meeting closed at 15:50	

DRAFT

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS – PUBLIC MEETING

Minutes of the meeting of the Trust's Board of Directors held in Public on Tuesday 26 April 2022 at 09:30 via MS Teams

Present:	Suzy Brain England OBE - Chair of the Board (Chair) Mark Bailey - Non-Executive Director Alex Crickmar - Interim Director of Finance Anthony Jones – Acting Director of People & Organisational Development Sheena McDonnell - Non-Executive Director Dr Tim Noble - Executive Medical Director Richard Parker OBE - Chief Executive David Purdue - Deputy Chief Executive and Chief Nurse Neil Rhodes - Non-Executive Director and Deputy Chair Jon Sargeant - Interim Director of Recovery, Innovation & Transformation Kath Smart - Non-Executive Director	
In attendance:	Fiona Dunn - Deputy Director Corporate Governance/Company Secretary Lois Mellor - Director of Midwifery Angela O'Mara - Deputy Company Secretary (Minutes) Emma Shaheen - Head of Communications & Engagement Andrea Squires - Divisional Director of Operations for Urgent & Emergency Care Abigail Trainer - Director of Nursing	
Public in attendance:	Peter Abell - Public Governor Bassetlaw Dennis Atkin - Public Governor Doncaster Mark Bright - Public Governor Doncaster Lisa Gratton – Staff Governor Clare Hermon - Member of the Public Jordan Howard - Member of the Public George Kirk - Public Governor Doncaster Zoe Lintin – Member of the Public Lynne Logan - Public Governor Doncaster Andrew Middleton – Public Governor Bassetlaw Lynne Schuller - Public Governor Bassetlaw Andy Tibbs - Member of the Public Sheila Walsh - Public Governor Bassetlaw John Williamson – Member of the Public	
Apologies:	Gill Marsden - Deputy Chief Operating Officer - Elective Debbie Pook – Deputy Chief Operating Officer – Non-Elective Marie Purdue - Director of Strategy & Improvement	
P22/04/A1	**<u>Welcome, apologies for absence and declaration of interest (Verbal)</u>**	
	The Chair of the Board welcomed everyone to the virtual Board of Directors meeting, including governors and the members of public in attendance. A warm welcome was extended to Zoe Lintin who joined today's meeting as an observer, prior to commencing in post as the Chief People Officer on 6 June 2022.	

	The above apologies for absence were noted. No declarations of interest were noted, pursuant to Section 30 of the Standing Orders. The Chair of the Board noted the continuing impact of Covid 19 across South Yorkshire & Bassetlaw.	
P22/04/A2	**Actions from Previous Meetings (Enclosure A2)**	
	Action 1 - Safeguarding Information to Board – an update would be provided at May's Board of Directors meeting, subsequently a bi-annual report would be received at the Quality and Effectiveness Committee and an annual report at Board. Action 2 – Principles for 2022/2023 – item D1 on today's agenda.	
	The Board: - ***Noted the updates to the action log.***	
P22/04/B1	**Maternity Update (Enclosure B1)**	
	The Board received the Maternity Update which provided the findings of perinatal deaths, Health Safety Investigation Branch (HSIB) referrals, training compliance, service user voice feedback and progress in achievement of Clinical Negligence Scheme for Trusts (CNST) 10. The Director of Midwifery invited colleagues to feedback on the amended report presentation. A return to a more settled position was reported in respect of still births, following previous increases potentially linked to Covid 19. Vacancy and sickness absence rates continued to limit training compliance levels, however, there remained a focus on the required improvements and a recovery trajectory to achieve the minimum compliance in respect of CNST had been agreed. Recruitment of two practice development midwives had taken place, funded by Ockenden/CNST monies. Year 4 CNST remained on pause and was unlikely to change prior to the publication of the East Kent maternity services paper, expected in June 2022. **Final Ockenden Report** The Board received a copy of the final Ockenden Report and supporting paper in which the Chief Nurse outlined the key learning, including the required immediate and essential actions. A visit from the Local Maternity & Neonatal System would take place on 29 April 2022, to review the Trust's response to the seven immediate actions contained within the initial Ockenden report. In preparation, the Trust had undertaken a self-assessment, a series of colleague interviews would be conducted as part of the visit.	

	Following publication of the East Kent maternity services report an overarching maternity improvement plan would be implemented. In response to a request from the Acting Director of Finance, the Board confirmed their unanimous support for the 2021/22 Ockenden funding to be ring fenced. In response to a question from Kath Smart, the Director of Midwifery confirmed the decision for colleagues to complete only the competency assessment tool for K2 satisfied the key element of compliance required by the regulator. The vacancy position remained unchanged, incentives and agency support continued to be offered; the staffing position was reported to be challenging but safe. Cohort recruitment of student midwifes had taken place cross the Integrated Care System, with a total of 54 applicants. Organisation's vacancy rates would inform the distribution of new recruits across the system. Kath Smart welcomed the increasing level of engagement in the Maternity Voices Partnership. Sheena McDonnell recognised the work required to implement the recommendations of the maternity safety reviews on what was an already challenged workforce. In respect of timescales for the wider actions, the Chief Nurse confirmed no timeframe had been set, recruitment of an audit midwife would provide an additional resource to progress this work, and appropriate end to end system support was already in place. An overarching maternity improvement framework would support the necessary actions required to address improvements in maternity services The Chief Executive confirmed discussions had taken place with senior colleagues to determine a future management structure for the service to provide the required capacity. The Chair of the Board encouraged communication across the system to promote the Trust as an employer, the Director of Midwifery also confirmed local and national support to promote recruitment and retention within maternity services.	
	The Board: - ***Noted and took assurance form the Maternity Update***	
P22/04/C1	**<u>Business Plan & Budget Setting – 2022/2023 (Enclosure C1)</u>**	
	Budget Setting The 2022/23 budget paper was presented to the Board following scrutiny at the Finance & Performance Committee. A shift back to a pre-pandemic financial regime was noted, with a significant loss of funding and local and national cost pressures. Extensive discussions had taken place across the South Yorkshire Integrated Care System in respect of its deficit position, as a national outlier a request to further reduce the Trust deficit of £29.7m had been received. A final proposal of a £25m deficit was agreed for submission, any further reduction was likely to impact on delivery of the national activity and quality requirement in the planning guidance. The system's proposed deficit position reduced	

	from an initial £140.4m to £76.5m, despite this further challenge by NHSE/I could not be ruled out. The Board's attention was drawn to the identified key risks to delivery of the financial plan, noting assumptions were based on low levels of Covid as seen in Summer 2021. The Trust's Cost Improvement Programme (CIP) stood at circa 4% of its income, a challenging target when compared to delivery in previous years, although in line with national levels. The paper provided an overview of the schemes, £4.5m of the £19.3m CIP remained unidentified. The Acting Director of Finance confirmed ongoing discussions between South Yorkshire and Nottingham & Nottinghamshire ICSs in respect of contract value, elective recovery funding and inter system arrangements. As they may not be resolved before submission the Acting Director of Finance agreed to keep the Board up to date on developments. A significant capital plan was in place for 2022/23, based on £20.6m operational capital and £10.3m for reinforced autoclaved aerated concrete works. In addition, the Trust had submitted bids for £15m (over 3 year) for the elective hub at Montagu, £8.6m for phase 2 of the Community Diagnostic Centre and a business case was being written for a new electronic patient record (EPR) system. In his capacity as Chair of the Finance & Performance Committee, Neil Rhodes commended the proposed income and expenditure budgets and capital plan to the Board. The plans had been considered at length by the Committee and whilst the proposed deficit was recognised, board members were reminded of the pre-pandemic challenge of underfunding. The Trust had demonstrated financial responsibility throughout the last four years and a further reduction in the deficit brought with it a greater degree of risk not appropriate to deliver the required service standards. The rationale and assumptions contained within the paper were fully supported and the work at a trust and system level acknowledged. The Chief Executive acknowledged the return to pre-pandemic planning and offered assurance of appropriate assessment and approval of capital allocation across estates, IT and medical equipment by the Executive Team. Support for the budget and business plans was confirmed. **Business Planning – Activity & Performance** The Interim Director of Recovery, Innovation and Transformation's report provided an update on 2022/23 business planning and the final submission to the ICS in relation to activity and performance. The plan had been iteratively developed over the last two months from business planning outputs and bottom-up capacity planning across the divisions and scrutinised at the Finance & Performance Committee. The report identified that the majority of plans would meet the national standards, where plans were at risk of not meeting the standard, they would be subject to in-year improvement plans. Significant colleague support and engagement was acknowledged to enable the plans to be developed. The Chair of the Board recognised the challenges in diagnostics performance from her recent attendance at the Finance & Performance Committee and enquired what support	**AC**

	was available from a recruitment, training and education perspective to address the shortage of sonographers. A range of workforce solutions, including use of locums, international recruitment and apprenticeships had been explored, however this was a national rather than local issue. The Executive Medical Director highlighted the extensive training programme for the role and the impact of ultrasound being a real time assessment, unlike other diagnostic services. Demand for diagnostics services and possible pathway changes had been subject to review by the Medical Director for Operational Stability & Optimisation. The Chief Executive reinforced the need for system wide solutions to facilitate pathway and care model changes to ensure delivery of a safe and sustainable service. Neil Rhodes highlighted the importance of clinical leadership involvement at the Finance & Performance Committee, to ensure all aspects of performance/activity could be considered alongside the financial aspect, the Executive Medical Director confirmed the support of his office. The Chair of the Finance & Performance sought clarity on when the previously discussed change to meeting structures and governance arrangements would be implemented. The Chief Executive acknowledged that plans had not progressed as quickly as hoped, largely due to the continued impact of Covid 19 and high levels of urgent and emergency care activity. The Executive Team would finalise arrangements within the week. In response to a question from Sheena McDonnell, with regards to the use of innovation, transformation and quality improvement (Qi), the Chief Executive confirmed the Trust continued to utilise Qi tools and techniques, for example in developing the drive through phlebotomy and Covid testing services. Trauma & Orthopaedics and theatres had also utilised quality improvement methodology. The Trust continued to be engaged in NHSI's Vital Signs Programme, which had been subject to change and now included the Virginia Mason Trusts. A need to re-energise larger scale projects at trust and system level was noted. The Board was reminded that the Trust had not been commissioned to deliver the national standards on a recurrent basis and had received top-up non-recurrent funding. Therefore the 2019/20 reference point against which the Trust would be required to deliver 104% would be challenging. As the Trust exited the pandemic there was a need to understand capacity and an assessment of lost activity; currently the Trust was running at 73% of pre-pandemic capacity and significant work had taken place across the divisions to unpick this, with external support. Mark Bailey acknowledged the importance of system working and enquired how this would be captured. The Chief Executive confirmed the development of the Acute Federation continued and shadow board arrangement would take place with effect from April. It was important that the work of the collective Acute Federation was greater than that of all the individual organisations, there was a clear need to identify those clinical services which were challenged, with a view to creating a system solution and identification of those services which could benefit from working in partnership. In respect of the sourced external support, the Chief Executive and Interim Director of Recovery, Innovation and Transformation clarified that the work undertaken had been in conjunction with Trust clinicians and management, who had oversight of the work and held responsibility for the plans and would be appropriately skilled to take plans forward.	

	The Board: - ***Noted and took assurance from the Business Plan & Budget Setting – 2022/2023***	
P22/04/C2	**<u>Ambulance Handovers (Enclosure C2)</u>**	
	The Ambulance Handover report had been subject to scrutiny at the Finance & Performance Committee on 25 April. In order to provide a comparison across South Yorkshire, the Divisional Director of Operations for Urgent & Emergency Care presented an overview by organisation of the average number of patients attending by ambulance each day and the number of patients waiting more than 30 and 60 minutes to be handed over to A&E staff. Despite the difference in population, the average number of patients attending by ambulance for Doncaster and Sheffield were closely aligned which meant that the Trust's number of ambulances per head was significantly higher. In addition, the Chief Executive highlighted the bed base of the Trust was roughly half that of Sheffield, potentially impacting flow out of the department. Work with both the Emergency Care Improvement Support Team and the Getting it Right First Time team continued to inform improvement plans. The Trust was also working closely with Real World Health to focus on a lean approach and to deliver quick wins at the front door. Processes were effective but reliant on flow out of the department, and at the busiest times there was a need to move one patient every twelve minutes. Further improvements were required in respect of assessment, flow and understanding exit blockers. In response to a question from Sheena McDonnell, the Divisional Director of Operations for Urgent & Emergency Care noted that whilst the majority of the items on the action plan were completed this did not necessarily deliver a performance improvement, work to monitor and review the impact of actions continued, however, this was a complex and adaptive system and results were not driven solely by changes within the department. The Chief Executive identified front door issues were not solely within the control of the Trust, increased attendances of up to 33% were being seen as compared to pre-pandemic levels. System improvements with partners were required, to take into account the end-to-end pathway, including discharge and education of the public with regards to appropriate usage of the Accident & Emergency Department. It was important to recognise that the action plan was iterative and via the plan, do, study act the Trust would be able to react to those lessons learnt and build on its improvement journey. Kath Smart thanked the Divisional Director of Operations for Urgent & Emergency Care for the insight into attendances across the patch, which provided helpful context and encouraged a review of what was required next to support continued improvements.	
	The Board: - ***Noted and took assurance from the Ambulance Handovers Update.***	

P22/04/D1	**<u>Corporate Objectives 2022/2023 (Enclosure D1)</u>**	
	The paper provided an update to Board on the proposed approach to the True North and Breakthrough objectives and the specific work to be led by the Chief Executive and Executive Directors to deliver the Trust's strategy in 2022/23. Despite the pandemic, the organisation's commitment to delivery of it's True North objectives remained. Engagement with the workforce, supporting and re-energising the Trust's approach was vital to build on the progress to date. The objectives identified senior responsible officers and alignment to the sub-committees of Board, where oversight and assurance would be gained. This included input from the Chief People Officer prior to her official start date in early June 2022. Following a review at the relevant committee the confirmed objectives would come back to Board for final sign off, with subsequent quarterly updates provided throughout the year. Kath Smart welcomed the inclusion of risk management, job planning and learning from incidents, complaints and claims but requested that consideration be given to expand the audit recommendation objective to explicitly reference the required increase to first response rates. Also, that an objective linked to clinical audit be considered by the Executive Medical Director. As clinical audit was an essential strand of governance the Executive Medical Director supported this request. In respect of the revised meeting arrangements and introduction of the Risk Committee, Kath Smart enquired of the need to consider an objective focused on its deliverables. Sheena McDonnell acknowledged the work to date, she reinforced the importance of colleague buy-in across the organisation, for the need of clearly defined success measures and for Trust values to be embedded. In respect of the Executive Medical Director's objectives, she enquired if a patient experience objective should be added. The Chief Executive recognised the need for a unitary approach by the Executive Team, to support and help individual objectives to be achieved.	
	The Board: - ***Noted and took assurance from the Corporate Objectives 2022/23***	
P22/04/E1	**<u>Minutes of the meeting held on 29 March 2022 (Enclosure E1)</u>**	
	The Board: - ***Approved the minutes of the meeting held on 29 March 2022.***	
P22/04/E2	**<u>Governor Questions regarding the business of the meeting (10 minutes) *</u>**	
	The following questions were asked on behalf of the governors: **"The paper before today's meeting on Ockenden demonstrates a clear culture of reporting and actions on the quality and safety of maternity services at DBTH. Notwithstanding the attention and actions on this service, how concerned is the Board**	

	and Executive Leadership about the sustainability of maternity services which are consistent with Ockenden expectations and best practice, particularly in respect of staffing levels, training compliance and clinical governance processes." The Chair of the Board acknowledged the Trust's position had been broadly covered in the meeting but invited further comment. The Chief Executive advised the question of appropriate staffing levels, skills, protocols and system support were fundamental in the day-to-day operation of services. The delivery of a safe service was the Trust's number one priority. It was recognised that national reports, such as Ockenden, were a source of anxiety for patient and staff but significant efforts to formally respond to report recommendations would be taken in order to regain public confidence in maternity services. **"The Ambulance Handover report highlighted extended waits of 4+ hours at Doncaster Royal Infirmary and 3+ hours at Bassetlaw, what is the escalation process and what triage takes place whilst in the ambulance?"** The Chief Executive confirmed that a call prior to presentation would take place, followed by a clinical review involving the ambulance personnel. Where time critical action was required, for example cardiac or stroke presentation this would impact upon the prioritisation of the handover. Historically, delays had not been seen at Bassetlaw, but system pressures were now impacting both sites. The data provided in the handover report highlighted the need for improvements at a Trust, Place and system level and informed the Urgent & Emergency Care Action Plan.	
	The Board: - ***Noted the governor question and feedback provided.***	
P22/02/E3	**Any other business (to be agreed with the Chair prior to the meeting)**	
	No items of any other business were received. To close, the Chair of the Board shared her personal thanks and those of the Board with Marie and David Purdue who were leaving the organisation to take up opportunities with the South Yorkshire Mental Health, Learning Disability and Autism Alliance and NHSE/I respectively. Both colleagues were wished the very best in their new roles and the Trust looked forward to continuing to work in partnership with them in their new organisations.	
P22/02/E4	**Date and time of next meeting (Verbal)** **Date:** Tuesday 24 May 2022 **Time:** 09:30am **Venue:** MS Teams	
P22/02/F	**Close of meeting (Verbal)**	
	The meeting closed at 11.34	