NHS

Doncaster and Bassetlaw Teaching Hospitals

NHS Foundation Trust

Board of Directors Meeting Held in Public
To be held on Tuesday 27 September 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	National Cancer Patient Experience Survey 2021 Lesley Barnett, Deputy Director of Nursing for Cancer Toni Peet, Personalised Care Manager	*Note*		15
C	**True North SA1 - QUALITY AND EFFECTIVENESS**			**09:55**
C1	Board Assurance Framework *Dr Tim Noble, Executive Medical Director & Abigail Trainer, Acting Chief Nurse*	*Assurance*		10
C2	Chief Nurse Update *Abigail Trainer, Acting Chief Nurse*	*Assurance*		15
C3	Maternity Update *Lois Mellor, Director of Midwifery*	*Assurance*		10
C4	Executive Medical Director Update • to include Q4 2021/22 Learning from Deaths Report *Dr Tim Noble, Executive Medical Director*	*Assurance*		15

D	True North SA2 & 3- PEOPLE AND ORGANISATIONAL DEVELOPMENT			10:45
D1	Board Assurance Framework *Zoe Lintin, Chief People Officer*	*Assurance*		10
D2	People Update *Zoe Lintin, Chief People Officer*	*Assurance*		10
D3	Guardian of Safe Working Quarterly Report *Dr Anna Pryce, Guardian for Safe Working & Consultant in Sexual Health* *Zoe Lintin, Chief People Officer & Dr Tim Noble, Executive Medical Director*	*Assurance*		10
D4	Workforce Race & Disability Equality Standards *Zoe Lintin, Chief People Officer*	*Assurance*		10
	BREAK 11:25 – 11:35			
E	True North SA4 - FINANCE AND PERFORMANCE			11:35
E1	Board Assurance Framework *Alex Crickmar, Acting Director of Finance*	*Assurance*		10
E2	Finance Update *Alex Crickmar, Acting Director of Finance*	*Note*		10
E3	Operational Performance Update • to include Ambulance Handovers *George Briggs, Interim Chief Operating Officer*	*Assurance*		15
E4	Update on COVID-19 Public Enquiry *Fiona Dunn, Director Corporate Affairs/Company Secretary* *George Briggs, Interim Chief Operating Officer*	*Note*		5
E5	Directorate of Recovery, Innovation & Transformation Update *Jon Sargeant, Interim Director of Recovery, Innovation & Transformation*	*Assurance*		10
F	STRATEGY			12:25
F1	*No updates to discuss*			
G	GOVERNANCE AND ASSURANCE			12:25
G1	Corporate Risk Register *Fiona Dunn, Director Corporate Affairs/Company Secretary*	*Review*		5
G2	Approval of Risk Management Policy, Risk Appetite Statement *Fiona Dunn, Director Corporate Affairs/Company Secretary*	*Approve*		5
G3	Trust Board Director Register of Interests & Fit & Proper Person Annual Review *Fiona Dunn, Director Corporate Affairs/Company Secretary*	*Assurance*		5
G4	DBTH Constitution – Review Update *Fiona Dunn, Director Corporate Affairs/Company Secretary*	*Approve*		10

H	INFORMATION ITEMS (To be taken as read)			12:50
H1	Chair and NEDs Report *Suzy Brain England OBE, Chair*	*Information*		
H2	Chief Executive's Report *Richard Parker OBE, Chief Executive*	*Information*		
H3	Performance Update Appendices *George Briggs, Interim Chief Operating Officer*	*Information*		
H4	Minutes of the Finance and Performance Committee – 26 May & 30 June 2022 *Neil Rhodes, Non-Executive Director*	*Information*		
H5	Minutes of the People Committee – 3 May 2022 *Mark Day, Non-Executive Director*	*Information*		
H6	Minutes of the Audit & Risk Committee – 17 June 2022 *Kath Smart, Non-Executive Director*	*Information*		
H7	Minutes of the Quality & Effectiveness Committee – 8 February, 5 April & 7 June 2022 *Kath Smart/Jo Gander, Non-executive Director*	*Information*		
H8	Minutes of the Charitable Funds Committee – 9 December 2021 & 24 March 2022 *Mark Bailey, Non-executive Director*	*Information*		
H9	Minutes of the Trust Executive Group – 11 July & 15 August 2022 *Richard Parker OBE, Chief Executive*	*Information*		
I	OTHER ITEMS			12:50
I1	Minutes of the meeting held on 26 July 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 25 October 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	13:05
*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 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 the day.
- Questions must be submitted in advance to Lynne Schuller, Lead Governor.
- Questions will be asked by Lynne Schuller, 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

NHS

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Action Log

Meeting:	Public Board of Directors	KEY	
Date of latest meeting: 26 July 2022		**Completed**	**On Track**
		In progress, some issues	**Issues causing progress to stall/stop**

No.	Minute No.	Action	Lead	Target Date	Update
1.	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. **Update 28.6.2022** – to be included on July's agenda and include a Q1 update. **Update 26.7.2022** – Objectives approved . Action closed
2.	P22/07/C1	**Board Assurance Framework – Strategic Aim 1** To incorporate narrative in respect of benchmarking of Getting It Right First Time and intelligence contained within CQC Insights into the BAF.	TN	**September 2022**	Updated Board Assurance Framework @ C1

3.	P22/07/E1	**Impact of Pay Award** To establish the costs and likely impact on the Trust's financial position once the funding had been established.	**AC**	**September** **2022**	Included within E2 – Finance Update
4.	P22/07/G1	**Risk Management** To provide a timeline for the revised risk policy and associated plan of work to review the Corporate Risk Register	**TN**	**September** **2022**	

National Cancer Patient Experience Survey 2021 Published July 2022
Lesley Barnett DDN Cancer and Toni Peet PCM

Survey Process :

The National Cancer Patient Experience Survey 2021 is the 11th iteration of the survey first undertaken in 2010. It has been designed to monitor progress on cancer care; to provide information to drive local quality improvements; to assist commissioners and providers of cancer care; and to inform the work of the various charities and stakeholder groups supporting cancer patients.

The survey was overseen by a national Cancer Patient Experience Advisory Group. This Advisory Group set the principles and objectives of the survey programme and guided questionnaire development. The survey was commissioned and managed by NHS England. The survey provider, Picker, is responsible for designing, running and analysing the survey.

Survey Process :

The sample for the survey included all adult (aged 16 and over) NHS patients, with a confirmed primary diagnosis of cancer, discharged from an NHS Trust after an inpatient episode or day case attendance for cancer related treatment in the months of April, May and June 2021. The fieldwork for the survey was undertaken between October 2021 and February 2022.

There were 116 patients responded out of a total of 201 patients, resulting in a response rate of 58%.

Breast and Colorectal patients being the highest number of responders.

The National Cancer Patient Experience Survey 2021

www.dbth.nhs.uk

Highlight report: ABOVE National average

	Case Mix Adjusted Scores			
	2021 Score	Lower Expected Range	Upper Expected Range	National Score
Q20. Treatment options were explained in a way the patient could completely understand	**91%**	75%	90%	**82%**
Q41_1. Beforehand patient completely had enough understandable information about surgery	**97%**	82%	97%	**89%**

Patient's average rating of care scored from very poor to very good:

National Score:	DBTH score:
8.9%	8.96% ⭐

The National Cancer Patient Experience Survey 2021

www.dbth.nhs.uk

Highlight report:

⭐ Overall 79% of responses were above the national average.

A selection of answers that were above the national average :

Q02 Patient only spoke to primary care professional once or twice before cancer diagnosis	80%
Q03 Referral for diagnosis was explained in a way the patient could completely understand	67.5%
Q14 Cancer diagnosis explained in a way the patient could completely understand	80.4%
Q16 Patient was told they could go back later for more information about their diagnosis	89.6%
Q18 Patient found it very or quite easy to contact their main contact person	88.8%
Q20 Treatment options were explained in a way the patient could completely understand	90.7%
Q21 Patient was definitely involved as much as they wanted to be in decisions about their treatment	84.9%
Q22 Family and/or carers were definitely involved as much as the patient wanted them to be in decisions about treatment options	80.7%
Q25 A member of their care team helped the patient create a care plan to address any needs or concerns	96.4%
Q26 Care team reviewed the patient's care plan with them to ensure it was up to date	100%
Q27 Staff provided the patient with relevant information on available support	92.7%
Q32 Patient's family, or someone close, was definitely able to talk to a member of the team looking after the patient in hospital	66.2%

The National Cancer Patient Experience Survey 2021

www.dbth.nhs.uk

Highlight report:

Overall 79% of responses were above the national average.

A selection of answers that were above the national average:

Q33 Patient was always involved in decisions about their care and treatment whilst in hospital 74.6%

Q34 Patient was always able to get help from ward staff when needed 88.5%

Q35 Patient was always able to discuss worries and fears with hospital staff 76.2%

Q36 Hospital staff always did everything they could to help the patient control pain 90%

Q37 Patient was always treated with respect and dignity while in hospital 93%

Q38 Patient received easily understandable information about what they should or should not do after leaving hospital 90.8%

Q39 Patient was always able to discuss worries and fears with hospital staff while being treated as an outpatient
or day case 81.1%

Q41(1) Beforehand patient completely had enough understandable information about surgery 96.9%

Q41(4) Beforehand patient completely had enough understandable information about hormone therapy 90.8%

Q42(1) Patient completely had enough understandable information about progress with surgery 90.9%

Q42(4) Patient completely had enough understandable information about progress with hormone therapy 76.9%

www.dbth.nhs.uk

The National Cancer Patient Experience Survey 2021

Highlight report:

Overall 79% of responses were above the national average.

A selection of answers that were above the national average:

Q43 Patient felt the length of waiting time at clinic and day unit for cancer treatment was about right — 88.7%

Q44 Possible side effects from treatment were definitely explained in a way the patient could Understand — 80.7%

Q46 Patient was given information that they could access about support in dealing with immediate side effects from treatment — 93.2%

Q47 Patient felt possible long-term side effects were definitely explained in a way they could understand in advance of their treatment — 68.1%

Q48 Patient was definitely able to discuss options for managing the impact of any long-term side effects — 62.4%

Q52 Patient has had a review of cancer care by GP practice — 24.7%

Q54 The right amount of information and support was offered to the patient between final treatment and the follow up appointment — 81.8%

Q55 Patient was given enough information about the possibility and signs of cancer coming back or spreading — 70.2%

Q58 Cancer research opportunities were discussed with patient — 52.7%

www.dbth.nhs.uk

The National Cancer Patient Experience Survey 2021

Highlight report: below National average

Responses that were below the national average but was within the expected range:

Q 5 Patient received all the information needed about the diagnostic test in advance
Q 9 Enough privacy was always given to the patient when receiving diagnostic test results
Q 28 Patient definitely got the right level of support for their overall health and well being from hospital staff
Q 41 -5 Patient completely had enough understandable information about progress with immunotherapy
Q 41 –2 Patient completely had enough understandable information about progress with chemotherapy
Q 41-5Patient completely had enough understandable information about progress with radiotherapy
Q 51 Patient definitely received the right amount of support from their GP practice during treatment
Q 50 During treatment, the patient definitely got enough care and support at home from community or voluntary services

Patient's average rating of care scored from very poor to very good:

National Score:	DBTH score:
8.92%	9.00% ⭐

The National Cancer Patient Experience Survey 2021

www.dbth.nhs.uk

Highlight report: below National average

Responses that were below the national average and below the expected range:

	Case Mix Adjusted Scores			National Score
	2021 Score	Lower Expected Range	Upper Expected Range	
Q42_2. Patient completely had enough understandable information about progress with chemotherapy	**65%**	66%	91%	**79%**

The National Cancer Patient Experience Survey 2021

www.dbth.nhs.uk

Highlight report: Responses that were low nationally overall

1. GP did not take me seriously
2. Delay to see GP
3. Difficulty accessing GP
4. Lack of proactive FU from GP
5. Inadequate communication
6. More detail on cancer type
7. Waiting times too long –diagnostic tests, Appt. and starting treatment
8. Negative comments about hospital staff –isolated incidents, unprofessional, inconsiderate, poorly staffed.
9. Wider hospital issues-poor food quality and variety, parking, lack of privacy noise at night, décor needs updating, beds uncomfortable and Covid-19 restrictions

Patient's want:

- Face to Face appts for breaking significant news and to observe non- verbals
- Single point of contact

Was there anything particular good about your NHS cancer care?

Ever since I went to A & E in May of this year, all the staff in every department have treated me with respect and consideration, despite the pressure they were under. All scans and diagnostic tests were carried out in a professional manner and all procedures were thoroughly explained. From people I have spoken with, my treatment started much earlier than I expected and has been carried out in a calm environment and efficient manner.

The care from the hospital couldn't have been better. Within the hospital and the Chatsfield suite the teams have been wonderful. I can't fault the care and support I have received.

Absolutely amazing from start to finish, I am currently having treatment for cancer if an undiagnosed primary which was shocked about after undergoing major surgery in August for rectum cancer. My consultants and their staff have been excellent and they all continue to support my care plan.

After being diagnosed the level of care and treatment received has been exceptional, I've met many outstanding individuals throughout my experience and all of them a credit to the NHS

The National Cancer Patient Experience Survey 2021

www.dbth.nhs.uk

Was there anything that could have been improved?

Given it was in the Covid period with staff shortages it was very streamlined. I feel that to be given my results over the phone and not in person was very clinical. I wasn't able to look at my scans and talk through them with the consultant. I still haven't seen them and again after six months my next appointment is by phone ... I think patients should be seen in person to deliver a prognosis.

Better parking at the hospital, a better understanding from A & E receptionists that a letter showing immune compromised status and that the person should be fast tracked out of the mass of people waiting should be easier recognised.

Maybe a phone call from the nurses to check I was ok, maybe a short time after my diagnosis. No contact was made from the hospital for five months.

I was told I had bowel cancer during the endoscopy procedure. I was most distressed and I felt this should have been told to me when I was on the recovery ward at least. I was offered (by the nursing staff) the chance to complain but declined.

The National Cancer Patient Experience Survey 2021

www.dbth.nhs.uk

Was there anything that could have been improved?

Initially there was a delay in results being provided back to my consultant. This did cause an elongated period of uncertainty & confusion over whether I had cancer of not. I appreciated them going to the lengths to get a specialist opinion - but clearer communication at that point would have been preferable.

I had to contact the nurses to chase up my CT Scan results as when I had a telephone appointment, the doctor did not have the results. It took a further week to get the results explained and relayed to me. Maybe this could be stream lined.

I delt with several specialist cancer nurses and it would be nice if some telephone appointments (as all appointments were by telephone) would have been done by Accurx (video). Don't give a telephone appointment time if you do not even ring remotely closely to that time.

I would like to suggest that the meals should be looked at. They were very unappetising.

The National Cancer Patient Experience Survey 2021

www.dbth.nhs.uk

Next Steps:

- Present the NCPES findings to clinical Governance, Cancer Programme Board, Cancer Management Team Meeting and CNS Forum
- Increase patient uptake in future survey's by improving communication and engagement channels.
- Increase patient uptake in all tumour groups by doing local surveys
- To participate in trialling future survey's to include outpatients.
- To Initiate an Action plan for some of the lowest patient responses to improve services

References:

Adobe Acrobat
Document

Microsoft Excel
Worksheet

Microsoft Excel
Worksheet

https://www.ncpes.co.uk/current-results/

We care values

W e always put the patient first.

E veryone counts – we treat each other with courtesy, honesty, respect and dignity.

C ommitted to quality and continuously improving patient experience.

A lways caring and compassionate.

R esponsible and accountable for our actions – taking pride in our work.

E ncouraging and valuing our diverse staff and rewarding ability and innovation.

The National Cancer Patient Experience Survey 2021

www.dbth.nhs.uk

Stay in touch

Keep up-to-date with the Trust by following our social media accounts and checking our website (link in the bottom right corner).

Facebook
@DBHNHS

Instagram
@DBTH_NHS

Twitter
@DBH_NHSFT

FB Staff group
DBTH Staff

www.dbth.nhs.uk

Thank you, any questions?

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 Appetite Summary for all Risk Level Categories (2022-2023)

Current risk appetite summary for DBTH 2022 / 2023 is: *(adapted from Good Governance Institute's Risk Appetite for NHS Organisations Matrix)*	**Reputation**	**Finance/VFM**	**Regulatory**	**Innovation**	**Quality**	**People**
	Seek (4)	**Open (3)**	**Minimal (1)**	**Open (3)**	**Open (3)**	**Open (3)**

Current Risk Level Summary

The entire current BAF was last reviewed in Sept 2022 reviewed alongside the corporate risk register and now incorporates the Board risk appetite statement for 2021/2022.

The entire BAF and CRR were reviewed at Board Sub Committee meetings during Aug/sept 2022 and by the Strategic aim sponsors in Sept 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 Aug/Sept Sub Committee and Trust Board. The individual BAF sheet SA1-COVID has now been incorporated within BAF SA1 Sheet.

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 Sept Trust Board and its subcommittees. The risk score for SA1-COVID has 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.
New sections within the individual BAF sheets SA1-SA4 now include reference to the individual risks that contribute to the BAF explanations
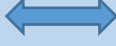
There has been no change in the overall BAF risk levels during quarter 2 of 2022/2023.

Heat Map of individual SA risks (identified 2021-2022 BAF)

	No Harm 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Rare 1					
Unlikely 2					
Possible 3				2 Q&E1, ARC01	3 F&P11, COVID 2472, F&P12,
Likely 4				4 F&P1, F&P6, PEO3, PEO2	2 F&P4 F&P20,
Certain 5		ARC02	Q&E9		

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	⬆

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 : September 2022 | | |

Strategic Objective
To provide outstanding care and improve patient experience

Breakthrough Objective
Achieve measurable improvements in our quality standards & patient experience

Measures:

- *Covid risk SA1* ID 2472 incorporated into SA1*

- *Updated existing Board Assurance Framework for IPC as new guidance due in May 2022 still not produced by NHSE*
- *Review and utilisation of PSIRF (patient safety incident framework) and the focus on embedded learning*
- *NICE – delivery of statutory audits of clinical effectiveness*
- *Continual role out of Tendable – ward / department quality assessment tool*
- *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, to include learning and engagement with stakeholders*
- *Patient survey outputs and effectiveness of action plans*
- *Insights profiles from CQC*
- *External review of patient safety and clinical governance which will incorporate patient experience*

- *Urgent and Emergency care programme in place , includes, relocation of AMU back to AMU , and the opening of EAU*

- *Increase in trolley capacity in emergency department to support ambulance handovers*

Risk Appetite:
The Trust has an appetite for this strategic risk as shown below by risk type:

Reputation	Finance/VFM	Regulatory	Innovation	Quality	People
Seek (4)	Open (3)	Minimal (1)	Open (3)	Open (3)	Open (3)

Overall Risk Scores for Strategic Objective

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

Risks:

- *Risk of patient harm if we do not listen to feedback and fail to learn*
- *Risk of not using available quality assurance data to best effect in order to identify areas to improve or manage patient care.*
- *Risk to safety and poor patient experience as a result of failure to improve the estate and infrastructure.*
- *Risk of non-delivery of national performance standards that support timely, high quality care*
- *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 due to uncertain covid pandemic pattern*

Please ensure gaps in assurance are qualified and explained in conjunction with current Trust Risk Appetite

CRR Risk cross reference	Q&E9 1517	F&P 6 7	F&P 8 16	Q&E F&P 2472			
Current CRR Risk Rating	15	16	16	15			
Risk Appetite Type	Qual	Reg	Qual Peop	Qual Peop Finance			
Risk Appetite Level	Open	Minimal	Open	Open			
Target Risk Rating	12	9	8	10			

Opportunities:
- Change in practices, new ways of working, regional Integrated Care Boards established for South Yorkshire and Nottingham & Nottinghamshire.
- Advent of more digital care –digital transformation including electronic patient record and virtual ward
- Greater opportunity for collaboration at place / system level
- Implementation of national patient safety strategies that improve patient care
- 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

Rationale for overall strategic risk current score:
Impact:
- Impact on performance
- Impact on Trust reputation
- Impact on safety of patients
- Impact on patient experience
- Potential delays to treatment
- Possible Regulatory action

Future risks:
- Impact of COVID on elective restoration
- Staff engagement post covid
- Patient expectations following Covid
- Staff working in separate areas following the incident in the women's hospital.
- Uncertainty re COVID recovery outcomes

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
Accountability Framework & Quality framework process Risk Stratification, Validation and Clinical Prioritisation of Patient Pathways.	September 2022	December 2022	Med Director (TN) & COO	Action plans in place, reviews on going Processes embedded within admitted pathways and diagnostics. Further work to support the processes for non-admitted pathways underway within

Appendix Level1

KPMG work complete and business as usual continues through the Outstanding Outpatients forum in terms of ongoing developments, improvements and digital transformation.					Digital Transformation and operationally, including the development of a patient pathway management system
Clinical Governance review complete. Awaiting completion of external patient safety and governance review prior to implementation	May 2022	November 2022	Med Director (TN)		None identified Awaiting outcome of recommendations to understand gaps In control, not currently mitigated
Urgent and Emergency Care Improvement Programme – ongoing	April 2022	November 2022	Med Director (TN) & COO		Actions & plans in place
Action plans to respond to CQC patient surveys	April 2022	November 2022	Chief Nurse & Med Director (TN)		Action plans in place and monitored through PEEC via regular reporting. Due to departure of current post holder time frame delayed. Recruitment process taking place currently
Patient Experience PPI and Accessible Standards in place which form part of the patient experience pathway	June 2022	November 2022	Chief Nurse		Work plan and strategy to be enhanced to improve patient experience Due to departure of current post holder time frame delayed. Recruitment process taking place currently

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
L1,L2	SNCT undertaken to ensure safe staffing completed in June2022, report outcome will be expected at board in September 2022.	Jan 22	QEC, Board	Full	Awaiting completion of SNCT data collection which is taking place in May 2022. Audit completed , data analysis taking place and will be presented at September 2022 Board
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	
L3	National Getting It Right First Time (GIRFT) reviews across specialties on a rolling programme of work.	September 2022	Board	Full	Medical Director Undertaking a full review of all recommendations and actions and links to Specialty level and Divisional Strategic plans.

Corrective Actions required			Action due date	Action status	Action owner	Forecast completion date
CQC (Picker) in patient 2021 survey results received May 2022. Results to be reviewed and actions plans to be developed and submitted to PEEC for August 2022.			September 2022	Survey reports shared with key stakeholders	Chief Nurse	November 2022 due to departure of Head of Patient Experience. Recruitment process taking place
Commission external review of patient safety and clinical governance which will incorporate patient experience, review recommendations and agree action plan			July 2022 for report , agree plan November 2022	Review underway	Medical Director Chief Nurse	Dependent on agreed action plan
Review patient experience strategy and develop work plan for 2022/23			November * 2022	Review to commence	Chief Nurse	Dependent on agreed action plan
Vulnerable Patients- nMAbs service established Dec21, and continues to react to prevalence of Covid within the community			April 2022	March 2023	Medical Director / COO	Business case complete – further discussion on future service model ongoing at SY ICB level

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:	27 September 2022	**Agenda Reference:**	**C2**
Report Title:	**Chief Nurse Report**		
Sponsor:	Abigail Trainer, Acting Chief Nurse		
Author:	Kirsty Clarke, Acting Deputy Chief Nurse (Workforce Lead) Simon Brown, Acting Deputy Chief Nurse Marie Hardacre, Head of Corporate Nursing		
Appendices:	None		

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

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

Assurance Route		
Previously considered by:		Quality and Effectiveness Committee
Date:	September 2022	**Decision:**	Regular updates required to QEC
Next Steps:		Update progress to QEC
Previously circulated reports to supplement this paper:		None

Chief Nurse Report September 2022

The national patient safety strategy defines 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.

The Just Culture approach has got to be our key priority to enable DBTH to fully embrace and implement the patient safety strategy.

The Patient Safety Incident Response Framework (PSIRF) was published on 16 August 2022, as a major piece of guidance on how NHS organisations respond to patient safety incidents and ensure compassionate engagement with those affected. All providers contracted under the NHS standard contract have been asked to begin preparing to transition to PSIRF from 1 September 2022. Preparation is expected to take 12 months with organisations transitioning to PSIRF by Autumn 2023.

Safer Culture, Safer Systems

Initial planning meetings have been held with the Patient Safety Specialists (PSS), People and Organisational Development and our Freedom to Speak Up colleagues, to plan how we are going to address annual Staff Survey findings for 2021/22.

Each division has received feedback on their results to generate their own action plans. Additionally, to support the monitoring of our safety culture, question sets have been chosen for the new Tendable (more on which can be found in this report) application which was launched on 1 July 2022.

This will allow a temperature check throughout the year of how we are progressing with our safety culture. The data for August is below and demonstrates positive feedback:

Do you feel able to raise concern about clinical practice?	99.5% answered yes (186 responses)
Can you tell me about a recent incident in your clinical area?	96.7% answered yes (182 responses)
Do you feel the Trust acts on concerns raised by patients?	94.5% answered yes (181 responses)

Insight

Serious Incidents

There were six serious incidents logged in June and July, see the details below:

- Medical imaging misdiagnosis
- Sub-optimal care regarding chest draining sighting and management

- Aggressive/violent behaviour resulting in severe harm
- Medication error
- Lost to follow-up following a request for a chest x-ray
- Lost to follow-up missed opportunities for earlier diagnosis.

This is a total of nineteen serious incidents reported year to date for 2022/2023. Of these, fourteen were for care issues. Work is underway to understand what learning can be gleamed, and how we can improve in future.

Healthcare Safety Investigation Branch (HSIB) Investigations

Two HSIB investigations, year-to-date, which are:

- Shoulder dystocia. Baby required prolonged resuscitation and therapeutic cooling
- Intra-partum still-birth at 40+5/40.

As a result of this, the Royal College of Obstetrics and Gynaecology Escalation toolkit was implemented on 18 July 2022.

For more information on the escalation tool kit please follow the below link: https://www.rcog.org.uk/about-us/groups-and-societies/the-rcog-centre-for-quality-improvement-and-clinical-audit/each-baby-counts-learn-support/escalation-toolkit/

The overall aims of the campaign to improve clinical escalation are:

- To reduce delays in escalation by improving the response escalation and action taken.
- To standardise the use of safety critical language.
- To reduce feelings of hierarchy, creating a supportive environment which empowers staff of all levels to speak up when they identify deterioration or a potential mistake.
- To promote a culture of respect, kindness and civility amongst staff. members, normalising positive feedback and saying thank you to each other
- To improve the ways in which we listen to women.

Patient Safety Incident Response Framework (PSIRF)

The initial project plan and communication Trust-wide has commenced to share the information that the PSIRF guidance has been published. Stakeholder meetings and a revised response framework plan is required to ensure all stakeholders are engaged with the planning process. The top five patient priorities identified previously are likely to remain largely the same. However, the discharge priority theme is communication and handover. To align with the ICB priorities, this may change following stakeholder meetings.

The current key priorities are listed below:

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

DBTH is also involved in collaboration with NHS Nottingham and Nottinghamshire Integrated Care Board (ICB) who have organised a steering group to ensure learning across the system that aligns our patient safety improvement priorities.

Patient Safety Specialists

The Trust patient safety specialists are Dr Juan Ballesteros (Associate Medical Director for Clinical Safety), Marie Hardacre (Head of Nursing for patient safety and corporate services) and 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. The transition to PSIRF will need a system wide change and will need to incorporate the 'Just Culture' approach.

Falls

There have been 159 falls in July and 143 falls in August. 213 (out of 302) of these resulted in no harm, and 10 were non-inpatient falls. 64 falls have resulted in low harm.

There have been six moderate harms, and six severe harms in the past two months.

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 and shared in a monthly newsletter, the themes this month include:

- Walking aid provision at the earliest opportunity. The falls team are providing education and supplies to the assessment units to ensure the appropriate aid is provided as soon as possible.
- The transfer of a patient's care from one department to another involves complex communication and handover. Risks of poor communication impacting on care delivery.

In July 2022 Mallard ward celebrated two years with no serious harm caused following an inpatient fall. This was achievable following a quality improvement project that was first introduced in February 2019. The project focused on using a

tool as part of a safety huddle to update staff on the patient's required level of supervision.

This required a change in culture during staff handover and highlighted those most at risk. The project also supported the promotion of low beds, and the prompt cohorting of high-risk patients. This supports the theory of patient safety and the value of learning from what goes well. The whole team approach demonstrated on Mallard ward is a huge achievement and clearly focuses on the themes identified above, surrounding handover and the transfer of care.

Hospital Acquired Pressure Ulcers (HAPU)

There were 46 HAPUs in July and 42 in August. This has affected 72 patients in total. Of these patients, zero were classified as category four HAPUs, six were category three HAPUs, five were unstageable HAPUs. four mucosal pressure ulcer and zero were uncategorisable pressure ulcers.

Learning from the Skin Integrity Improvement Panel continues monthly with the use of a Trust social media group, Trust intranet pages, bespoke ward training and Trust wide training via eLearning and face-to-face.

The Skin Integrity Team continue their Quality Improvement programme with the aim of achieving a 20% reduction across the Trust of category two and above HAPUs by the end of March 2023. The Trust remains on target with this trajectory.

Infection Prevention and Control (IPC)

Clostridium difficile (C.Diff): One in July and two in August 2022. All three of these cases were hospital onset, hospital associated (HOHA) infections. This is a total of twelve cases of C.Diff for the financial year, against a trajectory of 48.

E-Coli bacteraemia: In July, six cases were reported, in August six were reported. Seven were classed as HOHA and five as community onset hospital associated (COHA). This is a total of 34 cases with a current trajectory of 87 for the year.

MRSA bacteraemia: There were no MRSA bacteraemia reported in July or August 2022. This is against a trajectory of zero. The Trust has not had an MRSA bacteraemia since 26 February 2021 - a fantastic achievement.

MRSA colonisation: There were two reported colonisations in July, and one in August. This is a total of nine cases and will be closely monitored by the divisional teams and IPC.

Key learning identified from the TENDABLE weekly audit – exploring and showing areas of improvement and where we can improve.

Involvement

The framework for involving patients in patient safety

- Part a: Involving patients in their own safety
- Part b: Patient safety partner (PSP) involvement in organisational safety

The patient safety specialists have identified our first patient safety partner and initial meetings have taken place. There are four levels of patient safety partners and discussions within the patient safety team to develop our patient safety partner strategy at DBTH are underway.

Patient Safety Syllabus

The patient safety syllabus (level one) is on the ESR system and available for all staff to use. This is a national eLearning package to improve safety culture. PSIRF publication informs the Trust that there is a requirement for additional education for executive leads for PSIRF and bespoke training for investigators and Divisional leads, more information will follow.

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.

Due to national mourning, the planned World Patient Safety Day week-long programme of activities to engage the teams with patient safety pledges across DBTH, has been postponed. This will be revisited shortly with the planned activities rescheduled.

Digital Transformation

The TENDABLE accreditation application

Tendable is an innovative, app based digital tool that enables a wide range of audits to be undertaken in clinical areas providing a real time view of quality assurance. Tendable provides live, automated reporting so clinical teams can immediately identify what is working well and highlight areas requiring improvement. Audits are quicker and more efficient allowing more time for patient care and provides our

teams with the insight necessary to enable us to focus on what really matters to our patients and staff.

The roll out of this service continues apace, with good staff uptake for training and fantastic engagement with ward staff.

Nursing and midwifery staffing

All NHS trust providers are required to publish nursing and midwifery staffing data monthly. 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.

Our Trust submitted data within the submission timeframe for the months of July and August 2022. Across our 40 inpatient wards throughout this time frame, we regularly reviewed staffing against care hours per patient per day submission, with no exceptions.

Safer Nursing Care Data

DBTH uses the Safer Nursing Care Tool (SNCT) as a National Institute for Health and Care Excellence (NICE) endorsed evidence-based tool to determine optimal staffing levels. The tool supports the measurement of patient acuity and/or dependency to inform evidence-based decision making on staffing and workforce. DBTH has licences to run the SNCT for the following settings:

- Adult inpatient wards in acute hospitals
- Adult acute assessment units
- Children and young people's inpatient wards in acute hospitals.

The Trust also has a licence to use the SNCT for Emergency departments, this is a new tool and the senior nursing are in the process of undertaken the training and assessments required to utilise the tool.

This data, when triangulated with professional judgement and local intelligence helps the Divisional Directors of Nursing (DDoN) and Head of Nursing (HoN) to set/ review the ward establishment and agree the skill mix for each area with the Chief Nurse (CN) and in collaboration with matrons and ward/dept. managers.

The last data collection was undertaken in May 2022. At the time we identified the need to refresh training for some colleagues, as well as new starters with the Trust, and this work will be delivered by the Shelford Group in October.

The next data collection is planned to be undertaken by the end of November 2022, which will also support use of the data in annual planning processes.

Update on Staff nurse recruitment and retention

Following the last board report work has continued across a number of work streams including newly qualified nurse and internationally educated nurse recruitment to reduce the significant Band 5 staff nurse vacancy position.

Division	Headcount (WTE) accepted	Trust start date Sept/Oct - headcount	Placement start delay - headcount
Medicine	34 (32.84 wte)	25	9
Surgery (plus G5)	21 (20.8 wte)	16	5
CSS	1	1	N/A
Paediatric	6 (5.24wte)	6	N/A
Total	62 (59.88wte)	48	14

It is important to note that due to reduction in student nurse placement availability during the acute stages of the COVID pandemic (2020 to 2021), combined with sickness absence episodes, several healthcare students have not achieved the required placement hours to proceed to register with their professional body.

At DBTH 14 out of 62 NQ new starters are affected with four being delayed longer than two months from their intended start date. These students, where possible, will be supported to undertake some of their make-up placement hours within our Trust.

International nurse update

The Trust continues to progress with recruitment of internationally educated and recruited nurses to complement our existing workforce.

In addition to the planned recruitment of 50 adult nurses and five paediatric nurses across 2022/2023, DBTH was awarded funded from NHS England/Improvement (NHSE/I) to support with recruitment of an additional 20 internally educated nurses.

Ultimately, this will provide our Trust with an additional 70 adults nurses and five paediatric nurses from the recruitment work stream. A breakdown of our recruitment cohorts can be viewed below:

Cohorts 2022/2023	Number (WTE)
5 - arrived	10 adult
6 -arrived	10 adult
7 - arrived	10 adult
8 - arrived	10 adult
9 – arrive 28 Sept	10 adult
10 – arrive Oct	10 adult

11a – arrive Nov	5 paediatric
11b – arrive Nov	10
12 – arrive Dec/Jan	10

All internationally educated nurses are required to pass an objective structured clinical examination (OSCE) to enable them to transition on to the Nursing and Midwifery (NMC) UK register. DBTH has a 100% pass rate to date (on first or second attempt) however due to NMC changes to the OSCE process there is a possibility this pass rate may be affected. This would delay the transition of internationally educated nurses into the registered nurse positions they are appointed to and the requirement to continue to backfill the vacant post through temporary staffing solutions.

Agency summary

The July 2022 agency trend position demonstrated below shows the continued use of agency against a predicted static vacancy position across nursing and midwifery. Utilisation of agency as a temporary workforce solution is concerning, however it is recognised that in view of the significant vacancy position, compounded by maternity leave and sickness absence, it is necessary to further mitigate the risks to patient care delivery.
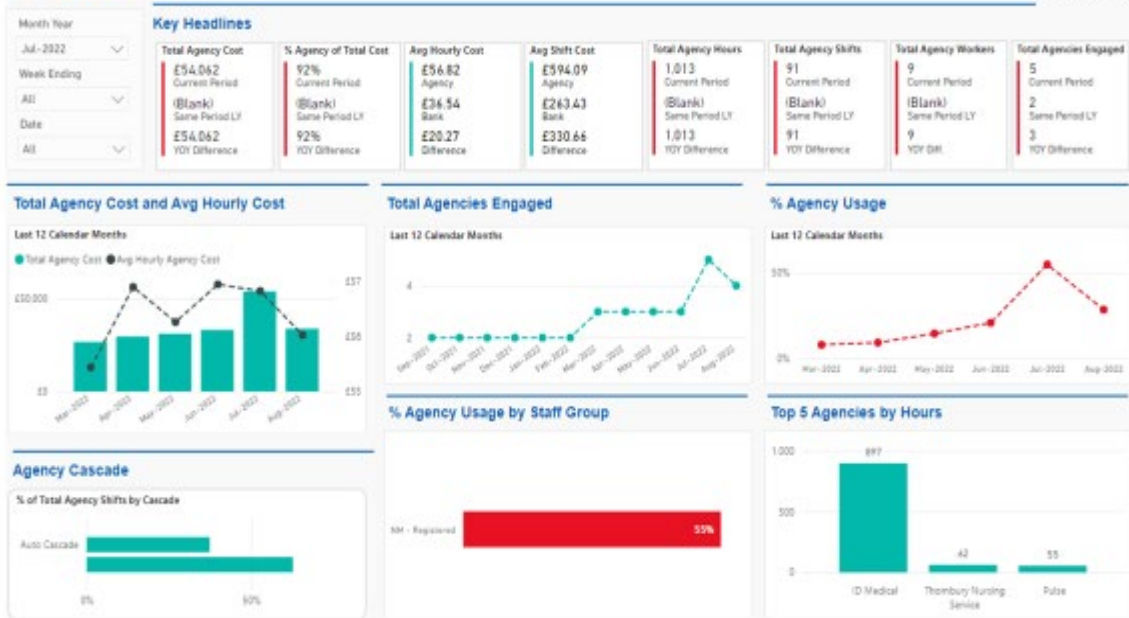
The average hourly agency cost across July has reduced and higher cost agency reliance patterns have shifted. Several of the high-cost agencies no longer appear in the top five agency chart. Work is now ongoing locally and across the ICB to further reduce enhanced rate agency costs with temporary workforce suppliers.
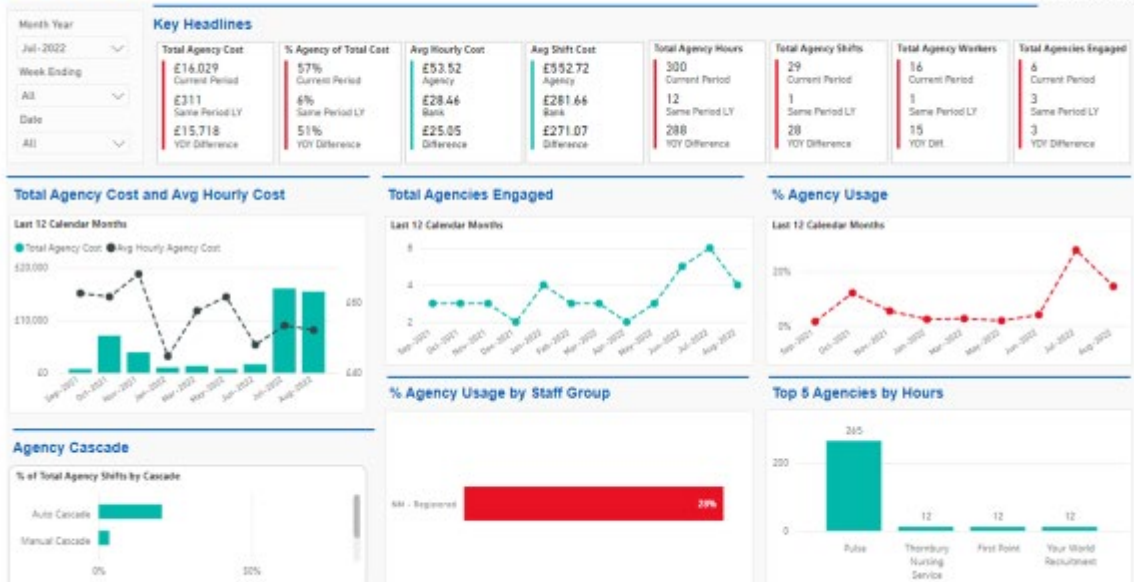
July Agency usage summary:

Midwifery

Key Headlines

	Total Agency Cost	% Agency of Total Cost	Avg Hourly Cost	Avg Shift Cost	Total Agency Hours	Total Agency Shifts	Total Agency Workers	Total Agencies Engaged
Month Year: Jul-2022	£54,062 Current Period	92% Current Period	£56.82 Agency	£594.09 Agency	1,013 Current Period	91 Current Period	9 Current Period	5 Current Period
Week Ending: All	(Blank) Same Period LY	(Blank) Same Period LY	£36.54 Bank	£263.43 Bank	(Blank) Same Period LY	(Blank) Same Period LY	(Blank) Same Period LY	2 Same Period LY
Date: All	£54,062 YOY Difference	92% YOY Difference	£20.27 Difference	£330.66 Difference	1,013 YOY Difference	91 YOY Difference	9 YOY Diff	3 YOY Difference

Total Agency Cost and Avg Hourly Cost
Last 12 Calendar Months
● Total Agency Cost ● Avg Hourly Agency Cost

Total Agencies Engaged
Last 12 Calendar Months

% Agency Usage
Last 12 Calendar Months

Agency Cascade
% of Total Agency Shifts by Cascade

Auto Cascade

% Agency Usage by Staff Group
NM - Registered 55%

Top 5 Agencies by Hours
JD Medical 897 | Thornbury Nursing Service 42 | Pulse 55

Paediatrics

Key Headlines

	Total Agency Cost	% Agency of Total Cost	Avg Hourly Cost	Avg Shift Cost	Total Agency Hours	Total Agency Shifts	Total Agency Workers	Total Agencies Engaged
Month Year: Jul-2022	£16,029 Current Period	57% Current Period	£53.52 Agency	£552.72 Agency	300 Current Period	29 Current Period	16 Current Period	6 Current Period
Week Ending: All	£311 Same Period LY	6% Same Period LY	£28.46 Bank	£281.66 Bank	12 Same Period LY	1 Same Period LY	1 Same Period LY	3 Same Period LY
Date: All	£15,718 YOY Difference	51% YOY Difference	£25.05 Difference	£271.07 Difference	288 YOY Difference	28 YOY Difference	15 YOY Diff	3 YOY Difference

Total Agency Cost and Avg Hourly Cost
Last 12 Calendar Months
● Total Agency Cost ● Avg Hourly Agency Cost

Total Agencies Engaged
Last 12 Calendar Months

% Agency Usage
Last 12 Calendar Months

Agency Cascade
% of Total Agency Shifts by Cascade

Auto Cascade
Manual Cascade

% Agency Usage by Staff Group
NM - Registered 29%

Top 5 Agencies by Hours
Pulse 265 | Thornbury Nursing Service 12 | First Point 12 | Your World Recruitment 12

Safe Care

Daily safe staffing meetings

The pilot of daily staffing meetings has continued throughout September at DRI with Surgery and Medicine areas now attending daily meetings, progression of the roll out at DRI will bring on board Critical Care and Paediatric areas.

This work is being led by safe staffing matron, divisional matrons and ward managers and provides a daily and weekly oversight of planned versus actual staffing, bed occupancy, acuity and dependency and red flag triggers.

NHSP colleagues will also form part of these daily meetings to provide rapid response to areas of need and also support housekeeping of shifts on the temporary workforce booking system / Eroster interface.

The above pilot has commenced using a manual data collection process for panned vs actual as the safe care pilot using the Allocate system remains stalled due to difficulties with recruitment to a key administration post in the workforce information team. The work stream continues to report through to the Trust Quality Strategy Group and by exception to the Quality and Effectiveness Committee.

Staff Retention

Recruitment and Retention self-assessment

Interim Deputy Chief Nurse and Head of Leadership & OD, EDI and wellbeing are completing the National Nursing & Midwifery Recruitment and Retention self-assessment tool to support development of a high level action plan that will feed into Trust wide P&OD work streams. Engagement to develop a Nursing & Midwifery recruitment & retention action plan will progress as part of this.

Staff nurse development

Following feedback from staff nurses at DBTH in terms of their development as leadership and recognition of how their contribution is valued at DBTH, successful pilot of the Royal College of Nursing Staff leadership programme has been completed. As a result of feedback a further 5 programmes have been funded via continuing professional development (CPD) funding. This will provide a further 75 staff nurses with the ability to complete the programme by March 2023.

Professional Nurse Advocate update

As part of the 3 year Chief Nurse Strategy to have 1 professional nurse advocate (PNA) to 20 registered nurses the Trust has increased the number of PNA's who have qualified through the master's accredited programme during 2022 to 17, this is an increase of 8 since the last reporting period. The PNA structure provides invaluable support to nursing teams, plays a key part in staff retention strategies and is included within the NHS contract.

Report Cover Page

Meeting Title:	**Board of Directors**

Meeting Date:	27 September 2022	**Agenda Reference:**	C3

Report Title:	**Maternity Update**
Sponsor:	Abigail Trainer, Acting Chief Nurse / Board level Safety Champion
Author:	Lois Mellor, Director of Midwifery
Appendices:	Perinatal Surveillance Dashboard (June 2022)

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 and 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 recommened 7 May 2022
Recommendation:	Board to note the content of the report and supporting dashboard.

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:	
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:	

Monthly Board Report (August 2022)

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

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

1.1 Stillbirths and late fetal loss > 22 weeks

- There has been an unfortunate increase in the number of stillbirths in the maternity service recently. An initial review has not identified any immediate trends and themes; however a more in-depth review is in progress, there is also work being undertaken in the LMNS.

1.2 Neonatal Deaths

- No update at present.

1.3 Actions/ Learning from PMRT

- Creation of suitable environment for families that have lost a baby. This is an ongoing action, funding has been established and work will commence soon on creating a bereavement suite on level 3.

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

Cases to date	
Total referrals	22
Referrals / cases rejected	4
Total investigations to date	18
Total investigations completed	15 ↑ 1
Current active cases	3 ↓ 1
Exception reporting	0

2.1 Reports Received since last report

HSIB criteria: HIE/ Cooling
Trust site: Doncaster
Incident date: 13.01.22

Safety Recommendation

The trust to ensure that staff are supported to resolve different clinical opinions when interpreting a CTG.

The service has introduced the Royal College of Obstetrics and Gynaecology (RCOG) Escalation Tool which was launched in July 2022 and will support staff when there is a difference of opinion.

2.2 Current investigations

HSIB criteria: HIE/ Cooling
Trust site: Doncaster
Incident date: 25.01.22
Referral date: 28.01.22

- Report with the parents
- Draft report received by the organisation

HSIB criteria: HIE/ Cooling
Trust site: Doncaster
Incident date: 11.05.22
Referral date: 18.05.22

- Staff meetings in progress

HSIB criteria: Stillbirth
Trust site: Doncaster
Incident date: 10.06.22
Referral date: 21.06.22

- Staff meetings in progress.
- Post-mortem uploaded to system.
- Second clinical advice meeting arranged for 19 September 2022.

3. Serious Incident Investigations (Internal)

There are two intrauterine deaths that have been presented to the serious incident panel and will be fully investigated. These will be led by the governance midwife. The families are aware of the investigations and will be involved.

4. Training Compliance

The service has set trajectories to meet 90% compliance with training by December 2022. Progression is being made in all areas of training and the current figures are:

CTG Study Day

- The training being currently delivered is in line with the recommendations from CNST Y4, the Ockenden report and HSIB investigations.
- There is discussion regarding adding an in house CAT at the end of this study day.
- 90% of all staff have to have attended the fetal monitoring study day by the 5 January 2023. Including the numbers that have attended and booked to attend, the trajectory up to the end of September 2022 will be:

Consultants	100%
Doctors	34.8% NB changeover of staff
Midwives	67.1%

- To increase attendance we are advertising on the Trust's Facebook group, emailing managers to book staff onto the study day, paying NHSP for staff willing to attend on their day off and promoting it at appropriate times.

In mitigation the K2 CTG compliance (on line) training compliance is good and there has been an overall improvement in training levels 30.9% in June to 42.1% in August

PROMPT Training (Obstetric Emergencies)

A trajectory has been set to achieve 90% compliance by December, and there has been an overall improvement from 43.3% (Divisional) to 46.7% this month.

There has been a pause over the summer and training recommenced on 1 September 2022. Currently the staff completed or booked on the PROMPT training is:

- Midwives 85.7%
- Consultant 46% (all staff have been contacted)
- Doctors currently being assessed due to the rotation of medical staff in August 2022. Attendance at another hospital will be accepted in this has been completed within the last rolling year.

5. Service User Feedback

The new maternity voices partnership (MVP) Chair continues to work proactively with the service and has shared both positive and negative feedback from current service users.

The Triage Service has been highlighted as an area that needs some collaborative work with the MVP. The service manager has spent some time with the Chair to discuss recent service user experiences, and there is planned work ongoing.

There has been some recent concern that there was no birthing pool available within the service. This was a temporary issue whilst the room at Bassetlaw Hospital was taken out of commission for short period, this has now been addressed and is now available once again.

Due to ongoing refurbishments works, there is not a pool at Doncaster Royal Infirmary currently and is anticipated to return when the Central Delivery Suite returns to level 6 of the Women's and Children's Hospital (when works complete in the next eight weeks). A temporary pool was considered but this not feasible due to time required to fill (several hours due to the water pressure) and empty the pool.

The Board level safety champion, and NED have made contact with the MVP Chair to be involved in the meetings and work collaboratively.

6. HSIB/ NHSR / CQC or other investigation with a concern or request for action made directly to the Trust

- None

7. Coroner PFDR (Reg 28) made directly to Trust

- None

8. Progress in achievement of CNST

Year 4 CNST standards ongoing.

Recruitment for admin support and project management has commenced.

At risk standards are:

Safety Action 5 – Midwifery Workforce (ongoing recruitment in place)
Safety Action 8 – Training (a trajectory to meet 90% training has been set)

9. Progress in implementing Continuity of Carer (MCoC)

Currently MCoC is paused due to the number of midwifery vacancies.

A plan has been set to achieve the target set of the majority of women being in receipt of MCoC by March 2024. This will be commenced as soon the staffing position allows, and the national team will support engagement with staff commencing in September 2022 to support reintroduction of MCoC.

10. Board Level Safety Champion staff feedback from walkabout

A safety champion walkabout took place on 2 September 2022 with Abigail Trainer (Acting Chief Nurse) and Mark Bailey (NED). The areas visited were:

- CDS
- ANC / ANAU
- M1
- Triage

The staff did not feedback any concerns specifically, but expressed how busy the service is, especially on Ward M1 (whilst M2 ward is closed – due to midwifery vacancies).

LMNS: South Yorkshire and Bassetlaw

Reporting period: July 2022 - September 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 (%)
July	1:31.1	26%	< 100%
Aug			
Sept			

NHS

Maternity unit	DBTH – Doncaster		

KPI (see slide 4)	Measurement / Target	Doncaster Rate		
		July	Aug	Sept
Caesarean Section rate	Elective	**<13.2%** 14.4%		
	Emergency	<15.2% 27.8%		
Preterm birth rate	≤26+6 weeks	0 — 0.4%		
	≤36+6 weeks	**<6%** — 9.1%		
Massive Obstetric Haemorrhage	**≥1.5l**	<2.9% — 2.7%		
Term admissions to NICU		<6% — 3%		
3rd & 4th degree tear	SVD (unassist'd)	<2.8% — 1.5%		
	Instrumental (assisted)	<6.05% — 0%		
Right place of birth		95% — 99.6%		
Smoking at time of delivery		<11% — 14.2%		
Percentage of women placed on CoC pathway		35% — 0%		
Percentage of women on CoC pathway: BAME / areas of deprivation	**BAME**	75% — 0%	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	Neonatal Deaths Late	Notification to ENS	Maternal Mortality (direct / indirect)
2021/2022 July		48	**69**	0	0	0	0	1	1	0	0	0	0	0	0
Aug															
Sept															
Q2															

Maternity Red Flags (NICE 2015)

		July	Aug	Sept
1	Delay in commencing/continuing IOL process	43		
2	Delay in elective work	1		
3	Unable to give 1-1 care in labour	1		
4	Missed/delayed care for > 60 minutes	3		
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: July 2022 - September 2022

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

Maternity unit	DBTH – Bassetlaw			

MW to birth ratio : BR+ recommendation	Vacancy rate (MW)	LW co-ordinator supernumerary (%)
1::28.25		
Jul		< 100%
Aug		
Sept		

NHS

KPI (see slide 4)3.9%	Measurement / Target	Bassetlaw Rate		
		July	Aug	Sept
Caesarean Section rate	Elective	**<13.2 %**	10.1%		
	Emergency	<16.9 %	37%		
Preterm birth rate	≤26+6 weeks	0	0		
	≤36+6 weeks	**<6%**	8.4%		
Massive Obstetric Haemorrhage	**≥1.5l**	<2.9%	4.20%		
Term admissions to NICU		<6%	2.77%		
3rd & 4th degree tear	SVD (unassist'd)	<2.8%	0.0%		
	Instrumental (assisted)	<6.06 %	11.1%		
Right place of birth		95%	100%		
Smoking at time of delivery		<11%	5.2%		
Percentage of women placed on CoC pathway		35%	0		
Percentage of women on CoC pathway: BAME / areas of deprivation	**BAME**	75%			
	Area of deprivation				

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	7	34	0	0	0	0	0	0	0	0	0	0	0	0	0
	May															
	June															
	Q1															

Maternity Red Flags (NICE 2015)

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

Assessed compliance with 10 Steps-to-Safety

		July	Aug	Sept
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

		July	Aug	Sept
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)

	July		Aug	Sept
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)	91% CTG	48.4% PROMPT		
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	🟩			

NHS

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

Maternity unit	JULY	AUGUST	SEPTEMBER
Freedom to speak up / Whistle blowing themes	None		
Themes from Datix (to include top 5 reported incidents/ frequently occurring)	Weight unexpectedly below the 10th centile PPH Shoulder dystocia Unexpected admission to NNU Staffing		
Themes from Maternity Serious Incidents (Sis)	No Si's in july		
Themes arising from Perinatal Mortality Review Tool	July meeting graded 3 cases CBA – Issues with off pathway delivery BBA – blood transfusion issues AB - MHP communication		
Themes / main areas from complaints			
Listening to women (sources, engagement / activities undertaken) CQC Women's Experience	CQC still suspended MVP ongoing and engaging with patient leaflets and guidelines		
Evidence of co-production			
Listening to staff (eg activities undertaken, surveys and actions taken as a result)	Ongoing OCR meeting Ongoing skills and drills scenarios Education lead now back in post supporting education needs of staff PROMPT going back to face to face in August		
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 LMNS meetings Safety summit in June went well for sharing across the LMNS good turn out for DBTH		

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 / Definition for use with Maternity papers

AN – Antenatal

ATAIN – term admission to neonatal unit (Term – 37-42 weeks gestation)

Cephalic – Head down

CNST – Clinical Negligence Scheme for Trusts

CTG – Cardiotocograph (fetal monitor)

Cooling – a baby is actively cooled lowering the body temperature

DoM – Director of Midwifery

EFW – Estimated fetal weight

FTSU – Freedom to speak up

G – Gravida (number of total pregnancies (including miscarriages)

HSIB – Health Service Investigation Branch

HIE – Hypoxic ischaemic encephalopathy (when the brain does not receive enough oxygen)

IUD – Intrauterine death

LMNS – Local Maternity and neonatal System

MVP – Maternity Voices Partnership

MSDS – Maternity Service dataset

NED- Non Executive Director

NICU = Neutral Intensive care unit

NND – Neonatal death

NMPA –National maternity and perinatal Audit

OCR – Obstetric case review

Parity – Number of babies born > 24 weeks gestation (live born)

PFDR – Prevention of Future Deaths Report

PMRT – Perinatal Mortality Review tool

PPH – Postpartum haemorrhage (after birth)

PROMPT – Practical Obstetric Multi- professional training

RIP – Rest in Peace

SVD – Spontaneous vaginal delivery

SBLCDV2 – Saving Babies lives care bundle version 2

MCoC – Midwifery Continuity of carer (6-8 midwives working in a team to deliver holistic are to a family)

MST – Microsoft teams

Other information

Term pregnancy is 37 – 42 weeks long

Viability is 24 weeks (in law) – gestation a pregnancy is considered viable

Resuscitation of a preterm baby can be offered from 22 weeks gestation (parent will need to be counselled)

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NHS Foundation Trust

Report Cover Page	
Meeting Title:	**Board of Directors**

Meeting Date:	27 September 2022	**Agenda Reference:**	**C4**

Report Title:	**Executive Medical Director Update**, incorporating: • Hospital Mortality Report • Clinical Update • Learning from Deaths Report, Quarter 4 2021/22
Sponsor:	Dr Timothy Noble, Executive Medical Director & Responsible Officer
Author:	Julie Butler, Senior Manager to the Executive Medical Director
Appendices:	Appendix 1 - Learning from Deaths Report, Quarter 4 2021/22

Report Summary	
Purpose of report:	To provide the Board of Directors with an update from the Executive Medical Director's portfolio.
Summary of key issues/positive highlights:	The Learning from Deaths Report considers deaths at DBTH in the period January to March 2022, as follows: • Total number of deaths in the period – 568 • 100% of all deaths in hospital for patients over the age of 18 were scrutinised by the Medical Examiner team • 16 Structured Judgement Reviews were requested in this period • 3 deaths of patients with learning disability, all 3 cases concluded to have received good care by the Medical Examiner team • Changes in legislation following expiration of the Coronavirus Act 2020 on the 24 March 2022.
Recommendation:	The Board is asked to note the update.

Action Required:	~~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:	Changes made to the Board Assurance Framework.
Corporate risk register:	No change to risks identified as a result of this report
Regulation:	CQC & NHSE Compliance,
Legal:	Compliance with regulated activities and requirements in Health and Social Care Act 2008.
Resources:	n/a

Assurance Route	

Previously considered by:	• Clinical Governance Committee – Mortality Summary Report • Audit and Risk Committee – Job Planning Update		
Date:	19/8/2022	**Decision:**	For Information and Assurance
Next Steps:		Presentation to Trust Board of Directors	
Previously circulated reports to supplement this paper:			

1. INTRODUCTION

This report provides an update from the Executive Medical Director's office, summarising:

- A clinical update on the key areas of work taking place across the directorate
- The Hospital Standardised Mortality Ratio and Summary Hospital-level Mortality Indicator
- The Learning from Deaths Report for quarter four of the 2021/22 financial year

2. CLINICAL UPDATE

2.1 Workforce and Specialty Development

The Medical Director for Workforce continues to work with colleagues in difficult to recruit specialties experiencing workforce challenges. Taking a collaborative approach involving medical HR, leadership and development team and education.

Within this portfolio of work is the job planning of senior medical colleagues within the Trust. The majority of job plans are now held centrally on the Allocate system, with 99 job plans completed and signed off. Further work to define trajectories and milestones for completion of the remainder is ongoing with Divisional Directors and Clinical Directors. The aim is that all job plans, where possible, will be completed and signed off by the end of March 2023.

For newly appointed Consultants to the Trust, there is a planned 'New Consultants Forum', led by the Medical Director for Workforce, which will help new consultants integrate into the organisation and the culture, build effective relationships and provide support and signposting for informal mentorship. The first forum is scheduled for November.

The wider Consultant group have a monthly Medical Advisory Committee meeting, which provides an opportunity for colleagues across the Trust to come and provide updates on emerging areas of work, and for executive and non-executive directors to attend to observe or contribute to discussions. This meeting has been well received with good feedback and many new topics requested at the last survey.

Revalidation and Appraisal of Medical Staff – the following data extract from the appraisal system covers the period 1 July 2021 to 30 June 2022, giving a rolling 12 month position. Those in the latest quarter still have time to complete and if that matches previous 100% achievement, then overall performance for the last 12 month period will be 96%.

Appraisal Status	Q2 01/07/2021	Q3 01/10/2021	Q4 01/01/2022	Q1 01/04/2022
No of doctors due to hold an appraisal (month part of their yearly appraisal date falls in this quarter)	80	156	39	107
No of doctors with appraisals scheduled	67	100	49	87
Total Completed Appraisals	**67 (100%)**	**92 (92%)**	**44 (89.8%)**	**30 (34.48%)**
Incomplete Appraisals	0 (0%)	8 (8.0%)	5 (10.2%)	57 (65.52%)

2.2 Operational Stability and Optimisation

The Medical Director for Operational Stability and Optimisation is involved in strategic planning of services such as developing the Community Diagnostic Centre (CDC) and supporting specialty teams in this transformation of diagnostic services. Other areas of involvement are Chair of the Diagnostic Steering Group and the health inequalities agenda with line management responsibility for the newly appointed Public Health Consultant, Dr Kelly Mackenzie, who is due to commence in post 1 November 2022, and will lead on Health Inequalities at Place level.

In respect of pathways and operational support, Dr John is supporting the Operational teams to help the specialties work in reducing backlogs of patients waiting for first appointments, such as the DrDoctor triage of dermatology referrals, and ICB level discussions on the organisation of services.

Covid Medicines Delivery Unit – the numbers of patients for consultant triage and admission for neutralising Monoclonal Antibody (nMABs) treatment for covid continue to fluctuate, in line with the prevalence of virus within the community. Currently the position is stable with low numbers of referrals. The service will continue to respond to future changes, including the development of new treatments as they emerge.

Getting It Right First Time (GIRFT) – the Medical Director is fully engaged in all local, regional and national GIRFT meetings and events and is currently reviewing all specialty level GIRFT recommendations that have been made following the national team's review of different services. This will form a comprehensive document that will show where changes and improvements have been made, and further opportunities for developments.

2.3 Clinical Governance and Patient Safety

The external peer review of the governance and patient safety structure has concluded and the final report for agreement and implementation is expected by the end of September 2022. We will then assess the recommendations in relation to the national changes in patient safety and implement a programme of changes. In the meantime, proposals for scheduled meetings for support of the Divisional Clinical Governance Leads on a quarterly basis have been made as well as a new way of updating and summarising all aspects of the Divisions' activities.

The Executive Medical Directors Directorate team are proactively engaged in, and focused on, improving patient safety and mitigating clinical risks across the organisation. A review of the governance structure took place during 2021/22, and the new framework has been developed and, as above, is awaiting the outcome of the external Peer review before being finally implemented.

Risk Stratification, Clinical Validation and Prioritisation – this is a Trust wide project to minimise the risk of any harm coming to our patients whilst waiting for hospital appointments and treatment.

There is a well-established process for admitted pathways which is working effectively, with information available on the electronic reporting information centre (DERICK) to support performance management and clinical decision making. The radiology team have also introduced a process for clinical prioritisation of patients awaiting imaging.

The current position for outpatients, or non-admitted pathways, is more ad-hoc. In order to support this a key project is underway within Digital Transformation and operationally across the Trust to develop a full view of all patients who are waiting for further care to take place and how long these patients have been waiting. It is intended that the single source of waiting data will assist in the management of the patients on a non-admitted pathway.

3. **HOSPITAL STANDARDISED MORTALITY RATIO (HSMR) & SUMMARY HOSPITAL-LEVEL MORTALITY INDICATOR (SHMI)**

    3.1 Crude Mortality

The figure for the Trust is 1.55, second lowest in the last 12 months with 1.71 at DRI, 1.17 at BDGH and a total of 125 deaths in July, however this is not a very precise indicator.

3.2 HSMR

Our monthly HSMR is starting to show an upward trend with April at 109.72 and May at 116.92, contributing to the 12 monthly rolling HSMR increase. In 2021, March, April and May 2021 were quite low monthly figures with 94.56, 80.04 and 98.13 respectively, we are seeing the impact of these being outside the 12 month rolling average now, having been replaced by the higher figures in April and May 2022.

For elective HSMR we have seen an increase in the number of elective discharges whilst the number of observed deaths has remained steady, with several months where we saw no elective deaths.

The HSMR for both 12 month rolling and monthly position is showing a downward trend and has stabilised at 104 with no peaks or trends that currently suggest that an investigation should be triggered.

HSMR Trend (monthly)

	2018	2019	2020	2021	2022
January	99.21	105.78	110.26	118.93	118.59
February	97.73	98.13	92.56	104.15	109.02
March	88.42	101.87	102.51	94.56	103.29
April	98.37	100.70	118.40	80.04	109.72
May	91.20	91.36	132.00	98.13	116.92
June	89.98	98.32	97.72	103.02	
July	107.07	104.77	91.35	90.92	
August	94.65	112.17	88.54	105.28	
September	90.09	83.64	87.38	102.09	
October	96.74	100.24	117.01	106.21	
November	99.04	88.64	131.37	110.09	
December	80.45	103.24	144.89	118.26	

Crude Mortality (monthly) - July 2022 (Month 4)

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Trust	1.82%	1.55%	1.77%	1.77%	2.46%	2.20%	1.74%	1.58%	1.91%	1.58%	1.54%	1.55%
DRI	1.82%	1.69%	1.76%	1.78%	2.62%	2.24%	1.74%	1.71%	1.94%	1.64%	1.66%	1.71%
BDGH	2.12%	1.41%	2.07%	2.08%	2.20%	2.36%	2.02%	1.28%	2.14%	1.68%	1.46%	1.17%

Month 2 Hospital Standardised Mortality Ratio (HSMR)

The Medical Examiner's Office continues to review 100% of all adult deaths in the Trust and highlight the identification of any potential care issues.

3.3 SHMI

SHMI is reported by NHS Digital, 5 months in arrears using Hospital Episode Statistics (HES) data and accounts for deaths occurred up to 30 days following hospital discharge including variables such as palliative care coding and levels of deprivation by quintile which are outside the Trust's control. It is therefore more likely to reflect the socio-economic environment of our population rather than just the care the Trust provides.

[Title]

The SHMI is composed of 142 different diagnosis groups and these are aggregated to calculate the overall SHMI value for each trust. Using Healthcare Evaluation data (HED) shared on 12 August 2022, the SHMI in February was 120.39, with a 12 month rolling SHMI at 113.69.

When reported as a percentage, as it is by the Clinical Indicators Team in NHS Digital, the most recent (August 2022) Rolling SHMI is 1.15 just outside of the Upper Control Limit of 1.12.

Summary Hospital-level Mortality Indicator (SHMI) • April 2021 - March 2022

I00699: Summary Hospital-level Mortality Indicator (SHMI)
Rolling 1 year period, 5 months in arrears: SHMI with 95% over-dispersion control limits

| Standardised ratio | | 0.2 | 0.4 | 0.6 | 0.8 | 1.0 | 1.2 | 1.4 | 1.6 | 1.8 | 2.0 | 2.2 | 2.4 | 2.6 | 2.8 | 3.0 |

TRUST LEVEL SHMI ❶ — Lower: 0.89, Upper: 1.12 — **1.15** ✓

RP5BA: BASSETLAW HOSPITAL ❷ — Lower: 0.84, Upper: 1.19 — **1.18**

RP5DR: DONCASTER ROYAL INFIRMARY ❷ — Lower: 0.86, Upper: 1.17 — **1.15**
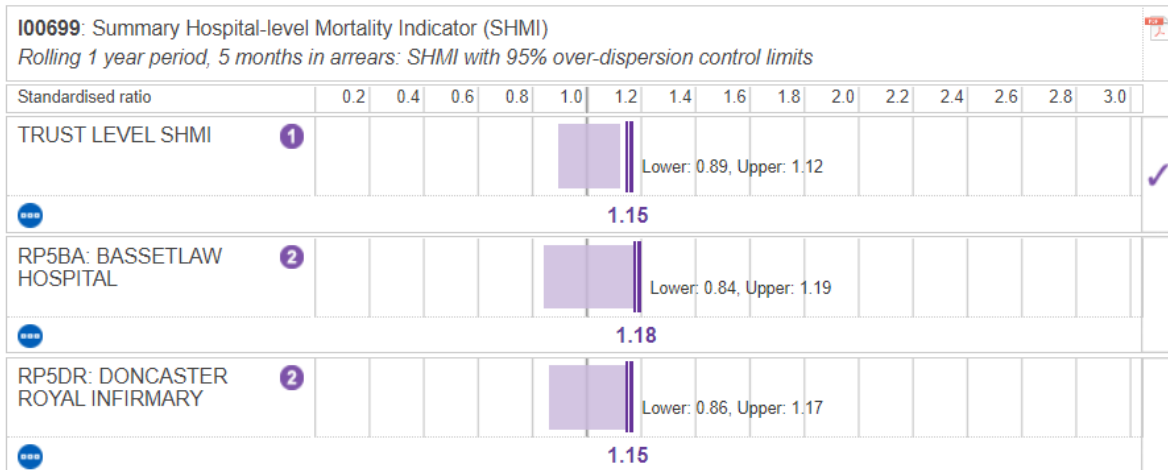
Diagnosis groups • April 2021 - March 2022

With SHMI value:

| Count of deaths | | 40 | 80 | 120 | 160 | 200 | 240 | 280 | 320 | 360 | 400 |

Acute bronchitis — Observed: 31, Expected: 20.4

Acute myocardial infarction — Observed: 57, Expected: 48.0

Cancer of bronchus; lung — Observed: 74, Expected: 58.4

Fluid and electrolyte disorders — Observed: 28, Expected: 24.2

Fracture of neck of femur (hip) — Observed: 40, Expected: 37.8

Gastrointestinal hemorrhage — Observed: 41, Expected: 28.9

Pneumonia (excluding TB/STD) — Observed: 342, Expected: 292.1

Secondary malignancies — Observed: 45, Expected: 43.2

Septicaemia (except in labour), Shock — Observed: 171, Expected: 141.3

Urinary tract infections — Observed: 71, Expected: 57.9

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Quarter 4

Learning from Deaths Report

January to March 2022
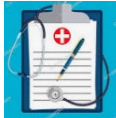
Karen Lanaghan – Lead Nurse End of life care services

Gemma Wheatcroft – Lead Medical Examiner Officer

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

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

Appendix 1

	Deaths in Quarter 4 (Adult inpatients) Doncaster = 399 Bassetlaw = 105 **Total Inpatient deaths =504**
	Deaths in Quarter 4 (A&E) Doncaster = 50 Bassetlaw = 14 **Total A&E deaths = 64** **TOTAL DEATHS = 568**
	Deaths Screened by MEO Doncaster = 448 Bassetlaw = 118 **Total MEO scrutiny = (100%)**
	Deaths scrutinised by ME Doncaster = 417 Bassetlaw = 112 **Total ME team Scrutiny (93)%**
	Total deaths screened/scrutinised by the ME Team = 566 (100%)
	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 February 2022 HMSR is 108.54
	Top 5 cause of death recorded on MCCD this quarter 1. Pneumonia (133) 2. Cardiac Related (49) 3. Sepsis (45) 4. Covid-19 (41) 5. Metatstatic Cancer (40)
	Top 5 "main condition treated" as coded from the notes: 1. Lobar Pneumonia (55) 2. Emergency use of U07.1 (36) 3. Congestive heart failure (30) 4. Sepsis, unspecified (26) 5. Acute renal failure / Cerebral infarction (22)
	Percentage of MCCDs issued within 3 working days of death when no coronial involvement Bassetlaw 105 (91%) Doncaster 395 (91%) .

Appendix 1

Contents

1. Executive Summary and Achievements

This is Quarter 4 (2021/22) Learning from Deaths report in accordance with the National Guidance on Learning from Deaths (March 2017) . This quarter has seen a significant decrease in numbers from 602 in Q3 to 568 Q4. This number of deaths is consistent with pre covid times 18/19 (581) and 19/20 (567) suggesting that Covid 19 is no longer having an impact on our crude mortality.

The Medical Examiner (ME) Team have scrutinised 100% (568) deaths this quarter. This is a great achievement.
As reported last 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. Work has continued to prove extremely challenging due the difficulties in accessing primary care IT systems.

The Chief ME and Lead MEO have identified a pilot GP practice to roll out the non-acute scrutiny during the non-statutory phase. This will start in May 2022.

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. The Learning from Deaths(LFD) lead nurse will start in post late May 2022 and take over the production of this quarterly report.

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 legislation laid out by the Coronavirus Act 2020 which was published on 25th March 2020. The Coronavirus Act expired at midnight 24th March 2022. The following should be noted:

3 provisions within the act are continuing:

1. The period before death within which a doctor completing a Medical Certificate of Cause of Death (MCCD) must have seen a deceased patient will remain 28 days (prior to the coronavirus pandemic, the limit was 14 days).
2. It will still be acceptable for medical practitioners to send MCCDs to registrars electronically.
3. The government's intention is that the form Cremation 5 will not be re-introduced after the Coronavirus Act expires.

From the 25th March 2022:

- Only a medical practitioner who has attended the deceased for their last illness will be allowed to complete a MCCD. A medical practitioner with GMC registration will be able to sign the MCCD if they attended the deceased during their final illness up to 28 days before death, or viewed the body in person after death, and can state the cause of death to the best of their knowledge and belief. The 28 day provision (the 'last seen alive' requirement), initially introduced in response to the coronavirus pandemic, has now been made permanent through a change to regulations and included in the MCCD guidance. 'Seen' in the context of attendance includes consultation using video technology. However, it does not include consultation by telephone/audio only. **The provision for any medical practitioner to complete the MCCD, introduced as a temporary measure by the Coronavirus Act, is now discontinued**

Requirements are different if the medical practitioner did not attend the deceased in the 28 days before death, or the deceased was not seen after death by the medical practitioner.

After 24 March 2022, the MCCD can still be completed by the medical practitioner if they can state the cause of death to the best of their knowledge and belief, but this will require coroner notification at registration, or preferably by the medical practitioner beforehand to

avoid distress to the bereaved. The coroner may then complete Form 100A and send this to the registrar to allow registration.

Similarly, if no medical practitioner can state the cause of death to the best of their knowledge and belief, the coroner will have to be notified. It would then be for the coroner to determine the cause of death.

3. Overview of Activity

In quarter 4 there has been a total of 568 trust deaths compared to 602 deaths in quarter 3. As can be seen on the table below, numbers have slowly returned to pre covid numbers.

a) Activity (4 years data)

Activity over 4 years

	2019	2020	2021	2022
January	253	238	234	221
February	162	171	162	171
March	169	172	171	176
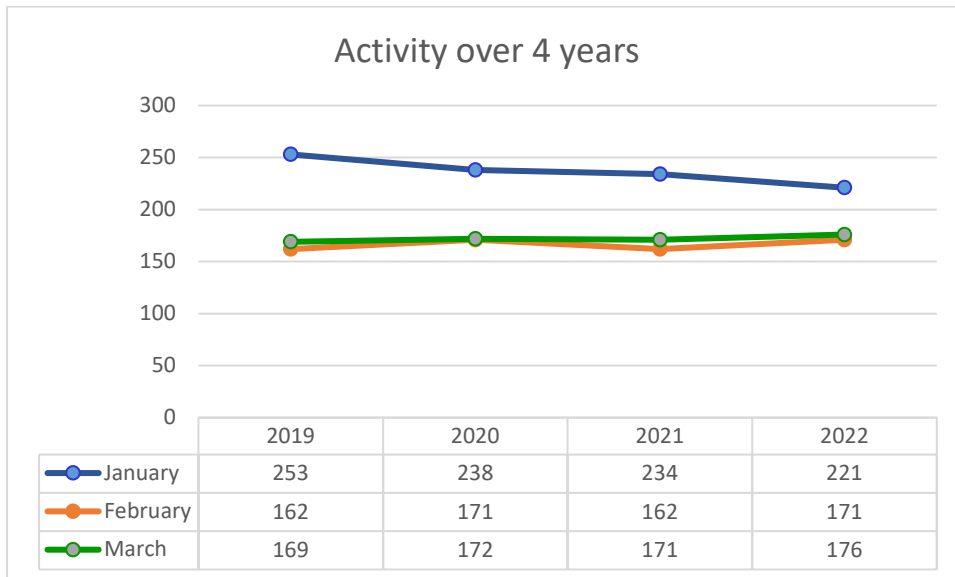
4. Medical Examiner Team

The Medical Examiner (ME) team consists of 8 part time Medical Examiners, this now includes 3 GP's and 3 WTE Medical Examiner Officers. One ME is off on long-term sick and is due to reurtn to work in late May.

The service began in December 2019 and has continued to work extremely hard to maintain circa 100% scrutiny of all adult hospital deaths since February 2021. The graph below illustrates the activity since February 2021.
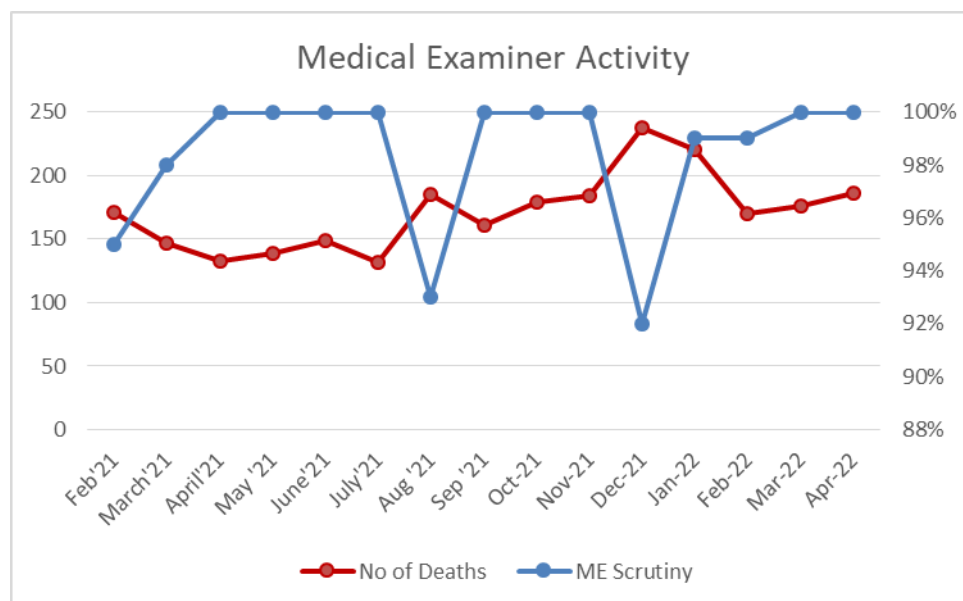
The introduction of medical examiner teams is part of the Department of Health and Social Care's death certification reforms programme for England and Wales and will ultimately be a statutory requirement for all Trusts. Although it was hoped this would be a statutory requirement by April 2021, the covid 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. There have been 5 (1%) cases this quarter where a significant concern about the quality of care provided has potentially contributed to death as identified by the medical examiner or staff.

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 549 families (97%) and 56 of these (10%) have raised concerns with 43 (8%) of these being offered the PALS contact number. Circa 123.5 hours has been spent speaking to bereaved people.

Phone Contact with NOK

	No of calls	Time hrs
ME	15	2.5
MEO	534	121
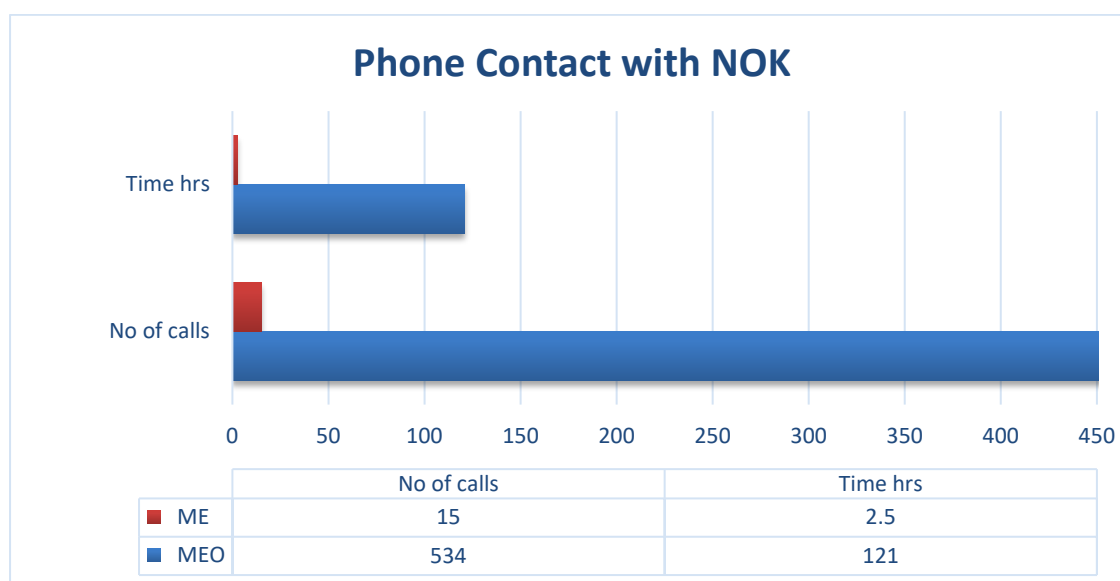
The types of concerns raised fall into the following categories:

- Unhappy with overnight transfers and NOK not being made aware until they phone the next day.
- Discharged patient to early.
- Poor Communication.
- Lack of compassionate visiting arrangements.
- Falls

- Issues with GP
- Care home issues

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 /Autismn
- 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, 16 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. 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 process can be agreed. This is to be undertaken as soon as the LFD nurse starts in post. The Regional Mortality team are facilitating an SJR training session in June and several Trust staff are attending this.

6. Elective Admissions

There were 4 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. 2 cases were referred to the Coroner for PM and to the specialty for an SJR. Both cases have been concluded by the coroner.

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 riggor however, to reassure the Trust should any issues with HMSR rates for elective deaths be alerted.

Elective Admissions

	January	Feburary	March
Deaths			
Elective	1	3	0
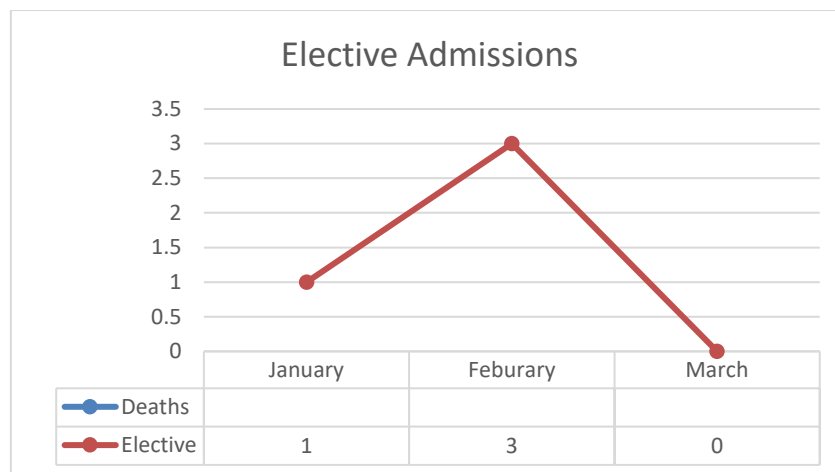
7. Learning Disability deaths

There were 3 deaths of patients with a learning disability this quarter, and 5 recorded in the previous quarter.
1 of these was at BDGH and 2 at DRI. All have been referred to the Learning Disabilities Mortality Review Programme (LeDeR). These 3 cases were concluded to have received good care by the ME team. 3 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 91% of the time at DRI and 91% at BDGH.

This in a significant increase from last month and a trend that should continue to improve as numbers of deaths have returned to pre covid times and staffing levels have also increased.

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 100A is issued. This is commonly known as an 'APASS'

This quarter, Coroner's referrals have slightly increased. The ME Team will continue to monitor this. 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.

Deaths Referred to Coroner Resulting in APASS Bassetlaw

- Deaths referred to the coroner
- Coroner Accepted Proposed MCCD 'APASS'

Deaths Referred to Coroner Resulting in APASS Doncaster

- Deaths referred to the coroner
- Coroner Accepted Proposed MCCD 'APASS'
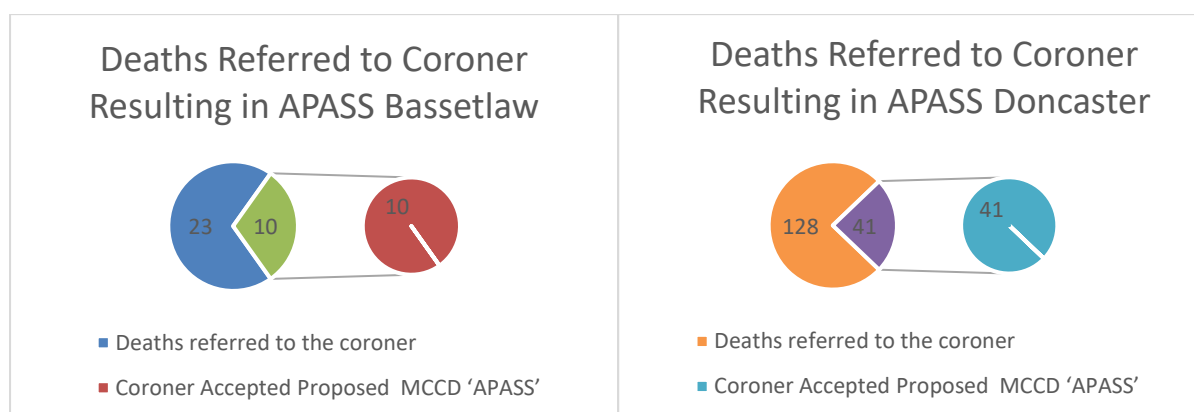
10. Cause of Death and Hospital Standardised Mortality Ratio (HSMR)

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

	From MCCD	Count
1	Pneumonia	133
2	Cardiac related	49
3	Sepsis	45
4	COVID-19	41
5	Metastatic cancer	40

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:

J181: Lobar pneumonia, unspecified	55
U071: Emergency use of U07.1	36
I500: Congestive heart failure	30
A419: Sepsis, unspecified	26
N179: Acute renal failure, unspecified	22
I639: Cerebral infarction, unspecified	22

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 must always be informed of ward and hospital transfers and admissions.
- Families have again 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.
- 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 has been an advert out to appoint another Berevaved Officer., which we did successfully however the candidate has given back word and withdrawn at last minute. Meaning we now have to go through the VCF process again.

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	Q4 91% across the Trust
Task and finish group to determine SJR process	To be completed once the LFD nurse is in post
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.
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.	June 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 LFD Nurse Addette Spencerly is due to commence post in Late May. 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 100% (568) deaths this quarter. This quarter has seen a reduction of 34 deaths compared to Q3 and these numbers are now comparable to the same quarter in pre covid times.

The ME team continue to scrutinise every death where a referral to the Coroner is indicated. This process is proving to be very successful as unnecessary referrals are avoided and the ME team are ensuring that individual QAPs are informed of the reason why no referral is necessary and so aids their individual learning.

The ME team alerted the Trust to an increase in deaths due directly to Sepsis last quarter. This information has been taken on board and we continue to send such cases to the Director of Infection Control in line with alerting any potential governance issues to the trust.

The New MEO and MEs have now completed induction and have settled into the team very well. The new MEs are GPs and so provide a valuable resource to the team. One of them has assisted in enabling the team to be able to pilot the scrutiny of non acute deaths which will commence towards the end of May.

Appendix 1

The part time lead MEO has now retired and these hours have been picked up by the other lead MEO who will continue to drive the implementation of non acute death scrutiny.

The ME team has been continually recognised by the regional medical examiner's office as performing extremely well in achieving almost 100 % scrutiny since January.

This Q4 reports a very promising position. Work contiunues to explore ways of scrutinising non- acute deaths. Initial work has proved extremely challenging due the difficulties in accessing primary care IT systems. This has been recognised by the trust and a business case has been put forward to assist with access to much needed IT systems to ensure the non-acute scrutiny can be started as soon as possible.

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.

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 : September 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.

- Yellow highlights are the updates since the version presented to People Committee on 6 September

* Target risk rating agreed to change to 12 as an in-year rating, following detailed discussion at People Committee. Overall ambition remains to reduce to 8

Risk Appetite:
The Trust has an appetite for this strategic risk as shown below by risk type:

Reputation	Finance/VFM	Regulatory	Innovation	Quality	People
Seek (4)	Open (3)	Minimal (1)	Open (3)	Open (3)	Open (3)

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
- Reliance on international recruitment whilst increase in education places come to fruition
- Levels of sickness absence impacting on staffing levels

Please ensure gaps in assurance are qualified and explained in conjunction with current Trust Risk Appetite

CRR Risk cross reference	PEO1 19	PEO2 16	PEO3 3104				
Current CRR Risk Rating	12	16	12				
Risk Appetite Type	Inn Peop	Inn Peop	Peop				
Risk Appetite Level	Open	Open	Open				
Target Risk Rating	8	12 *	9				

Opportunities:
- Change in practices, new ways of working
- Increase skill set learning

Overall Risk Scores for Strategic Objective

Initial Risk Rating	4(C) x 5(L) = 20 extr	**Risk Trend**
Current Risk Rating	4(C) x 4(L) = 16 extr	
Target Risk Rating	3(C) x 3(L) = 9 low	⬅➡

Rationale for overall strategic risk current score:
Impact:
- Impact on performance
- Impact on Trust reputation
- Impact on safety of patients & their experience
- Possible Regulatory action
- Recruitment and retention issues
- Increased staff sickness levels
- Deterioration in management-colleague/team relationships

Future risks:
Morale and resilience of colleagues as we move into recovery phase

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	Sept 2022	End Sept 2022	ZL	Appraisal Season launched 01 June 2022, ongoing monitoring of completion rates through appraisal season window, fortnightly reports and reviewed at Performance, Overview and Support meetings (POSM) with divisions. No gaps in control identified. Interim paper coming to Sept People Committee with full report to be presented at Nov meeting once appraisal season completed
Staff survey and focus groups – positive feedback on colleagues knowing Trust vision	Apr 2022	2022 staff survey results	JC/ZL	No gaps identified. Approach for 2022 staff survey action planning presented to People Committee, TEG and Board in July 2022 – supported. Plans in place for launch of 2022 staff survey, new provider secured. Actions taken by divisions in response to survey feedback being presented at POSM
Staff survey action plans to ensure appraisal conversations are meaningful as defined by the staff survey	Aug 2022	End Sept 2022	JC	Paper on People Committee Agenda 5 July 2022. Appraisal season monitoring through fortnightly reporting and Performance, Overview and Support meetings with divisions. People Committee update in September with full report to be presented at Nov meeting once appraisal season completed
Communication – Staff Brief, Listening Events, Facebook	Aug 2022	Oct 2022	AT/ZL	None – ongoing communication process. Addition of work on Board/Exec visibility. Monthly Board visits schedule began as planned in Sept 2022, Execs meeting being held monthly at Bassetlaw

Appendix Level1

Numbers accessing Leadership Development Programme, including QI	Jul 2022	Sept 2022	JC	None identified – Prospectus of Leadership Programme Training & Development launched Mar 2022

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 national staff survey results	Jul 2022	People, Board	Full	Papers to People Committee 05 July, 6 Sept and 1 Nov 2022. Addition of Staff Engagement as standing agenda item at People Committee
L1,L2,L3	KPMG Job Planning Audit	Nov 2021	People, ARC, Board	No assurance opinion	Action plan actively monitored by ARC and People Committee. Timetable for completion of job plans being developed, led by Medical Director. Updates to be presented to People Committee
L1	Staff Engagement paper and Appraisal Season update presented at September People Committee	Sept 2022	People	Committee assured	No gaps identified, Committee assured

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 – see additional update above. Details on progress on actions in Pentana (360 Assurance system)	Oct 2022 – deferred from May 2022	Amber -ongoing	TN	Autumn 2022
Review of Appraisal Season to be undertaken after the season and on receipt of staff survey results (feedback on appraisals), including refresh of paperwork for 2023 season – 2 stage review	Nov 2022 (initial review) March 2023 (review of survey results)	On track, yet to begin	ZL	March 2023
Development of new People Strategy from 2023	Jan 2023	On track – agreed to align with national People Plan themes. PC agenda format changed from Sept 2022	ZL	January 2023

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*

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 : September 2022		

Risk Appetite:
The Trust has an appetite for this strategic risk as shown below by risk type:

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

- Yellow highlights are the updates since the version presented to People Committee on 6 September

* Target risk rating agreed to change to 12 as an in-year rating, following detailed discussion at People Committee. Overall ambition remains to reduce to 8

Reputation	Finance/VFM	Regulatory	Innovation	Quality	People
Seek (4)	Open (3)	Minimal (1)	Open (3)	Open (3)	Open (3)

Overall Risk Scores for Strategic Objective

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

Risks:
• Failure to provide appropriate learner environment that meets the needs of staff and patients
• Failure to enable staff in self actualization
• Failure to deliver an organizational development strategy that allows implementation of trust values
• Low response rate for staff survey
• Low response rate in learner feedback
• Staffing levels impacting on how colleagues feel

Please ensure gaps in assurance are qualified and explained in conjunction with current Trust Risk Appetite

CRR Risk cross reference	PEO1 19	PEO2 16	PEO3 3104				
Current CRR Risk Rating	12	16	12				
Risk Appetite Type	Inn Peop	Inn Peop	Peop				
Risk Appetite Level	Open	Open	Open				
Target Risk Rating	8	12 *	9				

Rationale for overall strategic risk current score:
Impact:
• Impact on Trust reputation
• Impact on safety of patients & their experience
• Possible Regulatory action
• Recruitment and retention issues
• Increased staff sickness levels
• Deterioration in management-staff relationships
• Financial impact for the Trust if increased levels of absence and gaps

Future risks:
  Morale and resilience of colleagues as we move into recovery phase

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

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	Sept 2022	Nov 2022	PH/ZL	No gaps identified. Relaunch of Speaking Up planned for Autumn 2022, communication to begin late September with different themes being highlighted
Our people asked to respond to Payroll KPI questionnaire - improvements from previous payroll provider noted	Jun 2022	N/A	MB	Positive response to survey – no gaps identified / regular performance meetings with Payroll provider in place. Action closed
Staff survey action plans to ensure improvement	Aug 2022	2022 staff survey results	JC/ZL	Staff Survey Paper on People Committee Agenda 5 July. Updates and actions being taken provided at Performance, Overview and Support meetings with divisions. Approach for 2022 staff survey action planning presented to People Committee, TEG and Board in July 2022 – supported. Plans in place for launch of 2022 staff survey, new provider secured. Addition of Staff Engagement as standing agenda item for People Committee
Communication – Staff Brief, Listening Events, Facebook	Aug 2022	Oct 2022	AT/ZL	None – ongoing communication process. Addition of work on Board/Exec visibility. Monthly Board visits schedule began as planned in Sept 2022, Execs meeting being held monthly at Bassetlaw
Development programme to include Everyone Counts/Civility	Aug 2022	Oct 2022	JC	No gaps currently identified

Appendix Level1

Strong partnership working with Partnership forum and JLNC	Jul 2022	Sep 2022	AJ/ZL	No gaps currently identified
Race Code Audit completed – advisory rather than opinion audit, a high risk identified (see new action below)	Aug 2022	Oct 2022	JC	Audit report being presented to People Committee in Sept 2022 – see new action below
Actions to improve sickness absence, linked to ongoing health and wellbeing programme of work	Jul 2022	Sept 2022	AJ	Actions and next steps identified in plan presented to People Committee – work in progress

Assurances received (L1 – Operational L2-Board Oversight L3 External) **		Last received	Received By	Assurance Rating	Gaps in Assurance
L1,L2	Standard POD and Education & Research reports for Board. Research Strategy presented to Board July 2022	Jul 2022	People, Board	Full	None
L1,L2	Staff networks (BAME, LGBTQ+, Long term conditions); Reciprocal Mentoring programme – feedback to learning partners	-	People, Board		People Committee work plan to be reviewed to ensure appropriate attention given to EDI including networks. Reciprocal Mentoring Programme – graduation in July 2022, TEG supported next cohort to launch planned Sept 2022
L3	KPMG Job Planning Audit	Jun 2022	People, ARC, Board	No assurance opinion	Action plan actively being monitored Timetable for completion of job plans being developed, led by Medical Director. Updates to be presented to People Committee
1.3	Internal Audit – 360 Assurance Race Code advisory audit	Jul 2022	People, ARC		Audit report being presented to People Committee in Sept 2022 – see new action below
L1	Education report, Staff Engagement paper, Health and Wellbeing paper and Improvement Projects paper presented at September People Committee	Sept 2022	People	Committee assured	No gaps identified, Committee assured

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– see additional update above. Details on progress on actions in Pentana (360 Assurance system)	Oct 2022 – deferred from May 2022	Amber -ongoing	TN	Autumn 2022
New approach to timely and effective engagement in staff survey results to be developed and introduced – feedback sessions with teams to commence when embargo lifted Feb/Mar 2023 (date tbc nationally)	Aug 22 to develop approach Mar 2023 to implement	On track – approach designed and agreed	ZL	March 2023
Action from RACE Code audit – overarching action plan on EDI to be developed to ensure integration with wider EDI agenda	30 Sept 2022	Amber - ongoing	JC	Sept/Oct 2022
Development of new People Strategy from 2023	Jan 2023	On track – agreed to align with national People Plan themes. PC agenda format changed from Sept 2022	ZL	January 2023

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:	27 September 2022	**Agenda Reference:**	**D2**
Report Title:	**People Update**		
Sponsor:	Zoe Lintin, Chief People Officer		
Author:	Zoe Lintin, Chief People Officer		
Appendices:	N/A		

Report Summary	
Purpose of report:	To provide Board with an update on developments in relation to activities to support staff engagement and experience together with key national updates.
Summary of key issues/positive highlights:	There is a Board commitment and ambition to improve staff experience and engagement across DBTH, with a key indicator being our annual national staff survey results. This paper highlights some of the recent developments at DBTH and progress made against plans in relation to staff experience and supporting our people, including: - Launch of the 2022 national staff survey - Board development and visibility - Appraisal season - Health and wellbeing and cost of living support - Speaking Up
Recommendation:	The Board is asked to note the actions being taken and to support the work programmes described.

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:	SA2, SA3
Corporate risk register:	PE01 19, PEO2 16, PEO3 3104
Regulation:	None
Legal:	None
Resources:	None
Assurance Route	

Previously considered by:			Some aspects considered by Informal Execs, People Committee and Trust Executive Group	
Date:	September 2022	**Decision:**	Aspects shared and support for approach outlined	
Next Steps:			Update to Board in September 2022	
Previously circulated reports to supplement this paper:			N/A	

1. Introduction

The people metrics are presented to Board each month via the IQPR and the People Committee also receives additional information at each meeting. The People Update reports to Board will focus on activities being undertaken to improve our people metrics and staff experience together with relevant system and national updates.

This report provides an update in relation to the 2022 national staff survey, Board development and visibility, appraisal season, our health and wellbeing offer including our financial wellbeing provision to support colleagues with the increased cost of living and Speaking Up month.

2. 2022 National Staff survey

There is a Board ambition to continue to improve the experiences at work of our people and to further develop our approach towards staff engagement. The annual national staff survey is a key indicator of our progress in this regard.

We have completed a competitive tender exercise for the provision of the staff survey and Quality Health are our new provider for the 2022 survey. The survey will launch on 28 September and will run until late November 2022, with the majority of colleagues receiving their surveys to complete on-line via email and some departments receiving paper copies.

The new approach to engagement in the staff survey described at the last Board meeting has been agreed and is in place, so plans will be made for soon after the national embargo on the results is lifted (date to be confirmed nationally – usually late February, early/mid-March).

There will be a small number of spot prizes to encourage participation in the survey as this proved to be successful last year, together with a comprehensive communications and engagement campaign. The ambition is to exceed our 2021 response rate of 63%, as higher levels of participation provide us with richer feedback. This is ambitious as our 2021 response rate was high performing in the acute trust sector nationally.

Trust Executive Group members have been asked to ensure steps are being taken in their areas to share improvements made over the last year and to proactively support and encourage their teams to engage in the survey throughout the survey period. Regular updates on response rates will be provided throughout the survey period.

3. Board development and visibility

The following aspects have progressed since the last Board meeting:

- Board visits - the schedule of monthly Board visits across the organisation began as planned in September, with Non-Executive and Executive Directors pairing up to visit services across Doncaster Royal Infirmary, Bassetlaw and Montagu Hospital.

- #hellomynameis badges – the feasibility of adopting these name badges as part of the national campaign has been scoped, with a bid prepared for Charitable Funds and designs being drafted. New badges will include pronouns, following discussion at our Equality, Diversity and Inclusion Committee. Further details on the campaign, founded by the late Dr Kate Granger, can be found here: https://www.hellomynameis.org.uk/

- Buddying and 'Champion' role - The Director of Corporate Affairs has been working with the Chief People Officer to refresh and finalise the Non-Executive and Executive Director buddying arrangements and these pairings have recently been shared with Board members. Divisional Directors have also been allocated Executive and Non-Executive Director buddies, on a voluntary basis in recognition of their time commitment to the role.

  The Non-Executive Director 'champion' roles, such as for Speaking Up and the Maternity Board Safety Champion, have all now been reconfirmed given recent changes in Board membership. The Executive Director membership of Board committees has also been reviewed to ensure appropriate representation.

- Board development – the intention is to have a more structured programme of Board development sessions on a variety of topics, to complement other development activities such as external webinars and training courses. A practical session on key HR processes has been arranged for September 2022, particularly to support newer Board members, with a focus on the Director role in these processes for example chairing consultant interview panels.

  The Chief People Officer is currently working with colleagues and hopes to be able to provide development sessions on the Board's role in Speaking Up and an insight into our 'Leading to Outstanding' programme before the end of the calendar year. Further sessions will then be planned during 2023, with topics planned to include digital and diversity and inclusion. Further details will be confirmed once available.

  In addition, the Executive team are spending some time on their own development as a new team coming together over recent months. A 'time out' session is taking place in September 2022 and the Team Engagement and Development (TED) Tool has been completed to support this development. Information on the TED Tool has previously been shared with People Committee and Board, with a number of our teams across the organisation taking part in this pilot.

4. Appraisal Season

The appraisal season for non-medical colleagues runs from 1 June to 30 September 2022. As at 16 September, the recorded completion rate was 64%. The target for the season is 90%.

The latest position was discussed in detail at the People Committee meeting on 6 September. Whilst this is a disappointing recorded figure at this stage in the season, it is expected that the actual completion rate is higher than the recorded rate, with delays being experienced with data being correctly inputted.

It is important that all our people have the opportunity for an appraisal conversation, as part of a year round and ongoing conversation with their line manager. Resources and toolkits are available to support the appraisal process. Appraisals have remained a standing item for divisional Performance, Oversight and Support meetings.

A review of the appraisal season will be undertaken in the Autumn and the paperwork will be refreshed and shortened for 2023, to provide a framework for the conversation. A further evaluation will be undertaken in the Spring to assess the staff survey responses in relation to quality of appraisals. It is intended that in 2023 the appraisal season will revert to starting in April and that it will be maintained as a four month period, from 1 April to 31 July. A further paper will be presented to the November People Committee meeting.

5. Health and Wellbeing and Cost of living support

We continue to review and assess our health and wellbeing offer and have been paying particular attention to financial wellbeing in light of the cost of living difficulties being experienced currently.

5.1   Health and Wellbeing

The Chief People Officer has met with the Wellbeing Guardian to discuss how best this role can be supported and connect with the team and to understand the expectations of the Non-Executive Director in this role. This was a helpful conversation and a new approach to connecting with the Wellbeing team has been agreed. We will also refresh the national health and wellbeing diagnostic tool, once the new Head of Leadership and OD, EDI and Wellbeing has started in post to cover the substantive post-holder's secondment to Rotherham, Doncaster and South Humber NHSFT.

Following discussions at People Committee, a piece of work is underway to consider the future sustainability of our health and wellbeing offer noting that a number of aspects are dependent on time limited external funding streams, for example through the Integrated Care System wellbeing hub.

5.2   Cost of living and financial wellbeing

As an employer, we are mindful of the increasing cost of living and the impact this will be having on our colleagues, particularly as we head into the winter months with increased energy costs. We have refreshed the 'financial support and information' page on our website and communicated this to colleagues through the usual means, to ensure that people are aware of the services that are available and know how to access them. This information will be kept updated.

There are a number of services to support financial wellbeing, including financial information and support through Vivup our employee assistance programme, connections with a Credit Union and the implementation of Wagestream to enable colleagues to access their salary earlier in the month if this is needed on occasion. We are also more actively publicising the range of discounts and offers available to NHS colleagues, for example the Blue Light card.

We are taking steps to consider how else we can support colleagues and, earlier in the Summer, our mileage expense rates were increased on two occasions in response to the increasing cost of fuel. We are currently exploring other ideas, including making connections with our local community food banks. Discussions are ongoing at Place and system level about what other support can be provided to our health and care workforce and the Trust will continue to stay connected to this work.

6. Speaking Up month and national guidance

Speak Up month runs nationally in October each year, as a way of promoting the ethos and purpose of Freedom to Speak Up. We have a focused communication and engagement programme in place which goes live from late September and will run until December, with weekly themes and key messages. During this time, in addition to weekly communications through our usual channels, there will be a programme of engagement sessions held with teams in different areas, sharing of our Speak Up pledges and connections made with other areas linked to organisational culture such as inclusion, compassionate leadership, quality improvement and patient safety.

The Freedom to Speak Up Guardian will present her bi-annual report at the November Board meeting and this will include an update on this engagement activity as well as information on the new national guidance and resources.

7. Recommendations

The Board can be assured that actions are being taken to continue to improve our approach to staff experience and that progress is being made in different workstreams.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	27 September 2022	**Agenda Reference:**	**D3**
Report Title:	**Guardian of Safe Working Quarterly Report**		
Sponsor:	Zoe Lintin, Chief People Officer and Dr Tim Noble, Executive Medical Director		
Author:	Dr Anna Pryce, Guardian of Safe Working		
Appendices:	None		
Executive Summary			
Purpose of report:	As a Teaching Hospital we are committed to continuously developing the skills, innovation and leadership of our people to provide high quality, efficient and effective care.		
Summary of key issues:	The Guardian of Safe Working is required to provide quarterly reports to the Board of Directors to provide assurance as to whether our trainees have access to a safe working environment and appropriate educational opportunities.		
	This report draws attention to the low levels of exception reporting between May and July 2022.		
	Ongoing high workloads in medical specialties due to a combination of rota gaps and sickness absence have resulted in a low number of sporadic incidents of immediate safety concern over the past year.		
	However, Dr Pryce advises that no specific issues of concern regarding work schedules have been highlighted as a result of exception reporting. Rather, a widespread high workload amongst Junior Doctors is noted.		
	The specialties with the highest numbers of exception reports are those with the highest numbers of rota vacancies, suggesting that understaffed rotas combined with sickness absence and problematic locum cover is directly impacting upon Junior Doctors' abilities to work according to their work schedules, to work safely and to attend educational opportunities.		
Recommendation:	Members are asked to receive this report and to review the themes raised		

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 a sufficient workforce and to ensure colleagues have the right skills leading to: (i) Increase in temporary expenditure (ii) Inability to achieve Trust strategy (iii) Inability to provide viable services
Regulation:	
Legal:	
Resources:	

Assurance Route			
Previously considered by:	N/A – direct feedback to the Board followed by discussion at the Junior Doctor Forum		
Date:		**Decision:**	
Next Steps:			
Previously circulated reports to supplement this paper:	None		

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

Author: Dr Anna Pryce, Guardian of Safe Working

Report date: September 2022

Executive summary

The overall number of exception reports during the last quarter is low and therefore it is difficult to ascertain if there are any recent specific areas of concern. Reports made over the past year were most frequently made by Trainees working in General Medicine, General Surgery, Obstetrics and Gynaecology and Paediatrics.

Over the last 12 months, 2 reports raised issues of immediate safety concern and both occurred in Medical specialties during night-shifts. The impact of the Coronavirus pandemic on staff absence due to sickness or isolation continued to exacerbate the underlying problem caused by rota gaps. The specialties with the highest numbers of exception reports were usually those with the highest numbers of rota vacancies, suggesting that understaffed rotas compounded by sickness absence and a lack of adequate locum cover is the main cause of prolonged working hours and missed educational opportunities.

Introduction

This report sets out the information from the Guardian of Safe Working with regard to the 2016 Terms and Conditions for Junior Doctors to assure the Board of the safe working of junior doctors. This report is for the period 1st May 2022 to 31st July 2022. The Board should receive a quarterly report from the Guardian as per the 2016 contract, which will include:

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

- Details of fines levied against departments with safety issues

- Data on rota gaps, staff vacancies and locum usage

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

a) Exception reports (with regard to working hours and education)

Table 1. Number of exception reports by month, 1 August 2021 to 31 July 2022.

Month	Complete	Unresolved	Total
August 2021	1		1
September 2021	2		2
October 2021	4		4
November 2021	3		3
December 2021	10		10
January 2022	10		10
February 2022	6		6
March 2022	8		8
April 2022	4		4
May 2022	11		11 (2)*
June 2022	6		6 (3)*
July 2022	1		1
Grand Total	**66**	**0**	**66**

*It should be noted in May and June 2022 an individual Junior Doctor submitted 9 and 3 exception reports respectively in relation to a dispute regarding a change in their working pattern. The change was implemented as a result of concern about standards of practice and in order to facilitate their supervision and training. I believe that the resulting 12 exception reports should not be included in the monthly figures and have therefore adjusted the monthly figures (shown in brackets).

There is seasonal variation in Exception Reporting (ER) with the highest number of monthly reports occurring during the winter months. This has been noted in previous years within this Trust as well as being noted nationally. Overall, there continues to be a low number of ERs despite efforts to encourage reporting.

In order to provide assurance that the relatively low number of ERs reflects adequate work schedules and access to educational opportunities, rather than under-reporting, ongoing efforts to promote exception reporting will continue.

Table 2. Number of exception reports by specialty, 1 August 2021 to 31 July 2022.

Specialty	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	March 2022	April 2022	May 2022	June 2022	July 2022	Grand Total
Gastro-enterology													
General medicine					7	5		1			1		14
General surgery		2		2				2	1	9 (0)	3 (0)		19 (7)
Cardiology													
Geriatric medicine													
Renal Medicine			4										4
Accident and emergency				1		3					2		6
Obstetrics and gynaecology					3	1	1	1				1	7
Otolaryngology							4	2					6
Trauma and Orthopaedics							1	1					2
Paediatrics	1					1		1	3	2			8
Grand Total	**1**	**2**	**4**	**3**	**10**	**10**	**6**	**8**	**4**	**11 (2)**	**6 (3)**	**1**	**66**

Over the past 12 months, the majority of ERs have been submitted by Trainees working in General Medicine and in General Surgery. In more recent months, there has been an increase in reports from Trainees working in Paediatrics.

Table 3. Reason for submission of Exception Report, August 2021 to July 2022.

Additional Hours Worked	42
Change in pattern of work	15
Service Support	6
Educational opportunities	11
Total	**74**

Note: the total number of ERs (74) differs from that in previous tables (66) due to the 'date of the occurrence of the ER submission' being used in Table 3, rather than the 'date of the occurrence of the exception' detailed in Tables 1 and 2. If there is a delay in an individual submitting an ER on Allocate, there is a disparity between these two parameters.

Over the past 12 months, 11 ERs were submitted in relation to access to training, reflecting the ongoing high workload of Junior Doctors, staff absence and a resulting inability to attend scheduled teaching sessions or other educational opportunities.

Specific issues identified from the pattern and content of ERs:

- High junior doctor workload on medical wards, especially overnight. Although there were no ERs of immediate safety concern occurring in the last quarter, within the last 12 months there have been 2 ERs of immediate safety concern (March 2022 and December 2021) occurring in General Medicine which were due to insufficient staffing. In both instances understaffing occurred due to sickness absence and an inability to obtain sufficient locum cover for night shifts.

- As a result of the above incidents and of detailed pan-specialty discussion and feedback at the JDF, a review of locum rates of pay was undertaken and internal locum rates were increased to reflect those offered by locum agencies in order to attract internal locum cover. In addition, a drive to recruit to those specialties with a high number of rota gaps, including a return to international recruitment post-pandemic, is being implemented. The Trust has expanded its number of Foundation posts and posts for Higher Trainees in order to reduce Junior Doctor workload. Forward planning for provisional rota gaps should make recruitment more effective and work to improve the efficiency of VCF approval of posts has been undertaken.

- No exception reports were received from both the GP training schemes for which the Trust is the lead employer.

b)   Work schedule reviews

No work schedule review were requested within the last quarter.

c) Locum bookings

Locum and bank usage.

The data below details bank and agency shifts covered by training grade doctors. This data is for information and is difficult to comment on due to different working patterns, pressures and activity across specialties. Emergency Medicine, Acute Medicine, Orthopaedics/Trauma and Obstetrics and Gynaecology required the highest numbers of locum/bank hours during the last quarter with Emergency Medicine far exceeding other specialties in locum/bank usage.

The number of hours of locum/bank usage has increased over the past 3 months and 20425 locum/bank hours were utilised in July, with Emergency Medicine accounting for 30%, Orthopaedics and Trauma accounting for 11% and Acute Medicine 10% of those hours.

Table 4. Hours of work (agency, internal bank and regional bank) by month and specialty, May 2022 to July 2022.

Agency/Internal Bank	(All)			

Specialty	May-22	Jun-22	Jul-22	Grand Total
Acute Medicine	2679.25	2162.25	2040.25	**6881.75**
Anaesthetics		264	103	367
Anaesthetics and Critical Care	410.5	253	418.5	1082
Anaesthetics and Maternity	308.5	383	195	886.5
Anaesthetics and Theatres	642	644.5	736	2022.5
Care of the Elderly	1067.5	1340	1356	3763.5
Dermatology	192	176	212	580
Emergency Medicine	4845	5252.5	6041.25	**16138.75**

Endocrinology and Diabetes	194	247.75	676.75		1118.5
Endoscopy - Surgical	44	52	40		136
ENT	506.25	467.5	548		1521.75
Gastroenterology	379.5	410	334		1123.5
General Medicine	12	85	55		152
General Surgery	662.5	719.5	495.5		1877.5
Genitourinary Medicine	28	12	12		52
Intensive Care		39	26		65
Obstetrics and Gynaecology	1580.5	1391	1190		**4161.5**
Ophthalmology	54	15.5	59		128.5
Oral and Maxillofacial Surgery	65.5	8.5	47.75		121.75
Orthopaedic & Trauma for Emed	546.5	461.5	363.5		1371.5
Orthopaedic and Trauma Surgery	2255	2291.5	2348.5		**6895**
Paediatrics and Neonates	600.25	1057.5	1191		2848.75
Renal Medicine		152	130.5		282.5
Respiratory Medicine	946.5	855.5	1000.25		2802.25
Stroke Medicine	189	318	272		779
Urology	68.5	165	134		367.5
Vascular Surgery	190	216	224		630
Haematology	176	176	176		528
Paediatrics	25	8.5			33.5
Breast Surgery		4			4
Acute Internal Medicine	24				24
Community Paediatrics	24	16			40
Oral Surgery	19	28.5			47.5
Grand Total	**18734.75**	**19673**	**20425.75**		**58833.5**

Table 5. Cost of locum and bank usage (agency, internal bank and regional bank) by month and specialty, May 2022 to July 2022.

Agency/Internal Bank	(All)

Specialty	May-22	Jun-22	Jul-22		Grand Total
Acute Medicine	£137,203.43	£112,237.58	£127,306.21		**£376,747.22**
Anaesthetics		£19,106.64	£9,339.27		£28,445.91
Anaesthetics and Critical Care	£22,536.25	£13,509.35	£22,067.33		£58,112.93
Anaesthetics and Maternity	£21,512.70	£23,551.50	£13,227.00		£58,291.20
Anaesthetics and Theatres	£48,023.18	£48,583.27	£45,900.40		£142,506.85
Care of the Elderly	£55,978.58	£74,795.08	£78,883.98		£209,657.64
Dermatology	£15,239.28	£14,129.28	£17,028.24		£46,396.80
Emergency Medicine	£321,431.69	£363,432.29	£425,747.83		**£1,110,611.81**
Endocrinology and Diabetes	£10,693.28	£13,658.61	£34,712.06		£59,063.95
Endoscopy - Surgical	£3,260.00	£4,180.00	£3,200.00		£10,640.00
ENT	£35,409.50	£31,062.40	£36,639.54		£103,111.44
Gastroenterology	£20,540.24	£21,842.74	£18,276.06		£60,659.04
General Medicine	£0.00	£3,100.00	£400.00		£3,500.00
General Surgery	£39,275.26	£32,640.26	£20,040.65		£91,956.17
Genitourinary Medicine	£1,820.00	£780.00	£780.00		£3,380.00
Intensive Care		£799.89	£0.00		£799.89
Obstetrics and Gynaecology	£106,771.06	£106,499.66	£82,546.59		**£295,817.31**
Ophthalmology	£3,510.00	£1,278.75	£4,867.50		£9,656.25
Oral and Maxillofacial Surgery	£4,905.00	£701.25	£3,960.73		£9,566.98
Orthopaedic & Trauma for Emed	£43,987.96	£36,002.05	£27,745.54		£107,735.55
Orthopaedic and Trauma Surgery	£148,101.48	£153,363.73	£148,590.27		**£450,055.48**
Paediatrics and Neonates	£42,858.68	£72,394.82	£69,723.02		£184,976.52
Renal Medicine		£4,205.28	£5,662.50		£9,867.78
Respiratory Medicine	£54,838.02	£49,413.56	£57,204.72		£161,456.30
Stroke Medicine	£9,450.00	£17,291.82	£15,335.02		£42,076.84

Urology	£4,420.00	£9,000.00	£9,676.52		£23,096.52
Vascular Surgery	£15,109.28	£16,929.28	£16,882.28		£48,920.84
Haematology	£10,917.28	£10,917.28	£11,021.04		£32,855.60
Paediatrics	£0.00	£471.75			£471.75
Breast Surgery		£290.00			£290.00
Acute Internal Medicine	£960.00				£960.00
Community Paediatrics	£2,400.00	£1,600.00			£4,000.00
Oral Surgery	£1,235.00	£1,852.50			£3,087.50
Grand Total	**£1,182,387.15**	**£1,259,620.62**	**£1,306,764.30**		**£3,748,772.07**

The monthly cost of locum/bank usage increased monthly over the last 3 consecutive months from £1, 182, 387 in May to £1, 306, 764 in July 2022. The main reasons for locum/bank usage were rota vacancies (82%), sickness (5%), extra cover (3%) and annual and study leave combined (3%).

Table 6. Reason for locum and bank usage, May 2022 to July 2022.

Agency/Internal Bank

Reason for bank usage	May-22	Jun-22	Jul-22	Grand Total
Additional session – Endoscopy	11	13	10	34
Additional session – Outpatients	27	28	34	89
Additional session – Theatres	4	13	7	24
Annual Leave	40	69	53	**162**
Compassionate/Special leave	7	7	1	15
Extra Cover	79	44	55	**178**
Induction			1	1
Maternity/Pregnancy leave	7	27	33	67
Paternity Leave	12	2	1	15

Restricted Duties	26	25	15	66
Seasonal Pressures	1			1
Sick	76	92	156	**324**
Sickness - Covid-19	25	31	53	109
Study Leave	13	9	3	25
Vacancy	1629	1652	1653	**4934**
Grand Total	**1957**	**2012**	**2075**	**6044**

d) Vacancies

Rota vacancies have fluctuated over the course of the past 8 months, with the highest numbers of monthly vacancies occurring in February, March and August 2022 (39.1, 39.5 and 41.2 WTE respectively). Of the current rota vacancies in August 2022, 8.0 WTE were in Medicine (all specialties), 7.8 WTE in Paediatrics and 7.2 WTE were in Obstetrics and Gynaecology.

Of concern, in previous years August usually has the lowest number of rota vacancies when compared with the other months, however in August of 2022 the highest number of rota vacancies for any month of this year was reported. In previous years, monthly rota vacancies have varied between 19.2 WTE to 31.4 WTE (in 2021) and between 25.1 WTE to 34.2 WTE (in 2020) with the lowest number of vacancies occurring in August of those years. Overall, the trend for monthly rota vacancies in 2022 exceeds those of previous years.

Absence due to sickness and Coronavirus self-isolation has additionally impacted upon day-to-day Junior Doctor staffing.

Table 7. Trainee vacancies by specialty January 2022 to August 2022.

Trainee Vacancies by Specialty

	VACANCIES (WTE)	January	February	March	April	May	June	July	August
Medicine	Medicine (all sub-specialties)	5	7.8	6.8	6.2	6.4	6.4	6.4	8
	Emergency medicine	3.4	5.2	5.2	4.4	4.4	5.4	5.4	4
	Elderly Medicine	2	2	2	1	1	1	1	3.2
	Renal	0	0	0	0	0	0	0	1.2
Children & Family	Obstetrics & Gynaecology	6	8.8	9	9	9	9	9	7.2
	Paediatrics	5.5	6.9	8.1	8.1	8.1	8.1	8.1	7.8
	GU Medicine	0	0	0	0	0	0	0	0
Surgery & Cancer	ENT	0	1	1	1	1	1	1	0
	General Surgery	3	2.4	2.4	1.4	1.4	1.4	1.4	2
	Urology	0.4	0.4	0.4	0.4	0.4	0.4	0.4	2
	Trauma & Orthopaedics	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2
	Vascular	2	1	1	1	1	1	1	0
Clinical Specialties	Anaesthetics	1.4	1.4	1.4	2	1.6	1.6	1.6	1.8
	Radiology (POSTS DIS-ETABLISHED Oct 19-Oct 21)								

ICT		0	0	0	0	0	0	0	1.8
Total		**30.9**	**39.1**	**39.5**	**36.7**	**36.5**	**37.5**	**37.5**	**41.2**

e) **Fines**

No fines have been levied within the last quarter.

Qualitative information

It is concerning that two incidents of immediate safety concern were raised by Junior Doctors in relation to working hours on either the 2002 or the 2016 contracts (in March 2022 and in December 2021). I have been assured by the Medical HR department that all doctors have work schedules that are compliant with the 2002 and 2016 contracts, as applicable. The number of exception reports continues to remain low compared with other Trusts. A programme of engagement with Junior Doctors to raise awareness of Exception Reporting, its purpose and how to submit a report is ongoing. This will provide additional data in order to inform whether ER numbers have been low due to compliant work schedules and safe working practices or whether there has been under-reporting of exceptions. Any increase in reporting should lead to improved surveillance of Junior Doctors working hours and training opportunities.

Exception reports submitted in relation to missed educational opportunities increased significantly over the past 12 months when compared with previous years. There were 11 reports of this nature submitted between August 2021 and July 2022. Qualitative data supports that high workload pressure and understaffing is the cause of missed educational opportunities.

Summary

Ongoing exception reports highlight the high workload of Junior Doctors and especially those working in medical specialties. This leads to individuals staying late to ensure safe patient care, missing educational opportunities and on occasion working in conditions that are deemed to be unsafe for both patients and Junior Doctors. However, a high proportion of ERs continue to be submitted due to acutely ill patients requiring unpredictable emergency care resulting in individual doctors staying late in order to ensure patient safety. Exception report numbers typically show seasonal variation with higher numbers occurring over the winter months. An anomaly is noted for the months of May and June 2022 as a result of one Junior Doctor submitting multiple ERs and this data should be interpreted with an understanding of the underlying issues.

The specialties with the highest numbers of exception reports are those with the highest numbers of rota vacancies, suggesting that understaffed rotas are contributing to prolonged working hours and this is compounded by a difficulty in providing adequate locum cover. This is supported by qualitative data from ERs in General Medicine and in depth discussion at the Junior Doctor Forum.

Engagement

The regional Guardian Forum now takes place online twice a year and the last meeting occurred on the 6th July 2022. The local quarterly Junior Doctors' Forum (JDF) took place via MS Teams on 11th August 2022. A joint meeting with the Trainee Management Group has been implemented since December 2020. The JDF is open to all trainee Junior Doctors with the aim of improving engagement. The JDF Terms of Reference have recently been reviewed and now include a Medical Director's Office representative.

An ongoing programme of engagement to raise awareness of exception reporting, and to encourage attendance at and participation in the JDF is underway.

Recommendation

The Board of Directors can be assured that the majority of trainee doctors are able to work safely. Medical specialties remain a concern with regards understaffing and, in particular, sporadic low levels of staffing overnight due to sickness absence and an inability to provide adequate locum cover. The division are sighted on this and are taking steps to recruit to rota gaps and to improve locum cover in the shorter term. Junior Doctors are broadly able to access educational opportunities as envisaged in the 2016 contract, however over the past year missed educational opportunities are more frequently reported and are caused by high clinical workloads. An increase in the number of Foundation posts and posts for Higher Trainees is addressing this specific issue.

Report Cover Page	
Meeting Title:	**Board of Directors**
Meeting Date:	27 September 2022

Meeting Date:	27 September 2022	**Agenda Reference:**	D4
Report Title:	**Workforce Race Equality Standard and Workforce Disability Equality Standard data submission**		
Sponsor:	Zoe Lintin, Chief People Officer		
Author:	Jayne Collingwood, Head of Leadership and OD, EDI and Wellbeing		
Appendices:	DBTH WDES and WRES Data		

Report Summary	
Purpose of report:	To provide the Board with the Workforce Race Equality Standard (WRES) data and the Workforce Disability Equality Standard (WDES) data.
Summary of key issues/positive highlights:	The information below summarises the DBTH workforce position in terms of this year's WRES and WDES data submission. It is important to note the areas of positive change whilst recognising there is still work to do in the areas highlighted below. **Overall positives for WRES** • Overall BAME workforce has increased by 1.4% from 9.6% to 11%. • Band 3 from 7 to 17 Clinical Staff • Band 5 from 151 to 181 Clinical Staff • Band 7 from 7 to 11 Clinical Staff • Non-Clinical Band 3 from 1 to 4 staff • Non-Clinical Band 6 from 2 to 4 staff • Non-Clinical Band 8a from 2 to 3 staff • BAME staff have increased representation significantly at medical and consultant grades and trainee grades. • Shortlisting and appointment appear to have improved for people from a BAME background and people with a disability. **Overall positives for WDES** • Shortlisting and successful appointments is going in the right direction, and we have seen a marked increase in appointment of colleagues with a declared disability • Overall, the percentage of people with a disability being appointed has increased and the total number of people with a disability has increased from 2.9% of overall workforce to 3.28% • We have seen an increase in colleagues with a disability in Bands 5-7 (AFC). **Key areas of continued focus are:** • No Board representation from either BAME or Disabled colleagues. This is a recognised area of focus and work is ongoing to identify appropriate actions • No increase in the number of 8a non-clinical roles for BAME colleagues except an increase of 1 in an 8D role. This is key for diversity in our talent pipeline • Improved disclosure rates especially medical colleagues and disability status • The number of disabled colleagues entering a formal capability procedure who have then retired on grounds of ill health.

Recommendation:	Review the data and consider how to continue efforts to increase representatives of colleagues from a BAME background and those with a disability within the workforce at DBTH.			
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:	SA3 – BAF updated to include action from Race Code 360 Assurance advisory audit (update received by People Committee in September 2022)
Corporate risk register:	
Regulation:	NHS England Requirement
Legal:	Mandated data submission. Requirement to submit by 31 August 2022, which was completed.
Resources:	N/A

Assurance Route		
Previously considered by:		People Committee and Trust Executive Group
Date: 6 and 12 September 2022	Decision:	Data submission to be presented at September Board
Next Steps:		Already agreed necessary actions which will be incorporated into the overarching DBTH People Strategy and the specific Equality, Diversity and Inclusion plan.
Previously circulated reports to supplement this paper:		N/A

Collection name: **Workforce Disability Equality Standard (WDES) Data Collection**

For: **Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (RP5)**, FY2021/22

Submitted: **Wed, Aug 31, 2022, 2:02 PM** by **Qurban Hussain (kirby.hussain@nhs.net)**

Status: **Completed**

Home

Workforce Disability Equality Standard – Data Collection Framework

Introduction

This data is being collected as part of the 2022 data collection for the Workforce Disability Equality Standard (WDES). The aim of WDES is to improve the working and career experiences of Disabled staff in the NHS. The WDES is mandated through the NHS Standard Contract and has been approved as a data collection by the NHSX Data Alliance Partnership . It has also been subject to a data protection impact assessment.

The requirement to submit WDES data is outlined in clause 13.8 of the NHS Standard Contract 2022/23 Service Conditions, which state "The Provider (if it is an NHS trust or an NHS Foundation Trust) must implement and comply with the National Workforce Disability Equality Standard and submit an annual report to the Co-ordinating Commissioner on its compliance".

The Data Collection Framework (DCF) should be used to submit data for the WDES metrics (note the information on the tab for metrics 4 to 9a for NHS trusts). The survey tab contains a series of qualitative questions and should also be completed.

Guidance on how to complete the DCF has been produced and is available via this link .

Navigation and Completion

Each section of the DCF can be accessed using the links near the top of the page. Please note:

- White boxes will collect the data. The grey boxes will be automatically filled when all the required information has been entered.
- Items marked with a red asterisk * are compulsory.
- Entries and changes are not saved automatically. At the foot of each section is a button labelled "Save as draft": this should be used as often as possible.
- Once a section is complete, check the "This page is complete" box at the bottom.
- Once all sections are complete, the "Submit" button can be pressed at the foot of any section.
- Each page may be saved as a PDF or printed using the standard process for your browser. (For example, in Chrome, pressing the three dots at the top-right of the screen brings up several options including Print.)
- Once the data has been submitted, an option will be given allowing a PDF version of the submission to be produced. You are strongly advised to do this and retain it for your records, and to aid in the completion of your 2022 Action Plan.
- Do not use the Back button on your browser: this will return you to the Open Collections screen, and any unsaved data will be lost.

Bank and Agency staff

Trusts should only include Band and Agency staff in the 2022 return if they were also included in the 2021 return. Please use the Notes sections to indicate whether Bank/Agency staff have been included or not.

Deadlines

NHS trusts should submit their data between **1 July 2022** and by **close of business on 31 August 2022**.

The metrics data in this submission should be used to create a SMART action plan, in collaboration with Disabled staff. The action plan should be approved by the trust's Board, and published with the metrics data on the trust's website by 31/10/22. For comparison and benchmarking information on WDES metrics, see the Model Health System (Link:), the NHS Staff Survey (Link:) and the WDES 2021 report (Link:).

Queries

For advice on submitting the data, please email england.wdes-datahelpdesk@nhs.net (Link:)

Our information governance notice can be viewed here: data collection notice (Link:)

Our Guidance can be viewed here: Guidance (Link:)

Web form technical support queries should be sent to: ips.servicedesk@england.nhs.uk (Link:)

Technical support queries about your account and password, locked accounts and password resets should be sent to: itservicedesk@england.nhs.uk (Link:)

Metric 1 - non-clinical

The percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. The data for this Metric should be a snapshot as at 31 March 2022.

If including Bank and Agency staff, please enter them in the "Other" category.

Disability Unknown refers to those staff who have indicated that they prefer not to say, as well as those who have not responded to the disability monitoring question in ESR.

	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount
Under Band 1	2 *	15. %	11 *	84. %	0 *	0 %	13
Band 1	7 *	6.5 %	84 *	77. %	17 *	15 %	108
Band 2	39 *	4.3 %	775 *	85. %	88 *	9.8 %	902
Band 3	8 *	2.1 %	341 *	88. %	38 *	9.8 %	387
Band 4	7 *	3.9 %	151 *	84. %	21 *	11 %	179
Band 5	1 *	2 %	47 *	94 %	2 *	4 %	50
Band 6	5 *	5.7 %	76 *	87. %	6 *	6.9 %	87
Band 7	4 *	7 %	51 *	89. %	2 *	3.5 %	57
Band 8a	1 *	2 %	44 *	89. %	4 *	8.2 %	49
Band 8b	0 *	0 %	18 *	90 %	2 *	10 %	20

	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount
Band 8c	1 *	4.3 %	19 *	82. %	3 *	13 %	23
Band 8d	0 *	0 %	8 *	88. %	1 *	11 %	9
Band 9	0 *	0 %	2 *	10(%	0 *	0 %	2
VSM	0 *	0 %	4 *	66. %	2 *	33 %	6
Other e.g. Bank/Agency, please specify	0 *	%	0 *	%	0 *	%	0

Notes

slight improvement in number of staff in Under band 1 bands 2,4,7
Decrease in band 8A from 2.

Total non-clinical

Non-clinical summary by pay band grouping

	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount

	Headcount	%		%	Headcount	%	Percent
AfC Bands 1 (and under), 1, 2, 3 and 4	63	4 %	1362	85.? %	164	10.? %	1589
AfC Bands 5, 6 and 7	10	5.2 %	174	89.? %	10	5.2 %	194
AfC Bands 8a and 8b	1	1.4 %	62	89.? %	6	8.7 %	69
AfC Bands 8c, 8d, 9 and VSM	1	2.5 %	33	82.? %	6	15 %	40
	75	4 %	1631	86.2 %	186	9.8 %	1892

Metric 1 - clinical

The percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. The data for this Metric should be a snapshot as at 31 March 2022.

If including Bank and Agency staff, please enter them in the "Other" category

Disability Unknown refers to those staff who have indicated that they prefer not to say, as well as those who have not responded to the disability monitoring question in ESR.

	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount
Under Band 1	1 *	10 %	8 *	80 %	1 *	10 %	10
Band 1	0 *	0 %	7 *	77. %	2 *	22 %	9
Band 2	46 *	4.1 %	935 *	84 %	132 *	11 %	1113
Band 3	9 *	2.3 %	335 *	86. %	43 *	11 %	387
Band 4	2 *	1.6 %	101 *	82. %	19 *	15 %	122
Band 5	46 *	4 %	967 *	84 %	138 *	12 %	1151
Band 6	32 *	3.7 %	698 *	81. %	129 *	15 %	859
Band 7	8 *	1.8 %	372 *	83. %	67 *	15 %	447
Band 8a	1 *	1 %	87 *	87. %	11 *	11 %	99
Band 8b	1 *	7.1 %	13 *	92. %	0 *	0 %	14

Band 8c	1	*	8.3	%	11	*	91.	%	0	*	0	%	12
Band 8d	0	*	0	%	3	*	75	%	1	*	25	%	4
Band 9	0	*	0	%	3	*	75	%	1	*	25	%	4
VSM	1	*	50	%	1	*	50	%	0	*	0	%	2
Other e.g. Bank/Agency, please specify	0	*		%	0	*		%	0	*		%	0

Notes

Slight improvements in under band 1 bands 2,3,4, 5,6,8b and 1 VSM. A decrease in band 7 by 1

Medical & Dental Staff, Consultants	7 *	1.1 %	233 *	35.2 %	421 *	63.7 %	661
Medical & Dental Staff, Non-Consultants career grade	2 *	2.2 %	71 *	78 %	18 *	19.8 %	91
Medical & Dental Staff, trainee grades	3 *	1 %	178 *	59.9 %	116 *	39.1 %	297
Total clinical	148	3.5 %	3541	83.7 %	544	12.9 %	4233
Total medical & dental	12	1.1 %	482	45.9 %	555	52.9 %	1049

	Disabled Headcount	Disabled Percent		Non-disabled Headcount	Non-disabled Percent		Disability Unknown Headcount	Disability Unknown Percent		Total Headcount
Total clinical & non-clinical	235	3.3	%	5654	78.8	%	1285	17.9	%	7174

Clinical summary by pay band grouping

	Disabled Headcount	Disabled Percent		Non-disabled Headcount	Non-disabled Percent		Disability Unknown Headcount	Disability Unknown Percent		Total Headcount
AfC Bands 1 (and under), 1, 2, 3 and 4	58	3.5	%	1386	84.5	%	197	12	%	1641
AfC Bands 5, 6 and 7	86	3.5	%	2037	82.9	%	334	13.6	%	2457
AfC Bands 8a and 8b	2	1.8	%	100	88.5	%	11	9.7	%	113

| AfC Bands 8c, 8d, 9 and VSM | 2 | 9.1 % | 18 | 81.8 % | 2 | 9.1 % | 22 |

Metric 2

Metric 2 - Recruitment

Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.

Note:
i) This refers to both external and internal posts.

ii) If your organisation implements a guaranteed interview scheme, the data may not be comparable with organisations that do not operate such a scheme. This information will be collected on the Survey section to ensure comparability between organisations.

	Disabled	Non-disabled	Disability Unknown
Number of shortlisted applicants	116 *	2103 *	311 *
Number appointed from shortlisting	37 *	631 *	127 *
Likelihood of shortlisting/appointed	0.32	0.3	0.41

Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts

0.94

Notes

A significant increase in shortlisted applicant from 79 from last years figures to 116. this year. . A marked increase in appointed staff with disabilities from 26 to 37. Our overall direction is positive.

Metric 3

Metric 3 - Capability

Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

Notes:

i. This Metric will be based on data from a two-year rolling average of the current year and the previous year.

ii. This metric applies to capability on the grounds of performance and not ill health.

iii. If a member of staff enters the capability process for reasons of **both** performance **and** ill health, they should not be included in the count of "ill health only" cases.

iv. For clarification: the data required is the numbers of staff **entering** the capability process from 1 April 2020 to 31 March 2022, divided by 2.

	Disabled	Non-disabled	Disability Unknown
Number of staff in workforce	235	5654	1285
Average number of staff entering the formal capability process for any reason	18 *	225 *	44 *
Of these, how many are on the grounds of ill health only?	18 *	135 *	28 *
Likelihood of staff entering the formal capability process	0.000000	0.015918	0.012451

Relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff   0.000000

Notes

Overall the number of people with a disability recorded has increased from 206 to 235. However the number of staff entering the capability process has increased from last years figure of 0 to 18. Context of the pandemic may have influenced this.

Metric 4 - 9a

Metric 4 to 9a

Please note that you are not required to submit data for WDES Metrics 4 to 9a. These metrics relate to the NHS Staff Survey and the WDES Implementation Team will access this data directly.

However, you should include data for these metrics when discussing, producing and publishing your organisation's WDES annual report. The annual report, which should be developed in partnership with the organisation's Disabled staff network and ratified by the Board, must contain data for all 10 metrics along with an action plan that sets out the actions the organisation will deliver over the coming 12 months.

Metric 9b

Metric 9 - Staff Engagement

b) Has your organisation taken action to facilitate the voices of Disabled staff to be heard?

If no, please provide an explanation for your answer.

○ Yes
○ No

*

Please provide at least one practical example of current action being taken in the relevant section of your WDES annual report.

*

We have set the Ability Staff Network to champion the voices of staff with Disabilities & long term conditions,

Notes

We will also be attending Careers fairs that are focused on peoples with disabilities and are being hosted by the Job Centre. Reciprocal mentoring programme this year will have a focus on all the 9 protected characteristics.

Metric 10

Metric 10 - Board voting membership

Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:

- By voting membership of the Board
- By executive membership of the Board

The data for this metric should be a snapshot as of 31st March 2022.

	Disabled	Non-disabled	Disability Unknown	Total
Total Board members	0 *	11 *	0 *	11
How many are voting members?	0 *	11 *	0 *	11
Number of non-voting members	0	0	0	0
How many are Exec Board members?	0 *	5 *	0 *	5
Number of non-exec members	0	6	0	6
Number of staff in overall workforce (from Metric 1)	235	5654	1285	7174
Total Board members - % by Disability	0 %	100 %	0 %	
Voting Board members - % by Disability	0 %	100 %	0 %	
Non-Voting Board Member - % by Disability	%	%	%	
Executive Board Member - % by Disability	0 %	100 %	0 %	

Non-Executive Board Member - % by Disability	0	%	100	%	0	%
Overall workforce - % by Disability	3.28	%	78.81	%	17.91	%
Difference % (Total Board - Overall workforce)	-3.28	%	21.19	%	-17.91	%
Difference % (Voting membership - Overall Workforce)	-3.28	%	21.19	%	-17.91	%
Difference % (Executive membership - Overall Workforce)	-3.28	%	21.19	%	-17.91	%

Notes

Overall the workforce data shows there has been a slight increase in the representation of staff with a disability 3.28% compared to last years figure which was 2.97%. However we still have no staff with a declared disability on the board this is the same as last years figure.

Survey

Survey

Question 1

Name and contact details of the lead(s) compiling this report.

Name *

Rosie Rowley

Email Address *

Rosie.rowley@nhs.net

Name

Qurban Hussain (Kirby)

Email Address

kirby.hussain@nhs.net

Question 2

Name and contact details of the Board lead for the Workforce Disability Equality Standard.

Name *

Zoe Lintin

Job Title *

Chief People Officer

Email *

zoelintin@nhs.net

Question 3

Name of commissioner, name of commissioning body and email address that the WDES Annual report (containing the WDES metrics report and action plan) will be sent to.

Name of Commissioner

Doncaster CCG

Name of Commissioning Body *

Doncaster CCG

Email *

donccg.communications@nhs.net

Question 4

Unique URL link or existing web page on which the WDES Annual report will be published.

https://oesn11hpbml2xaq003wx02ib-wpengine.netdna-ssl.com/wp-content/uploads/2022/06/WDES-Submission-PDF-file.pdf   *

Question 5

Date of Board meeting at which organisation's WDES Annual report will be ratified. If the date is not known, please provide an approximate date or explain why a date cannot be provided.

27th September 2022   *

Question 6

Does your organisation participate in any programmes or initiatives that are focused on disability equality and inclusion?

*

- ○ Yes
- ● No

*

Question 7

Do your staff have access to the ESR self-service portal?

- ● Yes
- ○ No

*

Question 8

Since you published your action plan last year, have any steps been taken within your organisation to improve the declaration rate for disability status?

*

- ● Yes
- ○ No

If yes, please share any examples of interventions that have increased declaration rates at your organisation.

*

- ☑ Promotion of ESR self-service to encourage staff to update details
- ☑ Other internal communication activities (e.g. staff emails, intranet pages, internal events, poster campaign)
- ☑ Survey of staff to understand views
- ☑ Consultation exercise / workshops
- ☑ Raising visibility of senior Disabled Staff
- ☑ Include an ESR "How to" guide in induction pack or on intranet
- ☐ Other - please specify

Question 9

What level of Disability Confident accreditation does your organisation currently hold?

*

- ○ None
- ○ Level 1 - Committed
- ● Level 2 - Employer
- ○ Level 3 - Leader

Are you working towards obtaining a higher level of accreditation?

*

- ● Yes
- ○ No

Question 10

Do you encourage Disabled people to apply for jobs by offering an interview to any applicant who declares they have a disability and meets the minimum criteria?

* ○ Yes
○ No

*

Please add any examples of interventions that have impacted positively on the recruitment of Disabled staff.

* ☐ Review of the implementation of the commitment to interview an applicant who declares they have a disability and meets the *
minimum criteria
☐ Disabled people on interview panels
☐ Disabled people advising review of recruitment processes
☐ Review of recruitment policy and procedures
☐ Develop external communications to encourage Disabled applicants
☐ Refresh of website to encourage Disabled applicants
☐ Actions to support Disabled applicants through the application and interview process (e.g. providing questions in advance)
☐ Targeted recruitment campaigns
☐ Accept applications in alternative formats
☐ Other - Please specify

Question 11

Has your organisation compared any of the following other datasets you hold to the WDES Metric 4 (Harassment, Bullying or Abuse)?

* ☐ Grievance data *
☐ Disciplinary data
☐ Exit interviews or surveys
☐ Data held by Staffside representatives
☐ Data held by Freedom to speak up guardians
☐ Data held by Health and Wellbeing leads

Other

Question 12

Please add any actions taken since your action plan was published last year to reduce harassment, bullying or abuse in relation to Disabled staff.

*

*

- Dignity at Work Campaign
- ☑ Disability Awareness campaigns
- Harassment and Bullying policy revision
- Champions/ ambassadors/advisors
- Peer support scheme
- Training events
- NHS Civility and Respect toolkit
- ☑ Working with Staff Networks
- None applicable
- Other

Question 13

Does your organisation provide any targeted career development opportunities for Disabled staff?

*

*

- ◯ Yes
- ◯ No
- ◉ Not at present but planned in the next 12 months

If yes, or planned, please select relevant examples. Please feel free to expand in the free text box.

Reciprocal Mentoring programme this year will include all protected characteristics.

Question 14

Does your action plan from last year set out any targeted actions to reduce presenteeism i.e. feeling pressured to come to work when not feeling well?

*

○ Yes
◉ No
○ Not at present but planned in the next 12 months

*

Question 15

Does your action plan from last year set out any targeted actions to increase the workplace satisfaction of Disabled staff?

*

○ Yes
○ No
◉ Not at present but planned in the next 12 months

*

If yes, or planned, please select relevant examples. Please feel free to expand in the free text box.

*

☐ Working with Disability networks/groups
☐ Health and wellbeing days or events
☐ Line manager disability awareness training
☐ All staff disability awareness training
☐ Implementing changes following staff surveys
☐ Other – please specify

*

Question 16

Does your organisation have a reasonable adjustments policy?

○ Yes
○ No

○ Not at present but planned in the next 12 months

*

Question 17

Evidence shows workplace adjustments are more effective when costs are met from central budgets. Are costs for workplace adjustments in your organisation met through centralised or local budgets?

*

○ Centralised budgets
● Local budgets
○ Both

*

Question 18

Have you undertaken any actions in the last 12 months to improve the reasonable adjustments process?

*

● Yes
○ No
○ Not at present but planned in the next 12 months

*

If yes, or planned, please select relevant examples. Please feel free to expand in the free text box.

*

☐ Training for managers
☐ Guidance and support provision
☐ Internal communications
☐ Reasonable/workplace adjustment policy revision
☐ Sharing best practice examples through induction/intranet/training
☐ Disability/Workplace adjustments passport
☐ Other - please specify

*

Question 19

Please list any actions contained in your action plan from last year that have not been completed.

*

Our EDI action plan is ongoing

Question 20

Are there plans for your Trust to merge with another trust in the next 12 months?

*

- ○ Yes
- ● No

*

Question 21

When did the Board most recently review progress in delivering the action plan from last year?

*

- ○ In the last 3 months
- ● Between 3 and 6 months
- ○ Between 6 months and 1 year
- ○ More than 1 year

*

Question 22

Do annual Health and Wellbeing conversations take place with all staff which include opportunity to discuss disability?

*

- ● Yes
- ○ No

*

Please provide brief details *

This is included in the quality appraisal conversations that all staff have with their line managers

Question 23

What has been done specifically to support Disabled staff through the COVID-19 pandemic?

*

We created supportive wellbeing spaces and return conversations and TLC calls

*

Question 24

Have you taken specific actions to support staff with "Long COVID"?

*

- ◉ Yes
- ○ No

*

Please provide brief details *

We have a long covid pathway supported and delivered by Vivup our mental health and wellbeing staff service

Question 25

Do you have any further comments?

Collection name: **Workforce Race Equality Standard (WRES) Data Collection**
For: **Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (RP5)**, FY2021/22
Submitted: **Wed, Aug 31, 2022, 4:27 PM** by **Qurban Hussain (kirby.hussain@nhs.net)**
Status: **Draft**

Welcome to the WRES 2022 Data collection

- We will be introducing a separate WRES collection for NHS held Bank Workers later in the year, so please exclude all NHS held bank worker data from this submission Bank workers are defined as workers who in your organisation work solely on a zero hour/'bank only' contract. This data collection will be known as Bank WRES (BWRES)
- As Clinical commissioning groups (CCG's) will be subsumed into the integrated care systems (ICS's), there is no requirement for CCG's to submit data for this collection. There will be a separate collection later this year for ICS's and ICB's.
- Guidance and additional information can be viewed here: Guidance (Link:)and Additional Information (Link:)
- Our information governance notice can be viewed here: Information Governance Notice (Link:)
- Web form technical support queries should be sent to: ips.servicedesk@england.nhs.uk (Link:)
- Issues with your account and password, locked accounts and password resets should be sent to: ips.servicedesk@england.nhs.uk (Link:)
- Requests for access to the collection should be sent to: england.wres@nhs.net (Link:)
- Business / policy queries should be sent to: england.wres@nhs.net (Link:)

Indicator 1a - Non-Clinical Workforce

	Last Year			This Year			
	White	**BME**	**Ethnicity Unknown/ Null**	**White**	**BME**	**Ethnicity Unknown/ Null**	**Comments**
Under Band 1				12 *	1 *	0 *	We have an increase of 1 from last years which was 0.
Band 1				100 *	2 *	6 *	No change
Band 2				865 *	25 *	12 *	Very slight decrease from previous years figure of 26
Band 3				378 *	4 *	5 *	An increase from last years figure of 1

	Last Year			This Year			Comments
	White	BME	Ethnicity Unknown/Null	White	BME	Ethnicity Unknown/Null	
Band 4				177 *	1 *	1 *	A decrease of 2 from last years figure which was 3
Band 5				49 *	1 *	0 *	No Change
Band 6				82 *	4 *	1 *	Last year was 2 now doubled to 4
Band 7				52 *	5 *	0 *	No Change
Band 8A				46 *	3 *	0 *	An Increase of 1 from last year
Band 8B				20 *	0 *	0 *	No Change
Band 8C				22 *	0 *	1 *	No Change
Band 8D				8 *	1 *	0 *	Increase of 1 from last years figure which was 0
Band 9				0 *	0 *	0 *	No Change
VSM				6 *	0 *	0 *	No Change

Indicator 1b - Clinical Workforce

	Last Year			This Year			Comments
	White	BME	Ethnicity Unknown/Null	White	BME	Ethnicity Unknown/Null	
Under Band 1				8 *	1 *	1 *	No Change

Band 1				9 *	0 *	0 *	No Change
Band 2				1044 *	44 *	25 *	An Increase of 3 from last years figures of 41
Band 3				364 *	17 *	6 *	A significant increase from last years figure of 7 to 17. Positive shift .
Band 4				117 *	2 *	0 *	An Increase of 1 from last years figures
Band 5				943 *	181 *	27 *	Significant change in bands 5 from 151 last year - an increase of 30.
Band 6				800 *	40 *	19 *	An Increase of 2 from last years figures
Band 7				429 *	11 *	7 *	An Increase of 4 from last years figures
Band 8A				92 *	7 *	0 *	No Change
Band 8B				12 *	2 *	0 *	No Change
Band 8C				13 *	0 *	0 *	No Change
Band 8D				3 *	0 *	0 *	No Change
Band 9				3 *	1 *	0 *	No Change
VSM				1 *	0 *	0 *	No Change

Indicator 1 - Medical and Dental Consultants

	Last Year White	Last Year BME	Last Year Ethnicity Unknown/Null	This Year White	This Year BME	This Year Ethnicity Unknown/Null	Comments
Medical & Dental Consultants				105 *	169 *	386 *	An Increase of 10 from last years figures
Of which Senior Medical Manager				0 *	0 *	0 *	No Change
Non-consultant career grade				16 *	69 *	6 *	An Increase of 5 from last years figures
Trainee Grades				84 *	162 *	45 *	A significant Increase of 19 from last years figures
Other				7 *	2 *	1 *	An Increase of 2 from last years figures

Number of staff in Workforce

	Last Year White	Last Year BME	Last Year Ethnicity Unknown/Null	This Year White	This Year BME	This Year Ethnicity Unknown/Null	Comments
				5867	755	549	

Indicator 2 - Relative likelihood of staff being appointed from shortlisting across all posts.

	Last Year White	Last Year BME	Last Year Ethnicity Unknown/	This Year White	This Year BME	This Year Ethnicity Unknown/	Comments

			Unknown/Null			Unknown/Null		
Number of Shortlisted Applicants				1891 *	366 *	273 *	A large increase of 151 from last years figures - this is a positive shift
Number Appointed from Shortlisting				586 *	95 *	114 *	A big Increase of 42 from last years figures
Relative likelihood of appointment from shortlisting	%	%	%	. %	. %	. %	Recruitment processes are under review by the ED&I Committee, with a recommendation of more diverse recruitment panels.
Relative likelihood of White staff being appointed from shortlisting compared to BME staff			1.19				This is an improvement on last years figure of 1.40 - positive change

Indicator 3 - Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

Note: This indicator will be based on year-end data.

	Last Year			This Year			
	White	BME	Ethnicity Unknown/Null	White	BME	Ethnicity Unknown/Null	Comments
Number of staff in workforce				5867	755	549	Overall our BAME staff numbers have significantly increased from last years figures 664 TO 755. This reflects a positive shift.
Number of staff entering the formal disciplinary process				64 *	3 *	2 *	This has increased by 1 from last years figure which was 2
Likelihood of staff entering the formal disciplinary process	%	%	%	1 %	0 %	0 %	No Changes
Relative likelihood of BME staff entering the formal disciplinary				0			

process compared to White staff

Indicator 4 - Relative likelihood of staff accessing non-mandatory training and CPD.

	Last Year			This Year			
	White	BME	Ethnicity Unknown/Null	White	BME	Ethnicity Unknown/Null	Comments
Number of staff in workforce				5867	755	549	
Number of staff accessing non-mandatory training and CPD				5470 *	625 *	167 *	This has increased by 19 but may not reflect the true increase in number of staff from BME backgrounds.
Likelihood of staff accessing non-mandatory training and CPD	%	%	%	93 %	83 %	30 %	This has decreased from last years figures of 91.27%.
Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff				1.12			This has decreased compared to least year. Work to do to promote access to non-mandatory training and development programmes.

Indicator 9 - Percentage difference between the organisations' Board voting membership and its overall workforce.
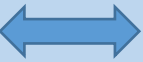
Note: Only voting members of the Board should be included when considering this indicator.

	Last Year			This Year			
	White	BME	Ethnicity Unknown/Null	White	BME	Ethnicity Unknown/Null	Comments
Total Board members				11 *	0 *	0 *	No Changes
of which: Voting Board members				11 *	0 *	0 *	No Changes

members						No Changes
Non-voting Board members				0	0	0	No Changes
Exec Board members				11 *	0 *	0 *	No Changes
Non-exec Board members				0	0	0	No Changes
Number of staff in workforce				5867	755	549	
Total Board Members - % by Ethnicity	%	%	%	100 %	0 %	0 %	This is recognised as a priority area of focus and actions will be developed this year to seek to improve representation.
Voting Board Members - % by Ethnicity	%	%	%	0 %	0 %	0 %	No Changes
Non-voting Board Members - % by Ethnicity	%	%	%	0 %	0 %	0 %	No Changes
Executive Board Members - % by Ethnicity	%	%	%	0 %	0 %	0 %	No Changes
Non-executive Board Members - % by Ethnicity	%	%	%	0 %	0 %	0 %	No Changes
Overall Workforce - % by Ethnicity	%	%	%	82 %	11 %	8 %	There has been a significant increase from last years figure of 9.6% to 11%. This is a positive shift. Work to do around disclosure rates and data we hold.
Difference (Total board - Overall workforce)	%	%	%	18 %	-11 %	-8 %	Currently no BME representation at Board level.

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 : September 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 an appetite for this strategic risk as shown below by risk type:

Reputation	Finance/VFM	Regulatory	Innovation	Quality	People
Seek (4)	Open (3)	Minimal (1)	Open (3)	Open (3)	Open (3)

Overall Risk Scores for Strategic Objective

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	

Risks:
- There is a very significant challenge in 22/23, with the current Trust plan showing a deficit of £10m. The Trust will be likely challenged to reduce its deficit plan further in year.
- The Trust is reporting a c £7.9m deficit at the end of M5 which is c£1.4m off plan. This is primarily being driven by higher than planned pay costs due to high temporary staffing usage. This in turn is due to the impact of vacancies, higher than planned levels of COVID sickness, operational pressures (high bed occupancy and demand in urgent and emergency care) and impact of patient safety decisions (e.g. maternity services). The Trust also has a cost pressure because of the pay award of c£0.3m which will impact on the Trust's future month's pay spend position.
- Part of the pay pressures are offset by non-pay underspends against elective recovery including the independent sector and a number of non-recurrent benefits against plan including VAT reclaims, review of previous years balances on the balance sheet, and £1m insurance proceeds relating to the W&C incident. The position reported includes all year-to-date Elective Recovery Funding given there is no clawback of funding in Q1 and Q2 despite the Trust not delivering electivity activity targets. An update on the rules for Q3 and Q4 ERF is not yet known. If the Trust's financial position was restated in line with the ERF rules and removing the impact of early year non-recurrent benefits, the Trust would be closer to c£7m off plan.
- Agency spend remains at historical levels and has been very high in the last three months and was at its highest level yet in month 5 at £2.2m, which is more than double pre-pandemic levels. The area of increase in agency since pre-pandemic continues to be nursing. The Chief Nurse has developed a plan to support reducing temporary staffing spend which is positive, however assurance is needed over the next months this is having an impact on spend levels.
- Non-pay inflation is currently very high in the economy and is not funded at those levels within the funding allocations. For example we have seen increasing pressures on utilities and a range of contracts which will extend into the next financial year without further funding.
- 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. However COVID levels are higher than plan impacting on bed occupancy and sickness driving expensive agency usage.
- Income allocations have been significantly reduced from pandemic levels, including Commissioners removal of previously provided non-recurrent funding. Therefore, focus on efficiency and productivity and cost reduction in 22/23 is paramount. The Trust also continues to ask the ICB regarding funding allocations as we move into future years.
- Whilst cash is currently in a healthy position the deficit this financial year along with the significant capital programme 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. This is being closely monitored.
- 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.
- 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

Rationale for overall strategic risk current score:
Impact:
- Currently the Trust is in a significant current and underlying deficit position with there still being uncertainty regarding the future financial regime.
  This impacts on:
  - o Trust's ability to invest in its services and infrastructure and maintain a sustainable site as its asset base ages further.
  - o Delivery of safe and sustainable services for patients including any backlogs in activity due to COVID.
  - o Ensuring the sustainability and safety of the Doncaster site.
  - o Impacts on Trust reputation with potential regulatory action
  - o 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

been provided in year of c£1.8m to support this. There however remains limited capital funding especially for significant builds given the Trust's estates risks. • Impact of inflationary pressures on capital projects within allocated funding – BEV, RAAC, ePR				

CRR Risk cross reference	F&P11 11	F&P12 1412	F&P20 1807	ARC01 13				Comments:
Current CRR Risk Rating	16	15	20	12				• See risks section
Risk Appetite Type	Fin	Fin Reg	Qual Fin	Rep Reg				
Risk Appetite Level	Open	Open	Open	Open				
Target Risk Rating	8	10	8	4				

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. Reintroduction of financial escalation process with Divisions from June.	July 2022	Ongoing	AC	Ongoing review of financial controls. No unexpected exceptions identified.
Budget Setting and Business Planning	June 2022	N/A	AC/JS	No unexpected exceptions identified.
Internal & External Audit programme design & compliance outcomes	September 2022	Ongoing	AC	Last Internal Audit provided significant assurance. External Audit on 21/22 provided an unqualified audit opinion. Further Internal audit to be completed in Q3.
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.	Ongoing	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	June 22	ARC, Board	Moderate Assurance	
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	June 22	ARC, F&P, Board	Unqualified Opinion	Nothing high risk identified in ISA 260, but some control recommendations to work on through the financial year with progress reported to ARC.

Corrective Actions required	Action due date	Action status	Action owner	Forecast completion date
1. Delivery of external and internal audit recommendations	Ongoing	Ongoing	AC	Internal audit recommendations implemented on time. External audit actions progressing
2. Working with the ICS regarding funding allocations for Doncaster	Ongoing	Ongoing	AC	Ongoing – piece of work commissioned by ICB looking at cost movements initially.
3. Delivery of reduced temporary staffing spend especially in Nursing	Ongoing	Ongoing	All Exec Directors especially Chief Nurse	Nursing plan developed, trajectories required. Workstream to be set up for Medics
4. Development and delivery of CIP plan	Ongoing	Ongoing	All Exec Directors, JS lead for Efficiency and Effectiveness	Ongoing – positive progress on delivery in year so far.
5. Development and implementation of financial assurance processes in line with new Governance proposals (including escalation and monitoring processes).	June 22	Ongoing	AC	June 22 – implemented

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*

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	27 September 2022	**Agenda Reference:**	E2
Report Title:	**Financial Performance – Month 5 (August 2022)**		
Sponsor:	Alex Crickmar, Acting Director of Finance		
Author:	Jenny Marsh, Acting Deputy Director of Finance		
Appendices:	None		
Executive Summary			
Purpose of report:	To report the Month 5 financial position to the Trust Board including any risks to the delivery of the Trust's financial plan.		
Summary of key issues	The Trust's deficit for month 5 (August 2022) was £2.7m, which was a £1.0m adverse variance to plan. The Trust's Year to Date (YTD) financial position was a deficit of £7.9m which is adverse to plan by £1.4m.		
	The YTD position is largely driven by pay continuing to be overspent by £4.7m due to high temporary staffing usage. This in turn is due to the impact of vacancies, higher than planned levels of COVID sickness, operational pressures (high bed occupancy and demand in urgent and emergency care) and the impact of patient safety decisions (e.g. maternity services premiums). With regards to non-pay pressures inflation is still very high in the economy (£0.7m pressure YTD). For example we have seen increasing pressures on utilities and a range of contracts which will extend into the next financial year without further funding.		
	Part of the pay pressures are offset by non-pay underspends against elective recovery (£2.4m) including the independent sector and a number of non-recurrent benefits against plan. This includes VAT reclaims, £1m insurance proceeds relating to the W&C incident and other non-recurrent benefits including a gas rebate (£0.2m) and review of prior years' balances on the balance sheet (c.£0.6m). The Trust is also seeing pressures on excluded devices and non-PbR drugs where spend is higher than plan, especially insulin pumps due to a change in NICE guidance. In the past these costs have been recovered through the contract, however given it is blocked this year, this pressure will sit with the Trust.		
	It should be noted that the position reported includes all year-to-date Elective Recovery Funding given there is no clawback of funding in Q1 and Q2 despite the Trust not delivering electivity activity targets. An update on the rules for Q3 and Q4 ERF is not yet known at this stage. If the Trust's financial position was restated in line with the ERF rules at the beginning of the financial year and the impact of early year non-recurrent benefits is removed, the Trust would be closer to c£7-8m off plan. This is shown in the table below.		

		YTD	
	Plan	**Actual**	**Variance**
	£000	**£000**	**£000**
(Surplus)/Deficit Position for the purposes of system achievement	**6,483**	**7,930**	**1,447**
Non-recurrent items			
75% ERF income following national agreement to not clawback	0	3,933	3,933
Interim insurance payment relating to the W&C major incident	0	1,000	1,000
Prior year VAT reclaim - Digital Transformation	0	161	161
Prior year VAT reclaim - Pathology	0	347	347
Other non-recurrent benefits	0	832	832
Underlying (Surplus)/Deficit Position for the purposes of system achievement	**6,483**	**14,209**	**7,726**

Key highlights by category of income and expenditure are set out below:

- **Clinical Income:** £0.7m favourable to plan, driven by non-recurrent funding for the Lung Health Checks project which is offset with expenditure. ERF has been assumed to be fully received YTD from Commissioners, in line with ICB guidance that there will be no national clawback of ERF from systems for underperformance in Q1 and Q2. A further key assumption is the recognition of £0.6m of income relating to the ongoing contract issue with RDASH which has yet to be arbitrated on by the ICB (therefore is at risk).

- **Non-Clinical Income:** £1.6m favourable to plan, mainly driven by the interim insurance proceeds relating to the Women's and Children's hospital major incident (£1.0m). Recharges are favourable to plan by £1.0m, offset by testing income (£0.5m) being lower than plan (offset by expenditure).

- **Pay:** £4.7m adverse to plan, with the variance mainly driven by Medical and Nursing spend in Medicine, Surgery and Children and Families Divisions. Agency spend in month has increased again by £0.2m from month 4 mainly driven by the agreed Midwife incentive payments that have been in place throughout August. Temporary staffing spend (£2.2m) remains significantly higher than pre-pandemic levels (c £0.9m pre-pandemic) and above last year levels, with the trend for spend continuing to rise rather than fall. COVID related pay is £0.8m over budget mainly on backfill for COVID sickness. The Chief Nurse has developed a plan to support reducing temporary staffing spend which is positive, however assurance is needed over the next months this is having an impact on spend levels with clear trajectories/targets needing to be agreed and monitored against.

- **Non-Pay:** £0.9m favourable to plan, largely due to an underspend against elective recovery including independent sector spend (£2.4m), VAT reclaim in year of (£0.5m) as part of the annual VAT return, finalisation of the year end positions on apprentice levy and Parkhill contract (£0.2m). These are offset with excess inflation costs of £0.7m (including continued pressures on utilities and other contracts), an increase in spend on insulin pumps and glucose monitors due to a change in NICE guidelines (£0.6m), drugs overspend (£0.5m) and other costs that are offset with income (£0.4m).

Capital

Capital spend in month was £1m against the plan of £1.7m giving an in-month under-performance of £0.7m. YTD capital spend is £3.6m against the plan of £7.3m, giving a YTD underperformance of £3.7m. The key variances to plan are underspends in Estates of £1.9m and Medical Equipment of £0.3m. Estates and ICT have progressed business cases on time through CIG, however, there has been a further delay in terms of MEG cases which has been escalated to the Medical Director and Divisions for resolution.

Cash

The cash balance at the end of August was £27m (July: £24.2m). Cash has increased by c £2.9m compared to month 4 due to the receipt of quarterly income from Health Education England, non-NHS cash expenditure going back to average levels and limited capital expenditure in month. However cash is expected to fall throughout the rest of the year as a result of the impact of the planned I&E deficit and a backloaded capital plan. Therefore this needs to be carefully monitored and managed in year, including robust cash flow forecasting.

CIPs

In Month the Trust has delivered £2.2m of savings versus the plan submitted to NHSi of £1.1m, an over achievement of £1.2m. YTD the Trust has delivered £8.1m of savings against a planned £5.7m, an over achievement of £2.4m.

2022/23 Pay Award

Following the recent announcement of the 22/23 pay award, the estimated annual cost to the Trust is circa £13.9m. Taking into account additional funding since planning, initial calculations show that the Trust will see an annual cost pressure in year of c.£0.3m arising from this.

HFMA Financial Sustainability Internal Audit

In April 2022 the Healthcare Financial Management Association (HFMA) produced a briefing Improving NHS financial sustainability: are you getting the basics right? The briefing included a detailed checklist for organisations to use as a self-assessment tool. NHS England (NHSE) has issued guidance that requires organisations to commission from their internal auditors a review of the completed self-assessment. It also sets out the scope and specifies the timing of the internal audit review. The self-assessment is progressing well and will be completed ahead of the 30th September deadline. The self-assessment will be reviewed at Finance and Performance Committee on the 26th September. The Internal Audit will be completed by the end of November, with the results reported to the Audit and Risk Committee.

Recommendation:	The Board is asked to note: • The Trust's deficit for month 5 (August 2022) was £2.7m, which was adverse to plan by £1.0m. • The Trust's deficit YTD at month 5 (August 2022) was £7.9m, which was adverse to plan by £1.4m. • The financial risks as outlined in the paper.				
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:	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:		Finance and Performance Committee
Date:	Decision:	N/A
Next Steps:		
Previously circulated reports to supplement this paper:		

FINANCIAL PERFORMANCE

Month 5 – August 2022

1. Income and Expenditure vs. Budget

Performance Indicator	Monthly Performance Actual £'000	Monthly Performance Variance to budget £'000		YTD Performance Actual £'000	YTD Performance Variance to budget £'000	
Income	(42,178)	(475)	F	(209,634)	(2,280)	F
Pay	28,346	1,298	A	139,721	4,710	A
Non Pay	16,024	38	A	75,256	(933)	F
Financing Costs	528	157	A	2,781	(69)	F
(Profit)/Loss on Asset Disposals	0	0	A	(97)	(97)	F
(Surplus)/Deficit for the period	2,720	1,017	A	8,028	1,331	A
Adj. for donated assets and gains on disposal of assets	(41)	2	A	(98)	116	A
Adjusted (Surplus)/Deficit for the purposes of system achievement	2,680	1,020	A	7,930	1,447	A

2. CIPs

Performance Indicator	Monthly Performance Plan £'000	Monthly Performance Actual £'000		YTD Performance Plan £'000	YTD Performance Actual £'000		Annual Plan £'000
Local	0	1,331	F	0	2,972	F	0
Workforce (vacancy control)	434	434	F	2,774	2,774	F	5,500
ERF productivity	458	458	A	2,292	2,292	A	5,500
Temporary staffing	100	0	A	300	0	A	1,000
Procurement	63	22	A	313	87	A	750
Non-pay cost containment	0	0	A	0	0	A	2,000
Unidentified	0	0	A	0	0	A	4,500
Total CIP	1,055	2,246	F	5,678	8,124	F	19,250

Key

Income: Over-achieved **F** Under-achieved **A**

F = Favourable **A** = Adverse

Expenditure: Underspent **F** Overspent **A**

3. Statement of Financial Position

	Opening balance £'000	Closing balance £'000	Movement £'000
Non Current Assets	246,595	246,001	-594
Current Assets	62,494	60,940	-1,554
Current Liabilities	-77,772	-68,007	9,765
Non Current liabilities	-13,286	-12,875	411
Total Assets Employed	218,031	226,059	8,028
Total Tax Payers Equity	-218,031	-226,059	-8,028

4. Other

Performance Indicator	Monthly Performance Plan £'000	Monthly Performance Actual £'000	YTD Performance Plan £'000	YTD Performance Actual £'000	Annual Plan £'000
Cash Balance		27,048		27,048	25,251
Capital Expenditure	1,711	1,041	7,342	3,616	34,190

5. Workforce

	Funded WTE	Substantive WTE	Bank WTE	Agency WTE	Total in Post WTE
Current Month	6,559.95	5,584.05	434.97	229.06	6,248.08
Previous Month	6,536.99	5,667.94	393.14	238.66	6,299.74
Movement	22.96	-83.89	41.83	-9.60	-51.66

1. Month 5 Financial Position Highlights

Executive Summary Income and Expenditure – Month 5

	Month 5			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000
Income	**-41,703**	**-42,178**	**-475**	**-207,353**	**-209,634**	**-2,280**
Pay						
Substantive Pay	25,469	23,361	-2,108	126,829	115,367	-11,462
Bank	49	2,428	2,379	173	9,540	9,367
Agency	172	2,199	2,027	1,134	9,355	8,221
Recharges and Reserves	1,357	358	-1,000	6,876	5,459	-1,417
Total pay	**27,048**	**28,346**	**1,298**	**135,012**	**139,721**	**4,710**
Non-Pay						
Drugs	883	748	-135	4,496	4,719	223
Non-PbR Drugs	1,822	2,064	242	9,111	9,407	296
Clinical Supplies & Services	2,980	3,615	635	15,085	15,903	818
Depreciation and Amortisation	1,257	1,278	22	6,285	6,215	-70
Other Costs (including reserves)	7,598	6,461	-1,137	33,982	30,804	-3,178
Recharges	1,446	1,857	411	7,230	8,207	977
Total Non-pay	**15,986**	**16,024**	**38**	**76,189**	**75,256**	**-933**
Financing costs	**372**	**528**	**157**	**2,850**	**2,685**	**-165**
(Surplus)/Deficit Position	**1,703**	**2,720**	**1,017**	**6,697**	**8,028**	**1,331**
Less donated asset adjustment and gains on disposal of assets	-43	-41	2	-215	-98	116
(Surplus)/Deficit Position for the purposes of system achievement	**1,660**	**2,680**	**1,020**	**6,483**	**7,930**	**1,447**

The Trust's deficit for month 5 (August 2022) was £2.7m, which was a £1.0m adverse variance to plan. The Trust's Year to Date (YTD) financial position was a deficit of £7.9m which is adverse to plan by £1.4m. The table and narrative below set out the key issues driving the year to date position (YTD).

	£m
Maternity pay pressure. Operational and safety pressures leading to higher than normal agency premiums (£0.2m increase in run rate in month).	-1.8
Pay Emergency / operational pressures. Operational pressures due to vacancies, sickness, and high bed occupancy rates.	-2.8
COVID costs in excess of plan - driven by higher sickness levels.	-0.8
Excess Inflation – Utilities and Contracts	-0.7
Underspend on elective recovery (Independent sector and other planned care)	2.4
Overachievement against plan on efficiency, due to VAT reclaim, W&C insurance payment and other new local schemes.	2.4
Excluded device income not recovered due to block contract arrangements (Insulin pumps following change in NICE guidance)	-0.6
Other Non-Recurrent benefits	0.6
YTD Variance to Plan	**-1.4**

The YTD position is largely driven by pay continuing to be overspent by c£4.7m due to high temporary staffing usage. This in turn is due to the impact of vacancies, higher than planned levels of COVID sickness, operational pressures (high bed occupancy and demand in urgent and emergency care) and the impact of patient safety decisions (e.g. maternity services premiums). With regards to non-pay pressures inflation is

still very high in the economy (£0.7m pressure YTD). For example we have seen increasing pressures on utilities and a range of contracts which will extend into the next financial year without further funding.

Part of the pay pressures are offset by non-pay underspends against elective recovery (£2.4m) including the independent sector and a number of non-recurrent benefits against plan. This includes VAT reclaims, £1m insurance proceeds relating to the W&C incident and other non-recurrent benefits including a gas rebate (£0.2m) and review of prior years' balances on the balance sheet (c.£0.6m). The Trust is also seeing pressures on excluded devices and non-PbR drugs where spend is higher than plan, especially insulin pumps due to a change in NICE guidance. In the past these costs have been recovered through the contract, however given it is blocked this year, this pressure will sit with the Trust.

It should be noted that the position reported includes all year-to-date Elective Recovery Funding given there is no clawback of funding in Q1 and Q2 despite the Trust not delivering electivity activity targets. An update on the rules for Q3 and Q4 ERF is not yet known at this stage. If the Trust's financial position was restated in line with the ERF rules at the beginning of the financial year and the impact of early year non-recurrent benefits is removed, the Trust would be closer to c£7-8m off plan. This is shown in the table below.

	YTD		
	Plan	Actual	Variance
	£000	£000	£000
(Surplus)/Deficit Position for the purposes of system achievement	**6,483**	**7,930**	**1,447**
Non-recurrent items			
75% ERF income following national agreement to not clawback	0	3,933	3,933
Interim insurance payment relating to the W&C major incident	0	1,000	1,000
Prior year VAT reclaim - Digital Transformation	0	161	161
Prior year VAT reclaim - Pathology	0	347	347
Other non-recurrent benefits	0	832	832
Underlying (Surplus)/Deficit Position for the purposes of system achievement	**6,483**	**14,209**	**7,726**

Further Detail

Income: The month 5 position is aligned to the contract values submitted in the final plan including growth assumptions, inflationary uplifts, and ERF allocations. The clinical income position is £0.7m favourable to plan year to date which is driven by non-recurrent funding for the Lung Health Checks project which is offset with expenditure. ERF has been assumed to be fully received YTD from Commissioners, in line with ICB guidance that there will be no national clawback of ERF from systems for underperformance in Q1 and Q2. Further information with regards to Q3 and Q4 ERF is yet to be announced, but the current expectation is this will be linked to performance. Inter-system commissioners have yet to all confirm agreement on ERF funding and therefore a risk of £230k has been included at month 5.

Within the plan the Trust included a contract risk relating to growth assumptions outside of the SY ICB as discussions (mainly relating to Notts ICB) continue to be held at a regional level. The risk included in the position at month 5 is £0.7m. A further key assumption is the recognition of £0.6m of income relating to the ongoing contract issue with RDASH. The Board should note that this is a potential risk whilst we await progress from the ICB regarding arbitration on the issue.

Non-clinical income was £1.6m favourable to plan, with a number of key variances to note:

- £1.0m favourable variance due to the interim insurance payment relating to the Women's & Children's hospital major incident.
- £1.0m favourable variance on recharges which is offset with a corresponding increase in expenditure.
- £0.5m adverse variance on COVID testing income which is offset with a corresponding decrease in expenditure.

Pay expenditure: is £4.7m adverse to plan, with the variance mainly driven by Medical and Nursing spend in Medicine, Surgery and Children and Families Divisions. COVID related pay is £0.8m over budget mainly on backfill for COVID sickness

Agency spend is continuing on an upward trajectory at £2.2m in month, an increase of £0.2m compared to month 4, mainly on medical and nursing staff. The majority of the nursing increase relates to the maternity incentives which have impacted throughout the month of August. The table below sets out the agency spend by type for quarter 4 of 2021/22 and month 1 to month 5 of 2022/23, demonstrating the continued agency spend on medical staff and increased agency spend on Nursing staff. This level of spend is c.£1.2m more than pre-pandemic levels and is an increasing trend over last year. The Chief Nurse has developed a plan to support reducing temporary staffing spend in nursing, which is positive, however assurance is needed over the next months that this is having an impact on spend levels with clear trajectories/targets needing to be agreed and monitored against.

Total agency spend by category	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
Administration and estates	42	55	33	63	70	55	108	49
HCA and other support staff	82	64	82	26	66	97	81	28
Medical and dental	760	722	886	805	881	943	895	1,015
Non Medical Non Clinical	43	37	78	64	68	56	40	186
Nursing & midwifery	380	418	755	702	616	626	801	923
Scientific, therapeutic and tech	31	25	40	28	22	17	26	-2
Total	**1,338**	**1,321**	**1,874**	**1,688**	**1,724**	**1,793**	**1,950**	**2,199**

Non-Pay Expenditure: £0.9m favourable to plan, largely due to an underspend against elective recovery including independent sector spend (£2.4m), VAT reclaim in year of (£0.5m) as part of the annual VAT return, finalisation of the year end positions on apprentice levy and Parkhill contract (£0.2m). These are offset with excess inflation costs of £0.7m (including continued pressures on utilities and other contracts), an increase in spend on insulin pumps and glucose monitors due to a change in NICE guidelines (£0.6m), drugs overspend (£0.5m) and other costs that are offset with income (£0.4m).

Capital

Capital spend in month was £1m against the plan of £1.7m giving an in-month under-performance of £0.7m. YTD capital spend is £3.6m against the plan of £7.3m, giving a YTD underperformance of £3.7m. The key variances to plan are underspends in Estates of £1.9m and Medical Equipment of £0.3m. Estates and ICT have progressed business cases on time through CIG, however, there has been a further delay in terms of MEG cases which has been escalated to the Medical Director and Divisions for resolution.

Cash

The cash balance at the end of August was £27m (July: £24.2m). Cash has increased by c £2.9m compared to month 4 due to the receipt of quarterly income from Health Education England, non-NHS cash expenditure going back to average levels and limited capital expenditure in month. However cash is expected to fall

throughout the rest of the year as a result of the impact of the planned I&E deficit and a backloaded capital plan. Therefore this needs to be carefully monitored and managed in year, including robust cash flow forecasting.

CIPs

In Month the Trust has delivered £2.2m of savings versus the plan submitted to NHSi of £1.1m, an over achievement of £1.2m. YTD the Trust has delivered £8.1m of savings against a planned £5.7m, an over achievement of £2.4m.

2022/23 Pay Award

Following the recent announcement of the 22/23 pay award, the estimated annual cost to the Trust is circa £13.9m. Taking into account additional funding since planning, initial calculations show that the Trust will see an annual cost pressure in year of c.£0.3m arising from this.

	£'000
Estimated annual cost of pay award	13,888
Source of Funding:	
Funding identified in plan (2.1%)	-6,262
Additional ICB funding (1.7%)	-7,332
Cost pressure for 22/23	**295**

HFMA Financial Sustainability Internal Audit

In April 2022 the Healthcare Financial Management Association (HFMA) produced a briefing Improving NHS financial sustainability: are you getting the basics right? The briefing included a detailed checklist for organisations to use as a self-assessment tool. NHS England (NHSE) has issued guidance that requires organisations to commission from their internal auditors a review of the completed self-assessment. It also sets out the scope and specifies the timing of the internal audit review. The self-assessment is progressing well and will be completed ahead of the 30th September deadline. The self-assessment was reviewed at Finance and Performance Committee on the 26th September. The Internal Audit will be completed by the end of November, with the results reported to the Audit and Risk Committee.

2. Recommendations

The Board is asked to note:
- The Trust's deficit for month 5 (August 2022) was £2.7m, which was adverse to plan by £1.0m.
- The Trust's deficit YTD at month 5 (August 2022) was £7.9m, which was adverse to plan by £1.4m.
- The financial risks as outlined in the paper.

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	27 September 2022	**Agenda Reference:**	**E3**
Report Title:	**Operational Update including Ambulance Handovers**		
Sponsor:	George Briggs, Interim Chief Operating Officer		
Author:	Andrea Squires, Divisional Director of Operations (Emergency Medicine) Laura Fawcett-Hall, Head of Performance		
Appendices:	Trust Integrated Exception Report & Ambulance Handover Update		
Report Summary			
Purpose of report:	The report is a monthly update to the Board on operational performance for information and discussion		
Summary of key issues/positive highlights:	**Operational Context** **Covid patients** have continued to reduce and the effect on flow through the organisation due to infection has reduced. Staff absence due to Covid 19 continued to reduce. **ED attendance** levels remain higher than previous 4 years with the majority of the increase in the minors pathway. 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 July and onwards. **4 Hour Access** – in July 2022 the Trust delivered 70.79% achievement against national target of 95%, which was is a slight improvement from the May and June positions of 69.97%. and 70.08%. **12 Hour Waits -** The Trust are reporting high numbers of 12-hour waits from arrival at 4.28% in July with the data for 12 hours from decision to admit being reviewed due to discrepancies in recording the admission times. **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. Doncaster Royal Infirmary (DRI) in July continue to be the 2nd highest reporting Trust for 60-minute ambulance handover breaches in Yorkshire. **Length of Stay -** Focused work to reduce LoS for non-elective patients has continued. The partnership patient focused Wednesday Walk-around continues with focus on patients with a 7 day + length of stay ensuring all patients have a discharge plan in place **Overview of actions** Early Senior Assessment reconfiguration to improve triage and ED Streaming regular meetings with YAS/EMAS early notice of patient acuity prior to arrival. Ensure ambulance handover times across DBTH are in accordance with national guidance. Further work around pathways such as Surgical Same Day Emergency Care is also being commenced.		

	Electives
	Activity - Overall, the Trust was not on plan for July 2022 and had lower activity levels compared to 19/20. **104 week waits -** At the end of July 2022, there was 3 patients waiting over 104 weeks, the patients had incorrect clock stop during Covid **Referral To Treatment (RTT)** - in July 2022 the Trust delivered 66.7% performance within 18 weeks, below the 92% standard. This position was slightly lower from last 2 months. **The total waiting list** increased again during June 2022 to 49727 (previous month 48517) **Diagnostics** – in June 2022 the Trust achieved 54.29% (previous month 53.41%). **Cancer** **Faster Diagnosis Standard –** In June 2022 the Trust achieved the FSD standard with 76.% against the performance target of 75%. Cancer performance still performs well compared to peers
Recommendation:	Board is asked to note and comment as appropriate on the attached.

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:	*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:	Finance and Performance Committee		
Date:	26/9/2022	**Decision:**	
Next Steps:			
Previously circulated reports to supplement this paper:			

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

4 Hour Performance & Attendances

Numbers of Patients Waiting Over 12 Hours
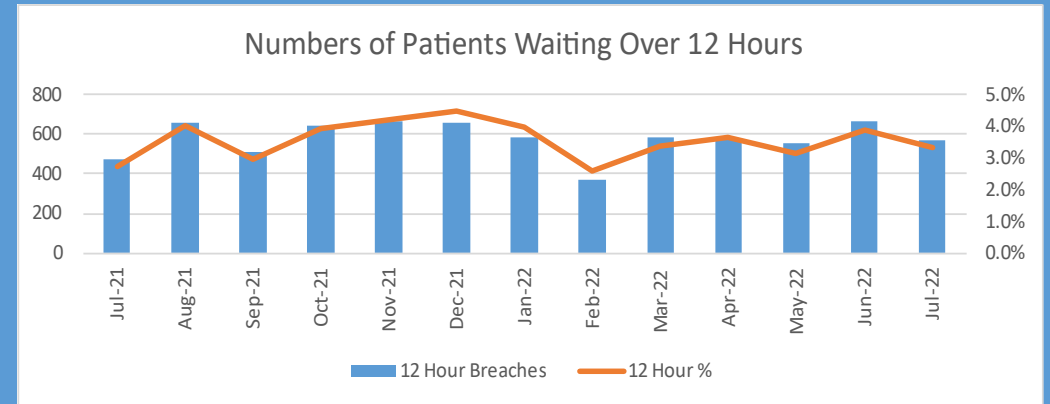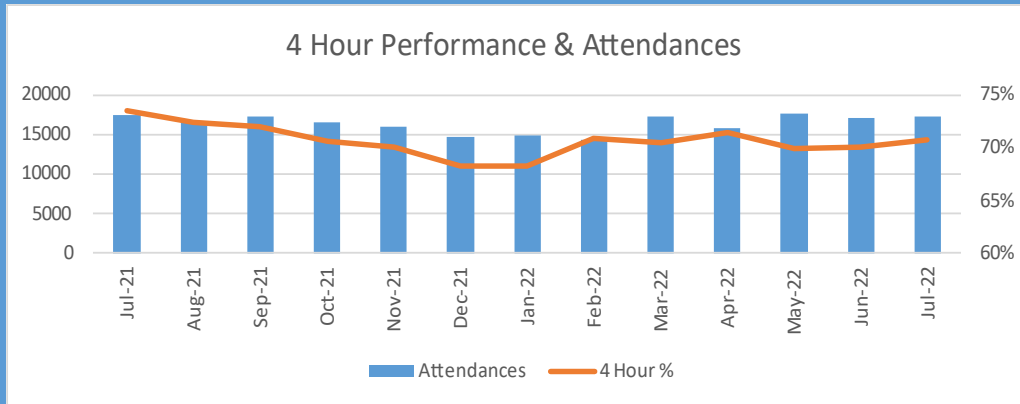
Key issues:
- 4 hour performance 70.79% for Trust. Main breach reasons continue to be doctor and bed waits
- Attendance levels remain higher than any of previous four years, with main increase across Minors pathway
- Reduced streaming to FCMS due to acuity of walk in patients and inconsistent service provision on Bassetlaw site
- Ambulance peaks in activity at high impact times
- Medical skill mix and vacancy
- Significant exit block impacting on flow with increased boarding times experienced as a result
- 12 hours from DTA compared to June - 1.30%
- 12 hours from arrival – 4.28%

Key actions:
- ESA model implementation completed on the Doncaster site - 8 hours, plan to increase to 12 hours
- EAU review complete as part of 'Larger Front Door' options appraisal - aim to reintroduce model by 3rd Oct to help increase ED flexibility and majors flow
- Preferred options reviewed for 'Larger front Door'- increased UTC capacity aligned with national specification being working in to business case as part of winter planning
- Continue to embed SDEC criteria led referral model for ESA and YAS patients
- ED streamer to be further embedded to increase streaming options
- Overnight observations and education with clinical teams to identify issues with overnight performance

July 2022 Performance

Hospital	4 Hour % Achieved	Attendances	Breaches	%Streamed From FDASS
Bassetlaw	80.06%	5361	1069	7.59%
Doncaster	60.95%	10095	3942	19.85%
Montagu	98.55%	1791	26	0.00%
Trust	70.79%	17247	5037	13.98%

2. Urgent and Emergency Care: Ambulance waits

Percentage of DRI Emergency Weekly Handover Breaches

Legend: 0-15 Minutes & 'Other' | 15-30 Minutes | 30-60 Minutes | 60 Minutes & Over
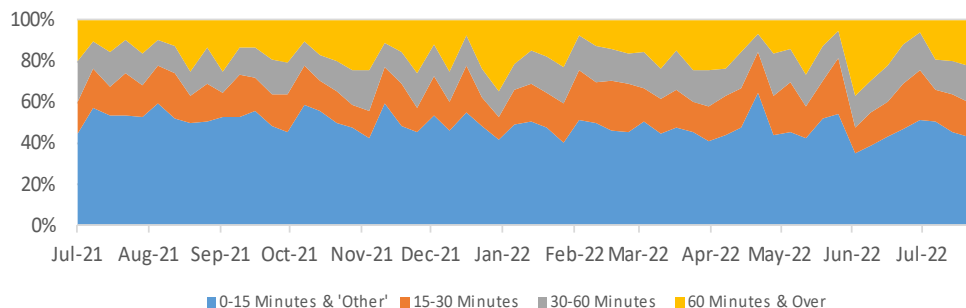
Percentage of Bassetlaw Emergency Weekly Handover Breaches

Legend: 0-15 Minutes & 'Other' | 15-30 Minutes | 30-60 Minutes | 60 Minutes & Over
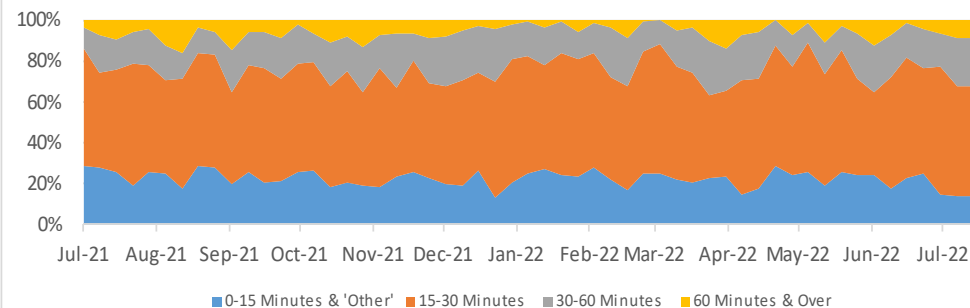
Key issues:

- Ambulance handover performance position continues to be challenging in August 2022
- Increased levels of ambulances continue in the Doncaster & Bassetlaw area.
- Increasing challenges to flow of ambulances coming into and the receiving of handovers.
- Issues related to flow out of ED & wider trust continue to cause delays
- Poor correlation between EPRF handover time and that reported from the CAD - ICS reviewing this
- PTS transfers (operational support for YAS)/ none- paramedic crews impacting as low acuity patients being conveyed
- Lack of knowledge of alternative pathways

Key actions:

- DBTH to attend YAS meetings to launch and educate regards direct SDEC pathways
- FCMS working on direct admission pathways due to number of ambulance arrivals that are referred from ED to FCMS
- Larger I.T work commencing regards direct access of EPRF information directly in to symphony to improve operational management of patients before they arrive
- Improvements to handover process to improve accuracy of data now complete - Qi observational work being completed on Bassetlaw site with EMAS colleagues
- Structural work commenced 30.08.22 to increase ESA capacity to receive ambulances
- EAU to be re-instated 3rd October 2022

Month	Hospital	Total Arrivals	%<15 Minutes	% 15-30 Minutes	% >30 Minutes	Longest Wait
Jul-22	Bassetlaw Hospital	755	16.82%	58.54%	24.64%	04:03
Jul-22	Doncaster Royal Infirmary	1974	47.52%	19.25%	34.25%	06:01
Jul-22	Trust	2729	39.03%	30.12%	31.59%	06:01

3. Urgent and Emergency Care: Length of Stay (LoS)

Average Length of Stay (Days)

Overnight Occupied Bed Days: % of which 14+ and 21+ Day LOS
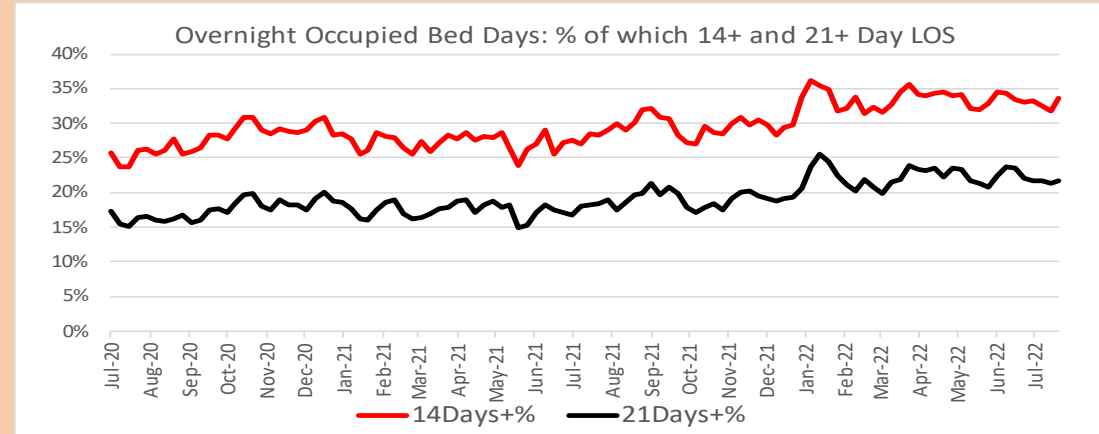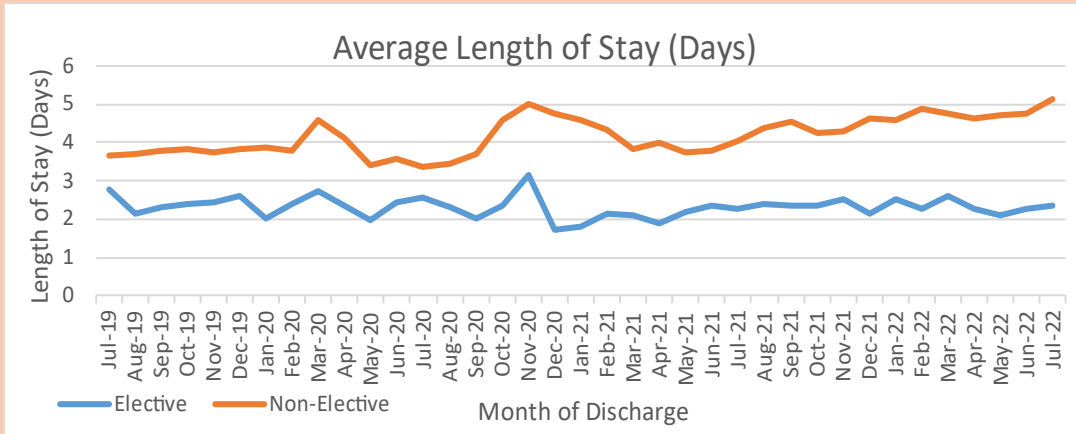
Key issues:

- Ongoing work to improve use of data on Length of Stay and Discharge Practice for internal teams.
- SAFER, Red 2 Green & Good Board Round Practice Standard shared with Divisions to support 100 day Discharge Challenge.
- Reduced support from R2G team from September.
- Ongoing review of site management processes, case under review.
- Challenges with patients who no longer have 'right to reside. Working with Communication team to develop Trust wide information for staff and patients regarding "Why Not Home, Why Not Today" and 100 Day Challenge.
- Implementation of Hospital and Community Discharge Policy across all area's in line with Transfer of Care Hub formation on both sites.

Key actions:

- Review 'Walkaround Wednesday's with focus on patients with 7 day + length of stay, ensuring all patients have a plan , potential to trial walkaround earlier in the week
- Red 2 Green team to continue with focus on supporting areas with lower compliance & engaging with wider multi-disciplinary team, data to be shared and development of assurance boards.
- Board Round Standards to be introduced across wards.
- Partnership working to develop Transfer of Care Hubs and a discharge to assess model of care.
- National Patient Pathways under development within Nerve Centre to support with reporting and understanding demand for community services.
- 100 day challenge action plan being progressed with partners focusing on discharge pathways

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	May-22	Jun-22	Jul-22
Before Noon	13.8%	14.9%	14.2%	13.1%	14.9%	15.4%	14.1%	13.5%	12.0%	14.1%	13.2%	12.8%	12.0%
Before 4PM	45.6%	46.7%	46.1%	45.8%	48.2%	47.7%	47.0%	46.5%	42.9%	46.8%	46.9%	46.4%	45.6%
After 4PM	53.9%	53.0%	53.5%	53.8%	51.3%	51.7%	52.7%	53.1%	56.8%	53.1%	52.8%	53.2%	53.9%

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 Surgical 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 Strategy team
- SDEC Pathways with surgical team being reviewed to access additional opportunity
- Direct referral pathways in place for YAS and EMAS to SDEC – now in monitoring stage
- Working with ICS SDEC Transformation group to make further improvements
- Re-implementing 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	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	#####	Jun-22	Jul-22
ACUTE MEDICINE DECISIONS UNIT							3.2%	5.2%	4.5%	4.0%	3.2%	4.2%	3.5%
AMBULATORY CARE UNIT - DONCASTER	8.8%	8.0%	7.7%	8.0%	8.1%	8.4%	7.5%	8.9%	8.8%	10.1%	9.2%	10.1%	11.1%
EMERGENCY SURGICAL AMBULATORY CARE	3.4%	4.4%	4.8%	4.3%	4.3%	4.7%	5.2%	6.3%	5.0%	5.0%	5.2%	5.2%	6.0%
GYNAE SAME DAY EMERGENCY CARE			0.2%	0.3%	0.4%	0.4%	0.4%	0.3%	0.2%	0.1%	0.0%	0.5%	0.8%
Grand Total	12.2%	12.4%	12.7%	12.6%	12.9%	13.5%	16.3%	20.8%	18.6%	19.2%	17.6%	19.9%	21.4%

Number of Non-Elective Admissions to an SDEC Ward													
Ward	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	#####	Jun-22	Jul-22
ACUTE MEDICINE DECISIONS UNIT							142	219	178	174	133	190	158
AMBULATORY CARE UNIT - DONCASTER	428	377	345	356	377	372	330	375	347	442	389	459	497
EMERGENCY SURGICAL AMBULATORY CARE	167	207	214	191	202	206	231	264	198	219	219	239	270
GYNAE SAME DAY EMERGENCY CARE			8	13	19	18	18	13	7	4	1	23	34
Grand Total	595	584	567	560	598	596	721	871	730	839	742	911	959

5. Elective: Daycase and Inpatient Elective

Daycase 22-23 vs Plan
Daycase Actual 22-23 — Daycase Plan
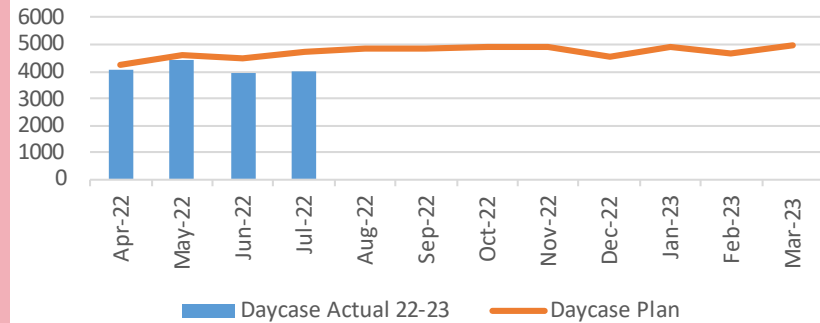
Elective 22-23 vs Plan
Elective Actual 22-23 — Elective Plan
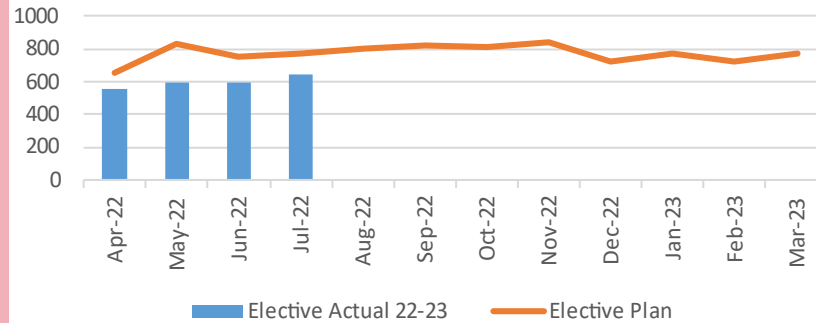
RTT PTL: Inpatient WL Categorisations
Cat2 — Cat3 — Cat4
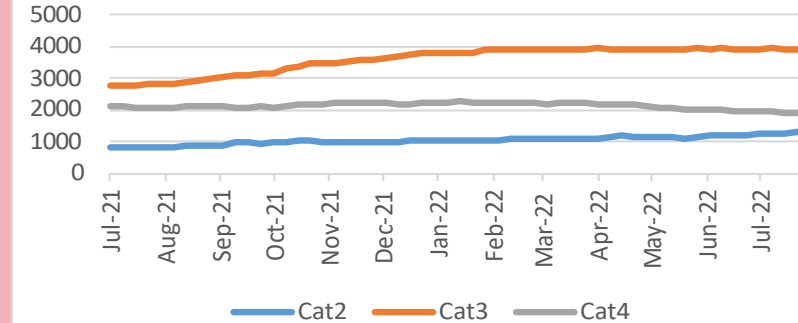
Key issues:
- Day case - Trust delivered 84.5% of plan (down 2.7 percentage points on previous month) and 86.1% of 19/20 activity (-5.5)
- Inpatients - Trust delivered 82.6% of plan (up 2.7 percentage points on previous month) and 85.4% of 19/20 activity (+0.6)
- All patients are listed on the basis of clinical prioritisation and longest waiting times
- Daily clinical review continues to prioritise patients according to available capacity
- Loss of available capacity throughout July due to lack of emergency surgical beds, prolonged spike in increased trauma demand, lack of non-elective flow and staffing gaps (leave and sickness, particularly in anaesthetics – 12 wte for 1 week)

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

Trust 52 Week Breaches

Values (52+ Actuals): Jan-22: 1172, Feb-22: 1175, Mar-22: 1204, Apr-22: 1285, May-22: 1270, Jun-22: 1310, Jul-22: 1431

Legend: 52+ Actuals, Trajectory

Patients on RTT PTL

Values (PTL Size): Jan-22: 41310, Feb-22: 42324, Mar-22: 43592, Apr-22: 44961, May-22: 46609, Jun-22: 48517, Jul-22: 49727

Legend: PTL Size, Trajectory
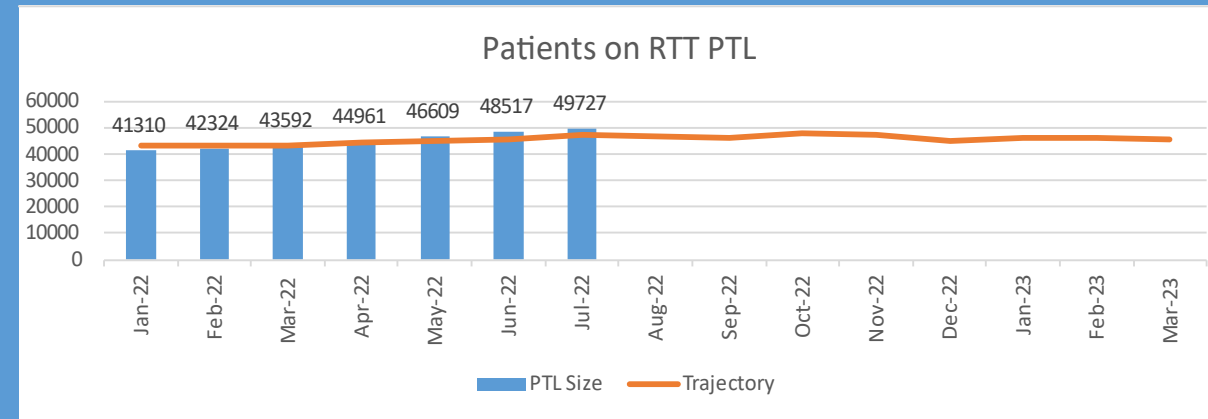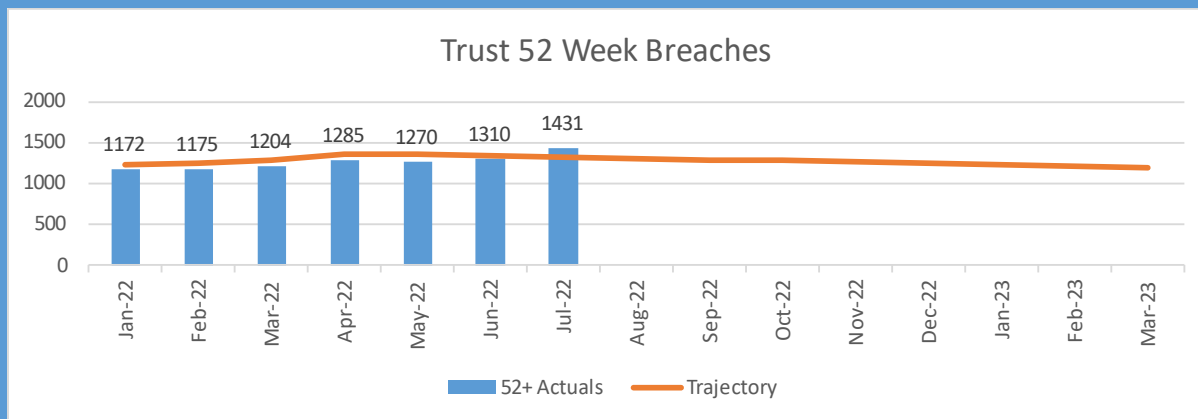
Key issues:

- 52 week wait position at the end of July 1,431 is up 121 waiters on previous month and above the target of 1334
- The total number of Incomplete pathways has increased in July to 49,727 from 48517 in June.
- **There were three 104 ww at the end of July.**
- The Trust Level month end 18 week performance for July 2022 is 66.7%, this is lower than any other month in 2022.

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
- RTT training for clinicians reinstated (recent audit in gynae showed 57% incorrect clock stops)
- Maintained focus on 104 week waiters with weekly external reporting to NHSEI
- All 78 ww patient pathways man-marked and tracked
- Ongoing focus on validation at specialty level with focussed training/support to ensure highest levels of data quality

CCG	Values	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
NHS Bassetlaw CCG	Total Waiters	9440	9269	8936	8848	9014	9334	9601	9922	10234	10507
	% Under 18 Weeks	69.2%	70.1%	66.6%	66.2%	66.3%	67.0%	67.3%	69.8%	68.1%	66.0%
NHS Doncaster CCG	Total Waiters	26942	26526	26083	25967	26589	27380	28196	29327	30620	31420
	% Under 18 Weeks	71.4%	70.9%	67.9%	67.0%	67.1%	68.3%	67.7%	70.7%	69.4%	67.2%
Trust	Total Waiters	43156	42372	41503	41310	42324	43592	44961	46609	48517	49727
	% Under 18 Weeks	70.3%	70.5%	67.4%	66.8%	67.3%	68.3%	68.1%	70.7%	69.1%	66.7%

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	May-22	Jun-22	Jul-22
TRAUMA & ORTHOPAEDICS	599	582	618	622	561	564	555	540	532	616	670	740	794
OPHTHALMOLOGY	153	193	230	252	239	275	279	287	321	317	224	150	154
GYNAECOLOGY	5	7	12	18	20	29	38	45	77	103	127	139	153
UROLOGY	72	89	192	81	67	92	91	92	103	88	76	88	125
ENT	131	114	106	111	107	108	119	112	96	91	103	112	114
ORAL SURGERY	36	26	18	20	26	24	21	20	17	20	24	25	23

7. Elective: Outpatients

OP First 22-23 vs Plan

Legend: 22-23 First Actuals, 22-23 Plan

OP FU 22-23 vs Plan
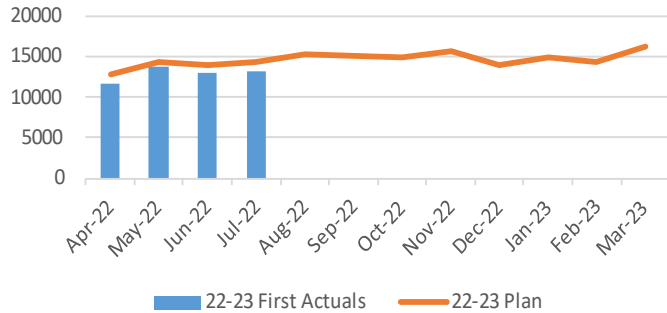
Legend: 22-23 FU Actuals, 22-23 Plan
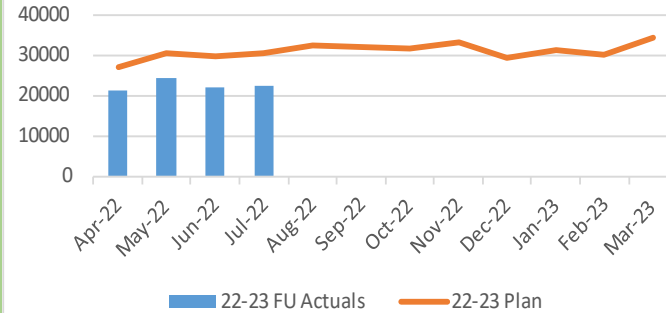
Advice & Guidance: Actual vs H2 Plan

Legend: A&G Responses, A&G No Response, A&G Plan
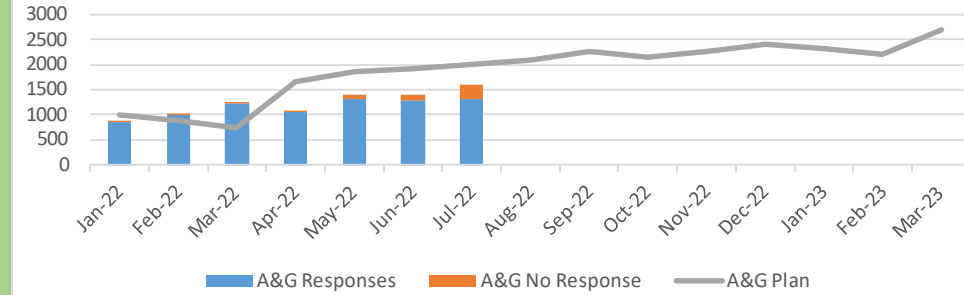
Key issues:

- First outpatient appointments the Trust delivered 91.8% of plan and 82.3% of 19/20 activity in July. A -1.2 percentage point decrease on June plan and -7.1 percentage point decrease on 19/20 activity
- Follow-up outpatient appointments the Trust delivered 74.1% of plan and 78.2% of 19/20 activity in July. A -0.1 percentage points decrease on June plan and a -6.4 percentage point decrease on June 19/20 activity
- Some activity stood down due to sickness, but also due to planned annual leave
- Advice & Guidance demand increasing; July had the highest monthly number of requests the Trust has ever received (1,611, 1,313 responses and 298 no response).
- PIFU plans progressing and considering open appointments as part of plan

Key actions:

- Look for opportunities to increase capacity, deal with the backlog and reduce waiting times for patients
- Review of booking rules for OP's
- Working across ICB to improve patient information, targeted support and self-management e.g. My Planned Care
- Increase A&G (16 per 100 OPFA 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 focussing on 22/23 targets but also continues to develop support systems/processes
- Continued focus on validating patient pathways
- Consultant RTT training to ensure sound understanding of RTT rules and guidelines

Number of Appointments with Patient Initiated Follow-Up Outcome

Legend: PIFU OP Outcome Actual, PIFU Plan

8. Diagnostic waits

Diagnostic Performance (99% Target)

	Waiters <6W	Waiters >=6W	Total	Performance
Trust	9513	8011	17524	54.29%
NHS Doncaster	6317	5317	11634	54.30%
NHS Bassetlaw	2391	2020	4411	54.21%

Exam Type	<6W	>=6W	Total	Performance	Longest Waits
MRI	1488	245	1733	85.86%	49
CT	2260	976	3236	69.84%	73
Non-Obstetric Ultrasound	3299	4430	7729	42.68%	55
Barium Enema	0	0	0	0	0
DEXA	382	892	1274	29.98%	32
Audiology	259	1019	1278	20.27%	58
Echo	463	331	794	58.31%	15
Nerve Conduction	129	90	219	58.90%	29
Sleep Study	16	0	16	100.00%	4
Urodynamic	89	23	112	79.46%	122
Colonoscopy	346	0	346	100.00%	5
Flexible Sigmoidoscopy	97	0	97	100.00%	5
Cystoscopy	325	5	330	98.48%	13
Gastroscopy	360	0	360	100.00%	5
Total	**9513**	**8011**	**17524**	**54.29%**	**122**

Key issues:

- Performance against the 6-week target increased to 54.29% compared with 53.41% in June.
- Significant improvement was achieved in Urodynamics, Respiratory Physiology, and Computed Tomography with increased performance of 28%, 20%, and 7% respectively.
- Performance of 100% was maintained for colonoscopy and gastroscopy.
- Audiology, NOUS, and DEXA remain well below target with performance between 20% and 43%.
- CT waits in excess of 6 weeks decreased from 1623 in June to 976 in July, a decrease of 40%.

Key actions:

- Audiology is implementing a plan to reduce waiting times via increased clinic capacity and transferring activity to other providers.
- An additional 1000 NOUS scans are being performed between June and September by an insourcing provider.
- Additional CT activity is being undertaken by an insourcing provider in July and August which will deliver around 1600 scans.
- Additional CT activity will be undertaken in August and September at Montagu Hospital using a mobile scanner as part of the CDC development.
- National CDC funding confirmed for continuing mobile CT and MRI scanning at Montagu Hospital.

9. Cancer: Referral to Diagnosis (Faster Diagnosis Standard & Diagnosis)

Day 28 - Referral to Diagnosis
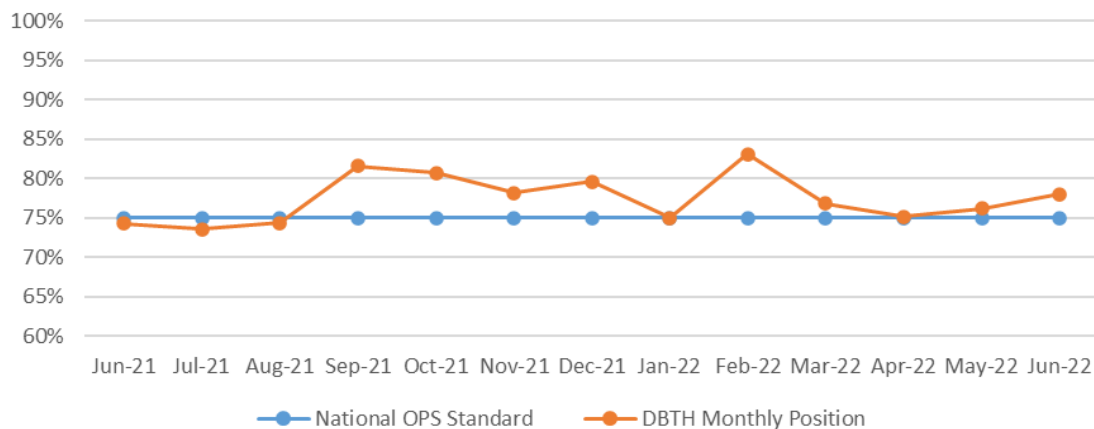
31 Day - Decision to Treat to Treatment
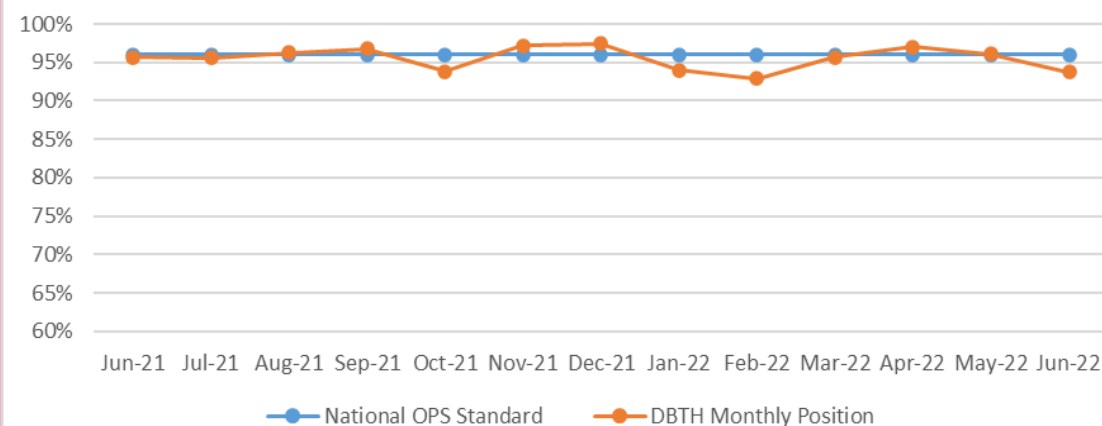
Key issues:

- Management of individual diagnostic waits within the Day 28 time line impacting on individual tumour groups achieving Best Practice Time Pathway milestone events
- 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

62 day - Referral to Treatment
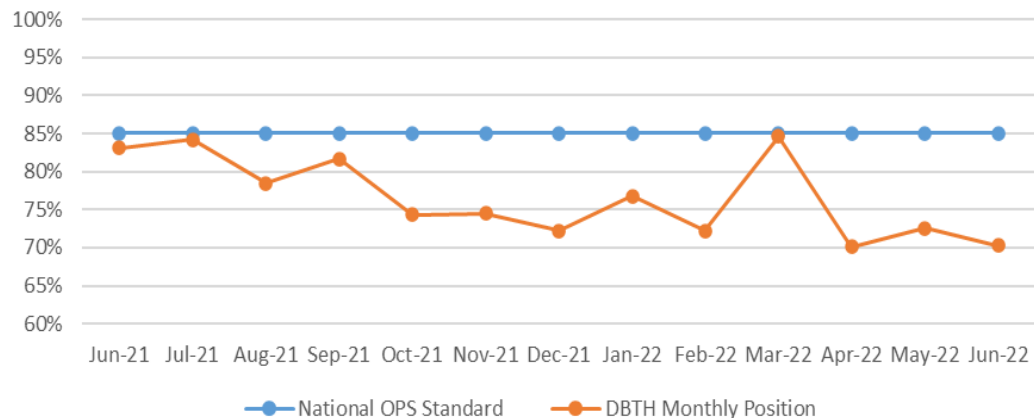
Jun-22	31 Day Classic	31 Day Sub Surgery	31 Day Sub Drugs	62 Day Classic 50/50	62 Day Screening	62 Day Consultant Upgrades
Operational Standard	96%	94%	98%	85%	90%	85% (locally agreed)
Trust	93.7%	100.0%	100.0%	70.3%	100.0%	67.6%

Key issues:

- Complexity of pathways either based on clinical findings or Genomic testing resulting in delayed pathways
- 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: July-22
Asian/Asian British	2.5%	1.1%	2.1%	1.5%
Black/African/Caribbean/Black Br	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%	83.9%
Not stated /Not known / NULL	0.0%	0.0%	0.0%	12.3%

Index of Multiple Deprivation (IMD) Decile (where 1 is most deprived 10%)	Doncaster Population %	Bassetlaw Population %	Doncaster and Bassetlaw Combined %	Waiting List IMD Breakdown: July-22
1	25.3%	8.3%	20.5%	19.9%
2	16.0%	13.2%	15.2%	15.3%
3	11.9%	12.6%	12.1%	12.7%
4	9.2%	8.5%	9.0%	9.2%
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%	9.0%
8	6.8%	14.0%	8.8%	8.5%
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 17/08/2022 Data

Key issues:

- Awaiting confirmation of SRO

- Delay in recruitment of Consultant in Public Health (joint funded with partners)

- 5 applications, interview date is 20th of July.

Key actions:

- Project manager now in post and initiating discovery work.
- Initially identified work streams
  - **Data set (Supply/need/demand)**
  - **Audit current position (ASIS)**
  - **Stakeholder/ initial engagement**
  - **Communication development**
  - **Education**
- Collaborative working with the community is underway (Place HI lead Mandy Espey)
- Initial Links with Midland NHS trust around work and data collections they have undertaken.

Socioeconomic factors
Education, employment, income, family and social support, community safety
40%

Physical Environment
Housing, access to green space, air quality
10%

Lifestyle factors
Diet and physical activity, tobacco use, alcohol use
30%

Health Care
Access to good quality health care services, experience of care and patient satisfaction
20%
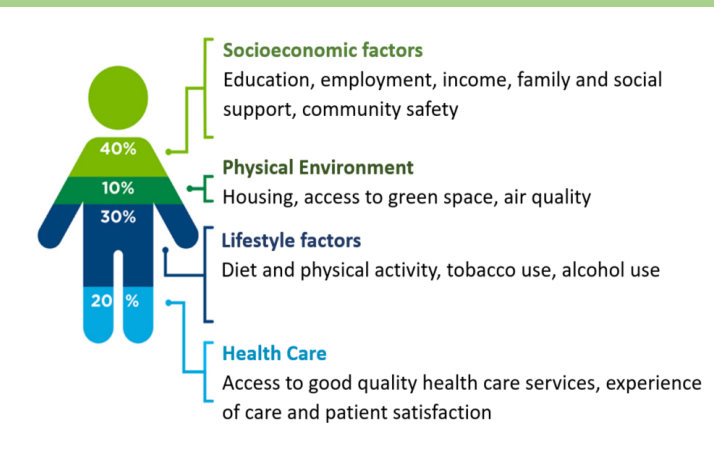
Ambulance Handover Update

- NHSE (2020) guidance states that ambulance handovers should reliably be completed within 15 minutes and that an 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 August was a challenging period with an increase of ambulances attendances vs June/July where the trend was decreasing.

- Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trusts (DBTH) August performance for patients waiting less than 15 minutes for ambulance handover deteriorated slightly from 36.92% to 36.67%, with an increase from 18.33% to 18.35% of patients waiting over 60 minutes.

- Performance improvement has been affected by bed waits due to activity increases, Covid sickness absence and increasing bed occupancy (97%) resulting in exit block in ED.

- Doncaster Royal Infirmary (DRI) in August became the 2nd highest reporting Trust for 60-minute ambulance handover breaches in Yorkshire.

- A full review of the action plan has taken place with new/revised actions.

- A deep dive into ambulance conveyances identified that there is an increasing trend in the percentage of patients that have been discharged without intervention/treatment at both DRI and BDGH. A piece of work is commencing with YAS/EMAS to look at this further.

- 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.

DRI summary

Problem Statement: Performance against the Ambulance handover within 15 minutes standard is currently 43.20% for Doncaster. **Current Trend:** Performance against the Ambulance handover within 15 minutes improved slightly over the month of August, increasing to 43.20% compared to 43.03% in June.	**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**: ⬆

May Performance:

Month	Hospital	No of Arrivals	% less than 15 minutes	% between 15 & 30 minutes	% over 60 minutes	Longest Wait (hrs & minutes)
	Doncaster	2030	43.20%	16.95%	23.35%	04:27
August 2022	Bassetlaw	787	19.82%	55.02%	5.46%	03:30
	Trust	**2817**	**36.67%**	**27.58%**	**18.35%**	**N/A**

DRI Emergency Weekly Handover Breaches
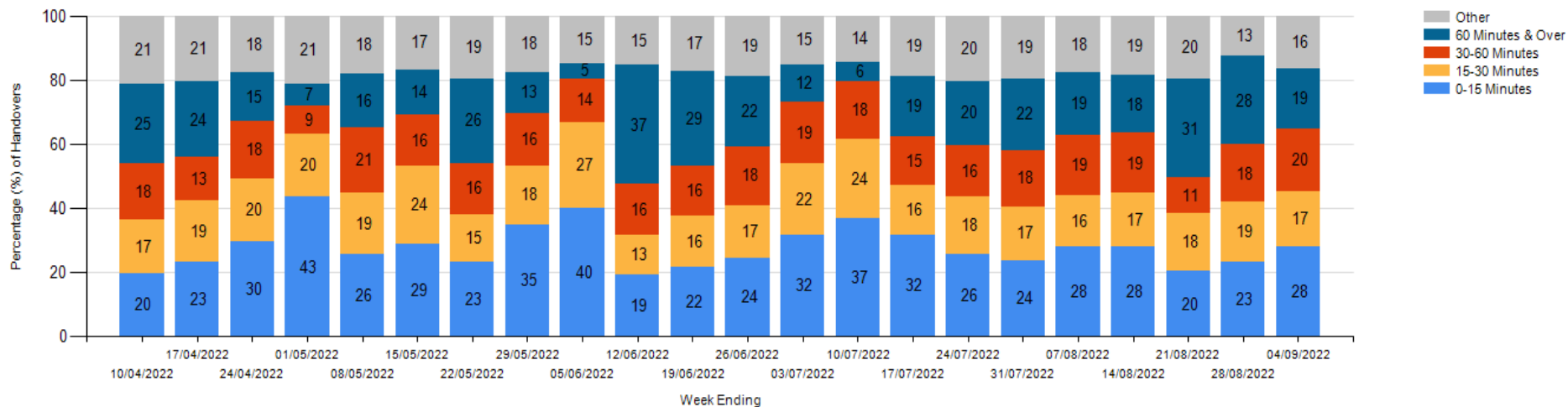
Percentage of DRI Emergency Handovers to Targets
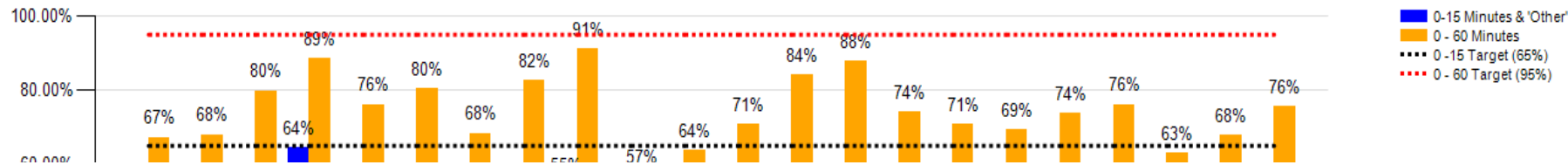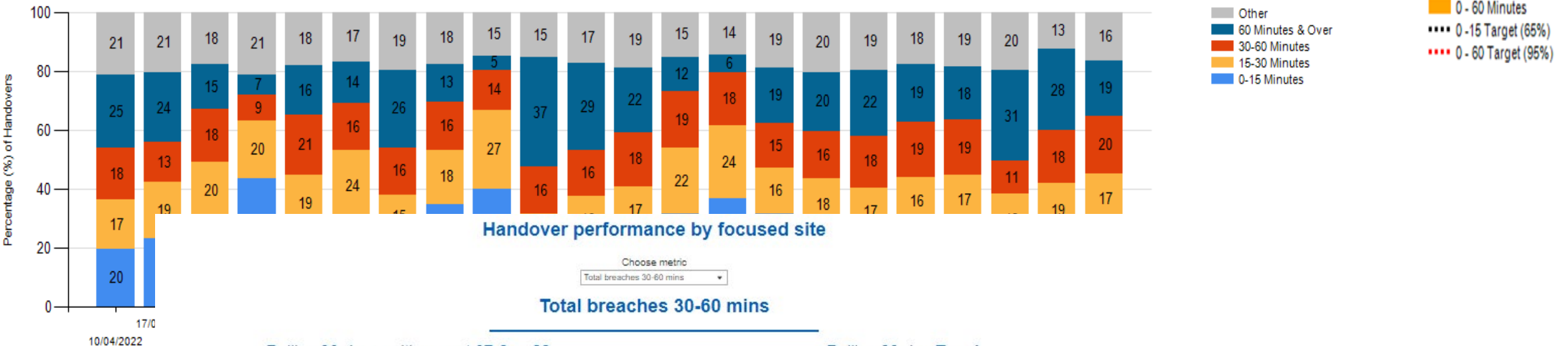
Legend:
- 0-15 Minutes & 'Other'
- 0 - 60 Minutes
- 0 -15 Target (65%)
- 0 - 60 Target (95%)

Values shown: 67%, 68%, 80%, 64%, 89%, 76%, 80%, 68%, 82%, 91%, 55%, 57%, 64%, 71%, 84%, 88%, 74%, 71%, 69%, 74%, 76%, 63%, 68%, 76%

DRI Emergency Weekly Handover Breaches

Percentage (%) of Handovers

Legend:
- Other
- 60 Minutes & Over
- 30-60 Minutes
- 15-30 Minutes
- 0-15 Minutes
- 0-15 Minutes & 'Other'
- 0 - 60 Minutes
- 0 -15 Target (65%)
- 0 - 60 Target (95%)

Handover performance by focused site

Choose metric
Total breaches 30-60 mins

Total breaches 30-60 mins

Rolling 30-day position as at **07 Sep 22**
click on a bar to highlight focused site on the trend chart

Ambulance..	Focused Site	Value
Yorkshire	Northern General Hospital	668
Yorkshire	Doncaster Royal Infirmary	428
Yorkshire	Hull Royal Infirmary	388
Yorkshire	Bradford Royal Hospital	327
Yorkshire	York Hospital	292
Yorkshire	Scarborough General Hospital	290
Yorkshire	Barnsley Hospital	281
Yorkshire	Pinderfields General Hospital	257
Yorkshire	Rotherham District General H..	240
Yorkshire	St James's University Hospital	171
Yorkshire	Accident And Emergency (hu..	161
Yorkshire	Harrogate District Hospital	142
Yorkshire	Accident And Emergency (cal..	109
Yorkshire	Leeds General Infirmary	102
Yorkshire	Airedale General Hospital	57

Rolling 30-day **Trend**

Doncaster Royal Infirmary

Handover performance by focused site

Choose metric

Total breaches 30-60 mins ▾

Total breaches 30-60 mins

Rolling 30-day position as at **07 Sep 22**
click on a bar to highlight focused site on the trend chart

Rolling 30-day **Trend**

Ambulance..	Focused Site	
Yorkshire	Northern General Hospital	668
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Yorkshire	Harrogate District Hospital	142
Yorkshire	Accident And Emergency (cal..	109
Yorkshire	Leeds General Infirmary	102
Yorkshire	Airedale General Hospital	57

Doncaster Royal Infirmary

28 Jul, 29 Jul, 30 Jul, 31 Jul, 01 Aug, 02 Aug, 03 Aug, 04 Aug, 05 Aug, 06 Aug, 07 Aug, 08 Aug, 09 Aug, 10 Aug, 11 Aug, 12 Aug, 13 Aug, 14 Aug, 15 Aug, 16 Aug, 17 Aug, 18 Aug, 19 Aug, 20 Aug, 21 Aug, 22 Aug, 23 Aug, 24 Aug, 25 Aug, 26 Aug, 27 Aug, 28 Aug, 29 Aug, 30 Aug, 31 Aug, 01 Sep, 02 Sep, 03 Sep, 04 Sep, 05 Sep, 06 Sep, 07 Sep

Associated Metrics

DRI Conveyances

Discharged Without Intervention %

The tables above show the total number Ambulance conveyances to DRI and number of patients discharged without an intervention or treatment. From January 2018, the total number of convinces per month is fairly consistent, with a drop in numbers at the start of the COVID period. Prior to COVID, the average number of conveyances per month was 2828, falling to 2712 in 2022.

Over the past 5 years, the percentage of patients that have been discharged without intervention/treatment is showing an increase in trend, with the main growth being from March 2021, peaking at 12.4% in November 2021 and 11.9% in July 2022. 2022 has the highest percentage for the time period. Prior to covid, the average number of patients discharged without interventions or treatment was 199 per month, rising to 279 per month in 2022, a 40% increase.

Shortness of breath, Fever and Abdominal pain are the 3 highest presenting complaints for patients discharged without an intervention or treatment.

BDGH Summary

Problem Statement: Performance against the Ambulance handover within 15 minutes standard is currently 19.82% for Bassetlaw. **Current Trend:** Performance against the Ambulance handover within 15 minutes has deteriorated over the month of August decreasing to 19.82% compared to 22.17% in June.	**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**:

May Performance:

Month	Hospital	No of Arrivals	% less than 15 minutes	% between 15 & 30 minutes	% over 60 minutes	Longest Wait (hrs & minutes)
	Doncaster	2030	43.20%	16.95%	23.35%	04:27
August 2022	Bassetlaw	787	19.82%	55.02%	5.46%	03:30
	Trust	2817	36.67%	27.58%	18.35%	N/A

Percentage of BDGH Emergency Handovers to Targets

Legend: 0-15 Minutes & 'Other'; 0 - 60 Minutes; 0 -15 Target (65%); 0 - 60 Target (95%)
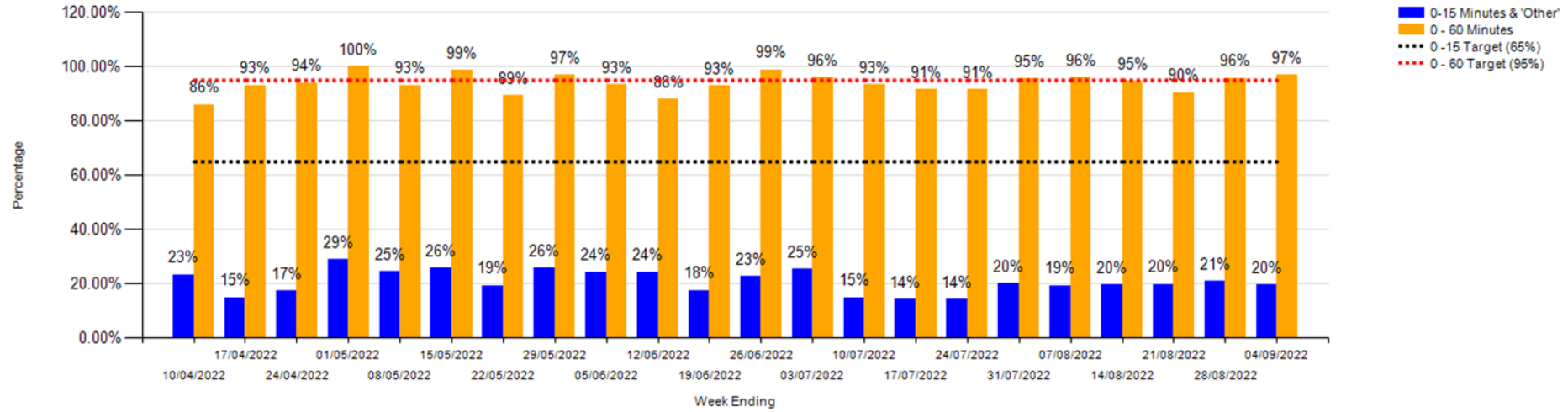
Ambulance handover delays (30-60 and 60+ minutes) and Arriving by ambulance
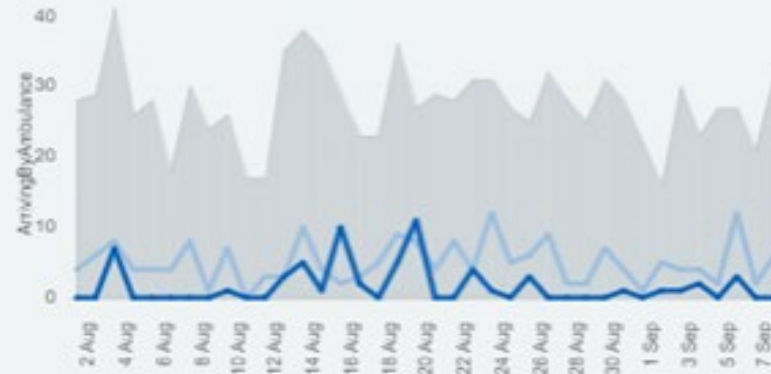
Decision to admit delays (4-12 hours and 12+...
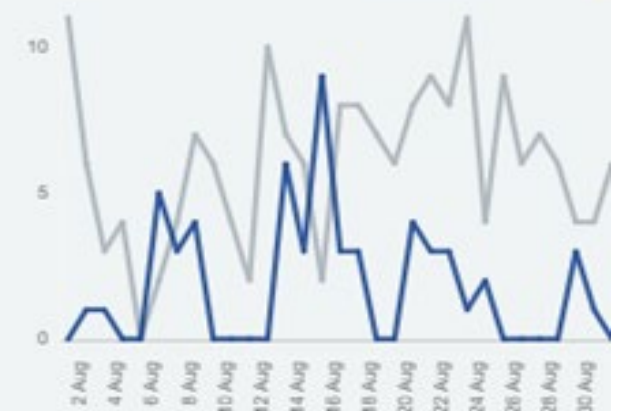
Escalation beds, core beds and bed occupancy

7+, 14+ and 21+ day long stays
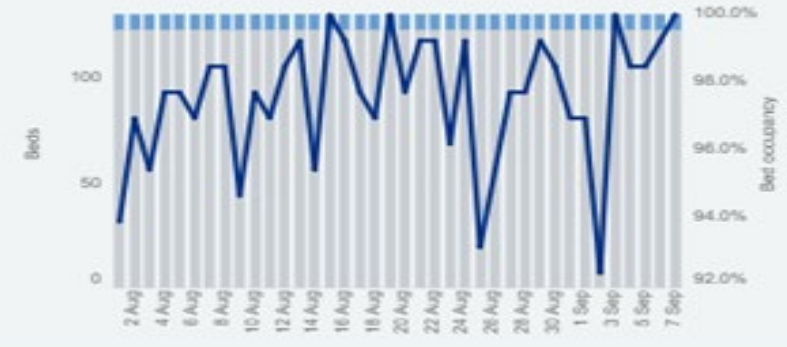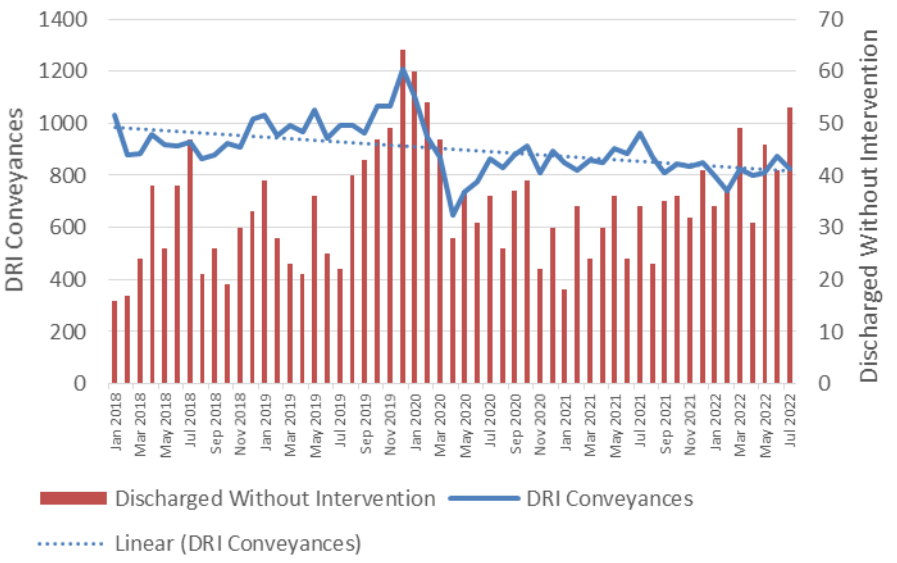
% of beds occupied by long stay patients

BDGH Conveyances

Discharged Without Intervention %
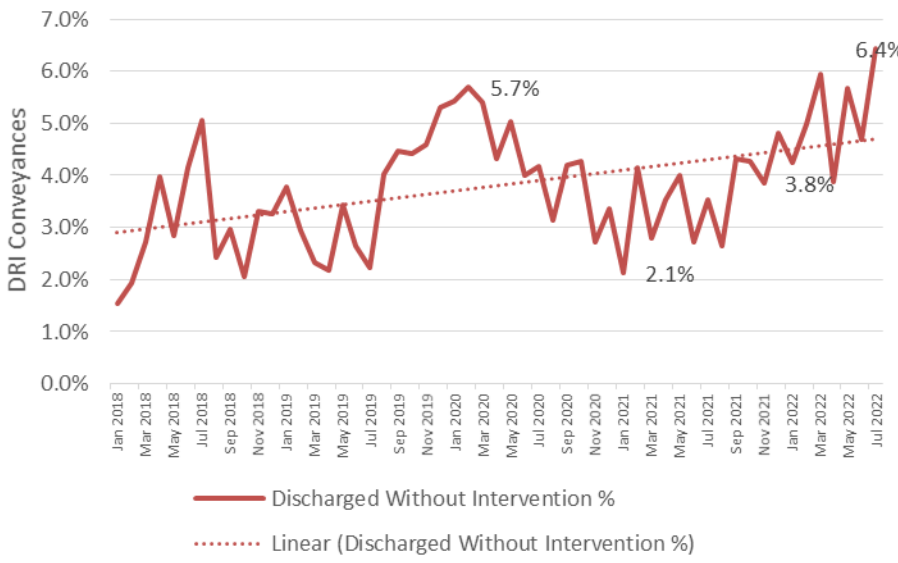
The tables above show the total number Ambulance conveyances to BDGH and number of patients discharged without an intervention or treatment. From January 2018, the total number of convinces per month is fairly consistent, but decreasing from 2018 with a drop in numbers at the start of the COVID period. Prior to COVID, the average number of conveyances per month was 972, falling to 811 in 2022.

Over the past 5 years, the percentage of patients that have been discharged without intervention/treatment is showing an increase in trend, peaking at 6.4% in July 2022. 2022 has the highest percentage for the time period. Prior to Covid, the average number of patients discharged without interventions or treatment was 32 per month, rising to 42 per month in 2022, a 31% increase.

'Suicidal thoughts', 'Self-harm' and 'Drug / alcohol intoxication or withdrawal' are among the highest presenting complaints for patients discharged without an intervention or treatment. In 2020 Suicidal Thoughts increased by 55% compared to 2018 and 43% in 2022 compared to 2018.

Key points and Actions

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 Streaming 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 community	• Re-instate Early Assessment unit in ED increasing capacity in majors by approximately 20 patients per day (October 2022) • Additional 16 beds to be opened on Ward 22 now built into winter planning (October 2022) • Extended hours in Discharge Lounge now funded for winter to increase capacity to support decompression of ED in a morning has been completed (October 2022) • Implementation of Criteria to Reside, Red to Green, and MDT Long Stay Wednesday walk-arounds aim to reduce LoS and increase discharges • Partnership winter plans to identify additional 26 community beds capacity and increased care homes and domiciliary care capacity • Additional 10 Rehab beds at Mexborough (October 2022)	DDO for UEC / CD DDN for UEC / COO DDN for Medicine DDNO (new post) COO COO	Delivery Delivery Delivery Delivery Delivery 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 • Interim COO appointed and will review existing UEC Transformation Programme	DDO for UEC DDO for UEC DDO for UEC DDO for UEC COO COO DDO for UEC COO	Monitoring Closed Closed Monitoring Monitoring Delivery Monitoring Delivery
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 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	• 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 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 DDO for UEC YAS DDO for UEC	Monitoring Monitoring Monitoring Monitoring Closed

12. Performance – The Forward Look

Priority - The Trust continues to experience significant operational challenges and to continue to focus on safety/sustainability/supporting its staff and our patients

Urgent and Emergency Care

- Established Urgent and Emergency Care Board with focus on recovery, extending the frailty pilot

- Develop "the winter plan"

- Reduce Ambulance handover delays

- Significant focus on patients with no right to reside (approx. 2 wards worth of beds)

Elective

- Agree and embed enhanced rates payment approach across clinical teams to further reduce waiting times

- Elective Recovery Board now established –target of 104% of 19/20

- Finalise plans for use of modular theatre and ward at DRI site from September for surgery (once central delivery suite have returned after refurb)

- Ward 19 now fully staffed with nursing team but aim to improve junior doctor cover to enable all 16 beds to be used for emergency surgery

- Maintain grip and focus on all long-waiting patients; IP challenges in ENT and ophthalmology due to sub-specialisation/orthopaedics due to demand and backlog

Cancer

- The Trust remains focussed on recovering its 62 day position and returning to pre-COVID performance

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	27 September 2022	**Agenda Reference:**	E4
Report Title:	**Update on COVID-19 Public Enquiry**		
Sponsor:	George Briggs, Interim Chief Operating Officer		
Author:	Fiona Dunn, Director Corporate Affairs/Company Secretary		
Appendices:			

Executive Summary	
Purpose of report:	To give a brief update to the Board of Directors as to the status of the UK COVID-19 Inquiry that has been setup to examine the UK's response to and the impact of the COVID-19 pandemic and learn lessons for the future. The briefing will also identify the current Lead for the response to actions identified in the inquiry for DBTH and identify the next steps for the preparations for Trusts response.
Summary of key issues:	The government set up an independent public inquiry to examine the UK's response to and impact of the Covid-19 pandemic and learn lessons for the future. • The Inquiry is Chaired by Baroness Heather Hallett, a former Court of Appeal judge. • UK Covid-19 Inquiry Terms of Reference have been set (see link) • UK Covid-19 Inquiry website established for key documents & updates • Inquiry broken down into 3 modules, 2 of which have started. Implications and Considerations for the Trust • Executive Lead identified for the Trust – Chief Operating Officer supported by EPRR team • Inquiry expects prompt answers from organisations when applicable • Not expected that Trust would be core participants as per definition in ToRs • There is a hold on destruction of data and records - all data to be retained. • Raise awareness of Inquiry within Trust – currently requirement to provide information is minimal at the moment • Understand what support staff will need during the inquiry • Understand what further requirements may be for the inquiry by understanding all new briefings and events – next seminar October 2022 • Prepare for eventuality that the initial inquiry findings will likely explore further areas, such as resourcing issues, NHS Management structures, public contact with the NHS and public health prioritisation.
Recommendation:	This is just as short briefing report as the inquiry is in its early stages, but the Board is asked to note the current status of the COVID-19 Inquiry and the impact this will on DBTH response to the Inquiry.

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:	N/A
Corporate risk register:	Risk 3103- DBTH ability to comply with National COVID-19 Inquiry (risk rating 10)
Regulation:	All NHSF trust are required to have a system 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:	Circulation x 2 to Board members x 2 (August & September) & TEG 12/9/22
Date: August 2022 **Decision:**	Comments incorporated into documents & recommendations actioned
Next Steps:	Approve to go to Board 29th September 2022
Previously circulated reports to supplement this paper:	Draft documents of the above

Background & Current Process

This brief paper provides the latest update on the UK Covid-19 inquiry. It includes an update on the planned national approach and timetable, dates for the first procedural and public hearings, and details of the modular structure of the inquiry.

Inquiry launch
On July 21, 2022, Baroness Hallett, Chair of the UK COVID-19 public inquiry set out the modular approach to the inquiry and timetable with the first procedural hearing taking place on 20 September 2022.

The inquiry approach is designed to fulfil the terms of reference (ToR), agreed by the Prime Minister.

The inquiry will be broken down into three modules (as set out below), with teams set up across the UK to investigate and report on each module, followed by public hearings chaired by Baroness Hallett.
The third and last module will examine the impact on the health sector and more information on timings for this module will be available in the coming weeks.

 A listening exercise will be conducted this autumn to hear from those impacted by the pandemic, including the bereaved. This will allow people to provide evidence outside the formality of the public hearings. This evidence will be analysed and emerging themes highlighted to inform the inquiry's ongoing investigations.

The inquiry will produce regular reports and recommendations and will expect prompt responses from relevant organisations. The implementation of recommendations will be monitored throughout the lifetime of the inquiry.

The Chair has made it clear that the process will be vigorous and fair but that it will be impossible to call all those who have been affected. The inquiry will use other sources to compile evidence such as research and the listening exercises. Baroness Hallett's focus will be on the key issues, and she wants to conclude the inquiry as speedily as possible.

National Inquiry Process

Module 1 (Link to Module 1 scope for reference only)

This module will investigate government planning and preparedness, including resourcing, risk management, pandemic readiness and lessons learned from previous pandemics, and simulations and modelling.

Applications for core participant status opened 22 July and closed on 16 August. A core participant is a person or an organisation with a significant interest in the inquiry. The chair has encouraged applicants with common interests to group together. It is not expected that trusts, or representative organisations such as NHS Providers to be core participants within the inquiry.

The first preliminary hearing was on 20 September 2022 with substantive public hearings commencing in spring 2023.

Module 2 (Link to Module 2 scope for reference only)
This will cover central government decision making, government communications, maintaining confidence, devolved matters, parliamentary oversight, regulatory control, use of scientific expertise, and use of non-pharmaceutical measures (such as lockdowns).

This module commenced in August 2022, with preliminary hearings in autumn and substantive hearings in summer 2023.

Module 3
This will examine the impact of COVID, and of the governmental and societal responses to it, on healthcare systems generally and on patients, hospital and other healthcare workers and staff. Among other issues, it will investigate healthcare systems and governance, hospitals, primary care (including GPs and dentists), the impact on NHS backlogs and non-COVID treatment, the effects on healthcare provision of vaccination programmes, and long COVID diagnosis and support.

Current implications and actions for DBTH

At this moment in time the Trust is just making itself familiar with the requirements of the inquiry as no request for information has currently been received.

The key actions and issues currently being recognised and/or actioned:

- Establish Trust Executive Lead for the Inquiry – Currently Chief Operating Officer (George Briggs) with support from Jeannette Reay and the EPRR Team.
- Become familiar with Terms or Reference of the Inquiry and potential impact on DBTH
- Currently all information, logs, data on hold within the Trust i.e. no disposal/deletion of documents, all data to be retained
- Ensure attendance at key "inquiry events" help by various providers.
- Raise awareness of the inquiry to the Board of Directors and provide updates when appropriate
- Inquiry expects prompt answers from organisations when applicable
- Not expected that Trust would be core participants as per definition in ToRs
- Raise awareness of Inquiry within Trust – currently requirement to provide information is minimal at the moment
- Understand what support staff will need during the inquiry
- Understand what further requirements may be for the inquiry by understanding all new briefings and events – next seminar October 2022
- Prepare for eventuality that the initial inquiry findings will likely explore further areas, such as resourcing issues, NHS Management structures, public contact with the NHS and public health prioritisation

Resources :

1. UK COVID-19 Inquiry Website : https://covid19.public-inquiry.uk/

2. UK COVID-19 Inquiry Terms of Reference:
    https://covid19.public-inquiry.uk/wp-content/uploads/2022/06/Covid-19-Inquiry-Terms-of-Reference-Final.pdf

3. UK Covid-19 Inquiry Opening Statement by Baroness Hallett July 2022 :
    https://covid19.public-inquiry.uk/wp-content/uploads/2022/07/UK-Covid19-Inquiry-Launch-Statement.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	27 September 2022	**Agenda Reference:**	**E5**
Report Title:	**Directorate of 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 in the Recovery, Innovation and Transformation Directorate.
Summary of key issues:	This report lays out the current status of work within the directorate including: • Service Line Review / Strategy • RDaSH Partnership Working • Performance Overview Support • Mexborough Elective Orthopaedic Centre (MEOC) • Single Site Trauma (SST) • Annual Plan.
Recommendation:	Board is asked to receive 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 our vision*	**TN SA3:** *Team DBTH feels valued and 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:	
Corporate risk register:	
Regulation:	None
Legal:	None
Resources:	None

Assurance Route			
Previously considered by:	These papers have previously been considered by TEG and F&P.		
Date:	N/A	**Decision:**	N/A
Next Steps:	N/A		
Previously circulated reports to supplement this paper:	N/A		

1. INTRODUCTION

This paper sets out the current state of the projects coming under the management of the Directorate of Recovery, Innovation and Transformation. It includes:

- Transformation Board and Performance, Overview and Support meetings (POSM) update
- the current status of the service strategy development and next steps towards the development of a site strategy for DBTH
- progress on the DBTH & RDaSH partnership working across place
- an update on the MEOC business case
- an update on progress for the development of a business case for trauma services at DBTH

2. MEETINGS (TRANSFORMATION & POSM)

The first meeting of the Transformation Board took place on Monday 8th August. There was full attendance from members or their deputies. The Terms of Reference, previously circulated and approved at TEG, were approved. The Trusts Governance was discussed, and updates provided from all the major projects including Service Line Review, Health Inequalities, Patient Safety and Data Assurance, Workforce and Recruitment, Urgent and Emergency Care, Elective Recovery as well as Capital Projects MEOC, BEV and CDC.

The POSM sessions have become an increasingly effective forum for identification and resolution of issues. There are however further improvements required to make them as beneficial as possible for the organisation including further definition of control environments from respective executives and more rapid resolution and progression of actions. A standard agenda provides the division with an opportunity to raise emergent issues or items which required further briefing. Each quadrant of the performance assurance framework is then discussed with the respective executive lead. The standard agenda includes:

#	Item	Executive Lead
1	Apologies for absence	
2	Items for discussion from division	
3	Action log update	
4	People	Director of People and Organisational Development
5	Performance	Chief Operating Officer
6	Quality	Medical Director and Chief Nurse
7	Finance	Director of Finance with CIP covered by Director of RIT
8	AOB	
9	Next meeting	

Each quadrant covers items requested to be discussed by the executive, identified through their 'control environments' and identified via an accompanying data pack based on improving or deteriorating performance.

Each Executive Director is currently identifying the key issues they wish to monitor to provide board assurance around delivery of the annual plan and how they will gain assurance on the organisation's delivery of these metrics. From the systems put in place in area the Executive should be sighted on and in agreement of what issues are live in divisions. Once these systems are in place and embedded, the agenda for each POSM meeting will be fed from these 'control environments.

The data pack is circulated in advance of the session and has expanded significantly since the meeting was established with a wide range of metrics now reported. Discussions to date have focussed on the following areas in each quadrant:

- **Performance** – Elective recovery planning trust-wide and recovery trajectories, alignment of modular theatre planning, interventions to improve diagnostic performance, management of long waiting patients and use of independent sector.
- **People** – Staff appraisal completion rates, actions from the staff survey, anaesthetics workforce planning, recruitment trajectories, job planning and the use of temporary staffing
- **Quality** – Divisional quality priorities, risk stratification, clinical letter turnaround rates, overdue follow ups, delays in trauma operating and staffing additional capacity i.e. modular ward and ward 22.
- **Finance** – Use of agency staff / pay overspends and specific non-pay overspends i.e., in theatres.
- **Divisional specific items** – Future of the Keep moat service, pain management service model, midwifery staffing pay enhancements, winter planning, use of the 'maternity modular theatre' and ward post the full resumption of services in the Women's' and Children's' Block.

Several trajectories and plans have been developed to improve performance which will be tracked through this forum or a separate designated forum (e.g. recovery meeting). Based on performance against the financial assurance framework Medicine and Children's and families were placed in level 4 (the highest level of escalation). The surgical division has also been placed in escalation (4th July) due to a number of performance issues and given specific areas of focus which required rapid progression. These included:

- Delivering the activity plan and outsourcing contracts
- Trauma performance
- Modular ward clinical model and staffing.

To ensure the meetings focus on the right issues a key requirement for the meetings to be successful is for the development and articulation of the control environment outside of these meetings in each quadrant. This forms part of the assurance framework and helps identify areas of high and low concern. This has been fully developed for finance and has progressed significantly in performance and people with the final frameworks planned to be signed off during September. The control environment within quality requires further development by the executive leads and clarity on how key issues will be channelled through this group.

The feedback from divisional teams has been that this an effective forum for prioritisation of tasks and rapidly resolving issues. There has however been challenges on the frequency of the meeting (currently fortnightly) and ability to demonstrate sufficient progress between sessions. This will be reviewed as the control environments and assurance frameworks are finalised in the respective quadrants with a planned shift to earned autonomy in areas with no performance concerns.

3. SERVICE LINE REVIEW / STRATEGY UPDATE

The clinical service strategy has been completed for all specialties however Children's and Families specialties need further development to move from draft to final. The clinical service strategy document has been shared with divisional colleagues for them to complete the priorities identified by them in advance of the start of the annual planning round.

Before the summer of 2022 an initial session was held with the executive to determine the development of a trust site strategy that sets a direction of travel for the balance of services across our 4 sites. Following this a further workshop was held with TEG that focussed on the core services that should be delivered at our Bassetlaw site. Whilst this was a helpful discussion and those that attended were engaged, attendance was impacted by the holiday season. This work requires revisiting and completing and a proposal is being finalised to do so. This process will involve

A further 3 x 2-hour workshops for Paediatrics, Maternity and Gynaecology are proposed to take place before the end of September to agree the key issues, options, and priorities for these specialties. This will conclude the specialty strategy work for all divisions.

A strategic framework for the clinical role and development of each of our hospital sites will be developed with the aim of informing our decisions and priorities for changes to our current service provision and investment. We will use this to inform and influence the wider acute strategy and collaboration with the ICS's and other providers across South Yorkshire and Nottinghamshire. The site strategy will play a key role in ensuring the long-term sustainability of the Trust and its services. The proposal is to undertake this is three phases:

1. Securing the role of DRI as the 2nd emergency site as a fixed point for South Yorkshire
2. Agreeing our direction, the core emergency services at Bassetlaw Hospital
3. Optimising the distribution of elective services between all of our sites.

The timescales for the project are detailed below:

- Children's and Families workshops completed w/c 26th September

- Phase 1 site strategy to be complete at the end of October 2022 with and interim report

- Phase 2 to complete by the end of November 2022

- Final report following phase 3 in December 2022.

4. DBTH & RDASH PARTERNSHIP WORK UPDATE

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) and Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) are actively engaged in partnership work across the places they serve and the Integrated Care Systems to which they belong. RDaSH and DBTH have worked collaboratively on a number of the pathways including urgent and emergency care, wound care, and Home First and have also made joint appointments into shared posts such as Director of Allied Health Professionals.

The Health and Social Care Act 2022 provides an enabling framework on which further collaboration can be built. As the two largest healthcare providers in the Doncaster area there is an opportunity for a more focused partnership working for the benefit of the local population and further collaboration options are being explored as well as their likely impact of these on the challenges being faced across Doncaster place.

DBTH and RDaSH sought to procure expertise to assist both organisations to identify and scope areas of potential further collaboration that would create benefits for patients, employees and generate value for money for Doncaster place. Following a procurement exercise Peopletoo were successfully awarded the contract to work with both organisations to:

- Identify opportunities for joint working
- Rank those opportunities in terms of size of opportunity/benefit and ease of implementation
- Identify some 'quick wins' to implement and more medium-term opportunities
- Work with the two organisations' Board of Directors to assess the extent of the appetite for joint working – benefits versus risk
- Co-develop an evaluation criterion for determining the benefits of further collaboration in clinical and non-clinical services
- Develop and/or supply a methodology to work on the defined set of opportunities in order to progress to implementation.

RDaSH and DBTH asked Peopletoo to support a review and prioritisation of opportunities for further collaboration, across clinical services, pathways and the back-office services that support them. This work was driven by the range of benefits expected through greater collaboration and to support both partners in addressing a number of challenges. They have developed a range of collaboration options based on learnings from elsewhere and these options were tested with a design group made up of both trusts' boards, which was then refined into an initial overarching draft model of community and intermediate care, comprising six service elements and three enablers.

The process to deliver the project's aims/ requirements involves:

1. Developing a long list of potential options/ approaches to achieving the project's aims and objectives based on previous Peopletoo experience
2. Developing a transparent evaluation framework to enable an objective assessment of the suitability of the options
3. Shortlisting the potential options/ approaches on the basis of the evaluation framework
4. Developing a draft, overarching model of integrated intermediate and community care based on discussions with a Design Group made up of senior leaders from both organisations
5. Secondary Research: Conducting desk-based research to determine the likely clinical, operational and financial implications of each of the model's elements and identify relevant best practice
6. Primary Research: Testing the draft model, general partnership opportunities and potential barriers to effective collaboration with wider senior stakeholders across both organisations
7. Refining the model on the basis of the feedback received
8. Summarising key findings, formulating recommendations and defining anticipated benefits
9. Refining the model/ approach on the basis of further feedback
10. High-level implementation planning.

The full long list of options (with a specific focus on those that were short-listed) was tested with a Design Group made up of both trusts' boards, which led to:

- Ratification of the options in the long list, where the decision had been made not to progress them at this stage
- Ratification of the shortlisted options, with some minor tweaks to the outline approach
- The refinement of the shortlisted options into an initial draft, overarching model of community and intermediate care, comprising six service elements and three enablers, shown below.
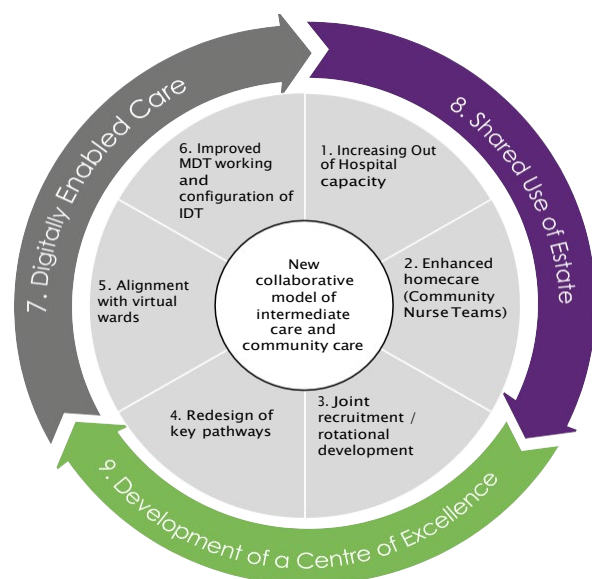
In total, implementing all the options shortlisted represent the development of a new collaborative model for joint delivery of community and intermediate care services within a Doncaster footprint, comprising changes to both services (inner ring) and enablers (outer ring).

The overarching model and its general acceptability were subsequently tested by both trusts' respective Directors of Strategy, with a range of key stakeholders and then further refined through 1-2-1's with a range of stakeholders which provides an understanding (from multiple viewpoints) of how the model should be adapted/ finalised, to maximise the benefits and respond to the needs of key stakeholders.

It is anticipated that implementing the collaborative opportunities being explored, will not automatically 'fix' the challenges identified; rather, provide a foundation on which they can be addressed faster/ more effectively, than by either organisation working in isolation.

Peopletoo and the strategy teams form DBTH and RDaSH are to agree and finalise the evaluation framework during the w/c 19th September 2022. Following this a joint meeting of RDaSH and DBTH executive is being arranged in which the above evaluation framework will be deployed so that the Executive can

- Test the proposed collaboration priorities
- Revise the prioritisation of shortlisted options based on the broader knowledge and experience of the executive teams and address underlying concerns surrounding the deliverability
- Agree and sign off prioritised collaboration opportunities
- Inform the development of the target future service models.

The output of these meetings will be reported via Teg into the Finance and Performance Committee and onto the Trust Board in due course.

5. MONTAGU ELECTIVE ORTHOPAEDIC CENTRE (MEOC) PROJECT

MEOC is a proposed investment in a ring fenced elective orthopaedic hub with beds and theatres to deliver reductions waiting lists in line with the Elective Recovery Plan (ERP). DBTH is developing the business case on behalf of the ICS together with its partners The Rotherham Hospital Foundation (TRH) Trust and Barnsley Hospital Foundation Trust (BH). The aims of the investment are:

- To reduce elective orthopaedic waiting lists

- Improve productivity and efficiency

- Increase quality and effectiveness of surgical interventions.

The funding awarded is £15m and this sum must not be exceeded if the faster, Short Form Business Case approach is to be adopted. Future developments may include a wider vision and patients from other parts of the ICS.

The Elective Recovery Targeted Investment Fund (TIF) process evaluated the various schemes submitted at ICS, Regional and National levels and on 11th May 2022 confirmation was provided that the Montagu Elective Orthopaedics Centre together with and equivalent facility at Royal Hallamshire had been approved for progression to business case stage.

The business case faces these key challenges:

1. *The cost of the new building remaining under £15m*
Ten alternate building options have been developed and an affordable option identified which converts 10 beds in Rehab 1 at Montagu Hospital into 8 orthopaedic beds and provides 10 new beds and 1 new theatre in modular build accommodation adjoining the Rehab Wards. This option costs £14.8m and is therefore marginally below the £15m target. Recently issued Key Lines of Enquiry (KLOEs) for digital, together with the level of contingency required by NHSEI and inflation is putting significant pressure on costs.

2. *Agreement between the organisations as to the use of MEOC*
The project team was unable to reach joint agreement across the three partner organisations around the model of care for MEOC. This issue was escalated and CEOs and Executive Director from each trust met on 3 occasions with a final meeting on the 22 September to establish a way forward. Following this meeting it was agreed that a proposal will be submitted to the ICB for the provision of 2 theatres and 8 beds to provide low complexity elective orthopaedic capacity for all three trusts on the Mexborough Site. This will

be worked up so that the facility, if approved, will be open to support the winter of 2023. Each of the partner trusts agreed to bring the medical leads for orthopaedics together urgently to agree the final parts of the bids. It was agreed that the work would be led by DBTH to its conclusion.

Further work may then follow to look at a joint strategy on orthopaedics between the three Trusts going forward beyond the use of Mexborough for low complexity Orthopaedic surgery.

6. SUSTAINABLE TRAUMA (FORMERLY SINGLE SITE TRAUMA)

Since March 2020 during the Covid-19 pandemic, the Trust has been operating a single site trauma model based at DRI. The single site model was introduced to ensure that staffing and capacity would be safely managed during COVID to allow trauma patients to be treated within optimal timescales. This arrangement was put in place as a temporary solution under Public Health (Control of Disease Act) 1984 and new legislation, the Coronavirus Act 2020, which provided additional measures to respond to the Covid-19 emergency.

The approach proved successful and is supported by clinicians and management. However, it constitutes a service change as described in *'Planning, assuring and delivery service change for patients'* NHS England, March 2018. To make a new service configuration permanent the trust will need to consult with the public. The business case now being prepared seeks to assess the best option for configuration of trauma services taking into consideration the opportunity to improve the quality, efficiency and effectiveness of services for patients and the relationship with elective recovery.

The aim of the project is to deliver sustainable trauma services that are efficient and effective with good patient outcomes and hit national standards, future proofed to the extent possible. To achieve these aims the project will:

- Right size capacity for current and expected future activity
- Determine the best deployment of services across our sites.

The business case will set out the options for delivering our aims and provide the evidence to support the preferred option selected. Solutions developed must consider the impact on elective recovery and other interdependent initiatives being undertaken. It is important that the evidence is robust and can withstand scrutiny through public consultation, particularly as our constituencies for the consultation may well include orthopaedic surgeons from other organisations.

The agreed approach to preparation of the business case was to understand the current service model and its strengths and weaknesses underpinned by data analysis. Based on this intelligence and a view of future growth the aim was to calculate the capacity and resources required to deliver the service and resolve the quality and performance issues which currently exist. Based on the revised view of the scale of services, options would then be developed for the best deployment of the forecast capacity and resources across the trust's sites.

The initial findings include (inter alia):

- Confirmation that there is up to 30% growth in trauma procedures between April 2019 and June 2022
- There is insufficient theatre capacity allocated to trauma for the current levels of activity and productivity – approximately 10 sessions per week
- There is insufficient bed capacity for trauma inpatients for the current levels of activity and productivity – approximately 10 beds
- Expected date of discharge and discharge planning is not working well enough especially due to the volume of patients with social care requirements

- Theatre capacity is used for minor operations that could be delivered in a different setting

- Best practice regarding surgical intervention has changed and this results in procedures being carried out where there weren't previously (e.g., collar bones) or different procedures carried out taking up more theatre time (e.g., fractured wrists)

- Outpatient clinics are overcrowded and suffer from a DNA rate more than 25%

- Lack of radiology supported theatre sessions, beds and sub-speciality surgeons results in very complicated allocation of patients to lists often resulting in delays to surgery

Clinical staff have been positively supportive of the development of the business case, but access and engagement has been inconsistent due to operational pressures. Despite best efforts the project was starting to stall. The SRO, Jon Sargeant, DCEO, has been briefed weekly on progress and given the challenges decided to meet with the project team to review and reset the project on 2nd September. The meeting was attended by operational, surgical and nursing representatives and it was agreed that:

- That the objectives set out in the Project Aims above form the basis for the project

- That form must follow function and that options would consider a more granular approach than just 'Single Site Trauma' which the group felt was misleading

- The attritional approach to developing the underpinning data was delaying the project and parallel development of the options and the data with subsequent iteration would accelerate the process

- Robust evidence is crucial to support the case for change under public scrutiny and resources to access and analyse data would be stepped up

- Sharing and engagement with the wider trauma stakeholder group would take place at regular intervals to ensure that decisions are not subsequently unpicked and alternative views and ideas are factored in

- monday.com will form the core management tool for the project

- Local KPI's/ measures will be developed for management of the trauma service.

The core project team has been established and reflects the breadth of professional skills required to deliver the business case. Meetings have been put in place for the next year to ensure continuity between the business case, consultation exercise and implementation of service change. It is recognised that the core team will need to morph to reflect the requirements of these different stages. The initial case for internal approval is scheduled to be completed by December 2022.

7. ANNUAL PLAN

The Annual Plan, previously submitted for consideration and review at F&P has been finalised and will be uploaded to the Hive.

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	27 September 2022	**Agenda Reference:**	**G1**
Report Title:	**Corporate Risk Register**		
Sponsor:	Jon Sargeant, Interim Director of Recovery, Innovation & Transformation		
Author:	Fiona Dunn, Director Corporate Affairs/Company Secretary		
Appendices:	CRR September 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:	Key changes to the CRR this period: • No new corporate risks rated 15+have been added or escalated from Management Board • Currently there are 94 risks logged rated 15+ across the • 11 of these risks are currently monitored via Corporate Risk register (CRR) • Risk ID3103 - DBTH ability to comply with National COVID-19 Inquiry, Risk rating 10, High Risk, has been added to the register by Chief Operating Officer. No concerns to raise to Board • 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, Vaccination campaign commences in September 2022. Action required • 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. • The current risk management review the Trust commissioned has completed. Recommendations considered from the report are being monitored via Monday.com. and new project governance structure via the Executive Team. • The key enabler for the recommendations will be the new Risk Management Board to be introduced and chaired by the Executive Medical Director. All recommendations for the risk management processes to be facilitated via this group.		
Recommendation:	• The Committee is asked to note the Corporate Risk Register information and the acknowledgement of the review outcomes being facilitated by the new Risk Management Board previously discussed via the Interim Director of Recovery, Innovation & Transformation 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 -Sept 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+	

Corporate Risk Register Summary September 21 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	30/09/2022	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 (12)	Apr-22	⬌
2664	PEO3	01/12/2022	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	**[13/09/2022] staffing reviewed Consultant recruitment commenced approval at CIG re psychology support and coordinators** **24/6/22** vcf approved, recruitment ongoing Can reduce risk rating once recruited**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.	Extreme Risk	16	High Risk (9)	Sep-22	⬌
2472	COVID1	31/10/2022	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	**30/8/22** Reduced risk due to on going 'return to living with covid'. Patient numbers continue to decline and staff absence decreased in last 2 months. Vaccination campaign commences in September 2022. **Covid risk to be added to SA1 due to acceptance of managing covid as part of business as usual.18/7/22** risk increased due to increased prevalnece and numbers . increased bed occupancy and staff absence, mask reintroduced . **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 (10)	Aug-22	⬇
11	F&P1	01/10/2022	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 (8)	Jun-22	⬌
7	F&P6	02/01/2023	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	George Briggs	**13/9/22 -**ICB now in place as overarching structure for SYB 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)	Extreme Risk	16	High Risk (9)	Sep-22	⬌

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)	13/12/2022	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	Zoe Lintin	[13/09/2022] Strategic approach to engagement in 2022 staff survey agreed and in place, including timely sharing of feedback with teams and involvement in identifying actions. Board visits schedule introduced from Sept 2022. New People Strategy to be developed from 2023 aligned with the NHS People Plan.(ZL) 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.[	Extreme Risk	12	Moderate Risk (8)	Sep-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 (10)	Mar-22	↔
1410	F&P11	31/03/2023	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	[21/09/2022] All supported servers are now on a regular patching interval. Immutable storage / backup configured and working OK with all compatible / supported systems enrolled. Further systems will be enrolled as servers are upgraded and can be included. Separate arrangements are needed for PACS - to be included in a business case for 23/24. A small number of Windows 7 stations remain due to the systems they run not being compatible with Windows 10. Procurements are underway to replace the systems concerned. Extended support or other mitigation arrangements (segmentation / restriction of use) has been applied to Windows 7 stations in the meantime. Network Access Control remains on hold due to resource constraints to implement. NHS Secure Boundary on hold pending business case to procure replacement perimeter equipment in 23/24. Log retention configured and working for Firewall and Domain Controllers only at this time. DSPT for 21/22 - requirements met. 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	Extreme Risk	15	Moderate Risk (4)	Sep-22	↔

Corporate Risk Register Summary September 21 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)	13/12/2022	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	Zoe Lintin	[13/09/2022 KPMG Workforce Planning tool project now underway (to be managed through Monday.com). International recruitment - additional cohorts agreed for nursing this year and other professional groups being explored. Work ongoing on agency controls and processes Risk rating discussed at length at People Committee on 06/09/22, agreed to increase target risk rating to 12 for 2022/23 given current context. Longer term aim is to decrease to 8. 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	Extreme Risk	16	High Risk (12)	Sep-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 (8)	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 (10)	Mar-22	⟷
13	ARC01	31/10/2022	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	Moderate Risk (4)	Jul-22	⟷
3103	ARC02	09/12/2022	Chief Operating Officer	Not Applicable (Non-clinical Directorate)	DBTH ability to comply with National COVID-19 Inquiry	DBTH ability to comply with the national enquiry . There is a national review of the Covid 19 pandemic management DBH will be expected to take part in the enquiry. The Trust will be required to collate and present evidence this will require non disposal of evidence notes minutes etc. There will be a requirement to archive and collate data	George Briggs	[13/09/2022 13:35:14 George Briggs] Agreement of Trust lead officer Guidance from national team available national seminar to be attended in October 22 review of proposed data by EPRR team introductory update to inform bard Sept 22 All data to be retained by DBTH Non disposable of notes and logs electronic and manual	High Risk	10	Moderate Risk (6)	Sep-22	New ⟷

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	27 September 2022	**Agenda Reference:**	G2
Report Title:	**Review of Risk Management Policy, Risk Appetite Statement & Risk Management Board Terms of Reference**		
Sponsor:	Richard Parker OBE, Chief Executive Officer		
Author:	Fiona Dunn, Director Corporate Affairs/Company Secretary		
Appendices:	G2i - Risk Management Policy, G2ii - Board Risk Appetite Statement		
Executive Summary			
Purpose of report:	To update the relevant documents in line with current/best practice and changes recommended following KPMG Risk Management Review and recommendations made from 360 Assurance Internal auditors audit opinion on the Trust risk management process.		
Summary of key issues:	The documents have been reviewed, with the following adjustments made following consultation with Executives, Non-executive Directors, Trust Executive Group and Trust Internal auditors: • Complete update of the risk management policy to include risk appetite, risk tolerance and risk grading grids • Update to roles and responsibilities in terms of risk management • Review of risk governance structure and process • Production of Board risk appetite statement • Identification of a Risk Management Board with terms of reference developed		
Recommendation:	• The Board is asked to approve the changes made in the risk management suite of documents in order to address the recommendations from the Risk management review and the Internal audit opinion for 21/22.		

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 to incorporate changes to these processes The corresponding TN SA's have been linked to the corporate risks.
Corporate risk register:	N/A
Regulation:	All NHSF trust are required to have a system 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:	Circulation to Board members x 2 (August & September) & TEG 12/9/22
Date: August 2022 **Decision:**	Comments incorporated into documents & recommendations actioned
Next Steps:	Approve to go to Board 29th September 2022
Previously circulated reports to supplement this paper:	Draft documents of the above

Risk Identification, Assessment, and Management Policy

This procedural document supersedes: CORP/RISK 30 v.3 – Risk Identification, Assessment and Management Policy

Did you print this document yourself?

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

Executive Sponsor	Chief Executive
Author/reviewer:	Fiona Dunn
Date written/revised:	June 2022
Approved by:	Board of Directors
Date of approval:	
Date issued:	
Next review date:	
Target audience:	Trust-wide

Amendment Form

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

Version	Date Issued	Brief Summary of Changes	Author
Version 4	June 2022	Changes to reflect new risk committee structure and reformatted Board Assurance Framework following review of process. Addition of Risk appetite, risk tolerance and updated scoring matrices.	F Dunn
Version 3	15 November 2017	Changes to reflect new committee structure and reformatted Board Assurance Framework	M Kane
Version 2	September 2015	Minor changes to reflect the implementation of the online integrated risk management system (Datix).	M Dixon
Version 1	11 August 2014	This is a new procedural document and replaces CORP/RISK 18 v.2 – Risk Assessment Policy (Clinical and Non Clinical) and CORP/RISK 10 v.4 – Risk Management Strategy.	M Dixon

Contents

1   INTRODUCTION

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust ('the Trust') recognises that healthcare provision and the activities associated with caring for patients, employing staff, providing premises and managing finances all, by their very nature, involve a degree of risk. The management of risk is therefore a key organisational responsibility and is the responsibility of all staff employed by the Trust. Failure to manage risk effectively can lead to harm, loss or damage in terms of both personal injury but also in terms of loss or damage to the Trust's reputation; financial loss; potential for complaints; litigation and adverse or unwanted publicity.

This policy covers all aspects of risk assessment and management within the Trust. The Trust has adopted an integrated approach to the overall management of risk irrespective of whether risks are clinical, organisational or financial. Risk management is embedded within the Trust's overall performance management framework and links with business planning and investment.

The Board of Directors has overall responsibility for corporate governance, including risk management. The Board has legal and statutory obligations to ensure that there are robust and effective risk management processes and structures in place.

The Trust uses an online integrated risk management system (DATIX) to record risk assessments and risk registers at all levels. The system enables risk register reports to be produced for review and audit purposes, and also enables risks to be escalated as appropriate, therefore supporting a culture of proactive risk management.

This policy is intended for use by all employees and contractors engaged on Trust work in respect of any aspect of that work. Although the management of key strategic risks is monitored by the Board, operational risks are managed on a day-to-day basis by employees throughout the Trust. The Trust's Board Assurance Framework and Corporate Risk Register provide a central record of the organisation's principal risks.

2   PURPOSE

2.1   The purpose of this policy is to ensure that risks to the following areas are identified, assessed, and managed; in addition to being prevented and controlled so far as is reasonably practicable:
    a.   the Trust's patients, visitors and members of the public
    b.   the Trust's strategic objectives
    c.   the Trust's employees,
    d.   the reputation, finances and business continuity of the Trust
    e.   the property, sites and equipment owned by the Trust

2.2   This policy highlights the legal requirements placed on the Trust by the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999, to carry out risk assessment to identify the hazards and risk associated with the workplace and the work carried out by employees.

3   RISK MANAGEMENT

3.1   Risk Management is the responsibility of all staff and managers at all levels. All staff are expected to take an active lead in risk management. The policy applies to all Trust staff referred to in section 4.

A risk is the chance of something happening that will have an adverse impact on the achievement of the Trust's objectives and the delivery of high-quality care.

Risk Management is the proactive identification, classification and control of events and activities to which the Trust is exposed. See Appendix 3 for further definitions that relate to this Policy.

3.2   Principles of successful Risk Management

It is the role of the Trust Board to lead and support risk management across the organisation. The principles of successful risk management are:

   a.   to embrace an open, objective and supportive culture.
   b.   to acknowledge that there are risks in all areas of work.
   c.   for all staff to be actively involved in recognising and reducing risk.
   d.   to communicate risks across the Trust via escalation / de-escalation processes.
   e.   to learn from mistakes.

3.3   Risk Appetite

The risk appetite is the amount of risk that the Trust is willing to seek or accept in the pursuit of its long-term objectives.

If the organisation's collective appetite for risk and the reasons for it is unknown, then leaders of the organisation will not know the levels of risk that are legitimate for them to take, or will not take important opportunities when they arise, which may stifle growth and development of the organisation, and patient / user outcomes may be affected.

In practice, an organisation's risk appetite should address several dimensions:

   a. The nature of the risks to be assumed
   b. The amount of risk to be taken on; and
   c. The desired balance of risk versus reward.

Each year, the Trust Board determines its risk appetite statement covering the overarching areas of:

   • Quality & clinical safety, Reputation, Finance/value for money, regulatory/compliance, People, Innovation

 The Trust's Risk Appetite Statement is approved annually by the Board of Directors and is available from the Trust Board Office.

3.4   Risk Tolerance

Whilst risk appetite is about the pursuit of risk to achieve objectives, risk tolerance is about what an organisation can cope with and thresholds at which it is willing to 'accept' a specific risk. Risk appetite and tolerance both need to be considered in the context of risk capacity. This is the amount of risk the trust can bear. The trust's board may have a high-risk appetite but not have enough capacity to handle a risk's potential volatility or impact. Conversely, the risk capacity may be high, but the trust may decide based on strategy and objectives to adopt a lower risk appetite. An example of how this can be illustrated is shown below.

Risk capacity	The maximum amount of risk the trust can **support** within its available resources
Risk appetite	How much and what type of risk the trust is generally prepared to accept to achieve its strategic objectives
Risk tolerance	The maximum amount or type of risk the trust is prepared to tolerate above risk appetite (eg treat, tolerate or terminate the risk)

3.5   Risk Management Assurance

Assurance is provided through transparent, timely and objective risk reporting. High quality and accurate risk management information helps to ensure that senior management is fully aware of material risks to which the organisation is exposed. Appropriate control processes are demonstrated via the 3 lines of defence model below and are used within the BAF.
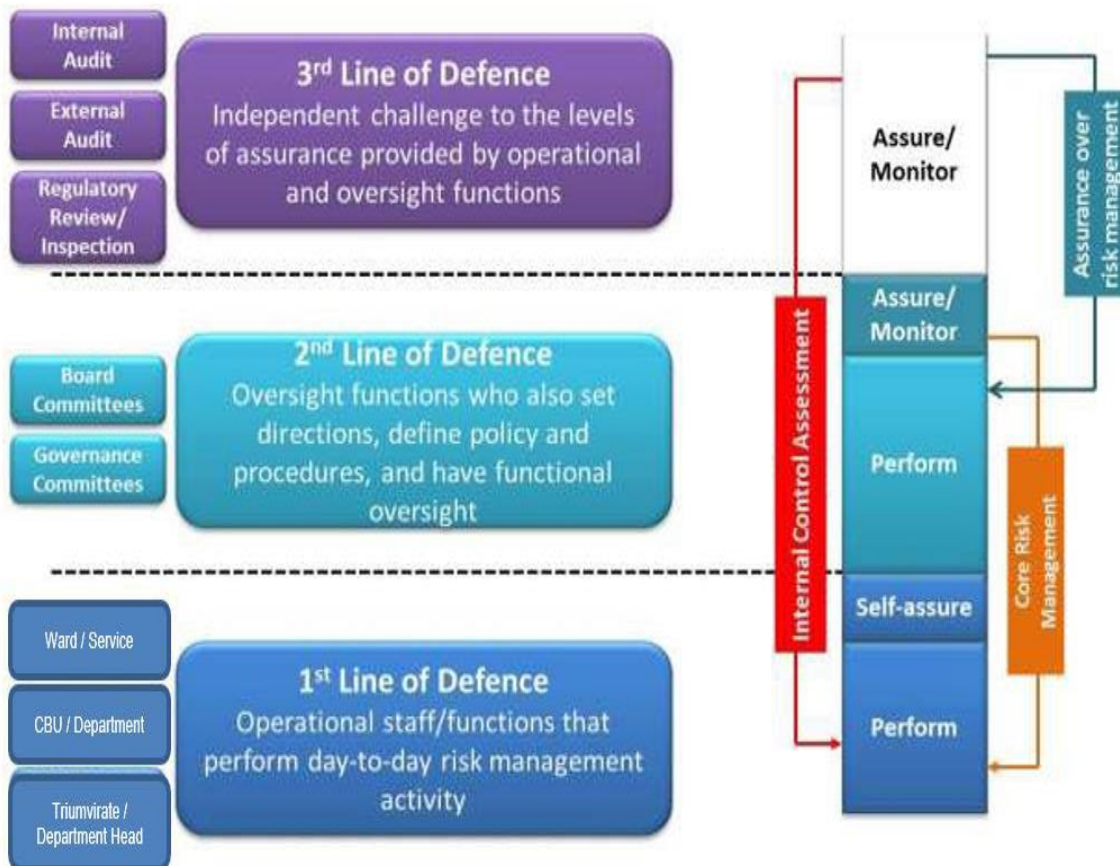
4   DUTIES AND GOVERNANCE FOR RISK MANAGEMENT

4.1   Chief Executive
The Chief Executive has overall accountability and responsibility for risk management within the Trust and for compliance with the relevant regulations and is responsible for making the Trust's Annual Governance Statement. Delegated responsibility for the implementation of this policy is as shown below.

4.2   Executive Medical Director
The Executive Medical Director has overall responsibility for risk management and ensuring Divisional Directors and managers are supported to fulfil out their responsibilities in line with this policy. This is facilitated by the Risk Management Board, Chaired by the Executive Medical Director.

4.3   Director of Corporate Affairs / Company Secretary
The Director of Corporate Affairs, on behalf of the Chief Executive, is responsible for the Board Assurance Framework and Corporate Risk Register.

4.4   Executive/Corporate Directors
The Executive and Corporate Directors are responsible for those risks which are relevant to their areas of responsibility. In particular, the Executive Medical Director and Chief Nurse, are responsible for risk that has a direct impact upon patient care, safety and quality of care, and the Director of Finance for financial risk. The allocation of risks to individual Directors is shown in both the Board Assurance Framework and Corporate Risk Register.

4.5   Board of Directors
The Board of Directors is responsible for ensuring that robust systems of internal control and management are in place, and for reviewing the effectiveness of internal controls through its assurance framework. This responsibility is supported through the governance committees of the Board of Directors (see 4.6).

To inform the Annual Governance Statement made by the Chief Executive in the annual accounts, the Board of Directors must be able to demonstrate that it has been informed, through the Board Assurance Framework, about all significant risks and that it has arrived at its conclusions on the totality of risk, based on the evidence presented to it.

4.6   Board Committees
The Audit and Risk (ARC), Finance and Performance (F&P), People (PEO) and Quality and Effectiveness (QEC) Committees are established as governance committees of the Board of Directors. The committees' primary role in respect of risk management is to seek assurance on behalf of the board that internal control and risk management systems are sufficiently robust to ensure delivery of organisational objectives. Where there are significant concerns or gaps in assurance or control, the committees escalate these to the Board.

Each committee owns relevant risks on the board assurance framework and corporate risk register. The committees review both documents at each of their meetings. The ARC also monitors the integrity of the financial statements of the Trust, while the QEC monitors clinical governance standards.

4.7   Trust Executive Group (TEG)
The Trust Executive Group is responsible for monitoring and reviewing the Corporate Risk Register (all the trusts risks rated ≥15) on a monthly basis and receiving risk escalations from the Risk Management Board where appropriate.

4.8   Risk Management Board (RMB)
The Risk Management Board meets monthly. It is made up of the Divisional Directors and other appropriate members of the Trust to ensure that assurance on risks can be received by providing challenge on overdue risk reviews and actions.

The RMB receives assurance from the Divisional Directors on all low and moderate and high risks in their divisions/corporate areas, that they are being actively managed and reviewed (Risk rated scores <12).

The RMB also considers all risks due for review since previous meeting and ensure that they are reviewed, and the risk information has been appropriately updated in the Trust's integrated risk management system.

The Risk Management Board reviews all the Trust's risks rated ≥12 monthly to ensure that they are scored appropriately and are ready and appropriate to be reviewed by TEG.

The Risk Management Board will consider if the risk scores are still correct for any risk they review and if it needs adjusting, they will adjust as appropriate, which may escalate or de-escalate a risk.

4.9   Risk Manager role
The Risk Manager role is to ensure the maintenance of a comprehensive risk register system and that the inclusion of prioritised risk issues are reported to the Risk Management Board.

The Risk Manager role is to ensure that standards and procedures relating to risk are embedded throughout the organisation and to oversee the delivery of a risk management training programme.

***4*.10   Senior Information Risk Owner (SIRO)**
The Chief information Officer is the SIRO for the Trust and is the nominated lead to ensure the Trust's information risk is properly identified and managed and that appropriate assurance mechanisms exist.

4.11   Clinical Governance Quality Committee (CG*QC*) Risks

The Clinical Governance Quality Committee is responsible for the operational aspects of clinical risk, clinical governance, and patient safety risks.

4.12   The Health and Safety Committee Risks

The Health and Safety Committee is responsible for the operational aspects of Health and Safety risks. The process to follow in identifying/recording/managing/reporting Health and Safety Risks is the same as any other risk identified within the Trust and must be logged on Datix (Trust's online integrated risk management system).

4.13   Trust Business Resilience Group

The Trust Business Resilience Group is responsible for managing all risks related to Emergency Preparedness, Resilience and Response (EPRR). The process to follow in identifying/recording/managing/reporting EPRR Risks is the same as any other risk identified within the Trust.

4.14   Divisional Directors /Managers or Head/Managers of Corporate areas

Divisional or Corporate Directors and managers will ensure that they have a lead for:

- The management of a divisions risks using the Trust's online integrated risk management system.
- Ensuring attendance of staff at appropriate education and training sessions.
- Ensuring divisional risk management procedures are up to date.
- The implementation of risk management systems and processes, both clinical and non-clinical, in each ward or department and specialty concerned.
- Review of all the divisions risk in line with the appropriate review frequency. (Annually for low risks (, quarterly for moderate risks, monthly for high and extreme risks.)
- Providing appropriate reporting and assurance for all the divisions risks to the Risk Group.
- Raising risk awareness amongst all staff at operational level.
- Ensuring compliance with external assurance assessments and standards.
- Confirming **the DATIX Risk Owner** who then approves the risk within the DATIX system. **Risk Owners and Risk Handlers** actively manage the risk

4.15   Employees

Management of risk is a fundamental duty of all employees whatever their grade, role or status. Employees are required to follow Trust policies and procedures, which explain how this duty is to be undertaken.

In particular, all employees must ensure that identified risks and incidents are reported and dealt with swiftly and effectively, reported in line with relevant Trust policies and divisional procedures to their immediate line manager and, if appropriate, their health & safety

representative, in order that further action may be taken where necessary. Health and Safety is a core element of each employee's responsibility.

Employees are responsible for keeping their Risk Management Training up to date.

5   BOARD ASSURANCE FRAMEWORK AND RISK REGISTERS

5.1 Board Assurance Framework (BAF)

The Board Assurance Framework is a tool to enable the Board to assure itself that the principal risks to the achievement of its organisational objectives are being appropriately managed. It is interlinked with the corporate risk register and is structured around the Board's strategic objectives.

The framework summarises the controls in place to mitigate each risk, and highlights where there are gaps in these controls. It also provides a summary of positive assurances received by the Board and its sub-committees in relation to these controls, highlighting where there are gaps in assurance.

The Chief Executive is required to sign an Annual Governance Statement each year, and the board assurance framework informs the declarations to be made in this statement.

The framework shows a summary description of each risk and is reviewed monthly as a minimum. The assurance framework also shows the executive lead, the relevant committee, the direction of travel, controls in place, assurance received, gaps in assurance, action being taken to address gaps and target rating to ensure that the measures in place will address the gaps to ensure the strategic risk appetite has not been exceeded.

When considering how a risk will be managed to ensure that it is within the Trusts agreed risk appetite, it Is important to understand the role of the risks target score. The target score of a risk is the ultimate level of risk that needs to be achieved given the available means and resource. Once the target level of risk is achieved and the risk continues to exist, the Trust must then tolerate this risk. In situations where the controls to manage a risk are effective and the risk is being tolerated at its target score, the current and target risk scores may be the same.

The framework will be continually reviewed and updated to ensure that it continues to provide the Board with assurance and will be discussed, with discussions logged in the minutes at the appropriate committee it is presented.

The board committees review the Board Assurance Framework in addition to receiving the Corporate Risk Register for information, in order to avoid taking a fragmented approach to risks at this level.

The board committees each focus on the risks which pertain to their remit and terms of reference. They seek assurance on behalf of the Board that key controls are in place and review risks through their annual work plans. The assurance framework is used to drive the agenda for the committees who will undertake occasional deep dives into the risks for which they are responsible.

The Board receives the board assurance framework and corporate risk register bimonthly.

At each meeting the Audit and Risk Committee (ARC) will review whether the assurance framework process and format remain fit for purpose and recommend changes to the Board where appropriate.

5.2 Corporate Risk Register (all risks scored ≥15 following TEG Escalation)

The Corporate Risk Register is a tool to enable Trust Executive Group (TEG) to review and manage the organisation's most important risks. It is interlinked with the Board Assurance Framework and is held on the Trust's online integrated risk management system.

Risks are added to the CRR if it is thought they may affect the delivery of the Corporate Objectives (from a strategic, clinical and business risk perspective).
The high level strategic risks identified in the CRR are underpinned and informed by risk registers overseen at the local operational level within Divisions.

The register will include:
- Source and consequence of the risk
- Executive/corporate director owner and lead committee
- The original, current and target risk rating
- Controls that are in place
- New and developing controls
- Owner of the new/developing controls and target date

Escalation of risks for consideration by Trust Executive Group shall be via the Chair of the Risk Management Board and the Director of Corporate Affairs.

The Risk Management Board shall review and approve the Corporate Risk Register on a monthly basis. Where changes to risks are made, this shall be reflected in the assurance framework where appropriate and reported to the Trust Executive Group and Board committees as appropriate.

 The Trust Executive Group will receive assurance regarding all risks rated ≥15 or more via the Risk Management Board.

Where changes to the corporate risk register are proposed which affect the content of the assurance framework (i.e. addition or deletion of risks), the proposed change shall be reported

to the board committees as appropriate in addition to being presented to the Board of Directors for approval.

The board assurance framework and corporate risk register will be reported to each board sub-committee meeting and to the Board of Directors bimonthly meeting.

At least once a year, the Trust Executive Group will review whether the corporate risk register process and format remain fit for purpose and agree changes where appropriate.

5.3 Divisional and Directorate Risk Registers (all risks in a division scored <15)

Each Division and Directorate will be responsible for maintaining their own risks on the Trust's online integrated risk management system (DATIX). The registers will be populated as a result of risk assessments, incidents, complaints and claims. The Divisional and Directorate risk register will be a standing agenda item at all Divisional and Directorate Senior Management Team meetings.

Any risk identified ≥15 must be escalated for consideration by the Trust Executive Group via Risk Management Board on to the Corporate Risk Register.
All risks identified ≥15 within the Corporate Risk Register will require a supporting action plan to ensure that the risk is managed to an acceptable level.
The action plans must be monitored by the Lead Director within the Division or Directorate

6   ORGANISATIONAL RISK PRINCIPLES

The Board of Directors has agreed the following principles with regard to its role in relation to risk:

(i)   The Board will consider all aspects of risk in relation to the decisions it makes and the information it receives. This will include:
   a. The risk of inaction
   b. Reward, where applicable
   c. How risks link to the Trust strategy, values and culture
   d. The adequacy of risk management and controls
   e. Structures and escalation processes
   f. The overall risk profile and risk burden of the Trust, and its capacity to manage that risk
(ii) The Board will assess risks both initially and on an ongoing basis, recognising that where risks are dynamic its risk tolerance and strategies must be dynamic to reflect this.
(iii) The Board will work to ensure it has sufficient information regarding key risks by, among other things:
   a. Seeking external advice where appropriate.
   b. Seeking ongoing assurance from management regarding the control and management of risks.

(iv) The Board will mitigate risk as far as it feels that it is sensible and appropriate to do so.

(v) The Board will ensure that risk surveillance and triangulation are factored into its work and discussions on an ongoing basis.

7   RISK ASSESSMENT PRINCIPLES

Risk assessment is the process of identifying, describing, measuring and recording risks. Judgments are made about the harm that might arise from an activity and the probability that the harm will occur.

The main purpose of risk assessment is to determine whether planned or existing control measures are adequate or need to be improved. It also promotes an improved awareness of risk and a better appreciation of the necessity for control measures.

7.1   Risk Identification
The Trust operates two major systems to facilitate the identification of risk:
- Proactive risk identification, through identification of risks before they lead to harm. This includes interventional near miss reporting.
- Reactive risk identification, through the adverse incident reporting process; Datixweb.

In order to identify risk, teams should conduct a detailed review of the activity or area being reviewed, including any hazards perceived, and any incidents that have occurred. Once hazards and potential risks have been identified, they should be formally assessed.

Divisional risk assessment process should be followed (see sections 8 and 9) and the risk assessment given to divisional management who will assess and input the risk onto Datix.

7.2   Legal Requirements
The Management of Health and Safety at Work Regulations 1999 (MHSWR) require employers to assess the risks to the health and safety of the groups below which are created by their undertaking, in order to identify the measures that are required in order to comply with statutory provisions.

- employees whilst they are at work;
- non-employees
- new or expectant mothers
- young persons, taking into account the young persons' inexperience, immaturity and lack of awareness of risks;

Further specific risk assessments that are required to be completed in accordance with the MHSWR 1999 include:

- Lone Working
- Violence and aggression
- Stress

- Slips, Trips and Falls, including Working at Height
- Musculoskeletal Disorders

There are a number of other regulations which suggest a requirement for risk assessments, including the Health and Safety (First-aid) Regulations 1981; the Environmental Protection Act 1990 and the Provision and Use of Work Equipment Regulations 1998. The relevant regulations should be referred in relation to any area of work undertaken as part of the business of the Trust, in order to determine where a risk assessment may be required.

The process to follow in identifying/recording/managing/reporting Health and Safety Risks is the same as any other risk identified within the Trust and must be logged on Datix (Trust's online integrated risk management system).

7.3   **Risk Assessment Documentation**

The findings of the risk assessment must be recorded using the Trust's online integrated risk management system (http://dbhdatixweb/datix/live/index.php). All staff who document risks using this system should receive appropriate training. All fields must be completed where appropriate and additional document to support mitigation of the risk attached within the system.

Documenting a risk using the Trust's online integrated risk management system requires the employee documenting the risk assessment to:

- describe the risk in full, covering the cause (situation giving rise to the risk), the event that may occur, and the effect of that event ie The risk should be described in the formulation "due to X, there is a risk that Y, and the impact of which is Z".
- assign a 'risk owner' (the senior manager who is responsible for the area which the risk assessment affects)
- identify the appropriate review frequency (monthly for all risks rated 8 or above)
- it is essential to describe any action already taken and control measures already in place
- determine the adequacy of existing control measures
- determine the likelihood of injury or harm arising, quantify the severity of the consequences of this harm, and assign a risk rating
- determine the target risk rating using the same principles
- identify potential additional control measures or actions, with timescales for implementation or details of process being followed.
- identify any specific legal duty or requirement which is relevant to the risk
- identify any reported incidents that relate to the risk
- provide sufficient information to enable the risk owner to monitor and manage the risk appropriately.

8   RISK ASSESSMENT PROCESS – ALL RISKS

The risk assessment process can be broken down into steps as follows:

(a)   Identify potential hazards or risks - Carry out a pre-assessment walkthrough or review of the activity to identify hazards or potential risks. Be systematic, list all credible/foreseeable hazards and consider all possibilities.

(b)   Plan the assessment - Assessments should be planned and prioritised for a specific area or activity and should cover likely risk issues including:

- work activities
- property and equipment
- known hazards
- accident and incident reports
- known 'near misses'
- risks to achievement of specified objectives or targets

(c)   Define the nature of the risk – Once identified, the risk should be defined. What might occur, or is occurring, and what adverse consequences might this cause?

(d)   Identify the people at risk - Identify all those who might be at risk including staff, contractors, patients, and the public.

(e)   Analyse exposure - Identify under what conditions, when and how exposure to the risks takes place.

(f)   Detail and evaluate the existing controls in place - Evaluate how the risk is being controlled, taking into consideration statutory compliance requirements and whether the controls are effective in practice.

(g)   Quantify the risk – Determine the likelihood and consequences of the risk being realised using the Risk Matrix shown at **Appendix 2.**
- Use these scores to allocate a risk rating. (The formula to calculate the risk score. Risk Score = Consequence Score x Likelihood Score. But DATIX will complete automatically)

(h)   Identify further controls - Identify further control measures or actions required to reduce the risk and prioritise these. (See the use of **5T's in the Appendix 2** for understanding risk control) and ensure fully documented within the DATIX system

(i)   Develop action plan - An action plan must be drawn up to implement any further control measures required. This should identify who is responsible for actions, and timescales for completion. This plan should be monitored at the identified appropriate level, dependent on the risk rating. Where actions require escalation in order to gain approval, this should be undertaken. This action plan must be in DATIX.

(j)   Quantify the target residual risk - The target residual risk is the lowest level which the department anticipates being able to reduce the risk to, following completion of the

action plan. The target residual risk should be quantified, and a timescale set for achieving this reduction.

NB: In some cases, the target residual risk may be the same as the current risk rating. In these cases, no action is required, although existing control measures must be maintained.

(k)   <u>Record the findings</u> - The significant findings of the assessment together with any actions identified should be recorded using the Trust's online integrated risk management system (DATIX). The risk assessment is passed on to divisional management to review, approve and record the risk into Datix.

(l)   <u>Agree the Divisional/Corporate Risk owner</u> is agreed. The Risk owner then approves risk within the DATIX system. Risk Owners and Risk Handlers actively manages the risk.

(m)   <u>Inform staff</u> - Staff should be informed of:
  - Any risks to their health and safety identified by the assessment
  - Control measures in place
  - Any emergency measures identified & planned action to be taken

9   REVIEW, APPROVAL AND MONITORING OF RISKS

(a)   The responsibility for the risk assessment lies with the Manager who is responsible for the area which the risk assessment affects (e.g. on a ward, the ward manager/sister) and should be logged as the risk owner or handler depending on the severity of the risk within the DATIX system.

(b)   Following completion of the online risk assessment, the head of department/senior manager will approve the assessment on the Trust's online integrated risk management system, to confirm agreement with both the risk assessment and action plan at the Departmental/Divisional SMT.

(c)   The Head of department/Senior manager will ensure an action plan has been developed where appropriate and appoint a lead person for each action point together with a completion date. Once finalised, the risk assessment and action plan will be notified to all persons who could be affected by the outcome of the risk assessment.

(d)   A programme of quarterly review must be established for risks rated 8 to 12 and monthly for ≥15 rated, to ensure that all agreed actions are carried out within timescales. The Risk Owner approves risk on Datix and Risk Owner and Risk Manager actively manage risk on DATIX.
All risk assessments rated lower than 8 should be reviewed on an annual basis as a minimum, or if there has been a change

(e)   Risks rated ≥15 should be escalated for inclusion in the Corporate Risk Register in

addition to the process outlined above (section 5.2). Risks on the Corporate Risk Register are reviewed monthly by the Risk Management Board.

(f)   In addition to the above, risk assessments should be reviewed if they meet the criteria outlined below:
- If new equipment is introduced
- If new substances or premises are used
- If new clinical techniques are introduced which impact on staff rosters or patient handling duties
- If other processes or operational parameters change significantly
- Following an accident
- If there is reason to suspect that the assessment is no longer valid
- If there has been a significant change in matters to which the assessment relates

10   TRAINING/ SUPPORT

The effective implementation of this policy will facilitate the delivery of a quality service, alongside employee training and support to provide an improved awareness of the measures needed to prevent, control and contain risk.

An assessment of the risk management training needs of all staff will be documented within the Trust's Training needs analysis which will be reviewed on an annual basis and action plans developed. This assessment will be linked to incidents, claims, complaints, risk assessments, external assurance and performance indicators. The Risk Manager role has responsibility to ensure this training process is in place and will liaise with Trusts Health and Safety Advisor in delivering the H&S Risk assessment process.

The Trust's training prospectus will include details of all risk management courses. Local risk management training needs identified by individual areas will be discussed with the Risk Manager.

The Training Department will maintain records of actual and expected completion of statutory and essential to role training, including corporate induction, and will address and rectify inadequate attendance. Divisions and Directorates will address and rectify inadequate attendance at local mandatory training courses.

The Trust will:
- Ensure all employees and stakeholders have access to a copy of this policy and risk awareness training and an understanding of the role of risk management in the organisation
- Provide new employees with risk awareness training and an understanding of the role of risk management in the organisation

- Provide general risk awareness training, Risk assessment training, Risk register training and management of risk for all senior managers
- Provide risk management awareness training to Board members, (both Executive, Corporate and Non-executive Directors) Divisional/Directorate Management teams on a minimum biennial basis.

Those carrying out assessments should be competent to do so and should have attended the Trust's internal training. The assessor should have an understanding of the workplace, an ability to make sound judgements, and knowledge of the best practicable means to reduce those risks identified. Competency does not require a particular level of qualification but may be defined as a combination of knowledge, skills, experience and personal qualities, including the ability to recognise the extent and limitation of one's own competence.

The Health and Safety Advisor, Trust Risk Manager role are available to provide support and advice to employees experiencing difficulties in assessing risk.

11   MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

Risk escalation in the Trust has been supported by initial internal audit reviews to date and the risk management system will continue to be reviewed by the internal auditors.

What is being monitored?	Who will carry out the monitoring?	How often	How reviewed / Where reported to?
Correct completion of risk assessments.	Risk lead for ward/department	Monthly	Audit via Divisional/Corporate SMT meetings/Clinical Governance meetings
Completion of action plan with each risk assessment where further action is necessary.	Risk lead for ward/department	Monthly	Audit via Divisional/Corporate SMT meetings/Clinical Governance meetings
Ward/department level risk register monitored monthly by ward/ department manager.	Risk lead for ward/department	Annually	Audit and or minutes / Divisional /Corporate SMT meetings/Clinical Governance meetings
Division / Directorate level risk register monitored monthly at appropriate forum.	Risk Manager Role	Annually	Meeting minutes / Risk Management Board
Corporate Risk Register monitored monthly by the Trust Executive Group	Risk Manager Role	Annually	Meeting minutes / Trust Board Office

12   EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified.   (See Appendix 4).

13   ASSOCIATED TRUST PROCEDURAL DOCUMENTS

- Claims Handling Policy - CORP/RISK 5
- Serious Incidents (SI) Policy - CORP/RISK 15
- Maternity Service Risk Management Strategy - CORP/RISK 16
- Incident Management Policy – CORP/RISK 33
- Complaints, Concerns, Comments and Compliments: Resolution and Learning - CORP/COMM 4
- Fair Treatment for All Policy – CORP/EMP 4
- Equality Analysis Policy – CORP/EMP 27
- Freedom to Speak Up Policy 'Speak up to make a difference' CORP/EMP 14
- Health and Safety Policy - CORP/HSFS 1
- Security Policy - CORP/HSFS 15

14   REFERENCES

- Control of Asbestos Regulations 2012
- Control of Lead at Work Regulations 2002
- Control of Substances Hazardous to Health Regulations 2002 (COSHH)
- Data Protection Act 1998
- Health and Safety at Work Act 1974
- Health and Safety (Display Screen Equipment) Regulations 1992
- Ionising Radiation Regulations 1999
- Management of Health and Safety at Work Regulations 1999 (SI No 3242).
- Management of health and safety at work - Approved Code of practice and Guidance (L21 - HSE)
- Manual Handling Operations Regulations 1992
- Noise at Work Regulations 2005

    Personal Protective Equipment at Work Regulations 1992

APPENDIX1 FLOWCHART FOR MONITORING & REVIEW OF RISKS ASSESSMENTS

Risk assessment completed using the Trust's online integrated risk management system

Action plan and control measures identified

Target residual risk identified, and timescale set

Risk assessment and action plan agreed and approved by head of department – logged in DATIX

Risk rating < 8

Risk rating ≥ 8

Monitor action plan and efficacy of control measures at ward level, and review risk at least annually

Monitor action plan and efficacy of control measures at divisional level, and review risk monthly or quarterly. (depending on score)

Risk rating < 12

Risk rating ≥ 12

In addition to the monitoring and review above, escalate the risk assessment and action plan to the Risk Management Board.
Review risk monthly at Trust Risk Group.

In addition to the monitoring and review above, escalate the risk assessment and action plan to the Trust Executive Group for consideration for inclusion on the Corporate Risk Register. Review risk monthly at Trust Executive Group

APPENDIX1 **FLOWCHART FOR MONITORING & REVIEW OF RISKS ASSESSMENTS**

Risk Identified	**Risk Assessed, Scored, and accepted by Risk Owner**

E S C A L A T I O N

N O I T A L A C S E D (DESCALATION)

Risk Score 1-7
Managed at Specialty / Department Level

Reviewed annually or upon change
Review and updates recorded on Datix

Monitored at **Divisional SMT** or **Governance Meetings**

Risk Score 8-12
Managed at Divisional &/or Directorate Level

Reviewed Quarterly or upon change
Review and updates recorded on Datix

Monitored at **Divisional SMT** or **Governance Meetings**

Risks Score ≥12
Managed at Divisional/Directorate and Executive Level

Reviewed Monthly
Review and updates recorded on Datix

Monitored at Divisional Governance or SMT Meetings and **ESCALATED to Risk Management Board & TEG**

Risk Management Board will validate risks and escalate risks to **TEG**

Risk Management Board review CRR receive assurance on lower risks

Monitored at appropriate board Sub-committee

Trust Executive Group
(TEG)

Audit & Risk Committee will receive a copy of risk report Risks rated ≥15 (CRR)

Trust Board of Directors

APPENDIX 2 – RISK MATRIX (CONSEQENCE VS LIKELIHOOD)

Table 1 - Consequence Score

Choose the most appropriate domain for the identified risk from the left-hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column. Consider how severe the impact, or consequence, or the risk would be if it did materialise.

The Formula for calculating the risk score: Risk Score = Consequence Score x Likelihood Score

	Consequence score (severity levels) and examples of descriptors				
	1 -Insignificant	**2 - Minor**	**3 - Moderate**	**4 - Major**	**5 - Catastrophic**
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work.	Minor injury or illness, requiring minor intervention. Requiring time off work for >3 days. Increase in length of hospital stay by 1-3 days.	Moderate injury requiring professional intervention. Requiring time off work for 4-14 days. Increase in length of hospital stay by 4-15 days. RIDDOR/agency reportable incident. An event which impacts on a small number of patients.	Major injury leading to long-term incapacity /disability. Requiring time off work for >14 days. Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects.	Incident leading to death. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality / complaints / audit	Peripheral element of treatment or service suboptimal. Informal complaint/ inquiry.	Overall treatment or service suboptimal. Formal complaint - local resolution. Single failure to meet internal standards. Minor implications for patient safety if unresolved. Reduced performance rating if unresolved.	Treatment or service has significantly reduced effectiveness. Formal complaint. Local resolution (with potential to go to independent review). Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on.	Non-compliance with national standards with significant risk to patients if unresolved. Multiple complaints /independent review. Low performance rating. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety if findings not acted on. Inquest/ombudsman inquiry. Gross failure to meet national standards.
Human resources / organisational development /staffing	Short-term low staffing level that temporarily	Low staffing level that reduces the	Late delivery of key objective/ service	Uncertain delivery of key objective /service due to	Non-delivery of key objective /service

/competence	reduces service quality (< 1 day).	service quality.	due to lack of staff. Unsafe staffing level or competence (>1 day). Low staff morale. Poor staff attendance for mandatory/key training.	lack of staff. Unsafe staffing level or competence (>5 days). Loss of key staff. Very low staff morale. No staff attending mandatory/ key training.	due to lack of staff. Ongoing unsafe staffing levels or competence. Loss of several key staff. No staff attending mandatory training /key training on an ongoing basis.
Statutory duty/ inspections	No or minimal impact or breach of guidance / statutory duty.	Breach of statutory legislation. Reduced performance rating if unresolved.	Single breach in statutory duty. Challenging external recommendation / improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low performance rating. Critical report.	Multiple breaches in statutory duty. Prosecution. Complete systems change required. Zero performance rating. Severely critical report.
Adverse publicity/ reputation	Rumours. Potential for public concern.	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House). Total loss of public confidence.
Business objectives / projects	Insignificant cost increase / schedule slippage.	<5% over project budget. Schedule slippage.	5–10% over project budget. Schedule slippage.	10–25% over project budget. Schedule slippage. Key objectives not met.	>25% over project budget. Schedule slippage. Key objectives not met.
Finance including claims	Small loss. Risk of claim remote.	Loss of 0.1–0.25% of budget. Claim less than £10k.	Loss of 0.25–0.5% of budget. Claim(s) between £10k and £100k.	Uncertain delivery of key objective /Loss of 0.5–1% of budget Claim(s) between £100k and £1m Purchasers failing to pay on time	Non-delivery of key objective / Loss of >1% of budget. Failure to meet specification /slippage. Loss of contract / payment by results. Claim(s) >£1m.
Service / business interruption	Loss /interruption of >1 hour.	Loss /interruption of >8 hours.	Loss /interruption of >1 day.	Loss /interruption of >1 week.	Permanent loss of service or facility.

Environmental impact	Minimal or no impact on the environment.	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic impact on environment.

Table 2 - Likelihood Score

What is the likelihood of the consequence described in the above Consequence Table, actually happening? The frequency-based score is appropriate in most circumstances and should be used whenever it is possible to identify a frequency. In the case of projects then the probability or chance of recurrence-based score should be used.

Frequency – How often might it/does it happen	Description of Likelihood Scale Based on time/broad description & probability					
	Likelihood Score	1	2	3	4	5
	Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
	Time Framed	Not expected to occur **for years**	**Expected to occur at least annually**	**Expected to occur at least monthly**	**Expected to occur at Least Weekly**	**Expected to occur at least daily**
	Broad Descriptor	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	This will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
	Probability for projects & Business	1-5%	6-30%	31-70%	71-90%	>90%

Calculate the consequence and likelihood rating using the scales below:

Likelihood Score

Consequence Score	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

First, cross reference the likelihood and impact scores on the matrix above.

For example, if you have a „*moderate*" consequence and „*almost certain'* likelihood then the overall risk rating would be:

Consequence x Likelihood = Overall risk rating
3 x 5 = 15
Moderate x Almost certain = Extreme Risk

The likelihood and consequence of a risk occurring is always a question of judgement, past records, relevant experience, expert judgements, and any relevant publication can be used to inform a judgement.

In grading risk the scores obtained from the risk matrix are assigned grades as follows:

1-3	Low Risk	Normal risks which can be managed by routine procedures
4-6	Moderate Risk	Risks requiring assessment and action planning allocated to Divisions & Directorates
8-12	High Risk	Risks requiring urgent Divisional & /or RM Board review linked with Action Plan
15-25	Extreme Risk	Risks requiring immediate action by Director & Risk Management Board for TEG consideration with Action Plan

Key Controls:
Not all risks can be dealt with in the same way. The '5 T's provide an easy list of options available to consider how to manage risk:

- **Tolerate** – the likelihood and consequence of a particular risk happening is accepted
- **Treat** – work is carried out to reduce the likelihood or consequence of the risk (this is the most common action)
- **Transfer** – shifting the responsibility or burden for loss to another party, e.g. the risk is insured against or subcontracted to another party
- **Terminate** – an informed decision not to become involved in a risk situation, e.g. terminate the activity
- **Take the opportunity** - actively taking advantage, regarding the uncertainty as an opportunity to benefit

In most cases the chosen option will be to treat the risk. When considering the action to take remember to consider the cost associated with managing the risk, as this may have a bearing on the decision. The key questions in this instance are:

- Action taken to manage risk may have an associated cost. Make sure the cost is proportionate to the risk it is controlling.
- When agreeing responses or actions to control risk, remember to consider whether the actions themselves introduce new risks or affect other people in ways which they need to be informed about.

Contingency Plans – if a risk has already occurred and cannot be prevented or if a risk is rated red or orange (extreme or high) then contingency plans should be in place should the risk materialise. Contingency plans should be recorded underneath the key controls on the risk register. Good risk management is about being risk aware and able to handle the risk, not risk averse.

APPENDIX 3 – GLOSSARY OF COMMON TERMS USED IN RISK MANAGEMENT

Action Plan	A plan outlining additional strategies/activities or mitigating actions the Trust needs to develop and implement should the risk level be unacceptable after controls are applied. An action plan should be specific to the risk and SMART (Specific, Measurable, Attainable, Relevant and Time bound) to evidence how the risk score can be reduced.
Assurance	Evidence that risks are being effectively managed.
Consequence (Impact)	The result of a particular threat or opportunity should it actually occur.
Control(s)	Existing strategies and processes currently in place such as systems, policies, procedures, standard business processes and practices to manage the likelihood or consequence of a risky practice.
Corporate Risk Register	A record of the risks identified through internal process that will impact on the Trust's business objects or major programmes and so are scored 15+.
Current Risk	Risk likelihood, consequence and total score with the current controls in place to manage the risk.
Gaps in Controls or assurances	Where an additional system or process is needed, or evidence of effective management of the risk is lacking and needs to be put into place.
Hazard	A potential source of risk/threat. Eg Damage or harm.
Incident / Issue	An event that has happened, was not planned, requires a management action, and be reported as appropriate and where required in line with the Incident Reporting Policy and Procedure.
Initial Risk (Inherent Risk)	The risk score where there are no controls in place to manage the risk.
Likelihood	A measure of the probability or chance that the threat or opportunity will happen including a consideration of the frequency with which it may arise.
Mitigating Actions	Actions taken to reduce the likelihood or Consequence of the risk. Mitigating actions should be specific to the risk and SMART (Specific, Measurable, Attainable, Relevant and Time bound) to be able to measure the impact of the action and evidence how the risk score can be reduced.
Operational Risks	These risks are by-products of the day-to-day running of the Trust and include a broad spectrum of risks including clinical risk, financial risk (including fraud), legal risks (arising from employment law or health and safety regulation), regulatory risk, risk of loss or damage to assets or system failures etc. Operational risks should be managed by the department or directorate which is responsible for delivering services.
Opportunity	An uncertain event that would have a favourable impact on objectives or benefits if it occurred.

Risk	An uncertain event or set of events that have not occurred, but should it occur, will have an effect on the achievement of business, project or programme objectives. A risk can be a threat or an opportunity.
Risk Appetite	The phrase used to describe where Trust considers itself to be on the spectrum ranging from willingness to take or accept risk through to an unwillingness or aversion to taking some risks.
Risk Assessment	The process used to evaluate the risk and to determine whether controls are adequate or more should be done to mitigate the risk within the organisations risk appetite.
Risk Management	This is about the Trust's culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse events. The risk management process covers all processes involved in identifying, assessing and judging risks, assigning ownership, taking action to mitigate or anticipate them, and monitoring and reviewing progress.
Risk Registers	These are repositories for electronically recording and dynamically managing risks that have been appropriately assessed. Risk Registers are available at different organisational levels across the Trust.
Strategic risks	These risks are those that represent a threat to achieving the Trust's strategic objectives or to its continued existence. They also include risks that are widespread beyond the local area and risks for which the cost of control is significantly beyond the scope of the local budget holder. Strategic risks must be reported to the Board of the Directors and should be managed at executive level, directly or by close supervision.
Target Risk	The risk score the Trust aims to get achieve with sufficient and effective controls in place.
Threat	An uncertain event that could have a negative impact on the delivery of objectives or benefits, should it occur.

APPENDIX 4 – EQUALITY IMPACT ASSESSMENT - PART 1 INITIAL SCREENING

Service/Function/Policy/Project/Strategy	Care Group/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Risk Identification, Assessment & Management Policy	Chief Executive	Fiona Dunn	Existing Policy	July 2022

1) Who is responsible for this policy? Name of Care Group/Directorate: Fiona Dunn – Chief Executive

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes? To provide a framework for risk management

3) Are there any associated objectives? Legislation, targets national expectation, standards No

4) What factors contribute or detract from achieving intended outcomes? Compliance with the policy

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? No

   • **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] N/A

6) Is there any scope for new measures which would promote equality? [any actions to be taken] N/A

7) Are any of the following groups adversely affected by the policy? No

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

Date for next review: **July 2023**

Checked by: F Dunn   Date: **July 2022**

DBTH TRUST RISK APPETITE STATEMENT

1. **Introduction**

Risk is inherent in the provision of healthcare and its services. It is necessary for the Trust to understand and agree the level of risk that it is willing to accept to achieve its strategic objectives. The purpose of a Risk Appetite Statement is to articulate what risks the Board is willing or unwilling to take in order to achieve the Trust's strategic objectives.

Well Led guidance[1] published by NHS Improvement references regular review of the Board's risk appetite and tolerance as part of evidence that there are clear and effective processes for managing risks, issues and performance.

2. **Background**

Work was undertaken by the Board during 2022 to agree the Trust's risk appetite across defined areas of strategic risk. This drew on guidance from the Good Governance Institute and its *'Risk Appetite for NHS Organisations Matrix'*[2]. (Appendix A)

In outlining its approach to and appetite for risk within a Risk Appetite Statement, the Board of Directors has defined its strategic approach to risk-taking by defining its boundaries and risk tolerance thresholds.

The Board will review its Risk Appetite Statement on an annual basis.

3. **Risk Appetite Statement**

3.1 **General principles**

Methods of controlling risks must be balanced. The Trust may accept some high risks either because of the cost of controlling them, or to deliver innovation or use resources creatively when this may achieve substantial benefit.

As a general principle the Trust will seek to control, all risks which have the potential to:

- Expose patients, staff, visitors and other stakeholders to harm
- Compromise the Trust's ability to deliver operational services
- Adversely impact the reputation of the Trust
- Have severe financial consequences which may impact on the Trust's future viability
- Cause non-compliance with law and regulation.

The risk appetite statement defines the Board's appetite for each risk identified to the achievement of strategic objectives for the financial year in question. Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk. Table 1 below articulates the Trust's agreed risk appetite levels. The tables below provide a breakdown of the risk appetite pertaining to strategic risk domains and corresponding risk appetite levels.

The Board of Directors have determined the Trust's risk appetite as an 'open' one. In practice this means that a level of risk taking is encouraged for the Trust to maintain a progressive approach to the delivery of services, where assurance can be sought that any associated risks can be mitigated to a tolerable level.

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[1] NHSI, Developmental reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts; June 2017.

[2] Good Governance Institute, Risk Appetite for NHS Organisations: A Matrix to support better risk sensitivity in decision taking. Jan 2012

3.2 Risk appetite definitions

Definitions for levels of risk appetite are set out in table 1, below.

These have been adopted from the Good Governance Institute's Risk Appetite for NHS Organisations Matrix (Appendix A).

Risk Levels (consequence)		Risk Appetite
AVOID	Avoidance of risk and uncertainty is a key organisational objective ALARP (As little as reasonably possible)	None (0)
MINIMAL (low)	Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	Low (1)
CAUTIOUS	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward	Moderate (2)
OPEN	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward and Value for Money (VfM)	High (3)
SEEK	Eager to be innovative and choose options offering potentially higher business rewards despite greater inherent risk	Significant (4)
MATURE	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust	Significant (5)

Table 1: Risk Appetite Levels

3.4 DBTH Risk Appetite Statement by areas of strategic risk for 2022/2023

Risk type	Risk Level & Appetite (Colour)
Reputation - (How will we be perceived by the public and our partners?)	**SEEK (4)**

- We are willing to take decisions that are likely to bring scrutiny of the organisation.
- We outwardly promote new ideas and innovations where potential benefits outweigh the risks.

Finance / Value for money – (How will we use our resources?)	**OPEN (3)**

- We strive to deliver our services within the budgets set out in our financial plans and are prepared to accept some financial risk as long as appropriate controls are in place.
- We have a holistic understanding of VFM with price not the overriding factor.

Regulatory / Compliance – (How will we be perceived by our regulator?)	**MINIMAL (1)**

- We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.
- Where the laws, regulations and standards are about the delivery of safe, high-quality care, or the health and safety of the staff and public, we will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set, unless there is strong evidence or argument to challenge them

Innovation	**OPEN (3)**

- The Trust has a risk tolerant appetite to risk where benefits, improvement and value for money are demonstrated. Innovation is encouraged at all levels within the organisation, where a commensurate level of improvement can be evidenced, and an acceptable level of management control is demonstrated.
- The Trust will not, however, compromise patient safety while innovating service delivery

Quality (How will we deliver safe services?)	**OPEN (3)**

- We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards.

People (How will we be perceived by the public and our partners?)	**OPEN (3)**

- The Trust is committed to working with its stakeholder organisations to bring value and opportunity across current and future services through system-wide partnership
- We are open to developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with our statutory duties
- We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.
- We will not accept risks, mor incidents or circumstances which may compromise the safety of any staff members and patients and contradict our Trust values

Risk Appetite for NHS Organisations
A matrix to support better risk sensitivity in decision taking

Developed in partnership with the board of Southwark Pathfinder CCG and Southwark BSU – January 2012

Good Governance Institute

Risk levels ► Key elements ▼	**0** Avoid Avoidance of risk and uncertainty is a Key Organisational objective	**1** Minimal (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	**2** Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	**3** Open Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	**4** Seek Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	**5** Mature Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

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Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	27 September 2022	**Agenda Reference:**	**G3**
Report Title:	**Trust Board Director Register of Interests & Fit & Proper Person Annual Review**		
Sponsor:	Richard Parker OBE, Chief Executive Officer		
Author:	Fiona Dunn, Director Corporate Affairs/Company Secretary		
Appendices:	Board Register of Interests		
Executive Summary			
Purpose of report:	To provide assurance to the Board on its statutory and regulatory requirements in requirement for declaration of Director interests.		
Summary of key issues:	The NHS Code of Accountability and NHS England's guidance on managing conflicts of interest in the NHS requires Board Directors to declare any interests which are relevant and material to the Board. This includes any interest that could conflict with the impartial discharge of their duties, and which could cause conflict between their private interests and their NHS duties. The Register for the Board was updated as of 1st August 2022 and is attached. This information will be made publicly available on the Trust website following the meeting. All Board members comply with the "fit and proper persons" self-declaration as required (reviewed as of 1st August 2022) which also includes checks on: • Insolvency & Bankruptcy check (by Dir Corporate Affairs) • Disqualified Directors check via Companies House (by Dir Corporate Affairs) In addition to this annual declaration, at each meeting of the Board of Directors and its Committees, members are asked to declare any further interests since the date of the last declaration and to notify the Chair of any conflicts of interest in relation to the agenda items for discussion (for which they may need to abstain). Any such declaration is recorded in the minutes Summary: All checks were passed, and no conflicts of interest have been identified		
Recommendation:	The Board is asked to receive and approve the Register of Interests & Fit and Proper Person annual check		

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:	N/A
Corporate risk register:	F&P6 – no changes (Failure to achieve compliance with performance and delivery, CQC and other regulatory standards
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 & CQC 2014 Regulations.
Resources:	N/A

Assurance Route			
Previously considered by:		Board - Outcome report 2021	
Date: Board 21/9/2021	**Decision:**		Approved & acknowledged register of Interest.
Next Steps:		Continue monitoring prior to each Board and sub-committee meeting.	
Previously circulated reports to supplement this paper:		Previous meeting minutes	

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
Register of Directors' Interests

Register of Interests

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

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

Neil Rhodes, Non-Executive Director
Chair, Doncaster and Bassetlaw Healthcare Services
Non-Executive Director at the Disclosure and Barring Service
Director, Kendal Green Associates, professional standards and senior personnel appointment consultancy

Mark Bailey, Non-Executive Director
Visiting Fellow at Cranfield University
Executive Leadership Coach – provider of freelance services
Executive Coach – NHS Leadership Academy (voluntary)
Non-Executive Director for MEDQP Ltd (Voluntary)

Jo Gander, Non-Executive Director
Managing Director Gander Healthcare Solutions (Dormant business)

Mark Day , Non-Executive Director
Health Development Director, Equity Solutions Group

Hazel Brand , Non-Executive Director
Councillor, Bassetlaw District Council
Parish Councillor, Misterton

Dr Tim Noble, Executive Medical Director
Spouse is a Consultant Physician at DBTH

Jon Sargeant, Interim Director of Recovery, Innovation & Transformation
Director, Doncaster and Bassetlaw Healthcare Services Ltd

George Briggs, Interim Chief Operating Officer
Director of Briggs Health Ltd

Zoe Lintin, Chief People Officer
Trustee on the Board of Sheffield Academy Trust

The following have no relevant interests to declare:

Alex Crickmar	Acting Director of Finance
Richard Parker	Chief Executive
Abigail Trainer	Acting Chief Nurse

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	27 September 2022	**Agenda Reference:**	**G4**
Report Title:	**DBTH Constitution – Review Update**		
Sponsor:	Richard Parker OBE, Chief Executive Officer		
Author:	Fiona Dunn, Director Corporate Affairs/Company Secretary		
Appendices:	Appendix 1. DBTH Trust Constitution 2022		
Executive Summary			
Purpose of report:	To provide assurance to the Board on its statutory and regulatory requirements. The document supports the delivery of the strategic aims by providing a clear, accountable and transparent governance platform through which decisions can be made.		
Summary of key issues:	The Trust is required to have a constitution which sets out how it is constituted, how it makes decisions and to whom it is accountable. It is based on NHS England core constitution statutory guidance issued in 2014. Some of the provisions are required by law while some are discretionary. Some minor statute changes have been proposed following the introduction of the Health and Care Act 2022 along with the launch of the Integrated Care Systems, and abolition of CCGs, on 1st July 2022. Both had implications on Foundations Trusts in terms of national guidance and local documentation. The Constitution is required to be reviewed in full every three years or earlier if changes are required. The last extensive review was in September 2020. A review of the Constitution has now been undertaken with minimal changes proposed. The main changes proposed are as follows: • Nomenclature throughout – the Health and Care Act 2022 abolishes "Monitor" so all references have been changed to NHS England (unless reference used is still an existing live document produced by "Monitor"). Likewise references to executive director titles have been changed e.g. Chief Nurse and Chief Operating Officer. • Clarification that volunteers to the Trust do not qualify for Membership of the Staff Constituency (p9) • Addition of Governors role within the Integrated Care System(s) (p13) • The current constitution (p.15) stipulates a Board of up to 7 NEDs and up to six Executive Directors. This has been removed to provide flexibility should it ever be required and clarifies the casting vote ability of the Chair		

	• Also addition of statement 21.11 (p15) for the avoidance of doubt the Deputy Chair shall have the casting vote in the event that the Chair is not participating at the meeting where voting takes place.
	
	• Within the Constitution, it is proposed to abolish the role of CCG partner governor on the Council of Governors given the organisation no longer exists w/e/f 1 July and the role. (p28). More widely a review of partner governors is needed. The Trust has power to appoint other partner governors provided more than half the Council of Governors is comprised of public governors. The current make-up of the Council without the CCG is as follows:
	   o Chair - 1
	   o Public governors – 20
	   o Staff governors – 6
	   o Partner governors - 9
	   o Total – 35
	There is therefore scope to have up to two further appointed governors on the CoG, for a total of 37. Provision has been made (p31) for the proposal of partner governors to be appointed by the Trust from new partner organisations when appropriate with the intention to increase the diversity of the governing body.
	
	• Removal of requirement to notify NHSE of amendments to Constitution (p24)
	
	• Please note that other changes captured by "track changes" were typographically or layout changes and include:
	   o Incorrect "section" cross references amended
	   o Deletion of repeated paragraphs where applicable.
	   o Clarification and consistency of wording throughout all sections
	
	Please note that the changes made to the Constitution are minor and generally clarification type changes, as the nature of this document is that it is not designed to cover every eventuality.
	
	In reviewing the documents, comments received from reviewers have been considered along with reference to statutory guidance.
	
	The draft document has previously been circulated to Board members and the Council of Governors prior to this submission to the Board, for review, and comments received incorporated where applicable.
	
	Amendments to the Constitution are required to be approved by both Board of Directors (on 27ᵗʰ September) and by Council of Governors (on 29th September).
	
	Once approved any changes will be reflected in the Trusts Standing Orders, Standard Financial Instructions and Council of Governors Standing orders.

Recommendation:	The Board of Directors is asked to APPROVE the proposed amendments to the DBTH Constitution.

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:	N/A
Corporate risk register:	**F&P6** Failure to achieve compliance with performance and delivery, CQC and other regulatory standards Leading to; (i) Negative patient and public reaction towards the Trust (ii) Impact on reputation
Regulation:	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., Health and Care Act 2022
Resources:	Actions required are currently being delivered within existing trust Resources highlighted in individual risks

Assurance Route		
Previously considered by:		Draft previously circulated to Board members and Council of Governors for review and comment
Date:	Sept 2022	**Decision:** Comments incorporated
Next Steps:		Check for consistency in the SO, SFI's
Previously circulated reports to supplement this paper:		

DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

CONSTITUTION

Name and title of author/reviewer:	Fiona Dunn, Company Secretary
Approved by The Board of Directors:	XX September 2022
Approved by The Council of Governors:	xx September 2022
Date Issued:	Xx September 2022
Date of Next Review:	September 2025

Table of Contents

1.   INTERPRETATION AND DEFINITIONS

In this Constitution:

"the 2006 Act"	means the National Health Service Act 2006 as amended from time to time;
"the 2012 Act"	means the Health and Social Care Act 2012 as amended from time to time;
"the 2022 Act"	means the Health and Care Act 2022 as amended from time to time;
"Accounting Officer"	is the person who from time to time discharges the functions specified in NHS England's NHS Foundation Trust Accounting Officer Memorandum; means the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act;
"Annual Members' Meeting"	means the annual members' meeting of the Trust as defined in paragraph 10 of this Constitution.
"Appointed Governors"	means the Partner Governors; those Governors appointed by the Partnership Organisations;
"Area of the Trust"	means the areas of Bassetlaw District and the Metropolitan BoroughCity of Doncaster (specified in Annex 1 as areas of the public constituency);
"Board of Directors"	means the board of directors as constituted in accordance with this Constitution;
"CCG Governor"	means each member of the Council of Governors appointed in accordance with the provisions of this Constitution by each of the Clinical Commissioning Groups specified in Annex 3;
"Chair"	means the chair of the Trust appointed in accordance with paragraph 25 of this Constitution;
"Chief Executive"	means the chief executive officer of the Trust appointed in accordance with the terms of this Constitution;
"Constitution"	means this Constitution and all annexes to it;
"Council of Governors"	means the Council of Governors as constituted in accordance with this Constitution, which has the same meaning as the council of governors in the 2006 Act and the 2012 Act;
"Deputy Chair"	means the Non-Executive Director appointed as deputy chair of the Trust in accordance with paragraph 26 25 of this Constitution;

"Director"	means an Executive Director or a Non-Executive Director on the Board of Directors;
"Elected Governor"	means the Public Governors and the Staff Governors; those Governors elected by the Public Constituencies and the classes of the Staff Constituency;
"Election Scheme"	means the election scheme set out in Annex 4;
"Executive Director"	means an executive director of the Trust;
"Financial Year"	means a period of 12 months beginning on 1st April in a calendar year and ending on 31st March in the following calendar year;
"Governor"	means a Governor on the Council of Governors and being either an Elected Governor or an Appointed Governor;
"Health Service Body"	means a body which is a health service body for the purpose of section 9(4) of the 2006 Act;
"Independent Regulator" or "NHS England"	is the body corporate known as NHS England, as provided by Section 61 of the 2012 Act;
"Lead Governor"	means a Governor elected by the Council of Governors to fulfil the statutory role originally set out by Monitor (now NHS England) and to Chair any meetings of Governors when the Chair or Deputy Chair are absent, for whatever reason
"Local Authority"	means the local authorities specified in Annex 3, which are local authorities for an area which includes the whole or part of the area of the Trust;
"Local Authority Governor"	means a member of the Council of Governors appointed by a Local Authority in accordance with the provisions of this Constitution and as specified in Annex 3;
"Member"	means a member of the Trust;
"Membership	means membership of the Trust as determined in accordance with the provisions of this Constitution and as specified in Annex 3;
"Monitor"	means the body corporate known as Monitor, as provided by Section 61 of the 2012 Act; incorporated into NHS Improvement in 2016, itself now operating jointly with NHS England
"Model Election Rules"	means the model form rules for the conduct of elections published from time to time by the Department of Health and as currently set out in Annex 4;
"Non-Executive Director"	means a non-executive director of the Trust;

"Partner Governor"	means a member of the Council of Governors appointed by a Partnership Organisation specified in Annex 3;
"Partner Organisation"	means those organisations designated as Partnership Organisations for the purposes of this Constitution specified in Annex 3;
"Public Constituencies"	means a public constituency as defined in Annex 1;
"Public Governor"	means a member of the Council of Governors elected by the Members of the Public Constituency;
"Registered Dentist"	a registered dentist within the meaning of the Dentists Act 1984;
"Registered Medical Practitioner"	a fully registered person within the meaning of the Medicines Act 1983 who holds a licence to practice under that Act;
"Secretary"	means the Trust Company Secretary or any other person appointed to perform the duties of the secretary to the Board, including a joint, assistant or deputy secretary;
"Senior Independent Director"	means the Non-Executive Director appointed by the Board as the senior independent director of the Trust;
"Staff Class"	means a class of Membership within the Staff Constituency as provided for in Schedule 7 to the 2006 Act and as set out in Annex 2;
"Staff Constituency"	means the part of the Trust's Membership consisting of the staff of the Trust and which is divided into the classes as specified in Annex 2;
"Staff Governor"	means a member of the Council of Governors elected by a Staff Class in accordance with the provisions of this Constitution;
"the Trust"	means Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust;

1.1 Unless the contrary intention appears or the context otherwise requires, words or expressions contained in this Constitution bear the same meaning as in the 2006 Act as amended by the Health and Social Care Act 2012.

1.2 References in this Constitution to legislation include all amendments, replacements or re-enactments made and references to paragraph numbers are references to paragraphs of this constitution unless the context provides otherwiseReferences in this Constitution to legislation include all amendments, replacements, or re-enactments made, and all regulations, statutory guidance or directions.

1.3 References to legislation include all regulations, statutory guidance and directions.

1.4 Headings are for ease of reference only and are not to affect interpretation.

1.51.4   If there is a conflict between the provisions of this Constitution and the provisions of any document referred to herein or the law then the provisions of this Constitution shall prevail unless the law requires otherwise.

1.61.5   All Annexes referred to in this Constitution form part of it.

1.6   References to paragraphs are to paragraphs in this Constitution save that where there is a reference to a paragraph in an Annex to this Constitution it shall be a reference to a paragraph in that Annex unless the contrary is expressly stated or the context otherwise so requires

2.   NAME

2.1   The name of the foundation trust is Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust.

3.   PRINCIPAL PURPOSE

3.1   The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

3.2   The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3   The Trust may provide goods and services for any purposes related to:

    3.3.1   the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

    3.3.2   the promotion and protection of public health.

3.4   The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

4.   POWERS

4.1   The powers of the Trust are set out in the 2006 Act and amended by the Health and Social Care Act 2012 and the Health and Care Act 2022.

4.2   All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

4.3   Any of these powers may be delegated to a committee of directors or to an executive director.

4.4   Without prejudice to the generality of paragraph 4.1, the Trust may:

4.4.1   provide hospital and other accommodation for the purposes of any of its activities;

4.4.2   provide the services of medical, dental, midwifery and nursing staff, other health care professionals, other staff and volunteers;

4.4.3   provide such other facilities for the care of expectant and nursing mothers and young children as it considers appropriate;

4.4.4   provide such facilities for the prevention of illness, the care of persons suffering from illness and the aftercare of persons who have suffered from illness as it considers appropriate;

4.4.5   provide such other services as it considers are required for the diagnosis and treatment of illness and the care of those suffering from illness;

4.4.6   conduct, or assist by grants or otherwise any person to conduct, research into any matters relating to the causation, prevention, diagnosis or treatment of illness and into any such other matters connected with any service provided by the Trust as it considers appropriate and publish the results of such research;

4.4.7   educate and train its own staff and students and those from other organisations or educational establishments in any trade, profession or other occupation relevant or related to any part of the Trust's functions and collaborate with other organisations in the provision of such education and training;

4.4.8   in fulfilling its statutory duty to co-operate with another body, provide to that body, and receive from it, goods and services on such terms as the Trust considers appropriate, including terms under which the goods or services are provided for are received free of charge;

4.4.9   provide goods and services outside England;

4.4.10   provide, or assist in providing, information, training and support to voluntary and community bodies within the area of the Trust or providing services within the area of the Trust;

4.4.11   raise charitable funds and, in so doing, appeal for any contributions, donation, grant or gift of money or property;

4.4.12   insure the property of the Trust against any foreseeable risk and take out other insurance policies to protect the Trust when required or enter into arrangements which have a similar effect;

4.4.13   insure the Governors, Directors, volunteers and any employee of the Trust against the cost of a defence to a criminal prosecution brought against them in their capacity as such or against personal liability incurred in respect of any act or omission which is, or is alleged to be, a breach of trust or a breach of duty, unless the Governor, Director, volunteer or employee concerned knew that, or was reckless whether, the act or omission was a breach of trust or a

breach of duty or enter into arrangements which have a similar effect;

4.4.14   provide and participate in external quality assurance schemes; and

4.4.15   carry out investigations into any aspect of the activities of the Trust.

5.   MEMBERSHIP AND CONSTITUENCIES

5.1   The Trust shall have Members, each of whom shall be a Member of one of the following constituencies:

5.1.1   a Public Constituency; or

5.1.2   a Staff Constituency.

5.2   An individual who is eligible to become a Member of the Trust may do so on application to the Trust.

6.   PUBLIC CONSTITUENCY

6.1   The Public Constituency comprises three areas as set out in Annex 1. Each area of the Public Constituency is to be known by the name listed in Annex 1.

6.2   An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a Member of the Trust provided that:

6.2.1   they have made an application for Membership to the Trust; and

6.2.2   they are not eligible to become a Member of the Staff Constituency; and

6.2.3   they are not otherwise disqualified from Membership under paragraph 4 or paragraph 2 of Annex 6.

6.3   Those individuals who live in an area specified for a Public Constituency are referred to collectively as the Public Constituency.

6.4   The minimum number of Members in each area for the Public Constituency is specified in Annex 1.

7.   STAFF CONSTITUENCY

7.1   An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a Member of the Trust provided that:

7.1.1   they are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least twelve (12) months; or

7.1.2   they have been continuously employed by the Trust under a contract of employment for at least twelve (12) months.

7.2   Those individuals who are eligible for Membership of the Trust by reason of paragraph 7.1 are referred to collectively as the Staff Constituency.

7.3   The Staff Constituency shall be divided into four (4) classes of individuals who are eligible for Membership of the Staff Constituency, each class of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

7.4   The minimum number of Members in each class of the Staff Constituency is specified in Annex 2.

7.5   An individual providing care in pursuance of a contract (including a contract of employment) with a voluntary organisation, or as a volunteer for a voluntary organisation, or who provides services to the Trust (for no remuneration) does not come within the category of those who qualify for Membership of the Staff Constituency.

8.   AUTOMATIC MEMBERSHIP BY DEFAULT AND BY APPLICATION – STAFF

8.1   An individual who:

8.1.1   is eligible to become a Member of the Staff Constituency pursuant to paragraph 7.1 above, and

8.1.2   invited by the Trust to become a Member of the Staff Constituency and a Member of the appropriate Staff Class within the Staff Constituency,

shall become a Member of the Trust as a Member of the Staff Constituency and appropriate Staff Class within the Staff Constituency without an application being made, unless s/he informs the Trust that s/he does not wish to do so.

8.2   The process by which an individual shall be invited or shall apply to become a Member of the Staff Constituency shall be in accordance with the provisions of Annex 6.

9.   RESTRICTION ON MEMBERSHIP

9.1   An individual who is a Member of a constituency, or of a class within a constituency, may not while Membership of that constituency or class continues, be a Member of any other constituency or class.

9.2   An individual who satisfies the criteria for Membership of the Staff Constituency may not become or continue as a Member of any constituency other than the Staff Constituency.

9.3   An individual must be at least sixteen (16) years old at the date of his/her application or invitation (as the case may be) to become a Member of the Trust.

9.4   Further provisions as to the circumstances in which an individual may not become or continue as a Member of the Trust are set out in Annex 6.

10.   ANNUAL MEMBERS' MEETING

10.1   The Trust shall hold an annual meeting of its members ('Annual Members' Meeting'). The Annual Members' Meeting shall be open to members of the public.

10.2   Further provisions about the Annual Members' Meeting are set out in Annex 7 – Annual Members' Meeting.

11.   COUNCIL OF GOVERNORS - COMPOSITION

11.1   The Trust is to have a Council of Governors, which shall comprise both Elected and Appointed Governors and the Chair of the Trust.

11.2   The composition of the Council of Governors is specified in Annex 3.

11.3   The members of the Council of Governors, other than the appointed members, shall be chosen by election by their Constituency or, where there are classes within a constituency, by their class within that Constituency. The number of Governors to be elected by each Constituency, or, where appropriate, by each class of each Constituency, is specified in Annex 3.

12.   COUNCIL OF GOVERNORS - ELECTION OF GOVERNORS

12.1   Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules 2014.

12.2   The Model Election Rules as may be varied from time to time, form part of this Constitution and are attached at Annex 4.

12.3   A subsequent variation of the Model Election Rules by the Department of Health & Social Care 2014 shall not constitute a variation of the terms of this Constitution for the purposes of paragraph 42 of the Constitution (amendment of the Constitution).

12.4   An election, if contested, shall be by secret ballot.

12.5   In the event that a vacancy is not filled by election, or a vacancy arises, the Council of Governors, by agreement at a meeting, may co-opt to that vacancy for an agreed period of time but the co-optee must be from the same constituency as the vacancy.

13.   COUNCIL OF GOVERNORS - TENURE

13.1   An Elected Governor may hold office for a period of up to three (3) years.

13.2   An Elected Governor shall cease to hold office if s/he ceases to be a Member of the Constituency or class by which s/he was elected.

13.3   An Elected Governor shall be eligible for re-election at the end of his/her term but no Elected Governor may hold office for more than nine (9) years. An Elected

Governor may not stand for election again on completion of the maximum nine years. An Elected Governor who does not complete the maximum nine-year term may stand for re-election but only for the remaining years to achieve nine (9) years in total.

13.4   An Appointed Governor may hold office for a period of three (3) years.

13.5   An Appointed Governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him/her. Or if the appointed governor loses contact or has no opportunity to report into the appointing organisation.

13.6   An Appointed Governor shall be eligible for re-appointment at the end of his/her term but no Appointed Governor may hold office for more than nine (9) years.

13.7   Service by a current or previous governor as at 26 October 2017 will count towards the maximum time period specified in paragraphs 13.3 and 13.6 above.

13.8   Governors in post on 26 October 2017 that have exceeded nine years' service may complete the remaining portion of their existing term but are not eligible for re-election or re-appointment.

14.   COUNCIL OF GOVERNORS – DISQUALIFICATION AND REMOVAL

14.1   The following may not become or continue as a member of the Council of Governors:

14.1.1   a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

14.1.2   a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

14.1.3   a person who within the preceding five (5) years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him/her

14.1.4   A governor, who is the subject of a conduct/disciplinary investigation, will be suspended from governor duties pending the outcome of the investigation (*see section 2.5 Annex 5*)

14.1.5   A governor, who makes a formal written complaint about another governor, non-executive director, director, member of staff, or volunteer, may be requested to stand down as a governor while the complaint is investigated, pending the outcome of the investigation.

14.2   Governors must be at least sixteen (16) years of age at the date they are nominated for election or appointment.

14.3   Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 5.

14.4   Provisions for the removal of governors are set out in Annex 5 and the Standing Orders of the Council of Governors.

15.   COUNCIL OF GOVERNORS – DUTIES OF GOVERNORS

15.1   The general duties of the Council of Governors are:

15.1.1   to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors; and

15.1.2   to represent the interests of the members of the Trust as a whole and the interests of the public.

15.1.2   as a result of the Health and Care Act 2022 governors are required to factor into their decision making a balance between serving the public interest of their constituents (ie the Trust and local community which elects them) with a wider (regional) public interest across the Integrated Care Systems the Trust is linked with.

15.2   The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

15.3   Governors must take up the opportunities that the Trust offers to provide them with these skills and knowledge. Refusal to take up a reasonable request for training and development will be a breach of the Governor Code of Conduct.

15.4   As much of the Trust's business e.g. Board meetings and Committees, is carried out electronically, governors must have a working knowledge of commonly used IT platforms, and the equipment to access them.

16.   COUNCIL OF GOVERNORS – MEETINGS OF GOVERNORS

16.1   The Chair of the Trust (i.e. the Chair of the Board of Directors, appointed in accordance with the provisions of paragraph 25 24 below) or, in his/her absence, the Deputy Chair (appointed in accordance with the provisions of paragraph 26 25 below), shall preside at meetings of the Council of Governors save that if the Chair and Deputy Chair are unable to preside whether for reasons of absence, conflict of interest or otherwise the Senior Independent Director or Lead Governor shall preside.

16.2   The Lead Governor shall be a Public Governor and shall be elected by a majority of the Council of Governors in a secret ballot for a term of up to 3 years. The provisions of paragraph 8 of Annex 5 shall also apply.

16.3   Meetings of the Council of Governors shall be open to members of the public save that members of the public may be excluded from a meeting on the grounds of the confidential nature of the business to be transacted, or for other special reasons stated in the resolution.

16.4   For the purposes of obtaining information about the Trust's performance of its functions or the directors' performance of their duties, and to be able to hold the

non-executive directors to account for the performance of the Board, the Council of Governors may require one or more of the non-executive directors to attend a meeting.

16.5   *In extremis*, where the circumstances are beyond the Trust's control, meetings of members and the Council of Governors may be suspended until the circumstances that have caused the cessation of governors' meetings and activities have passed. The Chair is responsible for ceasing or re-starting governors' meetings.

16.6   There may be times and reasons why Council of Governors meetings are held "virtually online" and not in person. The Chair will decide these times in consultation with the Lead Governor

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

17.   COUNCIL OF GOVERNORS – STANDING ORDERS

17.1   The Council of Governors shall adopt its own standing orders, as may be varied from time to time, for its practice and procedure, in particular for its procedure at meetings.

18.   COUNCIL OF GOVERNORS - CONFLICTS OF INTEREST OF GOVERNORS

18.1   Governors are required to declare any pecuniary, personal or family interest on nomination for election and on appointment as a governor.

18.2   In addition, governors should declare interests, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors. The governor shall disclose that interest to the members of the Council of Governors as soon as s/he becomes aware of it.

18.3   The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed. The Chair of the meeting decides on exclusion on the facts.

18.4   See also Annex 5, section 7 for declarations of interest.

19.   COUNCIL OF GOVERNORS – TRAVEL EXPENSES

19.1 The Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Trust.

20. COUNCIL OF GOVERNORS – FURTHER PROVISIONS

20.1 Further provisions with respect to the Council of Governors are set out in Annex 5.

21. BOARD OF DIRECTORS – COMPOSITION

21.1 The Trust is to have a Board of Directors, which shall comprise both Executive and Non-Executive Directors.

21.2 The Board of Directors should include an appropriate combination of executive and non-executive directors (and in particular, independent non-executive directors) such that no individual or small group of individuals can dominate the board's decision taking.

21.3 All directors should be able to exercise one full vote, with the chairperson having a second or casting vote on occasions where voting is tied.

21.4 The Board of Directors is to comprise:

21.4.1 a non-executive Chair (who shall have a casting vote)

21.4.2 up to 6 other Non-Executive Directors (i.e. not including the Chair) (One Non Executive Director one of whichwill may be nominated by the BoardChair, and noted by the Council of Governors, as the Senior Independent Director); and

21.4.3 up to 6 Executive Directors (but not exceeding the combined number of Non-Executive Directors and the Non-Executive Chair).

21.5 One of the Executive Directors shall be the Chief Executive.

21.6 The Chief Executive shall be the Accounting Officer.

21.7 One of the Executive Directors shall be the Finance Director.

21.8 One of the Executive Directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

21.9 One of the Executive Directors is to be a registered nurse or a registered midwife.

21.10 One of the Non-executive Directors is to be, or have been in the past, a registered medical practitioner, registered dentist, registered nurse, registered midwife, registered pharmacist or other healthcare professional registered with the Health and Care Professions Council.

21.11 For the avoidance of doubt, the Deputy Chair shall have the casting vote in the event that the Chair is not participating at the meeting where voting takes place.

22. BOARD OF DIRECTORS – GENERAL DUTY

22.1   The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

23.   BOARD OF DIRECTORS – QUALIFICATION FOR APPOINTMENT AS A NON-EXECUTIVE DIRECTOR

23.1   A person may be appointed as a Non-Executive Director only if:

23.1.1   s/he is a Member of the Public Constituency; and

23.1.2   s/he is not disqualified by virtue of paragraph 28 27 below.

24.   BOARD OF DIRECTORS – APPOINTMENT AND REMOVAL OF CHAIR AND OTHER NON-EXECUTIVE DIRECTORS

24.1   The Chair and Non-Executive Directors are appointed for a term of up to three years. This may be extended by a further term of up to three years if the needs of the organisation so determine. The Chair and Non-Executive Directors may not usually serve for more than six years, unless it considers such an extension is in the best interests of the Trust.

24.2   The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair and the other Non-Executive Directors.

24.3   Removal of the Chair or another Non-Executive Director shall require the approval of three-quarters of the members of the Council of Governors attending the meeting.

24.4   The provisions of paragraph 9 of Annex 5 and paragraph 6 of Annex 6 shall also apply.

25.   BOARD OF DIRECTORS – APPOINTMENT OF DEPUTY CHAIR

25.1   The Board of Directors shall appoint one of the Non-Executive Directors as a Deputy Chair. The Deputy Chair will also be Deputy Chair of the Council of Governors.

25.2   The Deputy Chair shall be appointed for a term of 3 years and shall be eligible for re-appointment at the end of that term but may not serve as Deputy Chair for more than a total of 6 years., unless it considers such an extension is in the best interests of the Trust.

26.   BOARD OF DIRECTORS - APPOINTMENT AND REMOVAL OF THE CHIEF EXECUTIVE AND OTHER EXECUTIVE DIRECTORS

26.1   The Non-Executive Directors shall appoint or remove the Chief Executive.

26.2   The appointment of the Chief Executive shall require the approval of the Council of Governors.

26.3   A committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other Executive Directors.

27.   BOARD OF DIRECTORS – DISQUALIFICATION

27.1   The following may not become or continue as a member of the Board of Directors:

27.1.1   a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

27.1.2   a person who has made a composition or arrangement with, or granted a trust deed for, his/her creditors and has not been discharged in respect of it;

27.1.3   a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him/her;

27.1.4   a person who does not satisfy all of the 'fit and proper person' requirements set out in regulation 5(3) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; or

27.1.5   a person who falls within the further grounds for disqualification set out in Annex 6.

28.   BOARD OF DIRECTORS – MEETINGS

28.1   Meetings of the Board of Directors are meetings held in public and shall, therefore, be open to members of the public as observers. Members of the public may be excluded from a meeting for special reasons. Members of the public may not participate in Board meetings.

28.2   Before holding a meeting, the Board of Directors must make available the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must make available the approved minutes of the meeting to the Council of Governors.

28.3   The Chair (or Deputy Chair) shall give such directions as s/he thinks fit in regard to the arrangements for meetings and accommodation of the public such as to ensure that business shall be conducted without interruption and disruption.

28.4   There may be times and reasons why the Board of Directors meetings are held "virtually online" and not in person. The Chair will decide these times in consultation with the Chief Executive Officer.

28.5   Members of the public or representatives of the press are not permitted to record proceedings in any manner unless with the express prior agreement of the Chair (or Deputy Chair). Where permission has been granted, the Chair (or Deputy Chair) retains the right to give directions to halt recording of proceedings at any point

during the meeting. For the avoidance of doubt, "recording" refers to any audio or visual recording, including still photography, including use of social media.

29. BOARD OF DIRECTORS – STANDING ORDERS

29.1 The Board of Directors shall adopt its own standing orders, as may be varied from time to time, for its practice and procedure, in particular for its procedure at meetings.

30. BOARD OF DIRECTORS - CONFLICTS OF INTEREST OF DIRECTORS

30.1 The duties that a director of the Trust has by virtue of being a director include in particular:

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

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

30.2 The duty referred to in sub-paragraph 30.1.1 is not infringed if:

30.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

30.2.2 The matter has been authorized in accordance with the constitution.

30.3 The duty referred to in sub-paragraph 30.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

30.4 In sub-paragraph 30.1.2, "third party" means a person other than –

30.4.1 The Trust, or

30.4.2 A person acting on its behalf.

30.5 If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or, arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors.

30.6 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

30.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

30.8 This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

30.9 A director need not declare an interest –

30.9.1   if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

30.9.2   if, or to the extent that, the directors are already aware of it;

30.9.3   if, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered –

(a)   By a meeting of the Board of Directors, or

(b)   By a committee of the directors appointed for the purpose under the constitution.

30.10   The Standing Orders for the Board of Directors shall make provision for the disclosure of interests and arrangements for the exclusion of a director declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

30.11   The Standing Orders for the Board of Directors shall make provision for the Board of Directors to determine whether a situation may reasonably be regarded as likely to give rise to a conflict of interest.

30.12   The Standing Orders for the Board of Directors shall make provision for the authorisation of a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

30.13   Where a Non-executive Director has declared a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust, the Board of Directors will disclose details of this to the Council of Governors following any action it takes in accordance with paragraphs 31.1 and 31.2. The Council of Governors may then take further action in accordance with its powers under this Constitution.

31.   BOARD OF DIRECTORS – REMUNERATION AND TERMS OF OFFICE

31.1   The Council of Governors shall appoint members to form a Nomination & Remuneration Committee. This Committee shall agree the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors. The Committee will ask a general meeting of the Council of Governors to approve its recommendations. The provisions of paragraph 6 of Annex 6 shall also apply.

31.2   A committee of Non-Executive Directors shall be established to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors.

32.   REGISTERS

32.1   The Trust shall have:

32.1.1   a register of Members showing, in respect of each Member, the constituency to which s/he belongs and, where there are classes within it, the class to which s/he belongs;

32.1.2   a register of members of the Council of Governors;

32.1.3   a register of interests of Governors;

32.1.4   a register of Directors; and

32.1.5   a register of interests of the Directors.

32.2   The process of admission to and removal from the registers shall be as set out in Annex 6.

33.   REGISTERS – INSPECTION AND COPIES

33.1   The Trust shall make the registers specified in paragraph 32 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

33.2   The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the Trust, if the member so requests.

33.3   So far as the registers are required to be made available:

33.3.1   they are to be available for inspection online and free of charge at all reasonable times; and

33.3.2   a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

33.4   If the person requesting a copy or extract is not a Member of the Trust, the Trust may impose a reasonable charge for doing so.

34.   DOCUMENTS AVAILABLE FOR PUBLIC INSPECTION

34.1   The Trust shall make the following documents available for inspection by members of the public free of charge on the website:

34.1.1   a copy of the current Constitution;

34.1.2   a copy of the latest annual accounts and of any report of the External auditor on them;

34.1.3   a copy of the latest annual report and quality accounts;

34.1.4   a copy of the latest Care Quality Commissioning report.

34.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge on the website at all reasonable times:

34.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.

34.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.

34.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.

34.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

34.2.5 a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act.

34.2.6 a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (NHS England), 65KB (Secretary of State's response to NHS England decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.

34.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

34.2.8 a copy of any final report published under section 65I (administrator's final report),

34.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.

34.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

34.3 Any person who requests a copy of or extract from any of the above documents is to be provided with access to the extract or document online.

34.4 If the person requesting access to a copy or extract is not a Member of the Trust, the Trust may impose a reasonable charge for doing so.

35. AUDITOR

35.1 The Trust shall have an External auditor.

35.2   The Council of Governors shall appoint or remove the External auditor at a general meeting of the Council of Governors.

35.3   The provisions of paragraph 11 of Annex 6 shall apply.

36.   AUDIT AND RISK COMMITTEE

36.1   The Trust shall establish a committee of Non-Executive Directors as an audit and risk committee to perform such monitoring, reviewing and other functions as are appropriate. The Council of Governors may appoint up to two governors as observers to the committee.

37.   ACCOUNTS

37.1   The Trust must keep proper accounts and proper records in relation to the accounts.

37.2   NHS Improvement/England may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

37.3   The accounts are to be audited by the Trust's external auditor.

37.4   The Trust shall prepare in respect of each financial year annual accounts in such form as NHS Improvement/England may with the approval of the Secretary of State direct.

37.5   The functions of the Trust with respect to the preparation of the annual accounts as set out in paragraph 25 of Schedule 7 of the 2006 Act, shall be delegated to the Accounting Officer.

37.6   The provisions of paragraph 12 11 of Annex 6 shall apply.

38.   ANNUAL REPORT, FORWARD PLANS AND NON-NHS WORK

38.1   The Trust shall prepare an Annual Report and send it to NHS Improvement/England.

38.2   The Trust shall give information as to its forward planning in respect of each financial year to NHS Improvement/England.

38.3   The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

38.4   In preparing the document, the directors shall have regard to the views of the Council of Governors.

38.5   Each forward plan must include information about:

38.5.1   the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

38.5.2   the income it expects to receive from doing so.

38.6   Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 38.5.1 the Council of Governors must:

38.6.1   determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and

38.6.2   notify the directors of the Trust and its determination.

38.7   A trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of health service in England may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

39.   PRESENTATION OF THE ANNUAL ACCOUNTS AND REPORTS TO THE GOVERNORS AND MEMBERS

39.1   The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors.

39.1.1   the annual accounts;

39.1.2   any report of the external auditor on them; and

39.1.3   the annual report.

39.2   The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors.

39.3   The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 39.1 with the Annual Members' Meeting.

40.   INSTRUMENTS

40.1   The Trust shall have a seal.

40.2   The seal shall not be affixed except under the authority of the Board of Directors.

41.   AMENDMENT OF THE CONSTITUTION

41.1   The Trust may make amendments to its Constitution only if:

41.1.1   more than half of the members of the Council of Governors voting at a meeting approve the amendments; and

41.1.2   more than half of the members of the Board of Directors voting at a meeting approve the amendments.

41.2 The Constitution shall be formally reviewed by the Council of Governors and Board of Directors every 3 years.

41.3 Amendments made under paragraph 41.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

41.4 Where an amendment is made to the Constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

41.4.1 At least one member of the Council of Governors most likely the Lead Governor must attend the next Annual Members' Meeting and present the amendment, and

41.4.2 The Trust must give the members an opportunity to vote on whether they approve the amendment.

41.5 If more than half of the members present and voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

41.6 Amendments by the Trust of its Constitution are to be notified to NHS Improvement/England. For the avoidance of doubt, NHS Improvement/England's functions do not include a power or duty to determine whether or not the Constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

42. MERGERS ETC. AND SIGNIFICANT TRANSACTIONS

42.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors voting at a general meeting.

42.2 The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction, voting at a general meeting.

42.3 For the purpose of paragraph 42.2, "significant transaction" means a transaction which meets any one of the following criteria:

42.3.1 where the gross assets subject to the transaction are greater than or equal to 25% of the gross assets of the Trust;

42.3.2 where the income attributable to the assets or the contract associated with the transaction is greater than or equal to 25% of the income of the Trust;

42.3.3 where the gross capital of the company or business being acquired or divested, or the effects on the total capital of the Trust resulting from a transaction, is greater than or equal to 25% of the total capital of the Trust following completion of the transaction.

ANNEX 1 – THE PUBLIC CONSTITUENCY

Table 1

1	2	3	4
Name of the Public Constituency	**Area of the Public Constituency (as defined by Local Authority boundaries)**	**Minimum Number of Members**	**Number of Governors to be Elected**
Bassetlaw	Bassetlaw District Council	300	5
Doncaster	City of Doncaster ~~Doncaster Metropolitan Borough Council~~	470	13
Rest of England & Wales	Any other electoral area in England and Wales with the exception of the above	50	2

ANNEX 2 – THE STAFF CONSTITUENCY

Table 1

Staff Class	Minimum Number of Members	Number of Governors to be elected
Medical and Dental Practitioners Staff Class	75	1
Nurses and Midwives Staff Class	450	2
Other Healthcare Professionals Staff Class	100	1
Non-Clinical Staff Class	375	2
TOTAL	1000	6

1. **CLASSES OF THE STAFF CONSTITUENCY**

    1.1   The Staff Constituency shall be divided into four classes as follows:

        1.1.1   Medical and Dental Practitioners Staff Class;

        1.1.2   Nurses and Midwives Staff Class;

        1.1.3   Other Healthcare Professionals Staff Class; and

        1.1.4   Non-Clinical Staff Class.

    1.2   Medical and Dental Practitioners Staff Class

        1.2.1   The Members of the Medical and Dental Staff Class are individuals who are Members of Staff Constituency who:

            (a)   are fully registered persons within the meaning of the Medicines Act 1956 or the Dentists Act 1984 (as the case may be) and who are otherwise fully authorised and licensed to practise in England and Wales or who are otherwise designated by the Trust from time to time as eligible to be Members of this Staff Class for the purposes of this paragraph having regard to the usual definitions applicable at that time for persons carrying on the professions of medical practitioner or dentist; and

            (b)   who are employed by the Trust in that capacity at the date of their invitation or application under paragraph 7 of the Constitution to become a Member in accordance with the

provisions of Annex 6 and at all times thereafter remain employed by the Trust in that capacity.

1.3   Nurses and Midwives Staff Class

      1.3.1   The Members of the Nurses and Midwives Staff Class are individuals who:

            (a)   are registered under the Nurses, Midwifes and Health Visitors Act 1997 and who are otherwise fully authorised and licensed to practise in England and Wales or are otherwise designated by the Trust from time to time as eligible to be Members of the Staff Class for the purposes of this paragraph, having regard to the usual definitions applicable at that time for persons carrying on the profession of registered nurse or registered midwife and individuals who are health care assistants; and

            (b)   who are employed by the Trust in that capacity at the date of their invitation or application under paragraph 7 of the Constitution to become a Member in accordance with the provisions of Annex 6 and at all times thereafter remain employed by the Trust in that capacity.

1.4   Other Healthcare Professionals Staff Class

Members of the Other Healthcare Professionals Staff Class are clinical staff who do not fall within paragraphs 1.2 or 1.3 of this Annex 2, including clinical therapists, scientists and technical staff, who are employed by the Trust in that capacity at the date of their invitation or application under paragraph 7 of the Constitution to become a Member in accordance with the provisions of Annex 6 and at all times thereafter remain employed by the Trust in that capacity.

1.5   Non-Clinical Staff Class

Members of the Non-Clinical Staff Class are Members of the Staff Constituency who do not come within paragraphs 1.2, 1.3 or 1.4 of this Annex 2.

2.   MINIMUM NUMBERS AND NUMBERS OF GOVERNORS

2.1   The minimum number of Members in each Staff Class and the number of Governors to be elected by each such Staff Class are given in Table 1.

3.   CONTINUOUS EMPLOYMENT

3.1   For the purposes of paragraph 7.1.2 of the Constitution, Chapter 1 of Part 14 of the Employment Rights Act 1996 shall apply for the purposes of determining whether an individual has been continuously employed by the Trust or has continuously exercised functions for the purposes of the Trust.

ANNEX 3 – COMPOSITION OF COUNCIL OF GOVERNORS

1.   **INTRODUCTION**

    1.1   The Council of Governors shall comprise:

        1.1.1   The Chair of the Trust

        1.1.2   Governors who are:

            (a)   elected by the respective Constituencies in accordance with the provisions of this Constitution; or

            (b)   appointed in accordance with paragraph 2 below.

    1.2   The Council of Governors shall at all times be constituted so that more than half the Council of Governors shall consist of Governors who are elected by Members of the Public Constituency.

2.   **BODIES ENTITLED TO APPOINT A MEMBER TO THE COUNCIL OF GOVERNORS**

    2.1   The following bodies in this paragraph 2 shall be entitled to appoint a Governor or Governors (as the case may be) to the Council of Governors as provided for in this paragraph 2.

    2.2   ~~Clinical Commissioning Group Governors~~

        ~~2.2.1   Bassetlaw Clinical Commissioning Group and Doncaster Clinical Commissioning Group shall each be entitled to appoint a Governor in accordance with a process of appointment agreed by each of them with the Trust. The absence of any such agreed process shall not preclude the said Clinical Commissioning Group from appointing its Governors provided the appointment is duly made in accordance with the Clinical Commissioning Group's own internal processes.~~

        ~~2.2.2   If a Clinical Commissioning Group named in paragraphs 2.2.1 above declines or fails to appoint its Governors within three months of being requested to do so by the Trust, the Trust shall in its absolute discretion be entitled to extend an invitation to any of those other Clinical Commissioning Groups to whom it provides goods and services to appoint Governors in substitution for the Clinical Commissioning Group which has failed or declined to do so. The Trust shall give notice of that invitation to NHS Improvement/England.~~

        ~~2.2.3   If the invitation referred to in paragraph 2.2.2 above is accepted by a Clinical Commissioning Group, that Clinical Commissioning Group shall appoint a Governor and the Clinical Commissioning Group which has previously failed to appoint a Governor shall cease to be entitled to do so, subject to the provisions of paragraph 2.2.7 below.~~

2.2.4   Subject to paragraph 2.2.6 below, if the invitation is not accepted within a reasonable period or such period as may have been specified in the invitation the Trust shall extend an invitation to any other such Clinical Commissioning Group until the invitation, is accepted and a Governor is appointed.

2.2.5   The Trust shall give notice forthwith to NHS Improvement/England of all invitations the Trust may extend under the preceding paragraph and of any acceptances.

2.2.6   Any Governor appointed under paragraphs 2.2.3 and 2.2.4 above shall serve on the Council of Governors for the period stipulated in Annex 5. At the end of that period the Trust shall in its absolute discretion decide whether to permit that Clinical Commissioning Group which had first failed or declined to appoint a Governor to do so for the next period of office or to invite that Clinical Commissioning Group which had appointed a Governor in substitution to do so.

2.32.2   Local Authority Governors

2.3.12.2.1 City of Doncaster Metropolitan Borough Council shall be entitled to appoint one Governor in accordance with a process of appointment agreed by it with the Trust.

2.3.22.2.2 Bassetlaw District Council and Nottinghamshire County Council shall each be entitled to appoint one Governor in accordance with a process of appointment agreed by each of them with the Trust.

2.3.32.2.3 The absence of any agreed process of appointment as referred to in paragraphs 2.32.1 and 2.32.2 above shall not preclude the said local authority from appointing its Governor(s).

2.3.42.2.4 If the local authority named in paragraphs 2.32.1 or 2.32.2 above declines or fails to appoint a Governor within three months of being requested to do so by the Trust, the Trust shall consult each local authority whose area includes the whole or part of the area of the Trust and the Trust in its absolute discretion may extend an invitation to any of those local authorities to appoint a Governor in substitution for the local authority which has failed or declined to do so.

2.3.52.2.5 A Governor appointed under this paragraph 2.3 2 shall then serve on the Council of Governors for the period stipulated in Annex 5. At the end of that period the Trust shall in its absolute discretion decide whether to permit the local authority which had failed or declined to appoint a Governor to appoint a Governor for the next period of office (provided it remains eligible to do so) or to invite the local authority which had appointed a Governor in substitution to do so.

2.42.3   Partner Governors

2.4.12.3.1 In addition to the organisations listed in 2.1 and 2.2, the following organisations have also been nominated by the Trust as Partnership Organisations for the purposes of this Constitution:

(a)   Bassetlaw Council for Voluntary Service;

(b)   University of Sheffield;

(c)   Sheffield Hallam University;

(d)   Doncaster College;

(e)   Doncaster Deaf Trust;

Partial Sighted Society -Doncaster

(f)   ;

2.4.22.3.2 Each of the above organisations shall be entitled to appoint Governors in accordance with a process of appointment agreed by it with the Trust. The absence of any such agreed process of appointment shall not preclude that Partnership Organisation from appointing its Governor provided the appointment is duly made in accordance with its own internal processes. A further two (2) appointed governors from new partnership organisations, nominated by the Trust may be proposed and added to this constituency. In this instance the Company Secretary will present the proposed nomination to the Council of Governors.

3.   COMPOSITION OF THE COUNCIL OF GOVERNORS

	Electing / Appointing Body	Number of Governors	Total
1.	**Public Constituencies**		20
	1.1 Bassetlaw District	5	
	1.2 Metropolitan Doncaster	13	
	1.3 Rest of England and Wales	2	
2.	**Staff Constituency**		6
	2.1 Medical and Dental Practitioners Staff Class	1	
	2.2 Nurses and Midwives Staff Class	2	
	2.3 Other Healthcare Professionals Staff Class	1	
	2.4 Non-Clinical Staff Class	2	
3.	**Appointed Governors**		~~10~~9
	3.1 ~~Doncaster Metropolitan Borough~~City of Doncaster Council~~Doncaster Clinical Commissioning Group~~	1 1 1	
	3.2 Bassetlaw District Council~~Bassetlaw Clinical Commissioning Group~~	~~1~~	

3.3	Nottinghamshire County Council	1	
3.4	University of Sheffield	1	
3.5	Sheffield Hallam University	1	
3.6	Doncaster College	1	
3.7	Doncaster Deaf Trust	1	
3.8	Bassetlaw Council for Voluntary Service	1	
3.9	Doncaster ~~College~~Partial Sighted Society		
	3.10 provision available for further two (2) appointed governors from new partnership organisations appointed by the Trust when appropriate)	2	
	Total Number of Governors (maximum membership)		~~36~~37

4. **FURTHER PROVISIONS**

   4.1   Further provisions relating to the composition of the Council of Governors are at Annex 6.

ANNEX 4 – THE MODEL ELECTION RULES 2014

PART 12: MISCELLANEOUS

PART 1: INTERPRETATION

1.   **Interpretation**
 1.1   In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this Constitution;

"*Council of Governors*" means the Council of Governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the Council of Governors;

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor elected by the Council of Governors to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act (since 2016 known as NHS Improvement/England);

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2   Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2: TIMETABLE FOR ELECTION
2.   Timetable

2.1   The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3.   Computation of time
3.1   In computing any period of time for the purposes of the timetable:

(a)   a Saturday or Sunday;
(b)   Christmas day, Good Friday, or a bank holiday, or
(c)   a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2   In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3: RETURNING OFFICER

4.   Returning Officer
4.1   Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2   Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5.   Staff

5.1   Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6.   Expenditure

6.1   The corporation is to pay the returning officer:

(a)   any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b)   such remuneration and other expenses as the corporation may determine.

7.   Duty of co-operation

7.1   The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8.   Notice of election

8.1   The returning officer is to publish a notice of the election stating:

(a)   the constituency, or class within a constituency, for which the election is being held,

(b)   the number of members of the Council of Governors to be elected from that constituency, or class within that constituency,

(c)   the details of any nomination committee that has been established by the corporation,

(d)   the address and times at which nomination forms may be obtained;

(e)   the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f)   the date and time by which any notice of withdrawal must be received by the returning officer

(g)   the contact details of the returning officer

(h)   the date and time of the close of the poll in the event of a contest.

9.   Nomination of candidates

9.1   Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2   The returning officer:
(a)   is to supply any member of the corporation with a nomination form, and
(b)   is to prepare a nomination form for signature at the request of any member of

the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10.   Candidate's particulars

10.1   The nomination form must state the candidate's:

(a)   full name,

(b)   contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and

(c)   constituency, or class within a constituency, of which the candidate is a member.

11.   Declaration of interests

11.1   The nomination form must state:

(a)   any financial interest that the candidate has in the corporation, and

(b)   whether the candidate is a member of a political party or pressure group, and if so, which party or pressure group, and if the candidate has no such interests, the paper must include a statement to that effect.

The Trust has guidance available on the types of interest to be declared at nomination.

12.   Declaration of eligibility

12.1   The nomination form must include a declaration made by the candidate:

(a)   that s/he or she is not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the Constitution; and,

(b)   for a member of the public constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13.   Signature of candidate

13.1   The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a)   they wish to stand as a candidate,

(b)   their declaration of interests as required under rule 11, is true and correct, and

(c)   their declaration of eligibility, as required under rule 12, is true and correct.

13.2   Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14.   Decisions as to the validity of nomination

14.1   Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the

returning officer:

(a)   decides that the candidate is not eligible to stand,
(b)   decides that the nomination form is invalid,
(c)   receives satisfactory proof that the candidate has died, or
(d)   receives a written request by the candidate of their withdrawal from candidacy.

14.2   The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a)   that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,
(b)   that the paper does not contain the candidate's particulars, as required by rule 10;
(c)   that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,
(d)   that the paper does not include a declaration of eligibility as required by rule 12, or
(e)   that the paper is not signed and dated by the candidate, if required by rule 13.

14.3   The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4   Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5   The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15.   Publication of statement of candidates

15.1   The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2   The statement must show:

(a)   the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and
(b)   the declared interests of each candidate standing,

as given in their nomination form.

15.3   The statement must list the candidates standing for election in alphabetical order by surname.

15.4   The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the

statement.

16.   Inspection of statement of nominated candidates and nomination forms

16.1   The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2   If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17.   Withdrawal of candidates

17.1   A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18.   Method of election

18.1   If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the Council of Governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2   If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the Council of Governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3   If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be Council of Governors, then:

(a)   the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b)   the returning officer may order a new election to fill any vacancy which remains unfilled, on a day appointed by him/her in consultation with the corporation unless the Council of Governors at a meeting agrees to co-option.

PART 5: CONTESTED ELECTIONS

19.   Poll to be taken by ballot

19.1   The votes at the poll must be given by secret ballot.

19.2   The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3   The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4   The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and
(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and
(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and
(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (including a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:
(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency,
(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,
(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and
(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21.   **The declaration of identity (public constituency)**

21.1   The corporation shall require each voter who participates in an election for a public constituency to make a declaration confirming:

(a)   that the voter is the person:
(i)   to whom the ballot paper was addressed, and/or

(ii)   to whom the voter ID number contained within the e-voting information was allocated,

(b)   that he or she has not marked or returned any other voting information in the election, and

(c)   the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,
("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2   The voter must be required to return his or her declaration of identity with his or her ballot.

21.3   The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22.   **List of eligible voters**

22.1   The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2   The list is to include, for each member:
(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which his or her voting information may, subject to rule 22.3, be sent.

22.3   The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23.   **Notice of poll**

23.1   The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the Council of Governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24.   Issue of voting information by returning officer

24.1   Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter's voter ID number,

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d)   contact details of the returning officer,

("e-voting information").

24.2   Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope;

("postal voting information").

24.3   The corporation may determine that any member of the corporation shall:
(a)   only be sent e-voting information; or
(b)   only be sent postal voting information; or
(c)   be sent both postal voting information (only if no e-mail) and e-voting information;

for the purposes of the poll.

24.4   If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5   The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25.   Ballot paper envelope and covering envelope
25.1   The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2   The covering envelope is to have:
(a)   the address for return of the ballot paper printed on it, and
(b)   pre-paid postage for return to that address.

25.3   There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –
(a) the completed ID declaration form if required, and
(b) the ballot paper envelope, with the ballot paper sealed inside it.

26.   E-voting systems
26.1   If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2   If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as "the telephone voting facility").

26.3   If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as "the text message voting facility").

26.4   The returning officer shall ensure that the polling website and internet voting system provided will:

(a)   require a voter to:
        (i)   enter his or her voter ID number; and
        (ii)   where the election is for a public constituency, make a declaration of identity;
        in order to be able to cast his or her vote;

(b)   specify:
        (i)   the name of the corporation,
        (ii)   the constituency, or class within a constituency, for which the election is being held,
        (iii)   the number of members of the Council of Governors to be elected from that constituency, or class within that constituency,
        (iv)   the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
        (v)   instructions on how to vote and how to make a declaration of identity,
        (vi)   the date and time of the close of the poll, and
        (vii)   the contact details of the returning officer;

(c)   prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d)   create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-
        (i)   the voter's voter ID number;
        (ii)   the voter's declaration of identity (where required);
        (iii)   the candidate or candidates for whom the voter has voted; and
        (iv)   the date and time of the voter's vote,

(e)   if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f)   prevent any voter from voting after the close of poll.

26.5   The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:
        (a)   require a voter to
                (i)   enter his or her voter ID number in order to be able to cast his or her vote; and
                (ii)   where the election is for a public constituency, make a declaration of identity;

        (b)   specify:
                (i)   the name of the corporation,
                (ii)   the constituency, or class within a constituency, for which the election is being held,
                (iii)   the number of members of the Council of Governors to be elected from that constituency, or class within that constituency,
                (iv)   instructions on how to vote and how to make a declaration of identity,

(v)   the date and time of the close of the poll, and

(vi)   the contact details of the returning officer;

(c)   prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d)   create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:
(i)   the voter's voter ID number;
(ii)   the voter's declaration of identity (where required);
(iii)   the candidate or candidates for whom the voter has voted; and
(iv)   the date and time of the voter's vote

(e)   if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f)   prevent any voter from voting after the close of poll.

26.6   The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:
(a)   require a voter to:
(i)   provide his or her voter ID number; and
(ii)   where the election is for a public constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b)   prevent a voter from voting for more candidates than he or she is entitled to at the election;

(c)   create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:
(i)   the voter's voter ID number;
(ii)   the voter's declaration of identity (where required);
(ii)   the candidate or candidates for whom the voter has voted; and
(iii)   the date and time of the voter's vote

(d)   if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(e)   prevent any voter from voting after the close of poll.

The poll

27.   Eligibility to vote

27.1   An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28.   Voting by persons who require assistance

28.1   The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2   Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29.   Spoilt ballot papers and spoilt text message votes

29.1   If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2   On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3   The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:
(a)   is satisfied as to the voter's identity; and

(b)   has ensured that the completed ID declaration form, if required, has not been returned.

29.4   After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter on a list ("the list of spoilt ballot papers"):
(a)   the name of the voter, and

(b)   the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c)   the details of the unique identifier of the replacement ballot paper.

29.5   If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6   On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7   The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8   After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter on a list ("the list of spoilt text message votes"):
(a)   the name of the voter, and

(b)   the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(d)   the details of the replacement voter ID number issued to the voter.

30.   Lost voting information

30.1   Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2   The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:
(a)   is satisfied as to the voter's identity,
(b)   has no reason to doubt that the voter did not receive the original voting information,
(c)   has ensured that no declaration of identity, if required, has been returned.

30.3   After issuing replacement voting information in respect of lost voting information, the returning officer shall enter on a list ("the list of lost ballot documents"):
(a)   the name of the voter
(b)   the details of the unique identifier of the replacement ballot paper, if applicable, and
(c)   the voter ID number of the voter.

31.   Issue of replacement voting information
31.1   If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2   After issuing replacement voting information under this rule, the returning officer shall enter on a list ("the list of tendered voting information"):
(a)   the name of the voter,
(b)   the unique identifier of any replacement ballot paper issued under this rule;
(c)   the voter ID number of the voter.

32.   ID declaration form for replacement ballot papers (public constituency)
32.1   In respect of an election for a public constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33.   Procedure for remote voting by internet
33.1   To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2   When prompted to do so, the voter will need to enter his or her voter ID number.

33.3   If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4   To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5   The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34.   Voting procedure for remote voting by telephone

34.1   To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2   When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3   If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4   When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5   The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35.   Voting procedure for remote voting by text message

35.1   To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2   The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3   The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36.   Receipt of voting documents

36.1   Where the returning officer receives:
   (a)   a covering envelope, or
   (b)   any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

   before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2   The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no

person obtains or communicates information as to:
(a)   the candidate for whom a voter has voted, or
(b)   the unique identifier on a ballot paper.

36.3   The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37.   Validity of votes

37.1   A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2   Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:
(a)   put the ID declaration form if required in a separate packet, and
(b)   put the ballot paper aside for counting after the close of the poll.

37.3   Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:
(a)   mark the ballot paper "disqualified",
(b)   if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,
(c)   record the unique identifier on the ballot paper on a list of disqualified documents (the "list of disqualified documents"); and
(d)   place the document or documents in a separate packet.

37.4   An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5   Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6   Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:
(a)   mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",
(b)   record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) on the list of disqualified documents; and
(c)   place the document or documents in a separate packet.

38.   Declaration of identity but no ballot paper (public constituency)[1]

38.1   Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

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[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

(a)   mark the ID declaration form "disqualified",

(b)   record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and

(c)   place the ID declaration form in a separate packet.

39.   De-duplication of votes

39.1   Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2   If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a)   only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b)   mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3   Where a ballot paper is disqualified under this rule the returning officer shall:

(a)   mark the ballot paper "disqualified",

(b)   if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c)   record the unique identifier and the voter ID number on the ballot paper on the list of disqualified documents;

(d)   place the document or documents in a separate packet; and

(e)   disregard the ballot paper when counting the votes in accordance with these rules.

39.4   Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a)   mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b)   record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) on the list of disqualified documents;

(c)   place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d)   disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40.   Sealing of packets

40.1   As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a)   the disqualified documents, together with the list of disqualified documents inside it,

(b)   the ID declaration forms, if required,

(c)   the list of spoilt ballot papers and the list of spoilt text message votes,

(d)   the list of lost ballot documents,

(e)   the list of eligible voters, and

(f)   the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6: COUNTING THE VOTES

STV41. Interpretation of Part 6

STV41.1   In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X",

"*non-transferable vote*" means a ballot document:

(a)   on which no second or subsequent preference is recorded for a continuing candidate, or

(b)   which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a)   "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b)   "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c)   in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

"*stage of the count*" means:

(a)   the determination of the first preference vote of each candidate,
(b)   the transfer of a surplus of a candidate deemed to be elected, or
(c)   the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42.   Arrangements for counting of the votes
42.1   The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2   The returning officer may make arrangements for any votes to be counted using vote counting software where:
(a)   the Board of Directors and the Council of Governors of the corporation have approved:
(i)   the use of such software for the purpose of counting votes in the relevant election, and
(ii)   a policy governing the use of such software, and

(b)   the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.
(c)   by contracting   an independent election service serves as organisation approval of the counting systems used

43.   The count
43.1   The returning officer is to:

(a)   count and record the number of:
(iii)   ballot papers that have been returned; and
(iv)   the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b)   count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2   The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3   The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1   Any ballot paper:
(a)   which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
(b)   on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,
(c)   on which anything is written or marked by which the voter can be identified except the unique identifier, or
(d)   which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2   The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV44.3   Any text voting record:
(a)   on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,
(b)   on which anything is written or marked by which the voter can be identified except the unique identifier, or
(c)   which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4   The returning officer is to endorse the word "rejected" on any text voting record which under this rule is not to be counted.

STV44.5   The returning officer is to draw up a statement showing the number of ballot papers rejected by him/her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him/her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

STV45. First stage

STV45.1   The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2   The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3   The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1   The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2   The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

STV46.3   At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1   Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

          (a)   according to next available preference given on those ballot documents for any continuing candidate, or
          (b)   where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2   The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3   The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4   The vote on each ballot document transferred under rule STV47.3 shall be at a value ("the transfer value") which:

          (a)   reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and
          (b)   is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5   Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which

was last received by that candidate into separate sub-parcels so that they are grouped:

(a)   according to the next available preference given on those ballot documents for any continuing candidate, or

(b)   where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6   The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7   The vote on each ballot document transferred under rule STV47.6 shall be at:

(a)   a transfer value calculated as set out in rule STV47.4(b), or

(b)   at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8   Each transfer of a surplus constitutes a stage in the count.

STV47.9   Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10   Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a)   less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b)   less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11   This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1   If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a)   The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b)   the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2   The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a)   record the total value of the votes transferred to each candidate,

(b)   add that value to the previous total of votes recorded for each candidate and record the new total,

(c)   record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d)   compare:

(i)   the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii)   the recorded total of valid first preference votes.

STV48.3   All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4   Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1   If:

(a)   all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b)   subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV9.2   The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a)   ballot documents on which a next available preference is given, and

(b)   ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3   The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4   The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5   If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6   The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7   The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8   Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9   After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10   The returning officer shall after each stage of the count completed under this rule:
            (a) record:
                 (i)   the total value of votes, or
                 (ii)   the total transfer value of votes transferred to each candidate,
            (b) add that total to the previous total of votes recorded for each candidate and record the new total,
            (c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and
            (d) compare:
                 (i)   the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with
                 (ii)   the recorded total of valid first preference votes.

STV49.11   If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12   Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13   If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:
            (a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of

votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b)   where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1   Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2   Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3   Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1   The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2   A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3   Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4   Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS
Council of Governors
STV52. Declaration of result for contested elections

STV52.1   In a contested election, when the result of the poll has been ascertained, the returning officer is to:
(a)   declare the candidates who are deemed to be elected under Part 6 of these rules as elected,
(b)   give notice of the name of each candidate who he or she has declared elected:
(i)   where the election is held under a proposed constitution pursuant to powers conferred on the Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust by section 33(4) of the 2006 Act, to the chair of the NHS Trust, or

(ii) in any other case, to the chair of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chair of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with "rejected in part",

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone

voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3   The returning officer must endorse on each packet a description of:
(a)   its contents,
(b)   the date of the publication of notice of the election,
(c)   the name of the corporation to which the election relates, and
(d)   the constituency, or class within a constituency, to which the election relates.

55.   Delivery of documents

55.1   Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56.   Forwarding of documents received after close of the poll

56.1   Where:
(a)   any voting documents are received by the returning officer after the close of the poll, or
(b)   any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or
(c)   any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chair of the corporation.

57.   Retention and public inspection of documents

57.1   The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2   With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3   A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58.   Application for inspection of certain documents relating to an election

58.1   The corporation may not allow:
(a)   the inspection of, or the opening of any sealed packet containing –
(i)   any rejected ballot papers, including ballot papers rejected in part,
(ii)   any rejected text voting records, including text voting records rejected in part,
(iii)   any disqualified documents, or the list of disqualified documents,
(iv)   any counted ballot papers, internet voting records, telephone voting records or text voting records, or
(v)   the list of eligible voters, or
(b)   access to or the inspection of the complete electronic copies of the internet

voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2   A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3   The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –
(a)   persons,
(b)   time,
(c)   place and mode of inspection,
(d)   production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4   On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:
(a)   in giving its consent, and
(b)   in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –
(i)   that his or her vote was given, and
(ii)   that Monitor (or successor body i.e. NHS England) has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

STV59. Countermand or abandonment of poll on death of candidate
STV59.1   If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:
(a)   publish a notice stating that the candidate has died, and
(b)   proceed with the counting of the votes as if that candidate had been excluded from the count so that –
(i)   ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and
(ii)   ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2   The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. **Election expenses**

60.1   Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to NHS Improvement/England under Part 11 of these rules.

61. **Expenses and payments by candidates**

61.1   A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a)   personal expenses,

(b)   travelling expenses, and expenses incurred while living away from home, and

(c)   expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100.

62. **Election expenses incurred by other persons**

62.1   No person may:

(a)   incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b)   give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2   Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. **Publicity about election by the corporation**

63.1   The corporation may:

(a)   compile and distribute such information about the candidates, and

(b)   organise and hold such meetings, whether online or face-to-face, to enable the candidates to speak and respond to questions, or to themselves gain further information.

as it considers necessary.

63.2   Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a)   objective, balanced and fair,

(b)   equivalent in size and content for all candidates,

(c)   compiled and distributed in consultation with all of the candidates standing for election, and

(d)   must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3   Where the corporation proposes to hold a meeting (face-to-face or online) to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at

the expense of the electoral prospects of one or more other candidates.

64.   Information about candidates for inclusion with voting information

64.1   The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2   The information must consist of:
(a)   a statement submitted by the candidate of no more than 250 words,
(b)   if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

65.   Meaning of "for the purposes of an election"

65.1   In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2   The provision by any individual of his or her own services voluntarily, in his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66.   Application to question an election

66.1   An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor or successor body (NHS England) for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2   An application may only be made once the outcome of the election has been declared by the returning officer.

66.3   An application may only be made to Monitor or successor body (NHS England) by:
(a)   a person who voted at the election or who claimed to have had the right to vote, or
(b)   a candidate, or a person claiming to have had a right to be elected at the election.

66.4   The application must:
(a)   describe the alleged breach of the rules or electoral irregularity, and
(b)   be in such a form as the independent panel may require.

66.5   The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by Monitor or successor body (NHS England).

66.6   If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7   Monitor or successor body (NHSEngland) shall delegate the determination of an

application to a person or panel of persons to be nominated for the purpose.

66.8   The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9   The IEAP may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

67.   Secrecy

67.1   The following persons:
         (a)   the returning officer,
         (b)   the returning officer's staff,

         must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:
         (i)   the name of any member of the corporation who has or has not been given voting information or who has or has not voted,
         (ii)   the unique identifier on any ballot paper,
         (iii)   the voter ID number allocated to any voter,
         (iv)   the candidate(s) for whom any member has voted.

67.2   No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3   The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68.   Prohibition of disclosure of vote

68.1   No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69.   Disqualification

69.1   A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

         (a)   a member of the corporation,
         (b)   an employee of the corporation,
         (c)   a director of the corporation, or
         (d)   employed by or on behalf of a person who has been nominated for election.

70.   Delay in postal service through industrial action or unforeseen event

70.1   If industrial action, or some other unforeseen event, results in a delay in:
         (a)   the delivery of the documents in rule 24, or

(b)   the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 5 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

1.   Council of Governors: Terms of Office (see also Section 13)

   1.1   A Governor:

      1.1.1   shall cease to hold office if:

         (a)   s/he ceases to be a Member of a Trust constituency or, in the case of an Appointed Governor, if the body which appointed him/her withdraws its appointment at any time;

         (b)   his/her term of office is terminated in accordance with paragraph 3 below and/or s/he is disqualified from or is otherwise ineligible to hold office as a Governor; or

      1.1.2   s/he resigns by notice in writing to the Trust.

   1.2   Notwithstanding the provisions of paragraph 1.1.1(a) above, a Public Governor elected by a Public Constituency who ceases to be eligible to be a Member of that Public Constituency but who is eligible to be and forthwith becomes a Member of another Public Constituency shall not by virtue of paragraph 1.1.1(a) above cease to hold office but shall continue in office as Public Governor for the Constituency which elected him/her for the remainder of the term for which he was elected.

2.   Council of Governors: Removal and Disqualification

   2.1   A Governor shall not be eligible to become or continue in office as a Governor if:

      2.1.1   s/he ceases to be eligible to be a Member, save in the case of Appointed Governors;

      2.1.2   in the case of an Appointed Governor, the appointing organisation withdraws its appointment of him/her;

      2.1.3   any of the grounds contained in paragraph 14 of the Constitution apply to him/her;

      2.1.4   s/he has within the preceding two years been lawfully dismissed otherwise than by reason of redundancy from any paid employment with a Health Service Body;

      2.1.5   s/he is a person whose term of office as the ~~chair~~ Chair or as a member or director of a Health Service Body has been terminated on the grounds that his/her continuance in office is no longer in the best interests of the health service, for non-attendance at meetings or for non-disclosure of a pecuniary interest;

      2.1.6   s/he has had his/her name removed by a direction under Section 154 of the 2006 Act from any list prepared under Part 4 of that Act and has not subsequently had his/her name included on such a list;

2.1.7   s/he has failed to make, or has falsely made, any declaration as required to be made under Section 60 of the 2006 Act or has spoken or voted in a meeting on a matter in which they have direct or indirect pecuniary or non-pecuniary interest and s/he is judged to have acted so by a majority of not less than 75% of the Council of Governors at a meeting;

2.1.8   NHS ~~Improvement/~~England has exercised its powers to remove him/her as a Governor of the Trust or has suspended him/her from office or has disqualified him/her from holding office as a Governor of the Trust for a specified period or NHS ~~Improvement/~~England has exercised any of those powers in relation to him/her on any other occasion whether in relation to the Trust or some other NHS Foundation Trust;

2.1.9   s/he has received a written warning from the Trust for verbal and/or physical abuse towards Trust staff;

2.1.10   s/he has at any time been placed on the registers of Schedule 1 Offenders pursuant to the Sexual Offences Act 2003 (as amended) and/or the Children and Young Person's Act 1933 to 1969 (as amended);

2.1.11   s/he has within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on him/her;

2.1.12   his/her term of office is terminated pursuant to paragraph 3 below;

2.1.13   s/he is a Member of a Staff Class and any professional registration relevant to his eligibility to be a Member of that Staff Class has been suspended for a continuous period of more than six 6 months;

2.1.14   s/he is incapable by reason of mental disorder, illness or injury in managing and administering his property and/or affairs;

2.1.15   the relevant organisation which s/he represents ceases to exist;

2.1.16   s/he is a member of the UK Parliament;

2.1.17   s/he is a Director of the Trust;

2.2   Where a person has been elected or appointed to be a Governor and s/he becomes disqualified from that appointment s/he shall notify the Company Secretary in writing of such disqualification as soon as practicable and in any event within 14 days of first becoming aware of those matters which rendered him/her disqualified.

2.3   If it comes to the notice of the Trust that a Governor is disqualified, the Trust shall immediately declare him/her disqualified and shall give him/her notice in writing to that effect as soon as practicable.

2.4   Upon the giving of notice under paragraphs 2.2 and 2.3 above, that person's tenure of office as a Governor shall thereupon be terminated and s/he shall cease to be a Governor and his/her name shall be removed from the Register of Governors.

2.5   If a complaint is received against a member of the governing body it shall be referred to the Trust Board Chair;

2.5.1   the Chair shall appoint a suitably experienced person to undertake the role of investigating officer on behalf of the Trust

2.5.2   the investigating officer (IO) shall conduct a short initial investigation into the matter to establish whether there may be a case to answer

2.5.3   if the IO determines the matter does not constitute a viable complaint they shall make such a recommendation, in writing, to the Chair. If the Chair accepts that recommendation the matter ends there

2.5.4   if the IO determines there may be a case then a fuller investigation shall commence. At that point the question as to whether the governor about whom a complaint has been made can continue to operate as a governor in the interim shall be considered. The IO shall examine the facts and circumstances known at that time and make a written recommendation to the Chair.

2.5.5   when considering whether suspension is appropriate there shall be a presumption that the governor will remain in office unless there are factors that, on the balance of probability, make that unacceptable. Suspension is a significant step, not to be taken lightly

2.5.6   factors that shall be considered –
         Either -
         (a)   the investigation of the case may be prejudiced unless the governor is suspended, or
         (b)   having regard to the nature of the allegation and any other relevant considerations the public interest requires that the governor should be suspended
         AND
         (c)   it is not practicable to restrict the role of the governor in any way that may still enable them to continue in their principal role
         (d)   for example asking a governor to step down temporarily from committee or meeting attendance, or placing restrictions upon them to prevent routine contact with a complainant.

2.5.7   The Chair upon receipt of the IO's report shall determine whether or not suspension shall be made whilst an investigation takes place.

3.   Council of Governors: Termination of Tenure

3.1   A Governor's term of office shall be terminated:

3.1.1   by the Governor giving notice in writing to the Company Secretary of his/her resignation from office at any time during that term of office;

3.1.2   by the Trust if any grounds exist under paragraph 2 above;

3.1.3 by the Council of Governors if s/he has failed to attend two consecutive meetings of the Council of Governors unless within one month of the second meeting, the Council of Governors is satisfied that:

(a) the absence was due to reasonable cause; and

(b) the Governor will resume attendance at meetings of the Council of Governors within such period as it considers reasonable.

3.1.4 if the Council of Governors resolves to terminate his/her term of office for reasonable cause on the grounds that in the reasonable opinion of not less than 75% of the Governors present and voting at a meeting of the Council of Governors convened for that purpose that his/her continuing as a Governor (with no rights of appeal in case of 3.1.4j), would or would be likely to:

(a) prejudice the ability of the Trust to fulfil its principal purpose or of its purposes under this Constitution or otherwise to discharge its duties and functions; or

(b) prejudice the Trust's work with other persons or body with whom it is engaged or may be engaged in the provision of goods and services; or

(c) adversely affect public confidence in the goods and services provided by the Trust; or

(d) otherwise bring the Trust into disrepute or is detrimental to the interest of the Trust; or

(e) it would not be in the best interests of the Trust for that person to continue in office as a Governor; or

(f) the Governor is a vexatious or persistent litigant or complainant with regard to the Trust's affairs and his/her continuance in office would not be in the best interests of the Trust; or

(g) s/he has failed or refused to undertake and/or satisfactorily complete any training which the Council of Governors has required him/her to undertake in his/her capacity as a Governor by a date six months from the date of his/her election or appointment; or from a date when they have been asked to undertake additional training or development for any reason;

(h) s/he has in his/her conduct as a Governor failed to comply and support in a material way with the values and principles of the National Health Service or the Trust, and the Constitution; or

(i) s/he has committed a material breach of any code of conduct applicable to Governors of the Trust and/or the Governors Standing Orders;

(j) a Governor who has breached a code of conduct and has attended a formal Conduct Committee (*see 6.2*), the outcome and recommendation of which is referred to the Council of Governors, has no means of appeal.

3.2   Upon a Governor resigning under paragraph 3.1.1 above or upon the Council of Governors resolving to terminate a Governor's tenure of office in accordance with the above provisions, that Governor shall cease to be a Governor and his/her name shall be forthwith removed from the Register of Governors.

3.3   The Standing Orders adopted by the Council of Governors (section5) may contain provisions governing its procedure for termination under these provisions and for a Governor to appeal against the decision terminating his tenure of office, except in the case of 3.1.4j above.

3.4   A Governor who resigns or whose tenure of office is terminated under this paragraph 3 shall not be eligible to stand for re-election for a period of 3 years from the date of his/her resignation or removal from office or the date upon which any appeal against his/her removal from office is disposed of whichever is the later except by resolution carried by a majority of the Council of Governors present and voting at a general meeting. Any re-election would take into account time served as a Governor so that a maximum term would not exceed nine years.

3.5   Where a Governor's membership of the Council of Governors ceases for one of the reasons set out in paragraph 2 or paragraph 3, Elected Governors shall be replaced in accordance with paragraphs 4.1 to 4.4 below and, in the case of Appointed Governors, the Trust shall invite the relevant appointing body to appoint a new Governor to hold office for the remainder of the term of office in accordance with the processes referred to in Annex 3 within 30 days of the vacancy having arisen.

4.   Vacancies – Elected Governors

4.1   In the case of an Elected Governor, where a vacancy arises within 6 months of the election then the candidate who secured the next highest number of votes for that Constituency will be appointed.

4.2   If the vacancy arises during the last 6 months of office, the office will remain vacant until it is filled at the next scheduled election.

4.2.1   If a vacancy arises at any other time it will be filled at the next scheduled election, in accordance with the Election Scheme. The Council of Governors may co-opt a member of the appropriate constituency whose term is just finishing, to fill a vacancy until the next scheduled election, but this shall be reserved for where deemed essential for reasons to ensure full functioning of Council of Governors business (see 4.3 below).

4.3   No defect in the election or appointment of a Governor nor any deficiency in the composition of the Council of Governors shall affect the validity of any act or decision of the Council of Governors.

5.   Council of Governors: Role

5.1   The Council of Governors and each Governor shall act in the best interests of the Trust at all times and with proper regard to the provisions of the NHS Foundation Trust Code of Governance and any code of conduct for the Council of Governors.

5.2   Subject to the requirement specified in paragraph 5.1 above, each Governor shall exercise his/her own skill and judgement in his/her conduct of the Trust's affairs and shall in his/her stewardship of the Trust's affairs bring as appropriate the perspective

of the constituency or organisation by which s/he was elected or appointed, as the case may be. Public governors are expected to represent all members and the public, and not to promote a single issue or cause.

5.3   Subject to the further provisions of this Constitution and without in any way derogating from them, the Council of Governors shall;

5.3.1   hold the Non-Executive Directors to account in assisting the Board of Directors in setting the strategic direction of the Trust and targets for the Trust's performance and in monitoring the Trust's performance in terms of achieving those strategic aims and targets which have been set; and

5.3.2   observe the activities of the Trust with the view to ensuring that they are being conducted in a manner consistent with this Constitution.

6.   Council of Governors: Meetings

6.1   The Council of Governors shall hold not less than 3 general meetings each financial year. However, in extremis (*see para 16.5*), the Chair may decided to suspend Council of Governors' meetings.

6.2   The Council of Governors may appoint sub-committees, consisting of its members, which are relevant and proportionate, to advise and assist it in the discharge of its functions. The outcomes of such committees will be in the form of recommendations to be presented to the Council of Governors. Recommendations presented to the Council of Governors therefore provide a second layer of oversight on a particular matter of interest by governor peers.

7.   Council of Governors: Declarations

7.1   A Member of a Public Constituency standing for election as Governor must make a declaration for the purposes of Section 60 of the 2006 Act in the form specified below stating the particulars of his qualification to vote as a Member and that s/he is not prevented from being a member of the Council of Governors by virtue of any provisions of this Constitution.

7.2   The specified form of declaration shall be set out on the Nomination Form referred to in the Election Scheme and shall state as follows:

"I, the above named candidate, consent to my nomination and agree to stand for election to the Council of Governors in the constituency indicated in Section One of this form. I also declare that I am a member in that constituency. I, the above named candidate, hereby declare that I am not:

a.   a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged

b.   a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it

c.   a person who within the preceding 5 years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than 3 months (without the option of a fine) was imposed on him/her

> d. excluded by any other provision detailed within the Trust's Constitution
>
> e. agree to support the values of the Trust and abide by the Governor Code of Conduct.

I confirm that, to the best of my knowledge, the information provided on (or in connection with) this form is accurate."

8. Council of Governors: Lead Governor

8.1 No person may serve as the Lead Governor for more than a total of nine years.

8.2 A person elected as the Lead Governor shall cease to be eligible to continue serving as the Lead Governor if s/he ceases to be a Governor or Member and the Lead Governor's term of office may be terminated by a majority of not less than 75% of the Governors present and voting at a meeting of the Council of Governors.

9. Council of Governors: Appointment of Senior Independent Director

9.1 A majority of the Governors shall at a general meeting of the Council of Governors agree the appointment of one of the Non-Executive Directors as recommended by the Board of Directors to be the Senior Independent Director for a term of three years. The Senior Independent Director shall be eligible for re-appointment at the end of that term but may not serve as Senior Independent Director for more than a total of six years.

9.2 The Senior Independent Director shall be available to Members and Governors if they have concerns which contact through the normal channels of the Chair, Chief Executive or Finance Director has failed to resolve or for which such contact is inappropriate.

9.3 A person appointed as the Senior Independent Director shall cease to be eligible to continue serving as the Senior Independent Director if s/he ceases to be a Non-Executive Director and the Senior Independent Director's term of office may be terminated by a majority of not less than 75% of the Governors present and voting at a meeting of the Council of Governors on the recommendation of the Chair.

ANNEX 6 – FURTHER PROVISIONS

1.   Eligibility for Membership

It is the responsibility of Members to ensure their eligibility and not the Trust, but if the Trust is on notice that a Member may be disqualified from Membership, the Trust shall carry out all reasonable enquiries to establish if this is the case.

2.   Public Constituency

2.1   For the purposes of determining whether an individual lives in an area specified as an area for Public Constituency, an individual shall be deemed to do so if:

2.1.1   his/her name appears on the electoral roll at an address within the said area and the Trust has no reasonable cause to conclude that the individual is not living at that address; or

2.1.2   the Trust is otherwise satisfied that the individual lives in the said area.

2.2   An individual who is a Member of the Public Constituency shall cease to be eligible to continue as a Member if s/he ceases to live in the area of the Public Constituency of which s/he is a Member save as may otherwise be provided in this paragraph 2.

2.3   Where a Member of a Public Constituency ceases to live permanently in the area of the Public Constituency of which s/he is a Member s/he shall forthwith advise the Trust that s/he is no longer eligible to continue as a Member and the Trust shall forthwith remove his/her name from the Register of Members unless the Trust is satisfied that the individual concerned lives in some other area of a Public Constituency of the Trust. Where the Trust is satisfied that such an individual continues to live in the area of a Public Constituency of the Trust it shall, if the individual so requests, thereafter treat that individual as a Member of that other Public Constituency and amend the Register of Members accordingly provided the Trust has given that individual not less than 14 days' notice of its intention to do so.

2.4   Where a Member ceases to live temporarily in the area of the Public Constituency of which s/he is a Member, the Trust may permit that individual nonetheless to remain on the Register of Members for that Public Constituency if it is for good cause satisfied that the absence is of a temporary duration only and that the Member will either return to live in the area of that Public Constituency of which s/he is a Member or will live in some other part of the area of the Trust in which case the provisions of paragraph 2.1 shall apply as appropriate.

3.   Staff Constituency

3.1   A Member of a Staff Class will cease to be eligible to be a Member of that Staff Class if they no longer meet the eligibility requirements of paragraph 7 of the Constitution and of Annex 2.

3.2   Where an individual is a Member by virtue of their eligibility to be a Member of a Staff Class and they cease to be eligible for Membership of that Staff Class but are eligible for Membership of some other Staff Class then the Trust may give notice to that Member of its intention to transfer him/her to that other Staff Class on the

expiration of a period of time or upon a date specified in the said notice and shall after the expiration of that notice or date amend the Register of Members accordingly.

4.   Membership Termination of Tenure

4.1   A Member shall cease to be a Member if:-

4.1.1   they cease to be entitled under this Constitution to be a Member of any of the Public Constituencies or one of the classes of the Staff Constituency;

4.1.2   they resign by notice in writing to the Secretary;

4.1.3   they die;

4.1.4   they are expelled under this Constitution;

4.1.5   if it appears to the Secretary that they no longer wish to be involved in the affairs of the Trust as a Member, and after enquiries made in accordance with a process approved by the Council of Governors they fail to establish that they have a continuing wish to be involved in the affairs of the Trust as a Member.

5.   Board of Directors: Disqualification

5.1   In addition to the grounds of disqualification set out in Sections 24 26 - 26 27 of the Constitution, a person may also not be or continue as a Director of the Trust if:

5.1.1   in the case of a Non-Executive Director, s/he no longer satisfies the relevant requirements for appointment;

5.1.2   s/he is a person whose tenure of office as a chair or as a director of a Health Service Body has been terminated on the grounds that his/her appointment is not in the interests of public service, or for non-disclosure of a pecuniary interest;

5.1.3   s/he has within the preceding two years been dismissed, otherwise than by reason of redundancy, by the coming to an end of fixed term contract or through ill health, from any paid employment with a Health Service Body;

5.1.4   information revealed by a DBS check is such that it would be inappropriate for him/her to become or continue as a Director on the grounds that this would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute;

5.1.5   in the case of an Executive Director, s/he is no longer employed by the Trust;

5.1.6   s/he is a person who has had their name removed by a Direction under Section 154 of the 2006 Act from any list prepared under Part 4 of that Act, and have not subsequently had their name included on such a list;

5.1.7   s/he is the subject of a disqualification order made under the Company Directors' Disqualifications Act 1986;

5.1.8   s/he has failed to sign and deliver to the Secretary in the form required by the Board of Directors confirmation that s/he accepts the Trust's Standards of Business Conduct Policy;

5.1.9   s/he has failed or refused to undertake any training which the Board of Directors requires all Directors to undertake;

5.1.10 s/he is a partner or spouse of an existing Director.

6.   Governors and Directors: Communication and Conflict

6.1   Summary

This paragraph describes the processes intended to ensure a successful and constructive relationship between the Council of Governors and the Board of Directors. It emphasises the importance of informal and formal communication, ~~a~~and confirms the formal arrangements for communication within the Trust. It suggests an approach to informal ~~communications, and~~communications and sets out the formal arrangements for resolving conflicts between the Council of Governors and the Board of Directors.

6.2   Informal Communications

6.2.1   Informal and frequent communication between the Lead Governor, Governors and the Directors is an essential feature of a positive and constructive relationship designed to benefit the Trust and the services it provides.

6.2.2   The Chair shall use his/her reasonable endeavours to encourage effective informal methods of communication including:

(a)   participation of the Board of Directors in the induction, orientation and training of Governors;

(b)   development of special interest relationships between Non-Executive Directors and Governors;

(c)   discussions between Governors and the Chair and/or the Chief Executive and/or Directors through the office of the ~~Secretary~~office of the Chief Executive or his nominated officer;and~~;~~

(d)   involvement in Membership recruitment and briefing at public events organised by the Trust.

6.2.3   Governors will be given information on to whom they should report operational issues.

6.3   Formal Communication

6.3.1   Some aspects of formal communication are defined by the constitutional roles and responsibilities of the Council of Governors and the Board of Directors respectively.

6.3.2   Formal communications initiated by the Council of Governors and intended for the Board of Directors will be conducted as follows:

(a)   specific requests by the Council of Governors will be made through the Company Secretary to the Chair to the Board of Directors;

(b)   any Governor has the right to raise specific issues to be put to the Board of Directors at a duly constituted meeting of the Council of Governors through the Chair. Such issues should be raised with the Chair (or, if it involves the Chair then the Deputy Chair) no less than 10 working days before the meeting in order to be included in the agenda. In the event of disagreement, two thirds of the Governors present must approve the request. The Chair will raise the matter with the Board of Directors and provide the response to the Council of Governors;

(c)   joint meetings will take place as and when, as, appropriate between the Council of Governors and the Board of Directors.

6.3.3   The Board of Directors may request the Chair to seek the views of the Council of Governors on such matters as the Board of Directors may from time to time determine.

6.3.4   Communications initiated by the Board of Directors and intended for the Council of Governors will be conducted as follows:

(a)   request the Chair to seek the view of the Council of Governors on the Board of Directors' proposals for the Strategic Direction and the Annual Plan;

(b)   presentation and approval of annual accounts, annual report and auditor's report;

(c)   request the Chair to seek the view of the Council of Governors on the Board of Directors' proposals for developments;

(d)   request the Chair to seek the view of the Council of Governors on Trust Performance;

(e)   request the Chair to seek the view of the Council of Governors for involvement in service reviews and evaluation;

(f)   request the Council of Governors to seek views of the Membership on proposed changes, plans and developments.

6.3.5   Formal communications will normally be conducted as follows:

(a)   attendance by the Board of Directors at a meeting of the Council of Governors;

(b)   provision of formal reports or presentations by executive and/or non-executive Directors to a meeting of the Council of Governors;

(c)   inclusion of minutes for information on the Agenda agenda of a meeting of the Council of Governors;

(d)   reporting the views of the Council of Governors to the Board of Directors through the Chair or Lead Governor;

(e)   Governors attend meetings in public of the Board of Directors as observers.

6.3.6   Wherever possible and practical, written communications will be conducted by e-mail, and meetings by video-conferencing.

6.4   Resolving Conflict

6.4.1   The Council of Governors and the Board of Directors must be committed to developing and maintaining a constructive and positive relationship. The aim at all times is to resolve any potential or actual differences of view quickly, through discussion and negotiation.

6.4.2   If as the first step, the informal efforts of the Chair do not achieve resolution of a disagreement or a conflict, the Chair will follow the process described in paragraph 7.4.3 below. The aim is to resolve the matter at the first available opportunity, and only to escalate to the next step if the step taken fails to achieve resolution.

6.4.3   In the event of a conflict between the Council of Governors and Board of Directors, the following action will be taken, in the sequence shown:

(a)   the Chair will call a Resolution Meeting of the members of the Council of Governors and Board of Directors, to take place as soon as possible, but no later than twenty working days following the date of the request. The meeting must comprise of two thirds of the Membership of the Council of Governors and two thirds of the membership of the Board of Directors. The meeting will be held in private. The ~~Agenda~~ agenda and any papers for the meeting will be issued in accordance with the Standing Orders of the Council of Governors. The aim of the meeting will be to achieve resolution of the conflict. The Chair will have the right to appoint an independent facilitator to assist the process. Every effort must be made to reach agreement;

(b)   if a Resolution Meeting of the members of the Council of Governors and Board of Directors fails to resolve a conflict, the Board of Directors will decide the disputed matter;

(c)   if, following the formal Resolution Meeting, and the decision of the Board of Directors, the Council of Governors considers that implementation of the decision will result in the Trust failing to comply with its Constitution, the Council of Governors will refer the specific issue of non-compliance to NHS Improvement/England.

6.4.4   The right to call a Resolution Meeting rests with the following, in the sequence of escalation shown:

(a)   the Chair;

(b)   the Chief Executive;

(c)   two thirds of the members of the Council of Governors;

(d)   two thirds of the members of the Board of Directors.

7.   Indemnity

Members of the Council of Governors and Board of Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their Board functions, save where they have acted recklessly. Any reasonable costs arising in this way will be met by the Trust and the Trust shall have the power to purchase suitable insurance or make appropriate arrangements with the National Health Service Litigation Special Health Authority or successor body to cover such costs.

8.   Validity of Actions

No defect or deficiency in the appointment or composition of the Council of Governors or the Board of Directors shall affect the validity of any action taken by them.

9.   Registers

9.1   The Company Secretary shall be responsible for compiling and maintaining the Registers. Removal from any Register shall be in accordance with the provisions of this Constitution. The Secretary shall update the registers with new or amended information as soon as is practical and in any event within 14 days.

9.2   Register of Members

9.2.1   Members must complete and sign an application in the form prescribed by the Company Secretary; and

9.2.2   the Company Secretary shall maintain the Register of members will be in two parts. Part 1 shall include the name of each Member Registers (see section 32 and 33) and the Constituency or class to which they belong and shall be open to inspection by the public in accordance with paragraph 33 of this Constitution. Part 2 shall contain all the information from the individual's application form and shall not be open to inspection by the public nor may copies or extracts from it be made available to any third party. Notwithstanding this provision, the Trust shall extract such information as it needs in aggregate to satisfy itself that the actual Membership of the Trust is representative of those eligible for Membership.

9.3   Register of Members of the Council of Governors

The Register shall list the names of members of the Council of Governors, their category of Membership of the Board (public, staff or organisation represented) and an address through which they may be contacted which may be the Secretary.

9.4   Register of Interests of the Members of the Council of Governors

Each member of the Council of Governors shall complete and sign a form as prescribed by the Secretary setting out interests to be declared in accordance with the Standing Orders and the register shall contain the names of all members of the Council of Governors and any interests declared including no interests.

9.5   Register of Interests of Directors

The Register shall list the names of Members of the Board of Directors, their capacity on the Board and an address through which they may be contacted which may be the Secretary.

Each Member of the Board of Directors shall complete and sign a form as prescribed by the Company Secretary setting out any interests to be declared in accordance with the Standing Orders for the Board of Directors and the Register shall contain the names of all members of the Board of Directors and any interests declared including no interests.

10.   Auditor

10.1   A person may only be appointed auditor if s/he (or in the case of a firm each of its members) is a member of one or more of the following bodies:

10.1.1   the bodies mentioned in section 3(7)(a) to (e) of the Audit Commission Act 1998; or

10.1.2   any other body of accountants established in the United Kingdom and approved by NHS Improvement/England.

11.   Accounts

11.1   The following documents will be made available to the Comptroller and Auditor General for examination at his/her request:

11.1.1   the accounts;

11.1.2   any records relating to them; and

11.1.3   any report of the auditor one them.

11.2   In preparing its annual accounts, the Trust is to comply with any directions given by NHS ~~Improvement/~~England with the approval of the Treasury as to:

11.2.1   the methods and principles according to which the accounts are to be prepared; and

11.2.2   the information to be given in the accounts.

11.3   The Trust must:

11.3.1   lay a copy of the annual accounts, and any report of the auditor on them, before Parliament; and

11.3.2   once it has done so, send copies of those documents to NHS Improvement/England.

11.4   Annual reports and forward plans

11.4.1   The annual report submitted by the Trust to NHS Improvement/England in accordance with paragraph 39.1 is to give:

(a)   information on any steps taken by the Trust to secure that (taken as a whole) the actual Membership of its public constituencies is representative of those eligible for such Membership; and

(b)   any other information NHS Improvement/England requires.

11.4.2   The Trust is to comply with any decision NHS Improvement/England makes as to:

11.4.3   the form of the reports;

11.4.4   when the reports are to be sent to it; and

11.4.5   the periods to which the reports are to relate.

ANNEX 7 – ANNUAL MEMBERS' MEETING

1.   ANNUAL MEMBERS' MEETING

1.1   The Trust shall publicise and hold an annual meeting of its members ('Annual Members' Meeting') prior to 30 September each year (unless the circumstances of para 16.5 apply).

1.2   The following documents are to be presented to the members and governors of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

　　　　1.2.1   the annual accounts;

　　　　1.2.2   any report of the External auditor on them; and

　　　　1.2.3   the annual report.

1.3   There may be times and reasons that the Annual Members' Meeting may be held "virtually online" and not face to face. The Chair will decide these times in consultation with the Lead Governor and Board of Directors.

2.   ADMISSION OF THE PUBLIC AND PRESS

2.1   Members, the public and representatives of the press shall be afforded facilities to attend the Annual Members' Meeting.

2.2   The Chair (or Deputy Chair) shall give such directions as s/he thinks fit in regard to the arrangements for meetings and accommodation of members, the public and representatives of the press such as to ensure that business shall be conducted without interruption and disruption.

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

3.   CHAIR

3.1   The Chair, if present, shall preside at the annual members meeting. If the Chair is absent from the meeting the Deputy Chair shall preside.

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

4.   NOTICE OF MEETING

4.1   The Company Secretary shall give at least fourteen ~~days notice~~days' notice of the date and place of the Annual Members' Meeting to all Governors. Notice will also be published in communications to Trust members and on the Trust's website.

4.2   The notice of the meeting will specify the business proposed to be transacted at it

4.3   Lack of service of the notice on any Governor shall not affect the validity of a meeting.

4.4   Before the Annual Members' Meeting, a notice of the meeting, specifying the business proposed to be transacted at it, shall be placed on the Trust's website and shall be delivered to every Governor by e-mail or sent by post to the usual place of residence of such Governor if e-mail facility not available, so as to be available to him/her at least three clear days before the meeting.

4.5   Where the AMM is held virtually, members will have opportunities to ask questions on the business transacted before and after the meeting presentations by submitting directly to the AMM website and/or via the Trust Board Office.

5.   PRESENTATION OF THE ANNUAL ACCOUNTS AND REPORTS

5.1   The following documents are to be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

      5.1.1   the annual accounts;

      5.1.2   any report of the auditor on them; and

      5.1.3   the annual report.

6.   AMENDMENT OF THE CONSTITUTION

6.1   Where an amendment is made to the Constitution in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

      6.1.1   at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment(s), and

      6.1.2   the Trust must give the members an opportunity to vote on whether they approve the amendment.

6.2   If more than half of the members present and voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the trust must take such steps as are necessary as a result.

7.   QUORUM

7.1   There may be times and reasons why the AMM is held "virtually online" and not in person. The Chair will decide these times in consultation with the Lead Governor and quoracy arrangements dependant on the nature of the business transacted.

7.2   In extremis (*see para 16.5*), the Chair may decide to review the terms of the meeting.

7.3   Where the Annual Members' Meeting is combined with a Council of Governors meeting for the purpose of receiving the annual accounts and reports, the quorum of the Council of Governors shall apply.

8. VOTING

8.1 Every question for decision at a meeting will be determined by a majority of the votes of the members present and voting on the question and, in the case of an equality of votes, the person presiding shall have a second or casting vote.

8.2 As members, governors may vote at the Annual Members' Meeting except where the matter under consideration is a Constitution amendment regarding the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust).

8.3 With the exception of the Chair, Directors may not vote at the Annual Members' Meeting.

8.4 All questions put to the vote shall, at the discretion of the Chair, be determined by oral expression or by a show of hands.

8.5 If a majority of the members present so request, the ~~voting on~~voting on any question may be recorded to show how each member present voted or abstained.

8.6 If a member so requests, his/her vote shall be recorded by name upon any vote

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

9. MINUTES

9.1 The names of Governors, Directors and Members present at the meeting shall be recorded. However, if meeting is held virtually then monitoring of "virtual views" will be performed by a member of the Communications team and information given to both Chair and Company Secretary.

9.2 The Minutes of the proceedings of a meeting shall be drawn up and maintained as a public record and submitted for final agreement at the next ensuing meeting where they will be signed by the person presiding at it.

9.3 They may be circulated for information prior to the next year's meeting and interim agreement of accuracy acknowledged by the Council of Governors (CoG) .

9.4 Minutes shall be made available to the public in draft (interim CoG accuracy approved) format and then once finally approved at the next AMM, unless AMM was held virtually where agreement of accuracy will be acknowledged by the Council of Governors.

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

10. AGENDA

10.1 A governor or member desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least ten clear days before the meeting is notified to Governors and members. Requests made less than ten days before a

meeting is notified to Governors may be included on the agenda at the discretion of the Chair.

11.   MOTIONS

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

11.2   A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

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

11.4   When a motion is under discussion or immediately prior to discussion it shall be open to a Governor or member to move:

(i)   An amendment to the motion.

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

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

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

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

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

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

12.   CHAIR'S RULING

12.1   Statements of Governors and members shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page	
Meeting Title:	**Board of Directors**
Meeting Date:	27 September 2022 **Agenda Reference:** **H1**
Report Title:	**Chair & NEDs Report to Board**
Sponsor:	Suzy Brain England OBE, Chair of the Board
Author:	Suzy Brain England OBE, Chair of the Board
Appendices:	None

Executive Summary	
Purpose of report:	To update the Board of Directors on the Chair and NED activities since July 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:**	**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:	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

Earlier this month I attended NHS Providers' Board meeting, in addition to the routine reports from the executive team, a summary of bookings for the Annual Conference & Exhibition was presented and consideration was given to how best facilitate future Board meetings. As the Chair representative on the Board's Governor Advisory sub-committee, I provided a verbal update on the business of the Committee.

Due to the sad loss of Her Royal Highness Queen Elizabeth II, the first of the Autumn Governor Workshops, scheduled for 12 September was stood down. At the time of writing this report, day two is expected to go ahead as planned on 22 September and governors from across the country, including those representing the Trust, will receive an update from the Governor Support Team, hear a national perspective on topical issues for governors and observe the sharing of good practice in respect of meaningful membership, from Liverpool University Hospitals NHS Foundation Trust. A series of breakout groups, one of which I will faciltate, will allow smaller groups of governors to come togther to share their views and experiences.

Governors

We continue to remain focused on ensuring the governors are well informed in developments at Trust, Place and System level. Since the last report governors have been able to hear from Amanda Sullivan, Chief Executive of NHS Nottingham & Nottinghamshire Integrated Care Board, looking at the role of governors in health and care systems, collaborative working and a focus on the health profile of Bassetlaw. The session was informative and engaging and I was grateful to Amanda for her time and for the offer of future opportunities to speak with the Council of Governors. On 22 September, Lois Mellor, Director of Midwifery will present an overview of the maternity safety reviews and the associated impact.

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, Lead and Deputy Lead Governor and Company Secretary. I have also met with the Deputy Chief Executive, Chief People Officer, Director of Communications & Engagement, Director of Midwifery and the Divisional Directors of Children & Families and Surgery & Cancer.

Following the appointment of non-executive directors, Hazel Brand and Jo Gander I have met with them as part of their local induction to support their understanding of the roles and responsibilities and will continue to support them through regular 1:1 meetings. As a group of non-executives, we also meet monthly and appraisals, including objective setting have been completed.

Other meetings and events

This month I have observed the People Committee and attended the Charitable Funds Committee; ahead of September's Board meeting I have met with the Acting Director of Finance and Chief

Executive to be briefed on the Trust's financial position.

In preparation for the Trust's Annual Members Meeting, I have worked closely with the Company Secretary and the Communications & Engagement Team, who have skillfully supported the preparation and recording of the event which will be available via YouTube at 6pm on 29 September 2022.

Along with the Trust's new clinical Non-executive Director, Jo Gander, I have once again welcomed the latest cohort of international nurses.

I continue to play an active role across the Integrated Care System, attending South Yorkshire & Bassetlaw Acute Federation Board meetings, joining my fellow Chairs at a monthly meeting with Integrated Care Board Chair, Pearse Butler and continuing to champion the Trust and its aspirations for a new hospital. The Chief Executive and I also continue to meet with the Chair and Chief Executive of NHS Nottingham & Nottinghamshire Integrated Care Board.

Following the legislative changes of 1 July and the impact on the role of governors I have supported South Yorkshire Acute Federation to develop a governor conference. The session will take place via Zoom at 5pm on 3 October 2022 and will be introduced by the Chairs of the Acute Federation and Mental Health, Learning Disability & Autism Alliance, Martin Havenhand and Sarah Jones. It will feature plenaries from Pearse Butler and Gavin Boyle, Chair and Chief Executive of the NHS South Yorkshire Integrated Care Board and Miriam Deakin, Director of Policy and Strategy and Interim Deputy Chief Executive at NHS Providers. I am also working with NHS Nottingham & Nottinghamshire Integrated Care Board to develop plans to support a governor briefing.

I have attended NHS England's leaders briefing on winter resilience, supported Doncaster's bid to be the home of the Great British Railways' headquarters and as a newly appointed trustee attended NHS Retirement Fund Board meeting.

Finally, along with the Acting Director of Finance, I have visited the dental and maxillofacial teams at Montagu, where we have been able to meet colleagues involved in their day-to-day duties, observe good practice and hear of potential challenges and required improvements.

NED Reports

Mark Bailey

Since the last Board report, Mark has participated in the Quality & Effectiveness and People Committees and chaired the meeting of Charitable Funds Committee. In addition, Mark has chaired interview panels for consultant appointments in Emergency Medicine and Obstetrics and Gynaecology.

On-site meetings at Doncaster Royal Infirmary have included assurance work as the interim Non-executive Director Safety Champion for Maternity with the Director of Midwifery and Acting Chief Nurse. And as part of the programme of Board visits, along with the Interim Chief Operating Officer, Mark was pleased to meet and listen to the experiences of the Clinical Therapies, Ambulatory Care and Assessment and Treatment Centre teams at Bassetlaw Hospital.

Assurance and 'buddy' calls have continued with the Chair, executive and non-executive colleagues. Specific areas covered include nursing, maternity, digital transformation, performance restoration and recovery, research, health and well-being and charitable funding. Contributing to work on the future

strategy for the Trust Charity, Mark has also met with representatives of the More Partnership.

Kath Smart

Kath has attended her regular committee meetings including Board, Finance & Performance and Charitable Funds Committee. She also attended recent governor briefings on Maternity Safety and the NHS Nottingham & Nottingham Integrated Care Board update with Chief Executive, Amanda Sullivan presenting.

July's Audit & Risk Committee was held as planned, with the next meeting being due in October, the agenda for which has been developed and agreed. As Chair of the Audit & Risk Committee, she has also observed the Trust's Health & Safety Committee and Information Governance Group, both of which report into the Audit & Risk Committee. Kath was also interim Chair of the Quality & Effectiveness Committee, and chaired the September meeting, she has met with the new clinical non-executive director, Jo Gander and Company Secretary to ensure a managed handover of the Quality & Effectiveness Committee Chair role.

Along with fellow non-executive directors she has had her appraisal; attended the NED catch up sessions led by the Chair; and attended the Integrated Care Board briefing session led by Gavin Boyle and Pearse Butler.

Kath has also supported recruitment within the Trust and chaired panels for the appointments of a Consultant Radiologist and a Consultant in Upper Limb Surgery.

Finally, it was great to attend the Level 2 Quality Improvement report out on 15 September, which showcased the work undertaken by individuals and teams across the Trust using the quality improvement methodology. The projects included 'Improving the Use of the Catheter Passport', 'Reducing Length of Stay (Red 2 Green)', and 'Targeted Temperature Management'.

Neil Rhodes

Since the last Board meeting Neil has met with the Chair for his formal appraisal, update meetings in relation to Nottingham & Nottinghamshire Integrated Care System work and a non-executive director monthly meeting. He has represented the Chair and the Trust at the Nottinghamshire Acute Provider meeting on 11 August and again on 5 September.

Neil spent a morning with Dr Tim Noble visiting wards and outpatient areas at Doncaster Royal Infirmary to better understand current pressures, staff and patient experience. He spent an afternoon at Bassetlaw hospital with Interim Director of Recovery, Innovation & Transformation, Jon Sargeant, discussing the approach to elective recovery and planning strategy in relation to our relationship with Nottingham & Nottinghamshire ICS.

On 14 September he met with newly appointed Non-executive Director, Hazel Brand to brief her in relation to the Nottinghamshire/Bassetlaw work.

Neil chaired a meeting of the wholly owned subsidiary board and held a monthly meeting with its Managing Director, Mark Olliver. He took part in September's Charitable Funds Committee meeting and will chair the meeting of the Finance & Performance Committee.

Mark Day

As well as attending July's Board, an additional meeting of the Finance and Performance Committee, and Charitable Funds Committee, Mark chaired his second People Committee which the Chair observed as part of a planned programme to gain assurance on the work of all Committees.

In addition to routine internal non-executive meetings and one-to-ones with the Chair, Mark also attended a South Yorkshire Integrated Care Board briefing, the Governor briefing by the Chief Executive of the Nottingham & Nottinghamshire ICB, and an introductory meeting with the President and Chief Executive of Doncaster Chamber, where he will support the Chair in strengthening links between local business and the Trust.

Thanks to the Trust Board Office team and colleagues across the organisation Mark's induction has been effective and he has quickly been able to contribute to the work of the Board and its Committees.

Hazel Brand

Since her appointment in mid-July, Hazel has been on a steep learning curve; the role is quite different from that of a Governor, which she had been for nine years.

Hazel has attended the Trust's induction for new starters and has had a number of 1:1s with directors to learn more about the structure of their directorates, roles and responsibilities, the challenges facing them - but also the opportunities going forward. As a member of the Quality & Effectiveness People and Charitable Funds Committees, she has attended a meeting of each. In addition, as the designated Freedom to Speak Up (FTSU) NED Champion, Hazel has had a helpful session online about the re-launch of the FTSU initiative and has met with Paula Hill, the Trust's FTSU Guardian. There is a further national webinar planned in October.

It is the intention for Hazel to take more of a lead on matters relating to Nottingham & Nottinghamshire (N&N) Integrated Care System. Neil Rhodes has been handling this to date and a briefing between the two has taken place. Hazel attended the Governors' briefing on N&N Integrated Care Board and then a N&N Chairs and Elected Members' meeting where the key points discussed were the Memorandum of Understanding between NHSE and N&N ICS, development of its strategy, and plans for an ICS-wide event for NEDs and elected members. A separate event for governors was under discussion.

A programme of non-executive/executive's visits is planned, and Hazel's first 'walkabout' took place on 20th September. Progress and training needs have been discussed in regular online meetings with the Chair and Hazel is booked on a 2-day NHS Providers' non-executive director induction programme in November. She would like to thank the Company Secretary and staff for their help in making all these, and more, practical arrangements since her appointment.

Jo Gander

Jo commenced in post on 25th July and attended her first board meeting the next day. Although August is generally quieter, due to the holiday period, Jo took the opportunity to spend a day on site at Doncaster Royal Infirmary where she met with several members of the executive team as part of her induction. She also attended the Trust's corporate induction.

Jo has attended her first Quality & Effectiveness and Charitable funds Committees and associated follow up meetings, the Nottingham & Nottinghamshire Integrated Care System briefing with governors as well as 'ICS Digital Care' and 'Taking Virtual Wards system wide' webinars.

Chief Executive's Report
September 2022

An update on the Trust's response to COVID-19 and activity

Over recent weeks the Trust had experienced a reduction in COVID-19 activity, however in recent days the number of patients admitted to hospital has increased and at the time of writing, there are 45 patents with active covid, one receiving Intensive Care and a further 25 patients who are in hospital having had COVID-19.

Although we have been able to ease certain restrictions within our hospital, such as wider access for visitors and the end of routine twice weekly testing for staff we do ask colleagues to test for the illness if they believe they are symptomatic, and we also require the wearing of face masks in all clinical areas – and we anticipate that preventative infection prevention and control measures will continue for the foreseeable future.

In the coming weeks we will begin to offer colleagues both the COVID-19 and flu vaccination. We have a fantastic track record when it comes to the efficiency, speed and uptake of our vaccination programmes and we expect this to continue with this year's programme.

Marking the passing of Her Majesty the Queen

This month we have been deeply saddened to mark the passing of Her Majesty the Queen.

Since her coronation in June 1953, Queen Elizabeth II has been a constant throughout the lives of so many people, and is a figure that, throughout her reign, has tied generations together through her unfailing sense of service and duty.

As a Trust we mourned her passing, and we have hosted memorial books for colleagues who wished to share their condolences. These have been placed within the Chapels at Doncaster Royal Infirmary and Bassetlaw Hospital, and the Quiet Room at Montagu Hospital.

We have also shared links to virtual condolence books that have been made available to the public, so that our patients, if they so wish, were able to pay their respects.

Reinforced autoclaved aerated concrete (RAAC) replacement programme at Bassetlaw Hospital

The main hospital building at Bassetlaw dates back to 1976, and at this time reinforced autoclaved aerated concrete was used in construction work and affects the Mental Health Building and part of the Theatres building.

Although considered a revolutionary new building material at the time, RAAC is now outdated and newer construction materials offer more longevity and durability, as well as having lower maintenance costs. Whilst there is no immediate risk to the buildings, as part of a national replacement programme launched by NHS England/ Improvement our Trust is taking proactive action to remove the material before any potential issues arise.

Work on the RAAC roof will be completed in March 2023, following which the construction of the Emergency Village will commence.

An update on the £2.5 million refurbishment of maternity services

The Central Delivery Suite (CDS) and Triage at Doncaster Royal Infirmary (DRI) is currently undergoing a £2.5 million refurbishment to update and modernised the area.

The works, which began in May 2022 includes a full refurbishment of the CDS birthing rooms, the creation of a new welcoming reception and waiting area, the opening of our first Midwifery Led Birth Centre and the creation of a serenity suite. The delivery suite will include a fully equipped Obstetric Observation Area to support women who need additional observations and a large well equipped Triage department to support all our women, families, and birthing individuals. Full details can be viewed here: https://www.dbth.nhs.uk/news/2-5-million-refurbishment-of-maternity-services-at-local-hospital

Whilst this development is underway the Central Delivery Suite has been situated within the ground floor of the of Women's and Children's Hospital with Triage situated on level 3, in the area which is often referred to as the 'modular build' which contains parallel wards on the ground floor and first floor (level 3 of the Women and Children's Building). A short film can be viewed here which highlights the ward environment (please note this was recorded when the area was initially used for paediatric services in late 2021 and early 2022): https://youtu.be/zkOgvN4Tq7E

In the coming weeks, Central Delivery Suite will move to level 3 before transitioning back later in the year to the refurbished area on level 6.

Work on the refurbishment has been supported by our Maternity Voices Partnership (MVP) and incorporates service user feedback – such as the inclusion of a fixed pool on both CDS and in the Birth Centre.

Throughout this process, our maternity team have worked very closely with our estates and facilities colleagues, as well as the contractors carrying out the building works. We have done everything in our power to ensure that, although the current areas are temporary, they are entirely fit for purpose, and our commitment to patient care, and the care of little ones, remains the same.

Introducing the Faster Diagnosis Framework (FDF)

Over the last two years colleagues at the Trust have been looking to further develop and enhance diagnostic services for patients with suspected illnesses such as cancer.

This has led to various innovations and improved patient pathways, however, much of this work has changed considerably during this time because of learning from the COVID-19 pandemic. With a significantly increased backlog of activity to work through, staff at the Trust are working to reduce the backlogs as soon as possible, with much of this activity coming under the Faster Diagnosis Framework (FDF).

The vision of this workstream is to provide personalised, accurate and speedy investigations, all of which will help us to start treatment quickly if needed, as well as provide a better patient experience.

A tangible example of the work we've undertaken so far is the creation of the Community Diagnostic Centre (CDC) at Montagu Hospital. As part of a five-year development, which is now in phase two following further investment of £9 million, mobile CT and MRI scanners have been located at the Mexborough site, and since 2022 around 2,500 patients have accessed the additional facilities which have helped to dramatically reduce our MRI backlog.

Further innovations that the FDF is looking to develop, implement and embed within the Trust are:

- Pilot a 'One-stop ovarian, cervical/vulval straight-to-test clinics and implementation of best practice timed pathways for gynaecology pathways.
- Evaluation of additional monthly ultrasound core biopsy clinics for head and neck pathway and implementation of best practice timed pathways.
- Histology – testing/evaluating new ways of working using new rapid tissue processors installed 2022.
- Further upper and lower gastroenterology improvements.
- General non-specific symptoms pathway improvements.
- General skin pathway improvements.
- Prostate – additional capacity for Clinical Nurse Specialists and Patient Navigators.

We will update colleagues on further FDF work in the coming weeks and months as well make progress with this workstream.

Appointments and departures at the Trust

Recruitment of a new Chief Nurse

The recruitment of a new Chief Nurse began in September. An integral role at the Trust, the Chief Nurse provides clear leadership to nurses, midwives, and allied health professionals, overseeing the development and delivery of outstanding patient care, while driving the organisation's strategies for quality, patient safety and experience.

As an organisation that cares for more than half a million patients each year, we are seeking to appoint a Chief Nurse who will bring great passion and energy to the role to inspire and lead our talented and committed workforce.

Preliminary interviews will be held in late September and final interviews in mid-October. All details can be found on the Trust's website www.dbth.nhs.uk.

Dr Alasdair Strachan, Director of Education and Research and Consultant Anaesthetist to retire

Dr Strachan has been a fantastic servant to Team DBTH throughout his time with the Trust, which began initially in 1994 when he first joined us as a trainee anaesthetist as part of the South Yorkshire Anaesthetic Training School, leading to him securing a consultant post in 2000.

In between his usual duties, Alasdair undertook several educational and mentoring roles within the organisation, regionally and nationally and in 2014 was appointed Director of Education. With the support of colleagues, Alasdair helped to further establish this team, and in just two short years, the Trust attained Teaching Hospital status – a magnificent achievement which owed much to Dr Strachan's vision and leadership.

Since that time, the Trust's educational approach has only gone from strength to strength, with partnership agreements put in place with local schools, colleges and universities to ensure we have a robust pipeline of talent coming into the Trust at all times, as well as the organisation of our We Care Into the Future event – the second of which was held, and attracted thousands of local young people to consider a career within health and social care.

Most recently, Alasdair has added the Research team to his portfolio, and, again, this service continues to develop, expand, and support ground-breaking studies with implications for the wider NHS.

For all of this, and the efforts Alasdair has continued to put forward for the benefit of our patients, and as he undertakes his clinical work, we want to say a huge thank you on behalf of everyone in the Trust. We wish him nothing but health and happiness in retirement.

Other appointments and departures:

- **Mark Day** has been appointed Non-Executive Director.
- **Hazel Brand** has been appointed Non-Executive Director.
- **Joanne Gander** has been appointed Non-Executive Director.
- **Karen McAlpine** has been appointed Acting Deputy Chief Operating Officer.
- **Adam Tingle** has been appointed Acting Director of Communications and Engagement
- **Heather Jackson** has been appointed Director of Allied Health Professionals.
- **Sara Ayre**, Deputy Director of Midwifery has left the Trust to take up the post of Deputy Head of Midwifery and York and Scarborough NHS FT.

Category	Indicator	Benchmarking Month Reported	Peer Benchmark	National Benchmark	Latest Month Reported	CURRENT MONTH			YEAR-TO-DATE			Trend Graph (Sep-20 - stated month) This is calculated based on rolling 24 month data with performance below expected control limits highlighted in red and above expected control limits in green
						Local Target	Actual	Variance	Local Target	Actual	Variance	
Performance (NHSI Compliance Framework - Emergency	A&E: Max wait four hours from arrival/admission/transfer/discharge (Type 1 benchmarking only)	Jul-22	62.7%	57.0%	Aug-22	95%	68.4%	-26.6%	95%	70.2%	-24.8%	
	ED Attendances (For Monitoring Only)	-	-	-	Aug-22	-	16114	-	-	83979	-	
4 Hour Access - Trust Boarding Times	Average Wait Time (from clinically ready to proceed to admission) - Medicine	-	-	-	Aug-22	<1 Hour	-	-	<1 Hour	-	-	
	Average Wait Time (from clinically ready to proceed to admission) - Surgery	-	-	-	Aug-22	<1 Hour	-	-	<1 Hour	-	-	
	Average Wait Time (from clinically ready to proceed to admission) - Gynaecology	-	-	-	Aug-22	<1 Hour	-	-	<1 Hour	-	-	
	Average Wait Time (from clinically ready to proceed to admission) - Paediatrics	-	-	-	Aug-22	<1 Hour	-	-	<1 Hour	-	-	
Performance (NHSI Compliance Framework - Elective Care)	Max time of 18 weeks from point of referral to treatment-incomplete pathway	Jun-22	70.9%	62.2%	Aug-22	TBC	66.2%	-	TBC	68.1%	-	
	RTT 52 Week Breaches to date	-	-	-	Aug-22	1304	1382	-78	1304	1382	-78	
	Waiting list size - 18 Weeks referral to treatment -Incomplete Pathways	-	-	-	Aug-22	46585	50601	-4016	46585	50601	-4016	
	% waiting less than 6 weeks from referral for a diagnostics test	Jun-22	78.2%	72.5%	Aug-22	99%	52.8%	-46%	99%	54.8%	-44%	
Performance (Cancer)	Maximum 2 week wait to see a specialist for all patients referred with suspected cancer symptoms	-	-	-	Jul-22	93%	-	-	93%	-	-	
	Maximum 2 week wait to see a specialist for breast symptoms, even if cancer not suspected	-	-	-	Jul-22	93%	-	-	93%	-	-	
	Day 28 Standard (patients received diagnosis or exclusion of cancer within 28 days)	-	-	-	Jul-22	75%	-	-	75%	-	-	
	Maximum 31 day wait from decision to treat to first definitive treatment for all cancers	-	-	-	Jul-22	96%	93.6%	-2%	96%	95.1%	-1%	
	Maximum 31 day wait for subsequent treatment - Surgery	-	-	-	Jul-22	94%	100.0%	6%	94%	95.8%	2%	
	Maximum 31 day wait for subsequent treatment - Drugs	-	-	-	Jul-22	98%	100.0%	2%	98%	100.0%	2%	
	Maximum 62 day wait for patients on 2ww pathway to first definitive treatment	-	-	-	Jul-22	85%	60.3%	-25%	85%	67.8%	-17%	
	Maximum 62 wait from referral from NHS cancer screening service to first definitive treatment	-	-	-	Jul-22	90%	85.7%	-4%	90%	86.6%	-3%	
	Cancer Waiting Times Open Suspected Cancer Pathways 63 - 104 Days - reduction of 10% month on month (trajectory at trust level - tracking only at specialty)	-	-	-	Jul-22	61	-	-	61	-	-	
	Cancer Waiting Times Open Suspected Cancer Pathways 104 Days +	-	-	-	Jul-22	0	0	0	0	43	43	
	Non Elective Activity - Discharges	-	-	-	Aug-22	-	4448	-	-	22102	-	
	TOTAL Activity (against plan - numbers)	-	-	-	Aug-22	53175	45480	-7695	247012	221303	-25709	
	Day Case Theatre Activity (against plan - numbers)	-	-	-	Aug-22	1012	749	-263	4435	3794	-641	
	In Patient Elective Theatre Activity (against plan - numbers)	-	-	-	Aug-22	470	408	-62	2048	1882	-166	
	Endoscopy Activity (against plan - numbers)	-	-	-	Aug-22	1537	1404	-133	7195	7016	-179	

Category	Metric				Date							Trend
Activity Against Plan	Non-Theatre Elective Activity -excluding Endoscopy (against plan - numbers)	-	-	-	Aug-22	223.2757	296	73	1267	1210	-57	
	Elective Patient Activity - Independent Sector	-	-	-	Aug-22	-	58	-	-	182	-	
	Outpatient New Activity - face to face (Including Procedures against plan - numbers)	-	-	-	Aug-22	12674	10407	-2267	58766	50483	-8283	
	Outpatient New Activity - telephone (against plan - numbers)	-	-	-	Aug-22	2404	2351	-53	11204	11684	480	
	Outpatient New Activity - video (against plan - numbers)	-	-	-	Aug-22	83	78	-5	399	332	-67	
	Outpatient Follow Up Activity - face to face (Including Procedures against plan - numbers)	-	-	-	Aug-22	27267	19252	-8015	125771	92007	-33764	
	Outpatient Follow Up Activity - telephone (against plan - numbers)	-	-	-	Aug-22	5225	4235	-990	24757	22105	-2652	
	Outpatient Follow Up Activity - video (against plan - numbers)	-	-	-	Aug-22	63	40	-23	305	202	-103	
	Outpatient Procedures (For Monitoring Only)	-	-	-	Aug-22	-	6320	-	-	30917	-	
	Outpatient Activity - Independent Sector	-	-	-	Aug-22	0	304	304	0	1222	1222	
Activity Against Value (19/20) - Elective Recovery Fund National Submission	TOTAL Activity Value (%19/20)	-	-	-	Aug-22	104%	90.35%	-13.7%	104%	84.74%	-19%	
	Day Case Theatre Activity Value (% 19/20)	-	-	-	Aug-22	104%	102.73%	-1.3%	104%	98.84%	-5.2%	
	In Patient Elective Theatre Activity Value (%19/20)	-	-	-	Aug-22	104%	78.54%	-25.5%	104%	69.89%	-34.1%	
	Outpatient New Activity Value (%19/20)	-	-	-	Aug-22	104%	94.24%	-9.8%	104%	87.35%	-16.6%	
	Outpatient Follow Up Activity Value (%19/20)	-	-	-	Aug-22	75%	86.07%	-11.1%	75%	82.07%	-7.1%	
Addressing Health Inequalities	TBC	-	-	-	-	-	-	-	-	-	-	
	TBC	-	-	-	-	-	-	-	-	-	-	
	TBC	-	-	-	-	-	-	-	-	-	-	
	TBC	-	-	-	-	-	-	-	-	-	-	
	TBC	-	-	-	-	-	-	-	-	-	-	
Performance Ambulance Handover Times	Ambulance Handovers Breaches -Number waited <= 15 Minutes	-	-	-	Aug-22	79%	36.7%	-42%	79%	39%	-40%	
	Ambulance Handovers Breaches -Number waited >15 & <30 Minutes	-	-	-	Aug-22	21%	27.6%	-7%	21%	28%	-7%	
	Ambulance Handovers Breaches-Number waited >30 Minutes	-	-	-	Aug-22	0%	35.7%	-36%	0%	33%	-33%	
Performance Stroke	Overall SSNAP Rating	-	-	-	Jun-22	B	B	-	B	B	-	
	Proportion of patients scanned within 1 hour of clock start (Trust)	-	-	-	Jun-22	48%	58.3%	10%	48%	58%	10%	
	Proportion directly admitted to a stroke unit within 4 hours of clock start	-	-	-	Jun-22	75%	41.7%	-33%	75%	42%	-33%	
	Percentage of all patients given thrombolysis	-	-	-	Jun-22	90%	100.0%	10%	90%	100%	10%	
	Percentage treated by a stroke skilled Early Supported Discharge team	-	-	-	Jun-22	24%	66.7%	43%	24%	58%	34%	

Category	Metric				Period	Target	Value	Var	Target	Value	Var	Trend
Performance - Outpatients	Percentage discharged given a named person to contact after discharge	-	-	-	Jun-22	80%	45.8%	-34%	80%	47%	-33%	
	New to Follow Up Ratio (DCCG) (For Monitoring Only)	-	-	-	-	-	-	-	-	-	-	
	New to Follow Up Ratio (BCCG) (For Monitoring Only)	-	-	-	-	-	-	-	-	-	-	
	New to Follow Up Ratio (TRUST) (For Monitoring Only)	-	-	-	Aug-22	-	1:1.83	-	-	1:1.83	-	
	Out Patients: DNA Rate (first appointment)	-	-	-	Aug-22	-	11.21%	-	-	11.40%	-	
	Out Patients: DNA Rate (Follow up appointment)	-	-	-	Aug-22	-	10.16%	-	-	10.54%	-	
	Out Patients: DNA Rate (Combined) (For Monitoring Only Target Set At Specialty Level)	-	-	-	Aug-22	-	10.52%	-	-	10.84%	-	
	Out Patients: Hospital Cancellation Rate (under 6 weeks)	-	-	-	Aug-22	-	12.83%	-	-	11.26%	-	
	Out Patients: Patient on the Day Cancellation Rate (For Monitoring Only)	-	-	-	-	-	-	-	-	-	-	
	Backlogs - To reflect Simple PTL Excluding Active Waiters (For Monitoring Only)	-	-	-	-	-	-	-	-	-	-	
	Typing Turnaround (Trust Contract)	-	-	-	Aug-22	7WD	84WD	77WD	7WD	82WD	75WD	
	Out Patient Clinic Utilisation - Booked 2 weeks Prior	-	-	-	Aug-22	95%	59.01%	-35.99%	95%	59.51%	-35.49%	
	Out Patient Clinic Utilisation (attended)	-	-	-	Aug-22	90%	87.47%	-2.53%	90%	89.06%	-0.94%	
	Registered Referrals not Appointed	-	-	-	Aug-22	0	28764	28764	0	139265	139265	
	Unreconciled Appointments 14 days + E-Reconcillation	-	-	-	-	-	-	-	-	-	-	
	Unreconciled Appointments 14 days + CAMIS	-	-	-	-	-	-	-	-	-	-	
	ERS Advice & Guidance Response Time	-	-	-	Aug-22	2WD	3WD	1WD	2WD	3WD	1WD	
	ERS Advice & Guidance Activity (Trust)	-	-	-	Aug-22	TBC	254	-	TBC	227	-	
	Number of Specialities offering PIFU (ENT / Cardiology / Dermatology) TRUST TAB ONLY	-	-	-	-	-	-	-	-	-	-	
	% of OP appointments delivered virtually (video or telephone)	-	-	-	Aug-22	25%	16.54%	-8.46%	25%	17.36%	-7.64%	
Performance - Theatres	Theatre Booking - 4 weeks prior -Lists Populated	-	-	-	Aug-22	50%	42.51%	-7.49%	50%	44.29%	-5.71%	
	Theatre Booking - 2 weeks prior -Lists Populated	-	-	-	Aug-22	75%	73.65%	-1.35%	75%	75.63%	0.63%	
	Theatre Booking - 1 week prior -Lists Populated	-	-	-	Aug-22	95%	88.90%	-6.10%	95%	89.58%	-5.42%	
	Theatre Utilisation	-	-	-	Aug-22	87%	83.02%	-3.98%	87%	81.29%	-5.71%	
	Number of Prioirity 2 Patients waiting 28 days + for surgery from date of listing/P2 Categorisation	-	-	-	Aug-22	0	648	648	0	2739	2739	
	% Cancelled Operations on the day (non-clinical reasons)	-	-	-	Aug-22	1%	1.38%	-0.38%	1%	1.43%	-0.43%	
	% Cancelled Operations on the day (clinical reasons) (For Monitoring Only)	-	-	-	Aug-22	-	-	-	-	-	-	
	Cancelled Operations Not Rebooked within 28 Days	-	-	-	Aug-22	0	8	8	0	47	47	

Patients (National Requirements)											
EBI (TBC)	-	-	-	Aug-22	-	-	-	-	-	-	
Validation (TBC)	-	-	-	Aug-22	-	-	-	-	-	-	
Infection Control Hosptial Onset C.Diff (Medicine & Surgery Only)	-	-	-	Aug-22	2.3	2	0.3	11.6	10	1.6	
Infection Control Community Onset C.Diff (Medicine & Surgery Only)	-	-	-	Aug-22	1	0	1	5	2	3	
Infection Control Combined Onset C.Diff (Medicine & Surgery Only)	-	-	-	Aug-22	3.3	2	1.3	17	12	4.6	
MRSA Cases Reported	-	-	-	Aug-22	0	0	0	0	0	0	
HSMR (rolling 12 Months - Combined)	-	-	-	Jun-22	100	109.27	-9.27	100	109.27	-9.27	
HSMR : Non-Elective (rolling 12 Months)	-	-	-	Jun-22	100	110.08	-10.08	100	110.08	-10.08	
HSMR : Elective (rolling 12 Months)	-	-	-	Jun-22	100	42.62	57.38	100	42.62	57.38	
Never Events	-	-	-	Aug-22	0	0	0	0	1	1	
Serious Incidents Reported in Month (For Monitoring Only)	-	-	-	Aug-22	-	4	-	-	17	-	
SI Action Plans closed within 3 months of CCG closure of incident	-	-	-	Aug-22	100%	-	-	100%	-	-	
All open incidents on Datix to be closed within 3 months of reporting (excluding patient experience)	-	-	-	Aug-22	100%	-	-	100%	-	-	
Pressure Ulcers - Category 4	-	-	-	Aug-22	0	0	0	0	1	-1	
Pressure Ulcers - Category 3	-	-	-	Aug-22	4	2	2	22	20	2	
Pressure Ulcers - Category 2 / UNS / DTI	-	-	-	Aug-22	61	39	22	307	226	81	
Falls with Severe Harm / Lapse in Care / SI	-	-	-	Aug-22	-	0	-	-	0	-	
Falls with Moderate or Severe Harm	-	-	-	Aug-22	1	0	1	6	0	6	
Complaints Resolution Performance (% achieved closure in agreed timescales with complainant)	-	-	-	Aug-22	95.0%	22.9%	-72.1%	95.0%	22.9%	-72.1%	
Complaints Upheld / Partially Upheld by Parliamentary Health Service Ombudsman	-	-	-	Aug-22	0	20	-20	0	20	-20	
Claims CNST (patients)	-	-	-	Aug-22	-	0	-	-	0	-	
Claims LTPS - staff	-	-	-	Aug-22	-	0	-	-	0	-	
Friends & Family Response Rates (ED)	-	-	-	Aug-22	15%	3.04%	-12%	15%	0.59%	-14%	
Friends & Family Response Rates (Inpatients)	-	-	-	Aug-22	30%	6.69%	-23%	30%	7.51%	-22%	
Emergency Readmissions within 30 days (PbR Methodology)	-	-	-	Sep-20	7%	6%	1.4%	7%	8%	-0.7%	
% Reduction on LoS for patients remaining in hospital between 7-14 days compared to 2019-20	-	-	-	-	-	-	-	-	-	-	
Mixed Sex Accommodation	-	-	-	Aug-22	0	1	-1	0	1	-1	
Sepis Screening - % of appropriate patients screened	-	-	-	-	90%	-	-	90%	-	-	

	Sepsis Prescribing - Antibiotics within 1 Hour	-	-	-	-	90%	-	-	90%	-	-	
	Deaths Screened as part of Mortality Review Process	-	-	-	-	100%	-	-	100%	-	-	
	NICE Guidance Response Rate Compliance	-	-	-	Aug-22	95%	95%	-0.37%	95%	94%	-1.06%	
	NICE Guidance % Non & Partial Compliance (For Monitoring Only)	-	-	-	Aug-22	-	-	-	-	-	-	
	% Patients Asked for Smoking Status	-	-	-	-	50%	-	-	50%	-	-	
People	Staff Flu Vaccinations (1.9.21 - 28.2.22)	-	-	-	-	-	-	-	-	-	-	
	Agenda for Change Appraisals (rolling 12 months)	-	-	-	Mar-22	90%	-	-	90%	-	-	
	Non-Medical Appraisals - in season (April - July)	-	-	-	Mar-22	90%	-	-	90%		-	
	Sickness (rolling 12 months)	-	-	-	Mar-22	4%	9%	-6%	4%	-	-	
	Job Planning (TBC)	-	-	-	Mar-22	TBC	-	-	TBC	-	-	
	SET Training	-	-	-	Mar-22	90%	84%	-6%	90%	-	-	
	Vacancies	-	-	-	-	5%	-	-	5%	-	-	
	Turnover (rolling 12 months)	-	-	-	Mar-22	10%	13%	-3%	10%	-	-	
	Casework - number of grievances opened in month	-	-	-	Mar-22	-	7	-	-	0	-	
	Casework - number of conduct cases opened in month	-	-	-	Mar-22	-	232	-	-	0	-	
	Number of Incorrect Payments (Trust Originated) (rolling 12 months)	-	-	-	Oct-21	-	25	-	-	0	-	
	Compliance with EWTD (on hold until 2021)	-	-	-	-	YES	-	-	YES	-	-	
	Time to Fill Vacancies (from TRAC authorisation - unconditional offer)	-	-	-	-	47WD	-	-	47WD	-	-	

**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 26ᵗʰ May 2022 at 09:00 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, Interim Director of Recovery, Innovation and Transformation Mark Day, Non-executive Director	
In attendance:	Ken Anderson, Chief Information Officer Fiona Dunn, Deputy Director Corporate Governance/Company Secretary Gillian Marsden, Deputy Chief Operating Officer – Elective Debbie Pook, Deputy Chief Operating Officer – Non-Elective	
To Observe:		
Apologies	Lynne Schuller, Public Governor	
		ACTION
FP22/05/A1	**Welcome, Apologies for Absence and declarations of interest (Verbal)**	
	The Chair welcomed members and those in attendance and welcomed Mark Day to his first F&P. No declarations of interest were declared.	
FP22/05/A2	**Requests for any other business (Verbal)**	
	None.	
FP22/05/A3	**Action Notes from Previous Meeting (Enclosure A3)** Updates were provided on the below actions: **Action 1 – FP21/11/C2** Closed as within the agenda – however a brief report would be presented at each Finance and Performance meeting. **Action 2 – FP21/11/D4** Closed as within the agenda **Action 3 – FP21/11/G1** Closed as within the agenda, a new action was opened to update on the detailed report	

	Action 4 – FP21/02/C2 Closed as within the agenda **Action 5 – FP21/02/C2** The report was from KPMG had been presented at Audit and Risk committee. This would also come under the risk committee chaired by the executive medical director. Any operational issues would be presented at F&P	
	The Committee: • *Noted the updates and agreed, as above, which actions would be closed.*	
	Action: Claudia Gammon would update the Action Log.	
FP22/05/ B1	**Recovery Update** o Sodexo Plans – within the pack however no discussion at the meeting The Interim Director of Recovery, Innovation and Transformation provided the key highlights: • The teams were finalised at the end of April/May, with the new Director of Innovation and Infrastructure starting in their new role and working with the strategy and improvement team. • The intention was that from the end of June the re structure would be in place to enable the support for the outpatients and emergency care teams. The Interim Director of Recovery, Innovation and Transformation discussed the key projects: **Bassetlaw Emergency Village** • An outline business case was to be put together before the end of June, however, there had been issues with the plan. The total cost for the scheme was £23million however the funding available was £17million but had increased to £19million. • Within the Trust the assumption was that they were working on a modern scheme with an element of modular build however, it had been planned as a traditional build with a 2-year programme. • The full business case would be presented in September 2022, with a final approvement of September 2023 and the completion of work by September 2025. • The Trust would look at the modular build for the extension and to reduce costs. The recovery directorate had been looking at the build and the programming and should hopefully be able to bring the full business case forward to March 2023 with approval. • The project team were being supported by Archus, meetings had been booked to look at the new build projects. • Discussions with the ICS maybe required to determine if the money could be drawn down from the RAC money. The Trust were given an allowance of £10million to spend	

	this financial year on the RAC work. If the building cost ran over the year, the Trust would be required to fund the remaining.	
	Electronic patient records system	
	• The business case would be presented on 6th June 2022. Positive feedback had been received by the centre who should receive £14m capital to create a business case. The centre had also indicated that the trust could receive some revenue support for the first years of the project.	
	The Interim Director of Recovery, Innovation and Transformation explained there was a huge amount of work on the other three cases along with the new build. Other work included Monday.com and the governance around this. The DRIT report would be sited at the trust executive group meetings in the future along with the integrated quality performance report. The integrated quality performance report would become digital with all indicators present by June 2022. It had been agreed that the accountability meetings would be retitled to Performance Overview and Support meeting.	
	The Chair had requested an overview/update of the projects to be received at each meeting. This would then be the basis for questions from the committee. The new meeting structure appeared to achieve grip and control around the performance, driving an elective recovery update, and managing agency budgets. The Interim Director of Recovery, Innovation and Transformation advised that meetings had been set up via Monday.com since February 2022. Any future issues surrounding grip and control would then be scrutinised at the future Performance, Overview and Support meeting.	
	The Chair also asked about an overview of the electronic patient records and a brief update of the Bassetlaw emergency village: • The Chief Information Officer confirmed that the minister for health had provided all trusts with a target for the end of 2023 for an electronic patient record to be in place. • This would include outpatients, bookings, inpatients and pre operation assessments. At present the information was received by multiple systems, the aim was to have fewer systems. • The Interim Director for Recovery, Innovation and Transformation discussed about the Bassetlaw emergency village and that there had been an update to the emergency department with an extension area that flows through the unit to ensure the trust had the right co locations. Investigations were in place as to how a Same day emergency care unit would be placed on the site.	
	Action: - ***Produce a report to include each project from the Recovery Directorate including updates.***	**JS**
	The Committee: - **Noted and took assurance from the Recovery Update**	
FP22/05/ B2	**Mexborough Trauma Work**	

- The Interim Director for Recovery, Innovation and Transformation confirmed that a proposal had been made for an orthopaedic centre at Mexborough for 24 beds and 2 theatres.
- The ICS requirement initially was for knees and hip replacements. The proposal was to look at 2 and a half sessions a day which would allow 2 procedures a session.
- The Trust was currently investigating into working alongside Barnsley and Rotherham with an ICS resource situated on the Mexborough site.
- There were some critical success factors into this proposal: Strategic and meets business needs, potential value for money, supplier capacity and capability, potential affordability, and potential achievability.
- There were several options for the build with the preferred option being a single build with beds and theatres within the same building. The other preferred options were modifying parts of the existing estate.
- Modular solutions were being investigated against the preferred option with the get it right first-time requirements agreed on everything in separate areas.
- The Trust were trying to keep the cost under the £15million threshold, this meant that a shortfall business case could be carried out and submitted for approval within the region.
- Whilst carrying out surveys on the site more work had been established on the power supplies, inflation along with the impact of Covid-19 had increased the prices.
- Additional power supply costs of £750,000 would be used from the Trusts capital funds to keep the cost below £15million
- The Trust were also looking investigating into the costs of a hydrotherapy pool.
- The project timetable for approval was the end of June/July, with the final full business case being assessed for approval in September.
- The ICS were providing increased pressure on the 9month build, legal advice had been taken for this.
- Discussions were in progress with Rotherham and Barnsley regarding the process for the business case to be seen/approved at their board further update would be received, with a six-week approval process.
- A draft memorandum of understanding had been supplied with responses from Rotherham but awaiting Barnsley.
- The ICS would cover any fixed costs if this couldn't be covered by the elective recovery funds.
- A meeting was to take place the on 27th May with the planners from the council to discuss new rules in which the systems had to be turned around in 10days.

Kath Smart asked if there were any financial risks in terms of the partners with Rotherham and Barnsley. The Interim Director of Recovery, Innovation and Transformation explained how the plan would run itself, no Trust would be disadvantaged as this work wouldn't be impacted by emergency work due to Mexborough being a non-acute site. This would allow more procedures to take place at Rotherham and Barnsley in other specialties. Both doctors and nurses from Rotherham and Barnsley would work in the unit.

Mark Bailey commented about where the trust was positioned could there be any future collaboration. Also, when the Trust goes through the business case was it possible that there would be other ways to ensure it was accepted. The Interim Director of Recovery, Innovation and Transformation confirmed that the contingency plan was that it was for £15million however any additional cost for equipment maybe purchased via the Charitable Funds Committee. A hydrotherapy pool could also be built on the Mexborough site with funding from the Fred and Ann Green charity.

	The Committee:	
	- *Noted and took assurance from the Mexborough Trauma Work*	
FP22/05/ C1	**Integrated Performance Report** The Deputy Chief Operating Officer for elective provided an update: • April had been a challenging month due to Covid-19. As a result, there were flow issues and staff sickness this impacted on elective recovery. • An elective recovery programme was being investigated to provide and care and deliver the 89 procedures that couldn't take place. • There was a slight deficit for May with the figures to date being at -29, the target was a lot higher. • The plan was to enable open ward 19 as a surgical ward on the 20th of June. The Trust were looking at the modular ward and the theatres from October 2022, currently they were used as a central delivery suite due to the continued work within women and children's. • The Trust were anticipating that the 104 weeks wait should be at zero by the end of June 2022. • Meetings with the clinical teams had been organised to help with the leadership of the recovery team. • The radiology plan had two key things that were progressing, firstly that the British medical ultrasound society guidance had been implemented. A pressure on the service was the CT scans and the increased demand from 2019/2020 and the current backlog however, a mobile scanner would be arriving on the Doncaster site in August to assist. • Recruitment and staffing were still an issue, junior staff, clinical health care workers were part of a training programme to become radiographers. The Chair referenced the ability to get some traction, helping with the ways that the Trust used to work prior to Covid-19. One of the large items for this committee was the new meeting structure which would allow the executives to have grip and manage resistance to change. The Chair Level asked what the was the level of confidence that the Trust have reached so far. The Deputy Chief Operating Officer for Elective confirmed there had been focus group meetings over a 12-week period, there was nervousness within the departments initially. However, once they had been participating in them, they provided good feedback. The Interim Director of Recovery, Innovation and Transformation confirmed that the new performance overview and support meetings would replace the old focus and delivery meetings. Further to a question from Kath Smart regarding elective surgery, day case inpatients and tracking waiting lists, do some areas require extra support with performance. The Deputy Chief Operating Officer confirmed that ophthalmology, trauma, and orthopaedics still required extra	

support. Due to an increased spike in trauma activities within the previous two weeks 22 procedures had been cancelled. Ophthalmology, Ear, Nose and Throat and trauma and orthopaedics were continued pressures within the ICS. A piece of work had taken place to ensure some patients had been reviewed via primary care instead of secondary care. Continued work was taking place across the SYB. Kath Smart added that a lot of time had been invested into the Quality Improvement and trauma and orthopaedics areas. The Chair added how new issues in trauma and orthopaedics would be raised. The Interim Director of Recovery, Innovation and Transformation explained that this would be escalated to Richard Parker OBE then to Finance and Performance. Understanding the trauma side and working with consultants was key.

The Deputy Chief Operating Officer for non-elective provided an update:

- The performance had been difficult throughout April, with a Covid-19 peak of 215 active cases at the highest. The figures were now declining.

- The 4hr attendance was at 71.49% within the Emergency Department

- The 12hr wait in the emergency department was now being reported and were recording about 3.6%

- There were two main reasons for breaches, the first was for review and early medical assessment via all specialties and the second was the flow out of the emergency department

- Continued work was taking place on the length of stay of patients

- There was improved data in the nerve centre with further investigations taking place on improving the no right to reside.

- Working with partners on the ambulance performance and handover work. Ongoing work was taking place across South Yorkshire on the ambulance performance and the triggers. This would allow the Trust to gain a better view of other trusts and their triggers.

- Same day emergency care pathways had been opened to ambulance services, east midlands ambulance services for Bassetlaw and working with the Nottinghamshire ICS.

Further to a question asked by Kath Smart regarding the discharge process, delays and working with partners, what was the outcome from this and were there any challenges within social care.
The Deputy Chief Operating Officer for non-elective explained that transitional beds were available and were used when patients were awaiting care packages.
Further work on figures was being carried out, as in December 2021 100 delays were reported internally with the figures now showing at 70. Benchmarking of the data along with shadow reporting would take place and would then be presented back to the Trust Executive Group meeting.
Kath Smart also requested some assurance on the 'positive steps' programme in Doncaster and working with Rotherham Doncaster and South Humber Foundation Trust.

	The Deputy Chief Operating Officer for non-elective responded that transitional care was taking place where there were beds, they were filled, and 10 extra beds were opening until the end of June 2022. Rotherham Doncaster and South Humber Foundation Trust main issue was physiotherapy, a Chief Operating Officer meeting would take place to look at moving forward. Following a question from Mark Bailey regarding an end date on red to green discharge pathway once it's set in place. The Deputy Chief Operating Officer confirmed that there would never be an end date and it would be refreshed with further training as new people start. For next 6 months there would be continued work on training and imbedding this. The Interim Director of Recovery, Innovation and Transformation added that there was a project plan with smart objectives which were on plan for 6months this financial. Mark Bailey also asked about general performance and was there a recovery trajectory. The Deputy Chief Operating Officer confirmed that there was until end of the financial year. A stretch target had been put into place to achieve recovery for the end of quarter 3. As the Trust know that quarter 4 was a maintenance position and was difficult. The Interim Director of Recovery, Innovation and Transformation explained that a meeting had been set up with clinical leads from the emergency department. They had been booked into diaries 6weeks in advance to ensure attendance. Virtual wards were also being investigated within respiratory and elderly care. Work from the clinical commissioning group confirmed that potentially there was 150 beds in the schemes.	
	Action - ***Recovery trajectory report to be presented including up to the end of quarter 3***	**DP**
FP22/05/ C2	**Ambulance Handover Report** The Deputy Chief Operating Officer for non-elective discussed the ambulance handover report within the Integrated Performance report.	
	The Committee: - ***Noted the Ambulance Handover Report***	
FP22/05/ C3	**Radiology Recovery Plan** The Deputy Chief Operating Officer for Elective discussed the Radiology recovery plan within the Integrated Performance report. The Chair asked the committee if there were any further questions regarding the recovery plan. Kath Smart commented about the next steps and the progress. The Deputy Chief Operating Officer confirmed that a brief report should be presented at every Finance and Performance meeting.	
	The Committee: - ***Noted the Radiology Recovery Report***	
FP22/05/ D1	**Financial Performance – Month by Month** The Acting Director of Finance provided an update: • The planning resubmission and the additional national funding of £1.57 billion had been announced.	

- It was split into four different pots, general inflation of £680 million this reflects the higher level of inflation in the economy. Another £150 million for ambulance trusts for the significant spends on fuel and service pressures around call handlers not for ambulance turnarounds. £345 million for commissioner pressures mainly around the funding for nursing care and the settlement schemes for Ukraine and refugees. Specific pressures for £400 million that was allocated to regions to target specific issues. First three of those were recurrent, last one was non recurrent.
- South Yorkshire would then receive about £40.6 million; this means that the position was that the system had a deficit of £76.7 million at the time of April submission. If all additional income was excluded, this then left the ICS with a £40 million gap.
- There was an issue that if the Trust don't agree to submitting in a balanced system plan the Trust wouldn't receive the £40 million. The ICS were currently investigating if the money sits at organisational or system level or a mixture of both.
- The Chief Executives had discussed at the system leaders' group that a system balance would be submitted and discussed further on the 27th of May 2022.
- The Trusts pre-pandemic level of agency spend would be investigated versus the current spend and the significant increases within nursing. An outlined plan would be received and presented at the next finance and performance meeting.
- An internal audit would be carried out by 360 Assurance on the processes and procedures, organisations were implementing the infection prevention and control issues against others within South Yorkshire.
- If the Trust didn't sign up to a system balance plan, then they can't sign off anything without NHS1/E and the capital may be restricted in some areas.

The Chair added about the risks and whether they were at system level or Trust level and if NHSE/I would authorise them. The Chair also commented that NHSI/E would require a credible plan. The Acting Director of Finance referenced that a plan would need to be submitted within the next few weeks and would require Board sign off.

The Acting Director of Finance provided an update on the financial performance for month one:

- A £2.6 million deficit was slightly averse to plan of £258,000. This was due to a significant underspend which would become clearer next month. Due to the pay being averse the main issue was due to temporary staffing.
- Sickness rates in the Trust were the highest in the Northeast and Yorkshire region which was why temporary staff were required. Sickness levels would be challenged if it wasn't reduced and would require a clear plan on a way forward with sickness.
- Capital was on plan and about 3 months earlier than in previous years and would be investigated via the new governance structure.
- Corporate Investment Groups first meeting involved a lot of estates schemes being signed off.
- Cash balance dropped by £13 million to £33.4 million excluding and was capital expected to be around £31 million.

Following a question from the Chair regarding agency staff and if the Trust doesn't always receive the correct number of staff within the Trust, who was then responsible. The Acting Director of Finance answered that the medical human resources and education team look at the rotation into the Trust. The divisions were then informed and look at gaps if any or any over subscription, this changes every 6 months. The Deputy Chief Operating Officer for non-elective confirmed that not only were there gaps on these rotations but on sickness and study leave.

	The Chair also asked who provides an overview of the numbers and compares it to the finance. The Acting Director of Finance answered that finance check once the Chief Operating Officers had advised of any issues.	
	Action – - **Update on safer staffing workforce and the outline plan for reducing agency spend on nursing.**	**AT**
	The Committee: - **Noted and took assurance from the Financial Performance Month by Month Report**	
FP22/05/ D2	**Going Concern** The Acting Director of Finance explained why the Trust was a going concern, this was due to the Trust still being required to provide services to the local area. The Trust would have a positive cash balance however, it was much less than the Trust had operated with recently. Cash committee had been on hold during Covid-19 and would observe over the next 12 months how the Trust manages cash in the admin teams. An update would be delivered via finance and performance committee. Auditors were looking at the financial plan, however, were less concerned due to the Trust receiving money for inflation which reduces the risk.	
	The Committee: - **Noted and took assurance from the Going Concern Report**	
FP22/05/ E1	**Board Assurance Framework SA1 and SA4** The Acting Director of Finance discussed the board assurance framework for SA4 which reflects year end position and the £2.6 million surplus. The board assurance framework covers areas for example, the £25 million deficit, temporary staffing and delivering work. This was scored as a 16 due to the current position including the levels of the deficit and the levels of risk within the plan. The Trust would be at this level for the first quarter but then reassessed. Corrective actions were added, which should show that the board assurance framework was fully complete with regular updates. The Deputy Chief Operating Officer for non-elective referenced the board assurance framework for SA1 and confirmed that it was too early to reduce the risk at present and further investigations would be requires on this regularly.	
	The Committee: - **Noted the Board Assurance Framework**	
FP22/05/ E2	**Corporate Risk Register** The Chair invited the committee to make comments on the risk register. No comments were received, and all took assurance from the report.	
	The Committee: - **Noted and took assurance from the Corporate Risk Register**	

FP22/05 /E3	**Committee Annual Report** Kath Smart referenced the standard committee effectiveness report and that this wasn't within the annual report. FD responded tot say this is being planned.	
	The Committee: - **Noted and took assurance from the annual report**	
FP22/05 /E4	**Assurance Summary (Verbal)** The Committee was asked by the Chair if it was assured, on behalf of the Board of Directors on the following matters. Any matters where assurance was not received, would be escalated to the Board of Directors: - Matters discussed at this meeting, - Progress against committee associated Executive's objectives, - Divisional compliance with the Trust's risk management process.	
	The Committee were assured on behalf of the Board of Directors on: *- Matters discussed at this meeting,* *- Progress against committee associated Executive's objectives,* *- Divisional compliance with the Trust's risk management process.*	
FP22/05/ F1	**Governor Observations** No governors present	
FP22/05/ G1	**Any Other Business** There were no items for any other business	
FP22/04/ G2	**Performance Report Appendixes**	
	The Committee - *Noted the Performance Report Appendixes*	
FP22/05/ G3	**Minutes of the Sub – Committee Meetings (Enclosure)** *The Committee noted:* - *Capital Committee –17th March 2022* - *Capital Committee – 21st April 2022*	
FP22/05/ G4	**Minutes of the meetings held on 25th April 2022** - *The Committee approved the minutes of the meetings held on the 25$^{th of}$ April 2022*	
FP22/05/ G5	**Date and time of next meeting (Verbal)**	
	Date: Thursday 30th June 2022 **Time:** 09:00 **Venue:** Microsoft Teams **Meeting Close:** Meeting closed at: 11:40	

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 30th June 2022 at 09:00 via Microsoft Teams**

Present:	Neil Rhodes, Non-executive Director (Chair) Mark Bailey, Non-executive Director Mark Day, Non-executive Director Kath Smart, Non-executive Director Alex Crickmar, Acting Director of Finance Jon Sargeant, Interim Director of Recovery, Innovation and Transformation
In attendance:	Claudia Gammon, Corporate Governance Officer (Minutes) Joseph John, Medical Director for Operational Stability and Optimisation Gillian Marsden, Deputy Chief Operating Officer – Elective Angela O'Mara, Deputy Company Secretary Debbie Pook, Deputy Chief Operating Officer – Non-Elective
To Observe:	Andrew Middleton, Public Governor
Apologies	Fiona Dunn, Deputy Director Corporate Governance/Company Secretary Lynne Schuller, Public Governor

		ACTION
FP22/06/A1	**Welcome, Apologies for Absence and declarations of interest (Verbal)**	
	The Chair welcomed members and those in attendance. No declarations of interest were declared.	
FP22/06/A2	**Requests for any other business (Verbal)**	
	None.	
FP22/06/A3	Action Notes from Previous Meeting (Enclosure A3) Updates were provided on the below actions: **Action 1 – FP22/02/C2 – Health and Safety Board** Closed as being presented at Audit and Risk in October 2022 **Action 2 – FP21/11/G1 – Datix, Complaints and Risk Management Position Update** Update to be provided by Simon Brown, Acting Deputy Chief Nurse, at the July meeting to confirm the current position with Datix and if the system will be used going forwards how this will be made fit for purpose and the associated timeline for the work.	

	Action 3 – FP22/05/C1 - Integrated Performance Report The Urgent & Emergency Care Programme to be reviewed by the Chief Operating Officer. To return to Exec and will then be looked at **Action 4 – FP22/05/D1 – Financial Performance – Month by Month** Paper received by the committee although a further update would be received at the July 2022 meeting	
	The Committee: • *Noted the updates and agreed, as above, which actions would be closed.*	
	Action: Claudia Gammon would update the Action Log.	
FP22/06/B1	**Integrated Performance Report** The Deputy Chief Operating Officer for Elective provided an update on the Integrated Performance Report: • Ward 19 had previously closed as an emergency surgical ward pre-covid but had now reopened on limited capacity due to medical cover. The ward had been opened to 10 beds with half of them for emergency surgical medical patients and the remaining were for medicine. • Recruitment had started in readiness for the modular ward to open later in 2022, additional trauma and orthopaedics consultant and junior doctors and would allow an extra 5 theatre lists per week. • Work had been carried out with KPMG to increase the number of cases per list, this had increased except for paediatric dentistry, podiatry, and vascular. • Inpatient and day case activity had increased from 878 in April to 1005 in May. • There had been significant spike in May of trauma activity before bank holiday which had an impact on converting elective lists to trauma lists. • The Trust were monitoring their long waiters, there were currently no 104-week waiter patients. The Trust was currently reviewing the patients that have waited 80 weeks and above by specialty. The Interim Director of Recovery, Innovation and Transformation added that a second surgical performance meeting would follow to escalate the number of issues with additional sessions taking place. There were concerns regarding access to the theatres in the modular unit and the private work interest from the surgeons including the liaison with the commissioning support service. Work was to be carried out around this with a pilot to be discussed within orthopaedics. Patients that maybe awaiting gallbladder surgery were presenting themselves at A&E requiring antibiotics. The Medical Director for Operational Stability and Optimisation added about the discussions being had and concerns over patients on the waiting list, attending A&E prior to surgery. A requirement was for consultants to take control of their own individual waiting lists. This would be investigated, then the consultants would take a lead on this plan, they were confident that they can source the staff to work evenings and weekends and take part in the pilot. The Chair	

commended this initiative and that the committee would track additional sessions to ensure that the waiting lists drop. The Interim Director of Recovery, Innovation and Transformation discussed that the idea for this was to add this as a piece rate so that staff were paid per piece of activity. One issue was with staff working out of hours and over the weekends, the purpose of this task was for the staff to speak to and support each other. The Deputy Chief Operating Officer for Elective added that a lot of work had already gone into the preparation with the surgical team and the help with this moving forward.

The Deputy Chief Operating Officer for Elective provided an update on outpatients, a health group had taken place, although they hadn't converted as many patients from a theatre list and wanted however, they had discharged 17% of the referral patients sent to them. Some of which were patients that didn't require the surgery any longer or didn't wish to have it. The Ear Nose and Throat triage process had reduced the number of patients by 20%. Ophthalmology outpatient baseline in 2019/2020 had an attendance of 78% and was now at 88.4% with backlogs reducing by 15% in the previous three months. Doncaster and Bassetlaw clinical commission group were supporting with extended community support which helped with reducing demand and increasing capacity.

Kath Smart commented that once the Trust were up and running with Monday.com this should provide data and further assurance to the committee. The Interim Director of Recovery, Innovation and Transformation confirmed that this was the plan, with a weekly report and would be discussed at informal Executive Team meeting each week. Sustainable plans were in progress and required a short-term plan, medium term plan and strategy plans. Over the next few weeks this would be worked on and seeing the governance, should be ready for September 2022. Kath Smart asked about the underspending surgery and the outsourcing of the work that continued to be front loaded to maximise flexibility. The Interim Director of Recovery, Innovation and Transformation answered that the underperformance would be against the targets and the plan and would allow a stronger position for Winter. The modular build had been delayed from July until October 2022.

Mark Bailey requested if it was possible to know which policies we were working within ahead of the pilot and review them. The Interim Director of Recovery, Innovation and Transformation added that there would be a Post Implementation Report (PIR) to review. Speaking with the consultants to encourage them to come forward, discuss and support the divisions with the vacancies and what the Trust plan to do. Mark Bailey also mentioned the patients that don't wish to have surgery outside of Doncaster, had support been looked at for them regarding cost of living/travel. The Interim Director of Recovery, Innovation and Transformation confirmed that a list would be put together to speak to those patients that were willing to move. The Deputy Chief Operating Officer for Elective confirmed that One Health would offer transport.

The Chair observed about the executive intervention with surgery management and required an update on progress of this at the next meeting in July. The Chair also added about the willingness of the surgeons, working outside normal hours, evenings and weekends and requested an update on this at the July meeting with assurance.

The Deputy Chief Operating Officer for non-elective surgery provided an update:
- The main issues were that the Trust weren't recovering from the 4 hr performance rates and the ambulance handover times.

	• Work was being carried out on the actions and other ongoing issues to assist with flow through the hospital. • A bid had been put in with the system partners around capacity with a large part of this being no right to reside patients. The bid was for 36 beds and 60 virtual wards beds. • The Medical Director for Operational Stability and Optimisation was working on a diagnostic piece of work in the emergency department. The Trust should be making an assessment however there isn't enough beds available at present. Once the Trust have flow out of the emergency department staffing can be looked at. • Length of stay now had a transfer of care hub which was in test with a lead manager being recruited for the system. • There was still no capacity outside of the organisation and recruiting remained difficult along with packages of care. Kath Smart commented about the actions and that they were working although the data didn't show this, how do the committee obtain the assurance that was required and gather evidence for this. The Deputy Chief Operating Officer for non-elective surgery explained that the reason it wasn't having an impact on the data was due to the lack of flow out of the department. In next month's report there would be a pilot showing early assessment for walk in patients with a consultant at the front door, actions were then processed immediately and diverted to other pathways if required. The Trust won't see the 4hr target improve until the flow does. Ambulance handovers were still an issue as there was nowhere for the patients to be taken to. Occupancy was running at 97%, with the requirement to run at 85% or over to maintain flow with restrictions due to covid and pathways being an ongoing issue. Following a question from Mark Day regarding the capacity bid, what was it and what was the value. The Deputy Chief Operating Officer for non-elective surgery explained that it was a system bid that was sent to NHS England. The project that was picked would have the biggest impact instead of a fair shared bid. On a fair shared bid, it would be around £1miliion for extra beds, transport and a discharge lounge waiting. Mark day added that there was a risk attached and do the Trust have an idea as to when they would find out, which would be soon due to winter planning. The Interim Director of Recovery, Innovation and Transformation added that there were some areas and interim solutions that required work including the diagnostic areas. Workshops were taking place to look at the processes and standards of the urgent and emergency care boards. Length of stays had increased but the Trust would investigate this further. The Chief Operating Officer would prioritise the update of the plan. The Medical Director for Operational Stability and Optimisation added that the culture in divisions needing to change the values within the areas.	
	Action - ***Update on the plan for the consultant incentive rates to support elective recovery to be provided at the July meeting***	**JJ/JS**

	The Committee: - **Noted and took assurance from the Integrated Performance Report**	
FP22/06/B2	**Ambulance Handover Report** Within the integrated performance report.	
	The Committee: - *Noted and took assurance from the Ambulance Handover Report*	
FP22/06/B3	**Radiology Recovery Update** The Deputy Chief Operating Officer for Elective confirmed that there had been a meeting with the commissioning support services team and there was a small MRI waiting list. Some additional mobile support had been secured to reduce the backlog in July. Non-obstetric scans were supported, and the numbers had reduced demand. There had been successful recruitment within radiology, 3 specialists and one breast specialty radiologist. The Interim Director of Recovery, Innovation and Transformation confirmed that all actions had been completed with the commissioning support service team finding a short-term resource to close the gap. There was work being carried with on demand management team and working alongside the emergency department. Kath Smart asked about the update on sonographers. The Deputy Chief Operating Officer for Elective explained that the Trust were trying to recruit for this at present. Kath Smart added about the data and what the Trust does moving forward. The Interim Director of Recovery, Innovation and Transformation confirmed that this could be picked up along with the performance figures. 10 anaesthetic vacancies with 9 being recruited this would help with the pressure within the team and the division. Along with overseas theatre nurses. Forecast for the CT was that the Trust were covering over 117% in month one and 113% in month two with the target still being over 120%. The CT scanning backlog would drop however, demand management needed to work. The Medical Director for Operational Stability and Optimisation added that there was a multi way approach coming into CT. The national guidelines were being investigated with assessments on the patients. Full support was provided for the changes and the demand of the CT scans, further update at next meeting.	
	The Committee: - *Noted and took assurance from the Radiology Recovery Update*	
FP22/06/B4	**Nursing Agency Spend Update** The Chair requested if this could be discussed in the finance section within the financial performance month by month item	
	The Committee: - *Noted the Nursing Agency Spend Update*	
FP22/06/C1	**Recovery Update** The Interim Director of Recovery, Innovation and Transformation provided a recovery update and explained that the following projects would be discussed:	

	- Bassetlaw Emergency Village (BEV) scheme and that the business case should be finished on time. - Reinforced Aerated Autoclaved Concrete (RAAC) work had been proceeding well. - Montague Elective Orthopaedic Centre (MEOC) had some issues surrounding costings **Montague Elective Orthopaedic Centre (MEOC)** The Chief Executives from Rotherham and Barnsley met with Doncaster to discuss the scheme and as an outcome a meeting would be held for the medical directors, Chief Operating Officers and Chief Executives to perform a visioning meeting and look at the cost pressures. The options were that the business case goes as short form with a quick turnaround or as a full business case that would take a year longer due to the approvals process. The Monday.com system was now in place, with the performance meetings and working alongside Derek the score card. It was available to be accessed via a trust network at present. Further to a question from Mark Bailey regarding Derek and would it pull out areas that required investigating. The Interim Director of Recovery, Innovation and Transformation confirmed that a score card could be created in the future and asked for the committee to come forward with any ideas. In the future a report would come from the performance meetings with any areas then escalated to the transformation board. **Reinforced Aerated Autoclaved Concrete (RAAC)** The Interim Director of Recovery, Innovation and Transformation gave an update on the RAAC project, there had been a lot of work 18mths ago with the department of health due to the issues within the panels in the ceilings over the theatres and the Emergency Department at Bassetlaw. There was a national requirement to have all RAAC removed over the next 2/3 years. The Trust were allocated £10.3m to cover this work, the money had to be used within this financial year and draw down. The overall cost of the scheme was £15.9m including 15% contingency. This was a capital contingency with a deadline of the end of March 2023. If the Trust only receive the £10.3m then only one panel within the emergency department would be replaced to allow continuation of the BEV project. A further bid would be put forward in the future. A plan along with a short form business case would be presented back to the committee. Temporary theatres and mobile theatres were required to be ordered. Discussions with the council had taken place without any issues and building regulations had been approved. The Interim Director of Recovery, Innovation and Transformation asked the committee if they were happy to allow the submission of the short form business case and to allow any additional money requests to be submitted. The Interim Director of Recovery, Innovation and Transformaion confirmed that this would come back to the committee in September, this allowed for the 6 weeks turnaround plan.	
	The Committee: - ***Noted the Recovery Update***	
FP22/06/D1	**Financial Performance – Month by Month** The Acting Director of Finance provided a month 2 update, the report had been looked at against the April plan and guidance was received from NHSI/E however, the month 3 plan would be investigated against the new plan. Against the £25m plan to show a year-to-date deficit of £9.2m mainly due to including an additional funding that had an impact of £1.4m. If the Trust adjusted the additional income and the underspend this could be captured in later months. This was mainly driven by the Trusts pay position with temporary staff. The levels of	

vacancies in some areas were high as they were using temporary staffing, with vacancies within healthcare assistants and registered nurses, this had caused an overspend. There were 2 thirds of unregistered nurses that were included within the overspend. The levels of sickness were over pre-covid levels and higher than last year, with them being one of the highest within the Yorkshire and Humber region. There were 2 divisions that were in escalation, medicine and children's and families, the international recruitment of nurses had an impact due to those shadowing nurses. Looking at sickness levels was important to ensure all correct, in medicine the levels were at 10% sickness rate, this was above the Trust target of 3%. Children's and families level overspend was due to changes in midwifery as they were paying double rates within the area.

- The Capital position was in line with plan
- Capital Investment Group had 2 months of meetings including medical equipment
- The Cash balance was £27m at the end of May mostly due to old invoices being paid. This would be monitored via the cash committee meeting.

The Agency paper required a clear action plan with milestones, the plan also required a trajectory on the spend of international nurses and the impact of temporary staffing. Clear sickness management plans were required, and division needed to be looking at this. There was also a significant issue with bed pressures and an understanding on the length of stay.

The Interim Director of Recovery, Innovation and Transformation discussed about the agency and premium rates and the requirement to be investigated. A weekly report was previously used that was shared amongst the executive directors to gain a view of the risks. The Interim Director of Recovery, Innovation and Transformation enquired about the grip and control meetings, the Acting Director of Finance requested that the committee had a follow up meeting to discuss the item regarding the agency spend.

Kath Smart raised concerns regarding the sickness absence and that it had previously been discussed at People Committee and if Mark Day could look to including this within the People Committee meetings. This was agreed with Mark Day.

	Action –	
	- ***Action plan to reduce agency spend to be discussed at a separate meeting of the Committee.***	**AC & AT**
	The Committee:	
	- ***Noted and took assurance from the Financial Performance Month by Month Report***	
FP22/06/D2	**Financial Plan Update** The Acting Director of Finance explained that this was the same paper that had been discussed previously at Board The Chair raised that the development had been tracked and that there was a 4% cost improvement programme (CIP) to achieve in 8 months, the Chair asked how the committee would receive an overview and assurance on how this was progressing. The Acting Director of Finance confirmed that this would be reported via the monthly finance paper, as it had pre-Covid. Targets had been set for the divisions and working out their plans and would be monitored via the performance meetings to improve moving forward. There was a risk in	**AC**

	delivering the plan due to the delivery of the elective plan, workforce, and issues with temporary staffing.	
	Further to a question from Kath Smart regarding the pressure within the divisions, their overspends and any performance issues this may have caused. The Acting Director of Finance answered that pre pandemic there was a financial performance process that rated each division on KPI's and how they were performing. This had been reinstated with the process reporting into the performance and oversight meetings. Actions and timelines were then set.	
	The Interim Director of Recovery, Innovation and Transformation added that all the cost improvement programme plans would go into Monday.com and further work would be carried out to validate the saving estimates for several schemes. When this was set the plan was to earn all the elective recovery funding money.	
	Action – - *Include a progress update in respect of the CIP plan within the Financial Performance report going forward*	**AC**
	The Committee: - *Noted and took assurance from the Financial Plan Update*	
FP22/06/E1	**Board Assurance Framework SA1 and SA4** The Acting Director of Finance provided an update on the SA4 board assurance framework, the risk around the spends had been highlighted with a risk score of 16 if the Trust receives all the elective recovery fund money and would be presented as an appendix at the next finance and performance meeting. The external audit received a good result, but there would be on internal audit on the finance, governance and processes and would be in line with the national guidance. Draft guidance had been received with the final guidance being received within the next couple of weeks. The internal audit actions had all been completed.	
	The Committee: - *Noted the Board Assurance Framework*	
FP22/06/E2	**Corporate Risk Register** The Interim Director of Recovery, Innovation and Transformation provided a brief update on the register that the first task was to set up the risk management meetings and validate the risk register and mitigations, there had been a delay on setting up the meetings. Kath Smart raised concerns that the risk register should have been updated for July and to look at the 94 risks that the Trust executive group were reviewing. This wasn't possible and would put the board in a difficult position when looking at timescales.	
	The Committee: - *Noted and took assurance from the Corporate Risk Register*	
FP22/06 /E3	**Corporate Objectives – Performance and Finance** The Interim Director of Recovery, Innovation and Transformation raised that the objectives were required to be signed off ahead of the board meeting in July. The Chair asked for any	

	feedback to be sent to the Interim Director of Recovery, Innovation and Transformation and the Acting Director of Finance.	
	The Committee: - ***Noted and took assurance from the annual report***	
FP22/06/E4	**Datix, Complaints and Risk Management Position Update**	
	This item was deferred, update to be provided at the next meeting, to take place on 21 July 2022.	
FP22/06/E5	**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.*	
FP22/06/F1	**Governor Observations** The Chair welcomed Andrew Middleton the new governor for Finance and Performance to the meeting. Andrew Middleton observed that he was impressed with the detailed papers and amount of work behind and providing an update on how things would be taken forward. Praising the robust challenges from the non-executive directors and the understanding of the staffing and agency spends. Andrew Middleton asked about the collaboration with the mental health system however, there were issues with the occupancy and a system solution was required to allow the RAAC work to commence. The Interim Director of Recovery, Innovation and Transformation answered that the due to the ward areas they were in there were specialised legal requirements, a capital scheme had been delayed. Work was continuing to work with them.	
FP22/06/G1	**Any Other Business** There were no items for any other business	
FP22/06/G2	**Performance Report Appendixes** There were no appendixes added for this item	
FP22/06/G3	**Minutes of the Sub – Committee Meetings (Enclosure)** - ***No minutes to approve as meetings had been stood down***	
FP22/06/G4	**Minutes of the meetings held on 26ᵗʰ May 2022**	

	- *The Committee approved the minutes of the meetings held on the 26th of May 2022*	
FP22/06/G5	<u>**Date and time of next meeting (Verbal)**</u>	
	Date: Thursday 21st July 2022 **Time:** 09:00 **Venue:** Microsoft Teams **Meeting Close:** Meeting closed at: 11:45	

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

PEOPLE COMMITTEE	

Minutes of the meeting of the People Committee
Held on Tuesday 3rd May 2022 at 09:00am via Microsoft Teams

Present:	Mark Bailey, Non-Executive Director Anthony Jones, Acting Director of People and Organisational Development Sheena McDonnell, Non-Executive Director (Chair) Kath Smart, Non-Executive Director Abigail Trainer, Acting Chief Nurse	
In attendance:	Jayne Collingwood, Deputy Director of People and Organisational Development Dr Sam Debbage, Deputy Director of Education and Research Claudia Gammon, Corporate Governance Officer (Minutes) Paula Hill, Freedom to Speak up Guardian (Item F1) 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 Zoe Linton, Director of People & OD Michelle McKenzie -Smith, Head of Education Dean Royles, Humber Trust	
Apologies:	Fiona Dunn, Deputy Director Corporate Governance/Company Secretary Dr Tim Noble, Executive Medical Director David Purdue, Deputy Chief Executive & Chief Nurse	
		ACTION
PC22/05/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. Welcome to Zoe Lintin and Dean Royles who were observing the meeting. This was Sheena McDonnell's last People committee as she was moving to Barnsley to become the Chair.	
PC22/05/A2	**Requests for Any Other Business (Verbal)**	
	There were no requests for any other business.	
PC22/05/A3	**Actions from previous meeting (Enclosure A3)** **Action 1 – PC21/07/G1 - Performance Assurance Framework**	

	Closed	
	Action 2 – PC21/11/D1 - People Strategy This was deferred until the new Chief People Officer was in post and would be brought back to the July People Committee meeting **Action 3 – PC21/11/C6 - Pre – Registration Learners** Part of this would be covered within the Education update but would be formally updated at the June meeting.	
	The Committee: - *Noted the updates and agreed, as above, which actions would be closed.*	
PC22/05/ B1	**Sickness Absence** The Acting Director of People and Organisational Development gave an update on the sickness absence deep dive however the presentation was delayed due to Covid-19. The report would show the sickness picture for the organisation supporting the trust sickness and absence figures during pandemic and lower the figures. The new reporting system now provides real time data as per the old system that was 2/3 months old. Sickness absence was a continued theme throughout the pandemic, everything was recorded, gathered, and presented to the organisation. The new process had taken a lot of the sickness management burden away from the line managers, with a central telephone line being used. This was then recorded via ESR for managers to view. Proposals had been investigated as to how the Trust could fast track some services to the teams such as occupational health. The Trust target for sickness absence was 3.5% however, this had not been achieved in the past 6 years and was usually 4%-4.5% at Trust Level. Currently the sickness rates on Friday 29th April were at 7.6% including covid and non-covid isolation. Of this 2.7% was covid confirmed cases and 4.9% non-covid absence. The non-covid absences were mostly stress related (1.42%), secondly was musculoskeletal conditions and gastro conditions were third. This was the lowest increment it had been in months. As the pandemic was high in January this had an impact and resulted in staff absences being at 13%, this had decreased slowly until April. However, the levels did go back up to 11% at the time that the government relaxed the rules. Work was being carried out with the HRD Network around the coding and that sickness absence was coded correctly. Work was in progress for those staff members that have been Covid-19 positive but have continued to work from home. Some staff may have been coded incorrectly; a future update would be received. Looking at the % rates within divisional areas estates was high and a significant amount of resource was used in this area. There were 20 staff suffering from long covid, with work being investigated with ICB to look at pathways for each case and managing through the process. The Trust were continually asking the government for updates on the approach with living with covid. As there had been a refresh of the policy and the way sickness absence was reported it then made stage 1 easier to manage and more streamlined for individuals. Training and support would be provided to managers in a workshop style. The role essential specific training was being looked into as they were regarding the toolkit, it had also been discussed about making some of the training mandatory. A new tool had been purchased to provide a more proactive approach in the recording of absence in a more detailed way.	

Health and wellbeing have recently won an award and nominated for another award. Working with ICS over the Health and Wellbeing to put things in place. Majority of the call volume around health and wellbeing was surrounding stress and anxiety. At present 98 staff off with this which was higher than in previous months and require support. Support for occupational health as present there was a wait time of 5 days to make contact and 10 days for an appointment. Health and wellbeing were also supported by a counsellor to assist with mental health issues and working alongside charities.

The Acting Director of People and Organisational Development explained the focus on the next steps and the ongoing pieces of work:
- Firstly – the review and update of the covid standards, operating procedures and the alignment and the regional approach to capturing the absence correctly.
- Secondly – the work around occupational health development training and support offered to managers to ensure all referrals were appropriate. The Trust was currently building on the complexity of the data across all staff groups.

Following a question from Kath Smart regarding Musculoskeletal being the 2nd highest reason for absence and how do we get those staff back to work and were there any moving and handling incidents and health and safety incidents that contribute to the high level of sickness absence. The Acting Director of People and Organisational Development answered that the new central reporting absence line receives call from staff, they can subsequently be fast tracked to service e.g., occupational health. This also means that anything Musculoskeletal can be supported quicker. Provide some immediate help links with occupational health and for them to support. Kath Smart also asked about the Quality Improvement project on the sickness absence policy and when would the committee receive feedback to see where improvements were required. The Acting Director of People and Organisational Development replied that part of the process, involved managers and what was and wasn't working well. There was currently a piece of work taking place to look at the data as the sickness policy was not always being followed and providing training and support. Ensure that improvements were being made and followed across the trust. The training had good engagement from operational managers. There were two challenges, one with the system and the other people not following the system requirements. Further discussions were being made and would then be presented at the committees.

Following a question from Mark Bailey regarding the long-term absence rate, and if they were able to get back to the target. Mark Bailey also asked which absence rates were high and were there any that were in corelation and boarder line of staffing. Also, what was the wellbeing referral can we get on top of stress related absence amongst staff. The Acting Director of People and Organisational Development answered that a conversation was needed on the rate and previously reviewed it looking at high levels and setting more realistic rates. The Deputy Director of People and Organisational Development also commented about the correlation between the staff survey and experience.

The Deputy Director of Education and Research commented about doctors in training and their health and wellbeing, that the offer of training on the sickness absence policy should extend to them. The Deputy Director of Education and Research requested that this be presented as a future deep dive.

The Chair added that putting some upstream activities into supporting staff and that training was completed. The Chair expressed that she was surprised at the numbers and volumes on the call handling, and do we have the capacity to continue in the way we are. Work had commenced alongside NHS E/I to investigate into the peaks in covid and as to why the trust was an outlier in

	South Yorkshire. What were the best trusts doing differently and what do their numbers look like? The Acting Director of People and Organisational Development confirmed that the ICS had been contacted to look at the figures from other trusts. Acting Chief Nurse explained that as part of Health and Wellbeing for all new starters including the international nurses and health care assistants that they undertake mandatory training. 10 practice development staff have been funded as part of the Chief Nurse Charitable Funds for 6 months to introduce/welcome/support new staff on and off the wards.	
	The Committee: - *Noted and reviewed the Sickness Absence Report*	
PC22/05/ C1	**Board Assurance Framework – True North SA2&3** The Acting Director of People and Organisational Development confirmed that the staff survey actions would be reviewed, be presented to the board, and would then come back to the committee. Also, the guardian for safe working annual report was on the agenda and the payroll survey report would come back to people committee. Following a question from Kath Smart regarding SA2 as it states that there were still some risks to staff being redeployed. Kath Smart asked did this still apply and was it relevant. The Acting Director of People and Organisational Development answered that there was still some redeployment however it was a very small number of staff. Kath Smart also asked about the leadership development programme and did it include quality improvement leader training in level 1 and 2 to be presented at people committee. The Quality Improvement Clinical Lead answered that level 2 would be in September. Following a question from the Chair regarding the listening events/focus groups and if they were still taking place across the trust as a result of the staff survey results. The Acting Director of People and Organisational Development confirmed that feedback had been gained from the listening events within the divisions. Dates for these events were yet to be confirmed. The Chair also queried about the ongoing work of the 15+ workforce risks and were we sufficiently assured on them, and nothing was missing. The Acting Director of People and Organisational Development replied that a piece of work was being carried out to identify any issues with the risks. The piece of work still requires triangulation and investigating.	
	The Committee: - *Noted and reviewed the* **Board Assurance Framework – True North SA2 & 3**	
PC22/05/ C2	**Workforce Assurance Report including Widening participation** The Acting Director of People and Organisational Development referred to the retirement data as this wasn't in the report but would be presented at a future meeting. Further work was being invested in to looking at the vacancy rates, investments, and welcoming new starters. Staff turnover was below the 10% benchmark in Health Care Science and Medical and Dental areas. All other areas were over the 10%. Work was continuing to support new staff members. Links within the staff survey were important to improve retention rates and bring the numbers down. This then links into the work around retirement figures, looking back over the past 4 financial years (2017/18) and including current data. There had been a steady increase in the number, in 2017 there were 161 staff that retired compared to 243 staff members in 2021. In 2017/18 93 fully retired and 68 staff flexi retired. Each year over 30% of staff opted for flexi retirement. This	

	year until the end of April 42 staff wished to retire, with 29 retired fully and 13 took flexi retirement. Looking at the age profile over the past 5 years, in 2017 35% of staff were over 50 with 7% of this being over 60, there had been a steady increase over the years. This had now risen to 10%. The Acting Director of People and Organisational Development explained that in a recent publication the NHS had received more than 7000 resignations each month. Following a question from the Chair regarding exit data to enable a more accurate understanding of why people were leaving enabling the trust to retain people rather than re recruit. The Acting Director of People and Organisational Development answered that the exit questionnaire was now being used via ESR, it links staff feedback to the termination process. Data would be investigated and presented back to the People Committee in July 2022. Look at staff survey data alongside factor into risks. The Chair asked another question about how quickly it was to fill vacancies and that it was important to work with partners and were all Health Care Assistants now in post. The Acting Director of People and Organisational Development answered that there were some areas that needed further staff and required improvement in recruitment. There had been some delays due to checks in the recruitment of the Health Care Assistants. A lot of work was to be put in to ensure that the new Health Care Assistants stayed at the trust. The Acting Chief Nurse added that there was a large recruitment drive within the next 3/6 months. A radio campaign had been signed off about all vacancies and what the trust offers. Jobs fairs and the promoting of the trust within local colleges. Widening participation The Deputy Director of Education and Research discussed the widening partnership and that the team have been working on a project to attract local people and become the leading supplier of excellence. There was currently no data on the process prior to starting with the organisation. A 'We Care' event was planned for July 2022. In January the first cohort of NHS cadets joined the trust. The Trust was also working with the job centre and holding virtual career events. Apprenticeships were working well 123 last year planning 173 this year. Incentive payments by government for apprenticeships. Work experience would begin in June as it was temporarily paused. The trust would welcome its first cohort of t level students in June.	
	Action: - *Review and present 3 months of the exit questionnaire data*	**AJ**
	The Committee: - *Noted and took assurance from Workforce Assurance Report*	
PC22/05/ C3	**Education Assurance Report (Includes SET, GMC & Pre-Reg Learners)** The Deputy Director of Education and Research have recently worked with estates around accommodation and the challenges it upholds. The accommodation links to aspirations for the trust to become a Neonatal Life Support (NLS) provider. There was continued work on the quality data and quality strategy framework. Close links were made with the university of Sheffield, Hull, and Lincoln with an uptake in the workforce being seen. Investment received would be used for a website to be used for Drs in training. This would enable the education team to share the educational activity. It was agreed that once the accountability meetings were set up that the Deputy Director of Education and Research would present the KPIS and how they were managed to ensure further assurance.	

	Following a comment from the Chair regarding the progress on estates and facilities along with feedback from the students about the environment. The Chair also thanked the team on behalf of the board and asked for this feedback to be passed on. The Chair and The Deputy Director of Education and Research confirmed that they would email those staff involved.	
	The Committee: - *Noted and took assurance from the Education Assurance Report*	
PC22/05/ D1	**EDI Strategy** The Deputy Director of People and Organisational Development shared a brief action plan, work around inclusion/health and equalities work. There were also framework initiatives in place within quit smoking, obesity, wellbeing, know your numbers across the local communities. Working alongside the patient experience team and services they provide. This was a work in progress and was aligned. Following a question from Kath Smart regarding patients' actions around accessibility and race equality. The trust had also been giving fair treatment for all and the adjustment for sickness absence and returning to work after long term sickness absence. The Deputy Director of People and Organisational Development confirmed that there was work to do around this area and having a proactive approach was important. The Acting Director of People and Organisational Development explained that there was a phased return to work after long term sickness created a reasonable adjustment report to support the return to work and capture the data. The main aim was to return people to their substantive posts. Following a question from Mark Bailey asked about if the trust saw a trust wide plan for any type of treatments in the future to avoid duplications. The Deputy Director of People and Organisational Development answered it brings everything all together in small areas, emerging topic at system level. Once brought together it would reduce duplications, keeping focus, this was a longer-term ambition. Following a comment from the Chair about whether there was enough focus on patients, the strategy across the board and does the trust understand the difference. What do the trust wish to achieve and where do they want to get to with the strategy. The Deputy Director of People and Organisational Development answered this would be investigated and discussed further with the patient experience team.	
	The Committee: - *Noted and took assurance from the EDI Strategy*	
PC22/05/ E1	**People Strategy Action Plan** The Acting Director of People and Organisational Development explained that the new strategy would be developed once the new Chief People Officer was in post. This work would be then linked with the National People Strategy updated in 2021 and any place-based plans alongside the ICB. Work was being out to ensure the trust works more collectively and collaboratively. The Chair commented that the people strategy was required to be reviewed in the future against staff survey results. The New Chief People Officer would supply this moving forward.	
	The Committee:	

	- *Noted and took assurance from the People Strategy Action Plan*	
PC22/05/E2	**Health and Wellbeing Update** The Deputy Director of People and Organisational Development explained that the health and wellbeing team were successful in receiving funds via charitable funds for the garden room. The trust was also successful in obtaining a silver award and making progress in the ambition to obtain gold. The trust was also a finalised for the employee's benefits awards 2022, this was work around the staff employment position and the highfive recognition app. Proactive work was taking place around 'On Your Feet Britain'. The Deputy Director of People and Organisational Development explained that a more detailed paper on the Vivup app would be presented at the next people committee meeting. The Chair praised the team and progress that had been made, well done on shortlisting and the focus on physical activity. Following a question from Mark Bailey regarding the rainbow rooms that were used in the pandemic to rest in, were they still available. The Deputy Director of People and Organisational Development explained that there was one room available in the main block with the others had been recommissioned for service provision. They were a good idea to have for staff to experience and have time away. The Chair added that finding sufficient space was not always possible and to look at some of the staff and accommodation areas. Conversations had been made regarding this at charitable funds previously and that the staff changing rooms and kitchens required refurbishment.	
	Action: - ***Staff facilities within the kitchens/changing rooms to be refurbished and funded via Charitable Funds committee.***	**AT/JC**
	The Committee: - ***Noted the Health and Wellbeing Update***	
PC22/05/F1	**Freedom to Speak up Annual Review** The Freedom to Speak up Guardian gave an update on the annual review and that the national guardians office had been informed that guardians were required to renew their training. Case reviews would be investigated as 9 had been raised and gap analysis had been raised across the trusts to then benchmark against. Health education England training had been investigated across level 3 and all senior leadership teams. Inductions were revised and the set package had freed staff up however, it didn't leave a lot of time for staff to do level 1 and 2. Level 3 was the strategic culture. Numbers have continued to grow, a peak in Quarter 4 was seen of polycystic ovary syndrome (PCOS) and the Covid-19 vaccinations, support was provided with this. Champions were still being recruited; a relationship had also been made with the Health and Wellbeing champions and the professional nurse advocate (PNA). More focus was required around the freedom to speak up forum. October was freedom to speak up month which created extra voice, having greater involvement and support following feedback was important. Significant difference from start to the finish and looking to improve this moving forward through the strategic review. Following a question from Kath Smart regarding resources and looking at what to reconsider during 2022/23. The Freedom to Speak up Guardian answered that all current guardians were	

	permitted to contribute 20hrs. The positions have been filled and business cases had been put together with how to support the case management in the future. Kath Smart also asked another question around assurance on learning and what was required if the trust needed to review any policies and procedures. The Freedom to Speak up Guardian answered that the data was reported for staff abuse and safety. Learning and asking staff to speak about challenging items. Freedom to speak up was also discussed about being included within sharing how we care. Following a question from Mark Bailey regarding Ockenden and how does it feed into freedom to speak up. The Freedom to Speak up Guardian informed that Ockenden was required via listening events and a report would come back to people committee. The Acting Chief Nurse commented about the sharing how we care newsletter and further work that was required on the freedom to speak up. It was confirmed that work had started on this. The Acting Director of People and Organisational Development commented that it was important that this was also delivered to the executive directors and board members, then added to a board workshop in the future. It was also around Compassionate Leadership and role specific training for our leaders. The Chair added about what we were doing as a trust regarding capacity and the challenges, also about the wellbeing champions and for people to have the opportunity to speak up. This was required to pick up within the people strategy and would be monitored via the people committee.	
	Action – - ***Include Freedom to Speak up within the sharing how we care***	**PH/MH**
	The Committee: - ***Noted and took assurance from the Freedom to Speak up Annual Review***	
PC22/05/F2	**Freedom to Speak up Progress** Trauma and Orthopaedic update The Medical Director for Workforce and Speciality Development gave information that there should have been three sessions that had been delayed due to Covid-19. There had been positive engagement on the course. Discussions were being made with the Director of Recovery, Innovation and Transformation to look at single site trauma unit and to make it a sustainable department, this was yet to be signed off. Alternatively, the unit would be put back to a dual site unit. The Acting Director of People and Organisational Development added that there had been a lot of good feedback and comments from the second session in mid-March. There had been a lot of discussions around how the team interact with each other. The team had been flexible with the sessions and offered to stay after shifts to not interfere with clinical time. The new freedom to speak up had an impact on the department and was awaiting a further update on this. The Deputy Director of People and Organisational Development added the importance of working together, understanding culture change and the monitoring of this. The Freedom to Speak up Guardian added that there was a new champion within the medical team also at theatre level. Emergency Department Update	

	The Deputy Director of People and Organisational Development highlighted that the department have been working hard at addressing employee voice, acknowledgment in recognition and team huddles. Strong work in culture changes, efficient care work, clinical governance structures were now in place and could be embedded. Efficient Patient Care group had been set up in medicine. An online survey was presented for the emergency department of which 97 staff completed it, good feedback regarding relationships with managers and working within the area. Enjoyment in work was at 96%, sense of achievement 91%, relationships with managers 69% and overall satisfaction 83%. The request to the committee was if this could this be embedded.

Following a question from The Chair regarding was there any difference in staff survey in Trauma and Orthopaedics compared to other areas and was this the same for the Emergency Department. Also how does this impact on the values of the trust. The Deputy Director of People and Organisational Development explained that the staff survey results would need to be investigated, further conversations were also required with the Chief People Officer. The Freedom to Speak up Guardian added that there wasn't much change in the emergency department staff survey. However, there were a couple of new Freedom to Speak Up in the emergency department this month, continued support and focus was required. The Chair confirmed that this was brought back to the committee due to concerns. The Medical Director for Workforce and Speciality Development added that more work was required with the new medics since the new Clinical Director was appointed and more support was required. The trust anticipated that the General Medical Council report wouldn't be acceptable, this was due to learning and staff picking up extra shifts throughout Covid-19.

Mark Bailey commented that the trust was a good learning organisation with good progress and to keep it going in a positive way.

The Acting Director of People and Organisational Development added that work was carried out within the medical team, how it was progressing and referenced to the workforce role, how this links in across all staff groups not just the medics.

The Chair confirmed that this item should be kept on the agenda for oversite until embedded. | |
| | ***The Committee:***
- ***Noted and took assurance from the Freedom to Speak up Progress Report*** | |
| **PC22/05/ G1** | **Corporate Risk Register**
The Chair confirmed with the committee that they would take this paper as read and the committee agreed and there were no questions to be asked.

The Acting Director of People and Organisational Development informed the committee that there was another meeting proposed for the 4th of May with 360 assurance to discuss the register and the Board Assurance Framework further. | |
| | ***The Committee:***

- ***Noted the Corporate Risk Register*** | |
| **PC22/05/ I1** | **Governor Observations (Verbal)**
Alexis Johnson commented about the strategic plan in South Yorkshire and that the outcomes of the staff workforce objectives need to match. Alexis also asked if there were any plans around the British Sign Language act and what the trust would be doing in order to support this, as all | |

	services were now required to be accessible to the deaf. The Chair confirmed that a response would be looked at and sent back to him. Kay Brown asked about the turnover of staff and the 7000 staff leaving every year, was there anything the trust can do differently to retain the staff. The Acting Director of People and Organisational Development confirmed that there was a lot of work around this theme. Sickness absence rates for non-covid were surprisingly lower than anticipated. Trying to improve work life balance and agile working was the challenge as we come out of this wave of the pandemic. The Chair added that agile working was important and how we attract and retain staff, opportunities, and challenges. The Deputy Director of People and Organisational Development commented that the trust had the opportunity to innovate, listen to staff and talk to them, shaping them, and doing things differently with the workforce. The Acting Chief Nurse referenced that there needs to be more kindness to each other, looking forward, feedback coming from leadership and understanding they were people and how we behave with each other. Mark Bright observed about the two culture change reports on the emergency department and trauma unit were informative. Mark Bright asked about the Emergency Department questionnaire would it be repeated periodically. The Deputy Director of People and Organisational Development confirmed that the survey would be repeated, this would allow the trend line to be investigated. Mark Bright also asked about how many people were eligible to answer the questionnaire. The Deputy Director of People and Organisational Development confirmed that it was about 250 possible staff and team huddles were important to gain feedback.	
	The Committee: - *Thanked the Governors for their observations.*	
PC22/05/ J1	**Minutes of the Sub-Committee Meeting (Enclosure J1)**	

	The Committee noted:
	
	   i. Freedom to Speak Up Forum – 25 January 2022
	   ii. Equality, Diversity & Inclusion Committee – 29 November 2021
	   iii. Health & Wellbeing Committee – 16 February 2022	

PC22/05/ K1	**Any Other Business (Verbal)** There were no items of any other business.	
PC22/05/ K2	**Minutes of the Meeting held on 1st March 2022**	
	The Committee: - *Approved the minutes of the meeting held on 1st March 2022.*	
PC22/05/ K3	**Items of escalation to the Board of Directors (Verbal)**	
	There were no items of escalation to/from: i. People Sub-Committees	

	ii. Board Sub-committees iii. Board of Directors	
PC22/05/ K4	**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.	

PC22/05/ K5	**Date and time of next meeting (Verbal)**	
	Date: Tuesday 5th July 2022 **Time: 9.00am** **Venue: Microsoft Teams** Kath Smart congratulated Sheena McDonnell on her new role and thanked her for her contributions on the People Committee.	
	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 Friday 17th June 2022 at 12:00 via Microsoft Teams

Present:	Kath Smart, Non-Executive Director (Chair) Mark Bailey, Non-Executive Director Mark Day, Non-Executive Director	
In attendance:	Matthew Bancroft, Head of Financial Control Alex Crickmar, Acting Director of Finance Fiona Dunn, Deputy Director of Corporate Governance/Company Secretary Claudia Gammon, Corporate Governance Officer (Minutes) Jenny Marsh, Acting Deputy Director of Finance Richard Parker, Chief Executive Hassan Rohimun, Ernst Young Dan Spiller, Ernst Young Ruth Vernon, Assistant Director, 360 Assurance	
To Observe:	Dennis Atkin, Public Governor	
Apologies:	Sheena McDonnell, Non-Executive Director Neil Rhodes, Non-Executive Director	**ACTION**
AR22/06/A1	**Welcome, apologies for absence and declarations of interest (Verbal)**	
	Kath Smart welcomed the members and attendees. The apologies for absence were noted. The Chair referenced that it would have been Sheena McDonnell's last Audit and Risk committee meeting and thanked her on behalf of the committee for her contributions. The Chair noted that all documents had previously been seen and considered in draft by ARC, except for the ISA 260 report.	
AR22/06/B1	**DBTH Final Annual Report 2021/2022** The Chief Executive explained that as per the previous meeting both the final annual report and the governance statement were to be presented. Some changes had been made around the renumeration report which had been discussed at the previous ARC. The document was to be approved ahead of the 30th June deadline. One item within the renumeration report regarding a director was to be finalised surrounding their earnings and was being scrutinised by EY and the Finance Team to ensure it was in line with the expectations from NHSE/I. The quality accounts were required to be changed due to Covid-19 and the final draft would be available within 3 days, it was confirmed that the narrative was written prior to Covid-19. With the scrutiny surrounding the narrative in the report and was also required for final submission by the 30th June.	

	Following a question from the Chair about who would sign off the final renumeration report and Annual report and it was agreed that if the committee was happy with the changes on the report, then any minor changes would be delegated to the ADoF and ARC Chair before being submitted. The quality accounts would be signed off at an Executive Team meeting. The Chair asked for confirmation that Ernst Young were comfortable with the revisions and if they had any further comments, which there were none.	
	The Committee: - ***Noted and approved the DBTH Final Annual Report** 2021/2022 **with delegated authority to the ADoF and ARC Chair.***	
AR22/06/B2	**Final Annual Governance Statement 2021/2022** The Chair mentioned that the extra audit report was now within the annual governance statement. There were no further update on the statement.	
	The Committee: - ***Noted and approved the Final Annual Governance Statement 2021/2022***	

AR22/06/B3	**Final – DBTH Annual Accounts & Financial Statements 2021/2022**
	The Acting Director of Finance confirmed that any adjustments that had been made didn't impact on the final accounts. This included cash, capital, level of spend and the surplus.
	
	    o Surplus was £2.6m
	    o Cash amount was £44.6m
	    o Capital spend was £35.6m
	
	The main adjustment related to the implementation of the fixed asset register which had previously been raised via finance and performance committee. This identified £35m of nil net book items that were within the fixed asset register and were accounted as gross but should have been written out. Another adjustment was made regarding the going concern disclosures which had been assessed and were now in a better position.
	
	Further to a question from the Chair about if within the annual accounts the ISA260 had been referred to with adjustments being added, this was confirmed.
	
	The Chief Executive referenced that it had previously been mentioned that more capital may be accessible from NHSE/I.	

	The Committee: - ***Noted and approved the Final – DBTH Annual Accounts & Financial Statements 2021/2022***	
AR23/06/B4	**DBTH Letters of Representation** The Acting Director of Finance confirmed that there weren't any changes to the letters of representation.	

	Hassan Rohimun commented that further information was due regarding Russia and Ukraine and the representation from either. Information on this would follow and be added if required.	
	The Committee: - *Noted and approved the DBTH Letters of Representation*	
AR22/06/B5	**External Audit ISA 260 Report** Hassan Rohimun explained that the audit was near completion subject to the production of a small number of outstanding items by the trust, which were not thought to be significant. Any significant issues are brought to the Committees attention in the ISA 260. A value for money opinion would be issued after the ISA 260 and would be certified as closed once the value for money audit responses were added to the report. The Acting Director of Finance added that when the accounts were submitted the opinion was also submitted highlighting if it included the value for money statement. The Chair asked if this made the trust an outlier and it was confirmed that as 40 other trusts were in a similar position. The Acting Director of Finance added that many trusts don't present their accounts before parliament prior to the summer recess. Dan Spiller confirmed with the Acting Director of Finance that further updates would be given regarding the laying date of the accounts to parliament. o The pre-payments part of the audit had now moved into review, awaiting responses from the Estates team, and would then be reviewed. o Internal consultation for the process was outstanding and was with the finance team, with further updates being presented prior to the approving of the accounts. o Going concern was signed off and agreed, and it was noted a lot of work was completed around this and the forecast deficit for 22/23. o It had been identified that there were no fraud issues required highlighting o Specific risks surrounding the fixed asset register had been reviewed and a number of recommendations included within the ISA 260 o The forecast deficit for 22/23 was £25m when the report was written however, this was now in a better position at £11m. o The valuation of the land and buildings with the desktop information that was presented was being praised due to the amount of information received. o The IFRS16 had been presented in April 2022 and this was still a work in progress. o No qualification was required on the renumeration report this year, small amendments had been made. o The control recommendations were contained within the ISA 260	

	o There were differences within the pre – payments systems with invoices being raised incorrectly. The Acting Director of Finance praised the audit opinion and that there was no qualification on the renumeration report. There were also no issues at present around the value for money with the report being positive. Within the report there were some control issues weaknesses graded "amber", which the ADoF and Finance Team would be addressing in the next financial year. A further meeting would be provided to keep everyone up to date and look at where improvements could be made. Thanks were given to the external auditors and the finance team. Mark Day requested a copy of the engagement letter and asked about the interim NHS balances and the discrepancies, and also queried the increase in the audit fees. Dan Spiller confirmed there were no financial disputes with other trusts and discrepancies were mainly due to timing issues. Any debt owed to the trust was reviewed by the trusts cash committee every month. Hassan Rohimun confirmed that the fees were as it was Year 1 of a new contract period which EY had tendered for during 2021. Mark Bailey praised the opinion, the report, the outcome, and the financial outlook that provided confidence moving forward. Mark Bailey also praised the closure of actions from last year. Further to a question asked by Mark Bailey about the HR processes and that it was an opinion of low risk however, who was assisting with the leavers and starters. The Acting Director of Finance answered that it had been raised to the new chief people officer and would be actioned via people committee and then presented back to audit and risk committee. The Chief Executive added that the intention was that any actions would be tracked throughout the year with progress updates. The Chair asked Ernst Young and the recommendations and should the trust be worried about their financial position, were there any concerns and were they manageable. Hassan Rohimun answered that they were manageable, with the previous year being challenging with significant strains on the team. It hadn't been as robust as in previous years and raised more questions from other teams. The Chair also requested policy review dates, and which were overdue, this had been passed on to the finance team and would be circulated. The ISA 260 recommendations progress would be presented at the October committee meeting.	
	The Committee: - *Noted the External Audit ISA 260 Report;* - *ADoF /EY agreed to provide a copy of the engagement letter* - *ARC agreed to review progress at the October ARC*	
AR22/06/B6	**DBTH Audit and Risk Committee Annual Report** The Chair discussed that the ISA 260 outcome was missing from the report due to timing and would be added prior to this being received at Board.	
	The Committee: - *Noted and approved the DBTH Audit and Risk Committee Annual Report*	
AR22/06/C1	**Governor Observations**	

	Dennis Atkin had joined the meeting late due to another meeting elsewhere. Therefore, no observation was made.	
AR22/06/D1	*Any Other Business* There were no requests for any other business	
AR22/06/D2	*Minutes of the meeting held in March and April 2022*	
	The Committee: - *Noted and approve the minutes held in March and April 2022*	
AR22/06/D3	**Issues Escalated From/To (Verbal)**	
	Issues escalated from/to: i) **QEC Sub-Committees – ISA 260 Recommendation relating to Payroll/ Starters/ Leavers would be escalated to People Committee** ii) **Board Sub-Committees** iii) **Board of Directors**	
AR22/06/D3	**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	
AR22/06/D4	**Date and time of next meeting (Verbal)**	
	Date: **14th July 2022** Time: **09:30** Venue: **Microsoft Teams**	
	Meeting Close: **13:00**	

FINAL

Doncaster and Bassetlaw
Teaching Hospitals
NHS Foundation Trust

QUALITY AND EFFECTIVENESS COMMITTEE

Minutes of the meeting of the Quality and Effectiveness Committee
Held on Tuesday 8th February 2022 at 13.00 via Microsoft Teams Videoconferencing

Members:	Mark Bailey – Non-Executive Director Pat Drake – Non-Executive Director and Chair Sheena McDonnell – Non-Executive Director Dr T J Noble – Medical Director	
In attendance:	Juan Ballesteros, Associate Medical Director for Clinical Safety Andrea Bliss, Divisional Director of Nursing for Children and Neonates Simon Brown, Associate Director of Nursing Kirsty Clarke, Divisional Director of Nursing for Surgery Sam Debbage, Deputy Director of Education and Research Fiona Dunn, Deputy Director Corporate Governance/Company Secretary Dr Eki Emovon, Divisional Director of Children and Families (B1) Claudia Gammon – Secretarial Support Officer (Minutes) (CG) Marie Hardacre, Head of Nursing Workforce and Ward Accreditation Karen Humphries, Clinical Governance Coordinator Joseph John, Medical Director for Operational Stability & Optimisation Lois Mellor, Director of Midwifery Denise Morgan, Clinical Governance Lead (B1) Debbie Pook, Deputy Chief Operating Officer Marie Purdue, Director of Strategy, and Improvement Andrea Squires, Divisional Director of Operations Abigail Trainer, Director of Nursing Jodie Roberts, Director of Allied Health Professionals	
To Observe:	Peter Abell, Public Governor Bassetlaw Lynne Logan, Public Governor Doncaster Anthony Jones, Deputy Director of HR Kath Smart, Non-Executive Director	
Apologies:	David Purdue – Chief Nurse/Deputy Chief Executive Stacey Nutt, Deputy Director of Nursing (Patient Experience)	
		ACTION
QEC22/02/A1	**Welcome, apologies for absence and declarations of interest**	
	The Chair welcomed the members, attendees, and governor observers. The Chair mentioned that this would be her last Quality and Effectiveness Committee with Kath Smart taking over as interim Chair until NED recruitment complete and new Chair of QEC in place. The Chair gave a specific welcome to Dr Joseph John and Juan Ballesteros for their attendance to their first QEC meeting	

	The above apologies for absence were noted and no conflicts of interest were declared.	
QEC22/02/A2	**Conflicts of Interest (Verbal)**	
	No conflicts of interest were declared.	
QEC22/02/A3	**Actions from previous meeting (Enclosure A3)**	
	Action 1 – Winter Plan – Within the agenda however a further update would be provided in April 2022	
	Action 5 – Board Assurance Framework – Patient Experience – On the agenda however further update to be provided in April 2022	
	Action 6 – Board Assurance Framework – On the agenda	
	Action 7 – Quality Framework – Full report required in April 2022	
	Action 8 – Quality Strategy – Full report required in April 2022	
	Action 9 – Ultrasound Scanners – Maternity – On the agenda – Closed	
	Action 10 – Datix Update – On the agenda	
	The Committee: - *Noted the updates and agreed, as above, which actions would be closed.*	
	Action: Claudia Gammon would update the Action Log.	**CG**
QEC22/02/B1	**Divisional Presentation – Women & Children's**	
	The Divisional Director for Children and Families welcomed his team to present the annual Divisional update to the Committee. He highlighted that there had been two main issues that had affected the Division. One; Covid-19 and the other was the major incident within Women and Children's. This had had an impact on both services and the staff. Key points highlighted from the presentation included: • Staff survey results had been within the top 3 as a division with staff satisfaction being at the top. • There were several open Serious Incident Actions between March and December: **March** **Action** – Paediatric ovarian torsion guideline **Update** – For approval in February's meeting **June** **Action** – Middle grades changing Paediatric Consultant plan **Update** – Reassurance audit being presented in February **Action** – Hypertension in pregnancy guideline amendment **Update** – Local Maternity and Neonatal System was preparing a guideline to incorporate **July** **Action** – Paediatric Feeding Guideline adherence	

Update – Assurance audit to be presented in February

Action – Documentation of paediatric clinical reviews

Update - Assurance audit to be presented in February

August

Action – Change to Paediatric Consultants rotas

Update – At level of Medical Directors office

September

Action – Sharing updated hypertension guideline

Update – Awaiting Local Maternity and Neonatal System guideline

November

Action - Staff guidance for managing Induction of Labour service

•Fetal movement awareness

•Incident report to SCH re delay in plastics Operating Department Practitioner appointment

•ID for patients with foreign body left inside

•Obstetric led individualised delivery plan

Update – December's consultants meeting –no January meeting to approve minutes

•awaiting sonographers' response

•awaiting response

•being implemented via a band on the patient that they have a pack for example in them

•For approval of consultants meeting minutes

Denise Morgan updated that all actions for November were in progress.

December

Action – Situational awareness and leadership training

Update – Course fully booked mitigated by adding CTG and PROMPT training days.

28 incidents had been documented within the Division and were open longer than 3months. 2 of these were from May with no harm. 20 moderate harms had occurred for the year with non-harms between January and May. There were 10 outstanding Duty of Candour letters.

Denise Morgan explained the audit activity in Women and Children's:
- Ongoing projects - 66
- Action plan in place as didn't meet standards – 70
- Action plan completed – 60
- Action plan not due – 9
- Action plan not completed – 1 as requires information from Primary Care

The Divisional Director for Children and Families discussed the 14 complaints within the area. Four of these were in Obstetrics and 10 in Gynaecology. A complaint within Gynaecology was yet to be completed within the 80-day target. Although it had been acknowledged within a day and was then presented to the Serious Incident panel by 20 working days. The patient was updated at 40 days and a report had been completed. All other complaints were on target.

Director of Midwifery gave an update on the Peer Reviews:
- Local Maternity & Neonatal System (LMNS) – Retention of midwives
- Clinical Negligence Scheme for Trusts (CNST) – Womens Choice
- Ockenden – On track to deliver, women's website in progress

	- Health Care Safety Investment Branch (HSIB) – Serious Incident actions - Getting it right first time (GIRFT) – Action plan logged at governance meetings - Operational Delivery Networks (ODN) – Discussed at perinatal meetings - Perinatal Mortality Review Tool (PMRT) – Discussed at perinatal meetings - Safety Forum, Paediatric critical care and Quality safety and Governance lead – within Governance agendas Improvements had been made across the department within paediatrics to ensure work was continued with the storage of controlled drugs. Daily checks were carried out on the fridges. Gynaecology was working to ensure that antibiotics have an end date. With this there have also been some quality improvements that include separate waiting area for midwife referrals to reduce risk of infection, this was still to be implemented. Multiple Pregnancy and Foetal medicine service and Perinatal Mental Health clinic all being implemented. Sheena McDonnell asked questions around the presentation; were they expecting good feedback on the recent staff survey? Was there a sense amongst the staff of their concerns? The Divisional Director for Children and Families answered that they were yet to receive the official responses from the survey. The recent major incident had affected staffs moral and therefore this may show in the results. Director of Midwifery added that additional support had been provided to staff. Health and Well-Being sessions, Reiki and other therapies were used by staff. A recruitment and retention lead had been appointed to support with the newly qualified midwives overseas recruitment. The Chair raised the following points: - Incidents that were over 3 months required a plan and to be discussed further at Clinical Governance. - Feedback on complaints was good - Staff sickness was still a challenge. The Chair thanked all those involved for their presentation and wished Andrea Bliss a happy retirement.	
	The Committee: - ***Noted and took assurance from the Divisional Presentation on Women & Children's***	
QEC22/02/B2	<u>**Complaints**</u>	
	The Deputy Director of Nursing (Patient Experience) was not available to present this deep dive presentation on complaints and patient experience. However, the Chair noted that looking at the two reports there appeared to be some data discrepancies which would mean that only partial assurance could be given by the committee. A further report would be delivered at the next Quality and Effectiveness Committee on 5th April.	
	Action: - ***To have control over Quality Governance specifically around Complaints. Themes, coloration of data and KMPG all required an update. Full actions and what can be learnt from them to be addressed.***	**AT/SN**
	The Committee:	

	- *Noted and took partial assurance from the Complaints update*	
QEC22/02/C1	**Board Assurance Framework (Enclosure C1)**	
	The Company Secretary gave an update on the new layout of the Board Assurance Framework in that there were new fields added for clarification; comments, control over when a risk was reviewed and the next review date., a new assurances section including 3 levels of assurance. The three assurance levels highlighted on the new report were; Level 1 was operations (L1), Level 2 internal assessment (L2) and Level 3 external assessment (L3). The strategic aims had been added to allow more assurance where sited and where there were gaps within this.

Following a question from Sheena McDonnell regarding the True North Strategic Objectives and that they were now included within Patient Experience and where was this from. The Company Secretary confirmed that it had been reviewed in April 2021. The strategic aim breakthrough objectives ensure everything was updated for the next year. Executives were required to update and ensure accuracy moving forward.

The Chair added that the National Surveys should also be added and include Patient Experience, A&E, and Maternity Surveys all of which were awaiting the results. | |
| | *The Committee:*
- *Noted the Board Assurance Framework* | |
| **QEC22/02/C2** | **Quality Strategy, Framework & Breakthrough Objectives** | |
| | The Chair referred to the Quality Strategy still being in draft form although the Clinical Governance Strategy was not out of date, it was to be updated ahead of QEC in April in terms of the Quality Framework. Although the report had been piloted there was still some work to carry out.

Director of Strategy and Improvement explained that within the Framework Quality Improvement was one part of this with strategies and breakthrough objectives creating the remainder. | |
| | *Action:*
- *Present the updated Quality Strategy and explain how it would be rolled out and used in the future.* | **DP/TN /MP** |
| | *Action:*
- *Present the Quality Framework* | **DP/TN /MP** |
| | *The Committee:*
- *Noted the* **Quality Strategy, Framework & Breakthrough Objectives** | |
| **QEC22/02/C3** | **Quality Assurance Report Items**
- **Summary of Clinical Governance Committee Activity**
- **Clinical Governance Review Position**
- **Maternity Ultrasound Scanners** | |

A summary of Clinical Governance included the Patient Safety Review Group issues around Datix.

- There was an update every month on Infection Prevention and Control.
- Policies were overdue in December 2021 by 10% with further improvement required.
- Ophthalmology review lists were uploaded via Camis with all 3,000 patients now reviewed. No serious harms and very few moderate harms were recognised. 29 avenues with 39 specialties were to follow the same steps and would be worked through in sequence.
- Medical Director confirmed that all Maternity ultrasound scanners had service contracts.

Sheena McDonnell commented on the progress of the policies and asked what the 'Datix rescue package' was? The Covid-19 death letters to the families were also mentioned and this was linked to the Datix plan.

The Medical Director confirmed that Datix was made up of complex dashboards with not everyone had access to all of them. However assurance was given that data is available for incident investigation.

The Director of Nursing added that significant investment was required for Datix and there were other systems on the market that could be used.

Marie Hardacre also added that the Datix team along with IT were working together to investigate access issues further.

The Chair requested that a detailed plan/timeline would be required for assurance for next meeting.

	Action: - *A paper to be presented explaining the current situation of the new system and to implement the plans moving forward. This would also require adding to the Board assurance framework.*	TN/DP
	The Committee: - *Noted the Quality Assurance Report Items*	
QEC22/02/C4	**Reporting of patients who wait more than 12 hours from the decision to admit**	
	The paper was taken as read and the Chair asked any questions to be brought forward. The Chair referenced the 12-hour waits and the system used to measure these. It was mentioned that there was a 10-hour point check along with an 8-hour bed from trolley check. Were the 12,10 and 8-hour waits being audited? The Deputy Chief Operating Officer explained that there was a provisional assurance report that highlighted these waits and whether patients have been fed/watered. Two-hourly training huddles commence with all senior staff reviewing each patient within the department. Following another question from the Chair regarding the Hospital-acquired pressure ulcers (HAPU) and should patients that come in with them go straight on to a bed as appose to a trolley? They would be assessed accordingly and put on to a bed if required. The Chair also asked about the clinical harms and the serious incidents, it was answered that there were no serious incidents of patients being on a trolley for 12-hrs. One clinical harm wasn't entered via Datix as they weren't authorised to do so.	

	The Associate Medical Director for Clinical Safety added that high risk patients (those with Covid-19) should be a priority and closely monitored. He added that the movement of patients around the hospital should also be considered.	
	The Committee: - **Noted and took assurance from the 12 hour wait update**	
QEC22/02/C5	**Quality Assurance Report Items** - **Incidents and Serious Incidents Report** - **Datix Update** - **Falls** - **HAPU**	
	Marie Hardacre confirmed that the incident report rate was in a good position with the severity of harm broadly in line with the National average. The top categories were: 1) Skin Integrity 2) Falls 3) Workforce/Staffing 4) Access and discharge 5) Medication There had been 28 serious incidents, these were reported to falls panel every month. Yellow blankets and socks had been implemented to distinguish those patients who had experienced a fall. A 20% reduction in pressure ulcers. Individual users had been added to Datix. Additional support was provided by Barnsley to assist divisions and improve communications. Following a question from Sheena McDonnell regarding visual aids for falls and what currently worked instead of implementing new ideas? Marie Hardacre confirmed that when a patient falls staff then intervene and advise accordingly with yellow blankets and socks being given. This had shown some improvement in the number of falls. Mark Bailey gave an idea that maybe video clips may assist with staff. It was confirmed that this was in progress and e-learning clips were currently being made for use with agency staff. The Chair asked about the Patient Safety Specialists, three had been given this role as short term ahead of interviewing someone permanent with a target of April.	
	Action: - *Update on Patient Safety Partners and Patient Safety Incident Response Framework*	AT/MH
	The Committee: - *Noted the Quality Assurance Report Items*	
QEC22/02/C6	**Quality Performance Impact Assessment (QPIA) (Verbal)**	
	There was nothing to raise under this item and no questions were asked	

	The Committee: - *Noted and took assurance from the Quality Performance Impact Assessment (QPIA)*	
QEC22/02/C 7	**Safer Staffing**	
	Divisional Director of Nursing for Surgery gave the highlights of November/December2021 that there had been an increase within bed occupancy. Other points covered included: • Increase in agency staff used therefore the Trust was now trying to book agency staff in advance. • NHSP had given an incentive to staff to cover extra shifts. • Increased staff sickness due to Covid-19. • Marie Hardacre had been recruited as the new Head of Workforce. • International nurse recruitment had been successful in 2021 with them all in post. 45 new nurses were expected in 2023. • Funding had been put forward for Health Care and Admin staff. • A weekly report was submitted to NHSI with an update on vacancies. • A senior advocate role had been recruited to support 20 nurses. Sheena McDonnell had commented that recruitment gaps were being investigated for bands 2 and 5. That it was good to see the focus on the workforce and asked if the Trust were using Allocate. The Director of Nursing confirmed a safe care module was in talks however a clinical nurse was required to oversee. A retired matron had been recruited to support the International Nurses. The Chair observed that as the hospital were receiving more patients the pressure increased. She also praised that the Trust would be gaining a further 45 International nurses in 2023. Staffing continues to be a major challenge going forward.	
	Action: - *International nurses report and the work they undertake*	**KC/AT**
	The Committee: - **Noted and took assurance from the Safer Staffing update**	
QEC22/02/C 8	**Winter Plan Update to include Covid Position**	
	There had been a gradual decline in Covid-19 with figures standing at: 122 – Covid-19 patients 80 – Active Covid-19 patients (53 DRI, 26 Bassetlaw and 1 Montagu) 2 – Intensive Care Unit The Director of Nursing confirmed that on ward 22 the extra beds were being utilised. Discharge of patients was a national priority and was being worked on. A work around had been implemented for a discharge care hub to work inline with the national discharge policy.	
	Action: - *Discharge of patients – update as to position of plan with a paper at April meeting*	**AT/JR/ DP**

	The Committee noted: - *Noted and took assurance from the Winter Plan and Covid Position update*	
QEC21/02/C9	**Ockenden Update**	
	Director of Midwifery explained that the Ockenden report was in two parts with the first submitted in December 2020 and the second for submission in March 2022. Following the first part there had been seven immediate actions. More evidence may be required with 150 pieces of evidence were submitted in December 2020. A meeting had been set up for the 9^{th of} February to discuss a Quality Strategy and create a framework.	
	The Committee: - *Noted and took assurance from the Ockenden Update*	
QEC22/02/C10	**Bassetlaw Children's Urgent & Emergency Care – Report from Senate**	
	Director of Strategy and Transformation gave an update on the report. The draft report had been sent back with comments and was awaiting circulation from the Senate before the signing off in March 2022. The feedback raised the development of Advanced Nursing Practitioner roles and the delivery of the service. The consultations were moving along well and were at over 80%. An update report to be brought back to QEC in April.	
	Action: - *Consultation Report to be delivered, with update on Health and Equality Plan and the ratified senate report*	**MP**
	The Committee: - *Noted the* Bassetlaw Children's Urgent & Emergency Care – Report from Senate	
QEC22/02/C11	**Mental Health Strategy Progress**	
	The Director of Nursing reported that there were on going risks around staffing at RDASH which had impact on our strategy. The Chair requested a written report in the six-monthly update.	
	Action: - *Written report to include capacity, training and safeguarding within the Mental Health Strategy.*	**DP**
	The Committee: - *Noted and took assurance from the Mental Health Strategy Progress plan*	
QEC22/02/C12	**Learning Disabilities Strategy Progress**	
	The Associate Director of Nursing gave a brief outline of the progress, the first steering group had taken place for Learning Disabilities. There had been a change that if an autistic patient died within our care that a Learning Disabilities Mortality Review (LEDER) had to be undertaken. At present there was a national issue in that there was no way of flagging an autistic patient. New Learning Disabilities Nurse had been appointed.	

	The Chair questioned when the Clinical Commissioning Group no longer has responsible authority where does the accountability go? This would be within the ICS. Autism flagging was undertaken internally however it was not robust or consistent, and the Trust rely on Clinical Commissioning Group to provide the information. Work had been carried out with RDASH to gain this information. Some patients don't wish to be flagged as having learning difficulties if they were autistic. Sheena McDonnell commented that a timeline would be useful on the workplan to follow the progression.	
	The Committee: - *Noted and took assurance from the Learning Disabilities Strategy Progress*	
QEC22/02/D1	**Patient Experience Update – incorporating Inpatient Survey Update and Urgent & Emergency Care – Report**	
	Several questions were raised within this item around the data and if there was a policy for the changing of wards at night that out Trust adheres to. The Chair requested that a full report be given at April's meeting	
	Action: - *Full report to be given including clear data*	**SN**
	The Committee: - *Noted and took partial assurance from the* **Patient Experience Update – incorporating Inpatient Survey Update and Urgent & Emergency Care**	
QEC22/02/D2	**Respect Audit Outcomes**	
	Sheena McDonnell commented that the audit was now complete although it had identified gaps which should be looked at wider than the Trust. It was more likely to be discussed within Specialty appointments within outpatients rather than in A&E. This should therefore be an ICS/ICB issue. Sheena McDonnell asked what the approach would be moving forward, and the right people need to be involved. The Medical Director replied that the patient could be seen under the Trust or primary care. He raised that although discussions around end-of-life care shouldn't be discussed too early but shouldn't be discussed too late either and that this was something that needed further discussion. Associate Medical Director for Clinical Safety referenced the meetings that occurred monthly including GP's, our Trust, and representatives from neighbouring hospitals to gain an understanding and to ensure patients were discharged with a respect form and that conversations have taken place so that everyone was aware of the plans. The Chair asked if a framework for this could be produced and if it could be delivered at QEC in 6 months.	
	Action:	

	- *Create framework for the Respect Audit and present in August 2022*	**JB/SN**
	The Committee: - *Noted and gave partial assurance to the Respect Audit Outcomes*	
QEC22/02/DF1	**Corporate Risk Register (Enclosure F1)**	
	The Company Secretary gave an overview of the Corporate Risk Register and that there were 111 risks rated 15+. • Three of them were on the Corporate Risk Register with no new ones added, • 1 risk regarding staff engagement had moved from 16 to 12 after being investigated further. Communications had improved with the head of communications joining the weekly Executive Meeting. • Progress was being made with operational risks among KPMG and 360. The Chair commented on the supply of medication however, this risk level hadn't changed. The Company Secretary explained that the controls in place maintain the level of this risk.	
	The Committee: - *Noted and took assurance from the Corporate Risk Register*	
QEC22/02/F2	**CQC and Regulatory Compliance Update**	
	The Company Secretary gave an update on the Care Quality Commission activity after a meeting that took place on the 8th of February. • CQC have reorganised and the Trust has a new Inspection Manager due to the CQC managers now being allocated as a system based territory. • Visits had been suspended during the recent Covid-19 phase but were beginning to role out on a risk-based approach. The Company Secretary explained that our Trust had always been open and pro-active in sharing information with CQC, keeping them briefed on papers and working openly. In April our Trust was hoping they would attend site face to face for an informal walk around of some of the departments. This would enable them to engage with staff and would be a positive move forward.	
	The Committee: - *Noted the CQC and Regulatory Compliance Update*	
QEC22/02/G1	**Gap Analysis for Patient Safety**	
	This item was required to be presented at Audit and Risk Committee prior to Quality and Effectiveness and would be presented at Audit and Risk on the 24th of March.	
	The Committee: - *Noted the request for the Gap Analysis for Patient Safety*	
QEC22/02/H1	**Governor Observations (Verbal)**	

	Peter Abell commented that we had a process of stratification and sent waiting list letters out to those involved. However, he also mentioned about the recent information the Secretary of State had published regarding patient wait times and that they should be able to log on to a site, enter their details and the patient can view the waiting list. Peter Abell asked if this would be looked at and would Finance and Performance Committee also have a view on it. The Chair answered that this would need to be investigated by the Chief Information Officer with an answer being sent back to Peter Abell. There were no observations from Lynne Logan	
QEC22/02/I1	**Sub-Committee Meetings (Enclosure I1):**	
	- Clinical Governance Committee Minutes, 19 November, and 17 December 2021 - Patient Experience and Engagement Committee Minutes – 10 November & 8 December 2021	
QEC22/02/J1	**Any Other Business (Enclosure J1):**	
	There were no items of any other business.	
QEC22/02/J2	**Minutes of the meeting held on 7ᵗʰ December 2021**	
	The Committee: - ***Noted and approved the minutes from the meeting held on 7ᵗʰ December 2021.***	
QEC22/02/J3	*Issues escalated from/to:* i) QEC Sub-Committees ii) Board Sub-Committees	
QEC21/12/J4	**Assurance Summary** The Committee was asked if it was assured, on behalf of the Board of Directors on the following matters. Any matters where assurance was not received, would be escalated to the Board of Directors: - Matters discussed at this meeting, - Progress against committee associated Executive's objectives, - Are there any emerging new risks identified The Chair wished to thank colleagues for their hard work.	
	The Committee were assured on behalf of the Board of Directors on: - ***Matters discussed at this meeting.*** - ***Progress against committee associated Executive's objectives,*** - ***No new emerging risks identified***	
	The Chair thanked everyone for the meeting and the improvements that had been made during her tenure.	

	All agreed and thanked the Chair for all her work with this committee		
QEC22/02/J5	**Date and time of next meeting (Verbal)** **To be chaired by Suzy Brain England**		
	Date: **Time:** **Venue:**	**Tuesday 5th April 2022** **13:00** **Microsoft Teams**	
	Meeting End time	16:18pm	

FINAL

NHS
Doncaster and Bassetlaw
Teaching Hospitals
NHS Foundation Trust

QUALITY AND EFFECTIVENESS COMMITTEE

Minutes of the meeting of the Quality and Effectiveness Committee
Held on Tuesday 5th April 2022 at 13.00 via Microsoft Teams Videoconferencing

Members:	Mark Bailey – Non-Executive Director Suzy Brain-England, Chair of the Board (Chair) Sheena McDonnell – Non-Executive Director Dr Tim J Noble – Executive Medical Director David Purdue – Chief Nurse/Deputy Chief Executive	
In attendance:	Juan Ballesteros, Associate Medical Director for Clinical Safety Kirsty Clarke, Divisional Director of Nursing for Surgery (Item C5) Fiona Dunn, Deputy Director Corporate Governance/Company Secretary Sara Elliott, Head of Radiology (Item B1) Claudia Gammon – Corporate Governance Officer (Minutes) (CG) Marie Hardacre, Head of Nursing for Corporate Services Lois Mellor, Director of Midwifery Graham Moore, Orthotics Therapy Lead (Item B1) Stacey Nutt, Deputy Director of Nursing (Patient Experience) Marie Purdue, Director of Strategy, and Improvement Jodie Roberts, Director of Allied Health Professionals Abigail Trainer, Director of Nursing Ruth Vernon, 360 Assurance (Item B1)	
To Observe:	Peter Abell, Public Governor Bassetlaw Lynne Logan, Public Governor Doncaster	
Apologies:	Sam Debbage, Deputy Director of Education and Research Karen Humphries, Clinical Governance Coordinator	
		ACTION
QEC22/04/A1	**Welcome, apologies for absence and declarations of interest**	
	The Chair welcomed the members, attendees, and governor observers. The above apologies for absence were noted	
QEC22/04/A2	**Conflicts of Interest (Verbal)**	
	No conflicts of interest were declared.	
QEC22/04/A3	**Actions from previous meeting (Enclosure A3)** **Action 1 – QEC21/12/B2**	

	Required for the June 2022 meeting **Action 2 – QEC21/12/C1** Closed – on the agenda **Action 3 – QEC21/12/C2** Closed – on the agenda **Action 4 – QEC21/12/C2** Closed – on the agenda **Action 5 – QEC21/12/C4** Closed – on the agenda **Action 6 – QEC22/02/B2** Required for the June 2022 meeting **Action 7 – QEC22/02/D2** Required for the August 2022 meeting **Action 8 – QEC22/02/C5** Closed **Action 9 – QEC/22/02/C7** Required for the June 2022 meeting **Action 10 – QEC22/02/C8** Closed **Action 11 – QEC22/02/C10** Closed – on the agenda **Action 12 – QEC22/02/C11** Date changed now due in June 2022 **Action 13 – QEC22/02/D1** Closed	
	The Committee: - *Noted the updates and agreed, as above, which actions would be closed.*	
	Action: Claudia Gammon would update the Action Log.	**CG**
QEC22/04/B1	**Divisional Presentation – Focus on Allied Health Professionals** The Director of Allied Health Professionals explained each of the areas within the Allied Health Professionals? • Paediatric Physiotherapy and Occupational Therapy – Children aged 0-16 working across inpatients, consultant led out-patients, Clinical led out-patients and support at home	

- Clinical Assessment and Treatment Services (CATS) – Physios, diagnostics and working with GP's and consultants.

- Paediatric Speech & Language – Children aged 0-16 working within the Doncaster Youth service. Assisting with communication skills, eating, and drinking.

- Orthotics – The enabling mobilisation of one or more joint and the use of braces and collars.

- Acute Physio – Orthopaedic wards and rehab for Doncaster and Mexborough stroke and general rehab.

- Occupational Health Therapy – Discharge in and out of hospital

- Speech and Language – Swallow and communication assessments

- Musculoskeletal Physio – Musculoskeletal patients with injuries or recovering from surgery.

- Dietetics – Assisting with home feeding outpatient, discharge and support healthy hospital agenda

The Orthotics Therapy Lead explained that they had 12 new Allied Health Professionals that had completed their internships. They were also pushing for more portfolio studies within Orthopaedics, Dietetics, Neurology and Rehabilitation. The key challenges were the recovery of staffing. There was a decrease in the number of staff applying for locum positions which had an affect if staff weren't available.

A document was published twice a month to raise the below Learning from Incidents themes:
- Covid-19

- Appointments

- Falls

- Environmental

- Harm/Security

The 5 themes were noted, including the associated risk rating:
- Staffing – Speech & Language/Dietetics – Extreme risk

- Wait Times – Paediatrics, high orthotics – Moderate risk

- Prescription of Air Mattresses to Smokers/Occupational Therapy – Moderate risk

- Servicing Non-Invasive Ventilation Machines/Acute Physio – Low risk

- Hydrotherapy Pool/Paediatric Physio – Low risk

Allied Health Professionals were called to coroner's courts on average once every 3 months this was due to a backlog during covid-19.

The Director of Allied Health Professionals gave information on the medical imaging across all sites in X-ray, CT scanning, Obstetric Ultrasound, and non-obstetrics ultrasound. With the Trust having one of the highest amounts of activity at 25% nationally, this was from the model hospital data.

The top five incidents were:
- Resources/Infrastructure

- Radiation

- Patient Information

- Access/Appointments (backlog)

- Injury/Accidents to staff or patients

The top five sub-categories were:
- Staff shortages

- Medical equipment's

- Appointments (backlog following Covid-19)

- Patient Radiation

- Scans/X-ray images

All trusts must have a radiation protection lead who raises any concerns.

Following a question from Sheena McDonnell regarding workforce challenges and how were they addressed. The Director of Allied Health Professionals answered that apprenticeships in Radiology had been advertised and they were rolling out with the remaining therapies. Health Education England had also given funding for staff. Work was being carried out with the local schools to encourage younger people to apply. Sheena McDonnell also asked about the staff survey results as the ones included within the update were from 2020 and if there was much difference in the latest results. The Director of Allied Health Professionals answered that there had been a deterioration over the last couple of years and that the focus was supporting each other and looking after the staff.

Further to a question from Mark Bailey about the coroners' courts and what support other than the medical examiner reports we provide. The Director of Allied Health Professionals explained that it was difficult for the Allied Health Professionals to attend especially when they were junior staff. They use videos to support the staff prior to attendance.

The Chair concluded in thanking the Allied Health Professionals team and fully supported them

The Committee:

	- *Noted and took assurance from the Divisional Presentation on Allied Health Professionals*	
QEC22/04/C 1	**Board Assurance Framework** The Director of Nursing recognised required improvements in respect of patient experience and engagement. Work was underway in clinical governance and patient safety. The key points of the Board Assurance Framework were that the Perfect Ward had now been agreed with staff in post. Work was continuing with external organisations, families and Health and Equalities. This work was on going with a wider patient safety review. Following a question from Sheena McDonnell about the key strategic objectives and that the document mentioned had no gaps however, not everything appeared to be aligned. The Director of Nursing confirmed that the work was being reviewed with KPMG and external companies around experience and complaints. Following a question from Mark Bailey about the clinical governance review and concerns about the gaps in the structure. The Executive Medical Director answered that as part of clinical governance that separate leads were required to improve and enhance the structure.	
	Action: - *Reviewing the need for audit leads in some specialities*	**TN**
	The Committee: - *Noted and reviewed the Board Assurance Framework*	
QEC22/04/C 2	**Quality Strategy, Framework & Breakthrough Objectives** The Chief Nurse provided an update on the Quality Strategy, Framework and Breakthrough Objectives, that there have been workshops provided to gain feedback from staff. Part of the Quality Strategy was to outline what had been learnt during the pandemic. Maintain a service that provides the best health outcome, positive patient experience and maintain patient safety to deliver safe care. The National drivers of this were: • NHS long term plan • Shared commitment to quality • Patient safety strategy • Quality improvement The key features of the patient safety strategy include: • Psychological safety • Diversity • Leadership and teamwork • Openness to learning Over the next three years the culture of learning and the approach would strengthen The six steps to the quality journey were: • The Trust would continue to set a clear direction and identify quality priorities each year • Bringing clarity to quality defining what it means to be outstanding	

	• Measuring and publishing quality to monitor standards • Recognising and sharing quality and best practice to avoid duplication • To ensure frontline staff have an understanding of quality improvement techniques and human factors • Staying ahead by continuing to champion innovation and research. The Trust would ensure the following quality priorities were appropriate, meaningful and resonate with all: • Patient safety – Reducing avoidable harm and deterioration and safer staffing levels • Clinical effectiveness – Ensuring mortality rates were at least within expected levels • Patient Experience – Acting on what patients tell us and co-producing solutions to challenges they face The report was in draft form at present and for Quality and Effectiveness Committee to make any changes required. Following a question from Mark Bailey regarding whether any items would follow, this was answered that it was important to receive data to improve. Measures were required to allow more visibility across the trust and then providing the Board with further updates. Following a question from the Chair regarding the roll out plan and when this would be. The Chief Nurse answered that this would be sent across the areas to gain views and then uploaded to the website including the strategies.	
	The Committee: - ***Noted and reviewed the Quality Strategy, Framework and Breakthrough Objectives***	

QEC22/04/C 3	**Clinical Governance Committee**
	
	Activity from January and February 2022 meeting including:
	   o **Q3 Learning from Deaths Report**
	   o **Update on Clinical Governance Review**
	   o **Clinical Governance and Quality Board TOR for ratification**
	
	The Executive Medical Director gave the key highlights from the Clinical Governance Committee:
	• Ward certificates for retaining new documentation was being investigated
	• Learning from Patient Safety Incident Response Framework and the Quality Programme was underway
	• Learning from deaths in adults was at 95% and was being scrutinised by the Medical Examiner team.
	• Ongoing discussions were taking place over the community deaths with an IT infrastructure being the main obstacle to perform over 80%.
	• Death certificates were delivered within the target of 3 days.
	• The main causes of death were Pneumonia (leading cause), Covid-19, infection of Sepsis, Cancer and Cardiology.
	• The Infection, Prevention and Control report was presented each month and was awaiting a resolution on the blood infections.
	• The Clinical Governance structure review was still on going.	

	• 12hr waits with regards to harms and the process summary was to be presented at June Quality and Effectiveness committee. Following a question from Mark Bailey about the 5 top reasons for death and how effective best practices were against the causes. The Executive Medical Director confirmed that via the Medical Examiner process they look at the causes and extract the learning. There was a high mortality rate from patients with pneumonia. Following a question from Sheena McDonnell regarding the risk to the trust if any policies were outstanding. The Executive Medical Director added that the policies were RAG rated and due to the volume of the policies they always require monitoring and updating. There was a high focus on what was required. The Chair asked about a piece of work and how they were RAG rated. The Deputy Director of Nursing (Patient Experience) explained that the work was ongoing as there were over 250 policies. The Clinical Governance structure allowed for more escalation over the process and any overdue risks they may cause. If any were out of date the assessment would go back to the author. An electronic system was being looked at make things more robust. Following a further question from Sheena McDonnell about the Terms of Reference and if there was enough focus on and contributing to vision, purpose, and feedback and if that was enough to deliver. The Executive Medical Director replied that this would be investigated outside of the meeting. It was added that if any were in red on the rating and were outstanding that they would be investigated prior to the June meeting.	
	Action: - ***Terms of Reference to be investigated to ensure enough focus and that it was enough to deliver.***	**TN**
	The Committee: - ***Noted and took assurance from the Clinical Governance Committee update***	
QEC22/04/C4	**Patient Safety Report** - **Datix Update** The Head of Nursing for Corporate Services highlighted that the Patient Safety Framework Guide would be received in June 2022, with the initial information taking 12months to implement. This would overlap with the serious incident framework. A new report was being implemented that would highlight the patient safety priorities. At present there was no one to lead the Medicine Safety Committee and were waiting the new post holder to start. Following a question from Mark Bailey regarding someone to replace Rachel Wilson within Pharmacy to allow for the Medicine Safety meetings to commence. The Head of Nursing for Corporate Services confirmed that this would commence at the end of April 2022. Following a question from Sheena McDonnell regarding the amount of work there was with Datix after the cleansing had taken place and if there were any changes to make after to ensure the effectiveness of the system. The Director of Nursing confirmed that there had been a large amount of data cleansing and that this would be built within the system in the future. The next phase was to have the system up and running and more efficient.	

	The Chair concluded that feedback would be required for the future with improvement expected.	
	The Committee: - ***Noted and took assurance from the Patient Safety Report***	
QEC22/04/C 5	**Safer Staffing** The Divisional Director of Nursing for Surgery gave the key updates to safer staffing: - Increased absences throughout January and February 2022 due to Covid-19 - H2 budget had increased with more band 2 and 5 nurses being recruited. - Ward 22 was open throughout winter. - Health Care Assistant budget had increased and so had agency staff which ensured safer staffing. - An additional 50 International nurses would be recruited with a 3/6month lead time. - An additional 16/23 beds were open across ward 19 and a modular ward. - In H2 30 Health Care Assistants were recruited, in January there were 102 vacancies with 69 vacant to date. 49 offers of employment had been made with 13 additional staff awaiting a start date. - Work was in progress with the local colleges and schools to promote the trust and the job opportunities. - It was difficult to recruit Health Care Assistants due to the level of wage as Doncaster was close to distribution sites that paid similar or more. - Safe care was now had accreditation and a matron had started within the role and update would be fed back to Quality and Effectiveness. Following a question from Sheena McDonnell about if there was anything the trust could do to influence the level of pay for a Health Care Assistant. Does the trust offer enough flexibility as well as pension packages? Was there anything else that the trust can do to support the local community and offering work force placements earlier. The Divisional Director of Nursing for Surgery confirmed that the central recruitment teamwork with staff to assist with the process. This was a large piece of work with the pay being investigated nationally. The trust had a proactive vocational team they work with to support flexible working. Funding had been approved for support staff to help new starters.	
	The Committee: - ***Noted and took assurance from the Safer Staffing Update***	
QEC22/04/C 6	**Infection, Prevention and Control Board Framework**	

| | The paper was confirmed as being read by the committee with the Director of Nursing adding that the framework covered the changes to staff and patients Covid testing and the Covid numbers across the organisation.

Following a question from Mark Bailey about the changes from the medical environment (Hospital) and the non-medical environment (Car Park) signage. The Director of Nursing confirmed that there was work being carried out at present regarding the Health Environment restrictions in the hospital. Working with estates to reiterate the ongoing issues. Staff were still required to maintain social distancing and wear masks in the hope of setting an example to visitors and patients. Restricted visiting was still in place in some areas. | |
|---|---|---|
| | *The Committee:*
- *Noted and took assurance from the Infection, Prevention and Control Board Framework* | |
| **QEC22/04/C 7** | **Winter Plan Update to include a report on the Discharge Plan (Verbal)**
The Director of Nursing gave the key points on the Winter Plan update:
• Ward 22 was open until the end of March to assist with Elective Surgery patients.
• The Quality Improvement team led by Sam Sidwell were working on a piece of work with the right to reside patients.
• Patient safety huddle boards were working with patients both internal and external.
• Review discharge policy, transfer of care hub and home first ethos were to be reviewed.
• Weekly ward walk rounds were in place to review patients that were in hospital for over 7 days.
• Length of stay was part of the winter plan but also included Easter as this could be as busy. | |
| | *The Committee:*
- *Noted and took assurance from the Winter Plan update including a report on the Discharge plan* | |
| **QEC22/04/C 8** | **Maternity Transformation and Ockenden Update**
The Director of Midwifery provided an update:
• The merging of the midwifery and ante-natal wards across all three sites would continue until October 2022 due to staff shortages.
• Main workstream had been paused in July 2021.
• Ockenden report for safety culture was written to improve leadership and culture in maternity services.
• A work round was to be implemented to assist with Mental Health mainly trauma after birth
• The number of smoking mums had reduced by 6% in the past year from 19% to 13%.
• The aim was to procure one maternity system
• The Clinical Negligence Scheme for Trusts (CNST) at the end of year 3 was not compliant. Year 4 started in September 2021 but then paused until March 2022 and would resume in April 2022.
• Within Ockenden's initial report there were 7 immediate actions. With the final Ockenden report having another 15 immediate actions. | |

	• An assessment visits for Ockenden was due on the 29th of April 2022. • Low neonatal still birth rates Following a question from Sheena McDonnell regarding staff moral and the challenges to support staff. The Director of Midwifery answered that staff morale was an ongoing issue with midwives and maybe difficult not to lose any due to increasing pressures. Sheena McDonnell also asked about the support from the Clinical Negligence Scheme for Trusts (CNST), what it means and what we needed to do. The Director of Midwifery confirmed that the Clinical Negligence Scheme for Trusts assisted with elements around midwifery staffing, education, and training. Maternity services were awaiting a new Non-Executive Director along with a Maternity Voices Partner to demonstrate compliance. There was a view to be fully compliant by year 5. The Ockenden and Local Maternity and Neonatal System assessments in each region were all completed in different ways, meaning Maternity Services were not consistent. Sheena McDonnell added was there a reason why the Trust couldn't submit only the Board assurance report. The Director of Midwifery answered that it was allocated randomly however, we missed a deadline by one day which may have been the reason. Following a question from Mark Bailey regarding staff morale and was data/feedback shared with them about the departments were performing. It was answered that regular updates were provided via the Yorkshire and Humber dashboard.	
	The Committee: - **Noted and took assurance from the Maternity Transformation and Ockenden Update**	
QEC22/04/C9	<u>**Bassetlaw Children's Urgent & Emergency Care – Report from Senate & Consultation Outcomes**</u> The Director of Strategy, and Improvement reiterated that the model and preferred option had been discussed and the consultation was completed. The clinical senate was to be reviewed and commissioned by the Trust and the Clinical Commissioning Group (CCG). Next steps in the process were that the Health Scrutiny Committee had given positive feedback on the consultation with NHSI giving assurance. The option 3 business case would be taken forward and subject to a final decision by the Clinical Commissioning Group and their Board of Governors. Following a question from the Chair regarding the timescale of the business case, money, and the start of the build. The Director of Strategy, and Improvement answered that the Outline Business Case (OBC) would be complete by June 2022, the Full Business Case would be complete by August 2022 ready for work to begin before Christmas. Following a question from Sheena McDonnell about the preferred option 3 and why were people with disabilities against this option. Was there a factor to this. The Director of Strategy, and Improvement answered that those people may have wanted the wards to reopen which wasn't feasible. Creating an environment for those with different needs, a neurodevelopmental environment and engaging with people was important.	
	The Committee noted: - ***Noted the Bassetlaw Children's Urgent & Emergency Care – Report from Senate & Consultation Outcomes***	

QEC21/04/D 1	**Patient Experience Update – incorporating Inpatient Survey and Urgent & Emergency Care Survey Actions to date**	
	• **Patient Story**	
	The Deputy Director of Nursing (Patient Experience) gave an update on the report and that it was a work in progress. There was increasing numbers of complaints month on month however, the Trust was 11% behind on last years to date but should be able to meet this by year-end. The timeframes on acknowledgement and responses had improved as there were more resources in the department. Volunteers were assisting with the feedback from the friends and family tests. Enquiries from the Parliamentary and Health Service Ombudsman (PHSO) had increased due to a pause throughout the pandemic. The Patient Experience Team were working alongside communications, appointments, and the deaf society. A detailed patient story was added to the update and would continue to move forward. The two main areas of focus were food and drink and discharges.

Following a question from Mark Bailey regarding software that could be used to analyse the data. The Deputy Director of Nursing answered that once Datix issues have been resolved this would be sufficient in pulling the data required.

The Chair added that it was a work in progress and benchmarking the Trust against others within the ICB was a good idea. | |
| | *The Committee:*
- *Noted the Patient Experience Update – incorporating Inpatient Survey and Urgent & Emergency Care Survey Actions to date and would continue to observe the progress.* | |
| QEC22/04/D 2 | **Maternity Survey**
The Director of Midwifery gave an update on the Maternity Survey and that the results within the report were from the survey taken in February 2021. The survey was given to all women whose babies were born in February 2021, with 32% completing the survey. The age range of those was 26–35-year-olds. From the results there were no delayed discharges at the Doncaster site although there were at Bassetlaw, this would be investigated further. There was an action plan for both sites to investigate into the bottom 5 worst scores. Rotherham scored high although they do have more midwives and were fully recruited, a meeting would be set up with Rotherham to discuss outcomes.

Following a question from Sheena McDonnell regarding when the results were from. The Director of Midwifery confirmed that they were the 2021 results and weren't received until December 2021 even though the survey took part in February 2021. There was a time delay on this, and more support was required from the Maternity Voices Partnership. Following a further question from Sheena McDonnell regarding the Trusts response time and how actions were followed up including why we get average results. The Director of Midwifery explained that the chair of the Maternity Voices Partnership was important to encourage new mums although this was proving difficult. Doncaster struggle to engage with new mums which maybe a time commitment. | |
| | *The Committee:*
- *Noted and took assurance from the Maternity Survey Update* | |

QEC22/04/D3	**Maternity Voice Partnership** The Director of Midwifery gave an update that within the better births document every maternity unit is required to have Maternity Voice Partnership representatives. At present there was one at Doncaster and the other at Bassetlaw but the Clinical Commissioning Group had merged these. At present these was no chair, this was proving difficult to recruit for. The new Chair would be involved in the design service of the bereavement suite amongst other projects. The non-executive directors support the Maternity Voice Partnerships. An external event during the Summer would take place to encourage and support new mums with the support from the Maternity Voices Partnership. The Chair referenced that the communications team were promoting the Maternity Voice Partnership roles.	
	The Committee: - *Noted and took assurance from the Maternity Voice Partnership Update*	
QEC22/04/D4	**Health Inequalities** The Director of Strategy, and Improvement explained that there was a 3-tiered approach in assisting with inequalities within the communities. Health inequalities was supported by the project management and the public health teams. Working as a system, working with our own staff and the wider community. Using the NHS confederation assurance tool to provide questions and to look at standards. The Director of Strategy, and Improvement asked if an update could be provided at the August meeting once a team was established.	
	Action: - *Further update on Health Inequalities to be presented at August Quality and Effectiveness meeting*	**MP/RC**
	The Committee: - *Noted and took assurance from Health Inequalities*	
QEC22/04/F1	**Corporate Risk Register** The Company Secretary confirmed that there had been no further updates since Board and that the outstanding points that were raised had been reviewed and the progress noted. No new risks had been added with a risk review follow up meeting scheduled for the 8th of April 2022.	
	The Committee: - *Noted and approved the Corporate Risk Register*	
QEC22/04/F2	**CQC and Regulatory Compliance Update** The Chief Nurse updated that the Care Quality Commissioning had a new relationship manager. Our action plan had been completed with no issues. The Care Quality Commissioning Group were going through consultations at present regarding work and the next steps of their new structure.	
	The Committee: - *Noted and took assurance from the CQC and Regulatory Compliance Update*	
QEC22/04/G1	**Medicine Management Audit Report**	

	The Executive Medical Director gave an update on the audit report and that there were 4 main strands of action, three of which were in progress, and one that was complete. Ward checks, spot checks, standardisation on wards and the assessment of prescriptions were being observed as a trust forward approach. There had been discussions about the changing of the FP10 (NHS Primary Care) prescriptions however, there was no inhouse pharmacy at Mexborough. The task and finish group were reviewing this, to determine a way forward. An app would also be investigated for the use of outpatient prescriptions. Ward spot checks, perfect wards and medication safety checks were on track. The action regarding the delivery of medication to the yellow wards had been reviewed and was now completed. A further update would be provided at Audit and Risk with any decisions would be agreed at Audit and Risk.	
	The Committee: - ***Noted and took assurance from the Medicine Management Audit Report***	
QEC22/04/H1	**Governor Observations (Verbal)** Peter Abell observed that the piece on the Clinical Governance Committees Terms of Reference was very complex, and that speciality governance was different to other areas. Peter Abell also asked for a briefing in this area for the governors. The Company Secretary confirmed that a briefing would be set up to include the structures however, this would be once a Chair was appointed for the Quality and Effectiveness Committee. Lynne Logan asked about the International Nurses and if there were any communication issues with patients and the elderly. The Head of Nursing for Corporate Services assured that checks were put in place prior to them coming to the UK, they also take part in an English test. A stay and thrive matron was in post to assist with supporting them.	
QEC22/04/I1	**Sub-Committee Meetings (Enclosure I1):**	
	- Clinical Governance Committee Minutes, January & February 2022 - Patient Experience and Engagement Committee Minutes – 10th November & 8th December 2021 - Audit and Effectiveness Forum Update - Learning from Deaths	
QEC22/04/J1	**Any Other Business (Enclosure J1):**	
	There were no items of any other business.	
QEC22/04/J2	**Minutes of the meeting held on 8th February 2022**	
	The Committee: - ***Noted and approved the minutes from the meeting held on 8th February 2022.***	
QEC22/04/J3	*Issues escalated from/to:* i) QEC Sub-Committees ii) Board Sub-Committees iii) Audit & Risk Committee – Medicine Management Audit Report	
QEC22/04/J4	**Assurance Summary**	

	The Committee was asked if it was assured, on behalf of the Board of Directors on the following matters. Any matters where assurance was not received, would be escalated to the Board of Directors: - Matters discussed at this meeting, - Progress against committee associated Executive's objectives, - Are there any emerging new risks identified? The Chair wished to thank colleagues for their hard work.	
	The Committee were assured on behalf of the Board of Directors on: - ***Matters discussed at this meeting.*** - ***Progress against committee associated Executive's objectives,*** - ***No new emerging risks identified***	
QEC22/02/J5	**Date and time of next meeting (Verbal)**	
	Date: **Tuesday 7th June 2022** **Time:** **13:00** **Venue:** **Microsoft Teams**	
	Meeting End time 16:08	

Final

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

	QUALITY AND EFFECTIVENESS COMMITTEE

Minutes of the meeting of the Quality and Effectiveness Committee
Held on Tuesday 7th June 2022 at 13.00 via Microsoft Teams Videoconferencing

Members:	Mark Bailey, Non-Executive Director Mark Day, Non-Executive Director Sheena McDonnell, Non-Executive Director Dr Tim J Noble, Executive Medical Director Kath Smart, Non-Executive Director (Interim Chair) Abigail Trainer, Acting Chief Nurse	
In attendance:	Ken Agwuh, Pathology Clinical Director (Item B1) Simon Brown, Acting Deputy Chief Nurse Kate Carville, Divisional Director of Nursing for Medicine (Item C6) Kirsty Clarke, Acting Deputy Chief Nurse Sam Debbage, Deputy Director of Education and Research Fiona Dunn, Deputy Director Corporate Governance/Company Secretary Claudia Gammon – Corporate Governance Officer (Minutes) (CG) Marie Hardacre, Head of Nursing for Corporate Services Sophie Hempsall, Head of Dietetics (Item D2) Stacey Nutt, Deputy Director of Nursing (Patient Experience) Angela O'Mara, Deputy Company Secretary	
To Observe:	Lynne Logan, Public Governor	
Apologies:	Peter Abell, Public Governor Bassetlaw	
		ACTION
QEC22/06/A1	**Welcome, apologies for absence and declarations of interest**	
	The Chair welcomed the members, attendees, and governor observers, including Mark Day who was joining the committee for the first time since his NED appointment. The Chair made a declaration of interest regarding the mental health strategy, in respect of her work with RDaSH on mental health act panels. Sheena McDonnell's role as Chair of the Board at Barnsley was also declared. The above apologies for absence were noted	
QEC22/06/A2	**Conflicts of Interest (Verbal)**	
	No conflicts of interest were declared.	

QEC22/06/A3	**Actions from previous meeting (Enclosure A3)**	
	Action 1 - QEC21/12/B2 - Perfect Ward Accreditation (now named Tendable)	
	On the June agenda – action closed	
	Action 2 - QEC21/12/C1 - Board Assurance Framework – Patient Experience	
	Closed – on the agenda	
	Action 3 - QEC21/12/C2 - Quality Framework	
	The Acting Chief Nurse provided an update that she was using PMO office to review and update implementation plan of framework across divisions. A timetable would be brought back.	
	Action 4 - QEC21/12/C2 - Quality Strategy	
	The Acting Chief Nurse provided an update that approaching PMO office to review and update implementation plan of framework across divisions. – clarify timescales meeting with PMO team WC 13th June to set work plan – AT bring back for October meeting with an update and a plan to roll out.	
	Action 5 - QEC21/12/C4 - Quality Assurance – Datix	
	Closed – on the agenda	
	Action 6 – QEC22/02/B2 - Complaints	
	Following the KPMG audit, it was confirmed that all actions were completed and closed. During the last QEC meeting in April the Patient Experience report the themes of complaints were easily recognisable and data that was now being extracted and monitored through the IQPR was consistent. The assurance at the start of this current year for the complaint's metrics came out as 'Reasonable Assured' overall - Closed	
	Action 7 - QEC22/02/D2 - Respect Audit	
	Update due at October meeting	
	Action 8 – QEC22/02/C7 - Safer Staffing	
	Item on the agenda for June and included in the Safer staffing report includes an update on the international nurses – Close.	
	Action 9 - QEC22/02/C10 - Bassetlaw Children's Urgent & Emergency Care Report	
	Closed – on the agenda	
	Action 10 - QEC22/02/C11 - Mental Health Strategy	
	Closed on this agenda	
	Action 11 - QEC22/04/C1 - Board Assurance Framework	
	Some areas have separate audit leads, and this proposal is still being developed. Further updates to come from the Executive Medical Director at the next QEC meeting.	
	Action 12 - QEC22/04/D4 - Health Inequalities	
	Update to be provided at the September 2022 meeting	
	The Committee:	
	- *Noted the updates and agreed, as above, which actions would be closed.*	

	Action: Claudia Gammon would update the Action Log.	**CG**
QEC22/06/B 1	**Divisional Presentation – Clinical Specialties** The Acting Deputy Chief Nurse provided the key themes from the presentation:	

QEC22/06/B 1

Divisional Presentation – Clinical Specialties

The Acting Deputy Chief Nurse provided the key themes from the presentation:

- The safety culture in theatres were a pilot with the university and their metrics cultures.

- The 5 at 5 was introduced, this was where a meeting took place at 5pm each day and would include the theatre manager for that day looking at common themes, issues,

- A summary of never events, incidents serious incidents and themes was provided

- Delayed discharges from critical care remained a top risk.

- The Trust was 92% compliant with National Institute for Health and Care Excellence (NICE).

- International recruitment to theatres had closed the gap on the number of vacancies. A "Dragons Den" event had taken place within the division to pitch ideas to help with patient's experience, with several staff putting ideas forward, including a warming device for orthopaedic theatres to improve patient experience. T

- The Getting it right first time (GIRFT) review within the critical care department had taken place and the Trust were awaiting the outcome.

- Mutual aid had been received from colleagues across the region to support the medical workforce. Capacity and demand in radiology was a concern and work continued to address this.

Sheena McDonnell questioned the "Dragons Den" approach which the Acting Deputy Chief Nurse confirmed was a means to consider and generate quality improvements and in response to a question from Mark Day, it was confirmed the division would look to hold similar events in the future.

In response to a question from Mark Bailey with regards to the imaging incident. The Executive Medical Director confirmed that tests had been set on ICE to support the implementation of the long covid pathway which included a chest x-ray. A subsequent review indicated that no patients had received an X ray that didn't require one. The Company Secretary confirmed an IT governance structure was now in place to provide the necessary process and assurance.

Sheena McDonnell enquired of the governance of opening and closing of incidents and the timescales for the Trust to review them. The Acting Deputy Chief Nurse confirmed that governance processes were in place and that all incidents and metrics were regularly discussed within the clinical governance meetings.

	The Committee: - *Noted the Divisional Presentation on Clinical Specialties*	
QEC22/06/C1	**Board Assurance Framework (BAF)** The Acting Chief Nurse provided an update on the Board Assurance Framework SA1 - Covid, noting a reduction in the overall risk rating due to a decrease in the levels of infection. Revised guidance was awaited in respect of the use of face masks in non-clinical areas and it was hoped that an updated Infection, Prevention and Control BAF would be received from NHS England before the next board meeting. The Chair commented that on both SA1 and SA1-Covid a future risk was identified in respect of staff working in separate areas as a result of the incident in the Women & Children's and asked if there was a need to update this. Also, in the comments field on SA1 the reference to development of the quality and patient safety strategy should be moved to assurance and controls section and the identified risk of not using available quality assurance data to best effect would be discussed later in the meeting and would need incorporating in the next iteration of the BAF.	
	The Committee: - *Noted and reviewed the Board Assurance Framework;* - *Agreed to include* the recent DQ Audit on the BAF in the "Gaps"	
QEC22/06/C2	**Clinical Governance & Quality Assurance Update** The Executive Medical Director discussed his previously circulated report and highlighted the three key points: - Assurance of no harms 12hr wait - Potential withdrawal of the phlebotomy service at the Doncaster Keepmoat - Review of Patient Safety ongoing with the report expected by 31 July 2022 **Emergency Department 12 hour wait** At the request of QEC in February, a Provisional Assurance Report to include the audit of harms was presented to CGC in March. The Trust has reviewed data from November/December 2021 and has identified patients waiting longer than 12 hours, however in February, the number has seen a decrease. It is acknowledged that there should be no patients waiting 12 hours in the department however figures identified 6.13% for December 2021, 5.75% for January 2022 and 3.48% for February 2022. CGC noted that no harm has been identified in all cases reviewed. In view of this, CGC deemed the matter closed from the governance agenda at this time on the understanding that this will continue to be monitored by the Emergency Care Board. In response to a question from the Chair in respect of the phlebotomy service, the Executive Medical Director confirmed that next steps were in place and the future of the service was being considered. This item will remain on the Clinical Governance Committee agenda until resolved. In relation to the changes from the Deprivation of Liberty Safeguards to the Liberty Protection Safeguards further work was required to understand the implications for the Trust. The Chair advised of a system review by 360 Assurance on the implications of the standards and understood that feedback would be shared with all trusts.	

	The Committee: - *Noted the Clinical Governance & Quality Assurance Report*	
QEC22/06/C 3	**Patient Safety Report** - **Datix Update** The Head of Nursing for Corporate Services provided the highlights on the previously circulated patient safety report including: • Patient Safety Incident Response Framework • Patient Safety Specialists • Patient Safety Partners • Incidents and Serious Incidents • Falls • Hospital Acquired Pressure Ulcers (HAPU) • Infection, Prevention & Control update Mark Bailey enquired how the themes of the incidents were monitored for corrective action and improvement, the Head of Nursing for Corporate Services confirmed the team looked across all areas to identify shared learning eg skin integrity work is a good example of the improvement. Mark Bailey also asked if the Trust would see a different top 5. This was answered that the Trust always aim to hit 20% reduction target. The top 5 were inpatient falls, medication errors, responding to clinically changing conditions, hospital acquired pressure ulcers and discharge, each of these align with the areas identified within PSIRF. Mark Bailey commented that with the continued tracking the levels would reduce in theory. The Acting Chief Nurse added that the lack of visitors over covid had an impact on the increase in falls and shouldn't be underestimated. Patients were a lot sicker and frailer due to Covid-19 and no visitors to help with day-to-day interaction whilst on the ward. The Chair praised the success of the "yellow blankets and socks" falls prevention initiative, also congratulating the quality improvement lead, and would send a positive note to the Qi lead for this project. The Chair also asked about the DATIX upgrade plan and what had been decided. The Head of Nursing for Corporate Services confirmed that no final plan had been made on Datix and that what was currently in place was an old server with work being carried out to stabilise the system during July/August, a further update would go to F&P in July.	
	The Committee: - *Noted the Patient Safety Report and DATIX update paper going to F&P July*	
QEC22/06/C 4	**Safer Staffing** The Acting Deputy Chief Nurse provided an update on safer staffing paper presented to the committee. The publication of Developing Workforce Safeguards in October 2018 was designed to help Trust manage common workforce problems, in line with the National Quality Board's (NQB) guidance. The aim being to have the right staff, with the right skills in the right place at the right time. The paper presented provided the Quality and Effectiveness Committee with detailed information relating to the Nursing and Midwifery Workforce; highlighting issues which may impact upon the Trust's ability to provide appropriate staffing levels and skill mixes.	

It also updated on the implementation of Care Hours per Patient Day (CHPPD), which has been a required national return since 01 May 2016 and the data submitted to UNIFY.

Key points highlighted to the committee:

- Improvements on recruitment within health care assistant and nurse roles.
- There had still been spikes within Covid-19 absence in March and April.
- Bed occupancy remains high within adult acute, nationally for quarter 4 the bed occupancy was at 84%.
- Daily meetings took place to review the RAG rating on safer staffing and included the red flagged data, delays in medication and observations.
- Continued work with ICS and NHS Professionals regarding pay rates. Also, with agencies regarding their pay rates.
- The international nurses complete an induction within the first 12weeks, after this some then transition into a registered nurse with others requiring further support.
- Currently there were 49 health care assistant vacancies down from 67 at the beginning of May. With a further 55 that had been appointed.
- 70 newly qualified nurses were progressing through with checks outstanding.
- Further work was continuing around focus recruitment with the assistance from the communications team.
- There was a focus on the expansion of the community diagnostic and imaging services at Mexborough.
- There had been a site visit from the regional workforce lead Victoria Bagshaw who provided some suggestions with the recruitment of the healthcare assistant roles.
- The pilot for the professional nurse advocate lead was supported and was well received locally and nationally. The Trust had 2 years to reach the target of one professional nurse advocate lead to every 20 nurses.

The Chair asked about the care hours per person per day and whether acute therapists were counted within this. The Acting Deputy Chief Nurse answered that this was included with rehabilitation areas where the therapists undertake a care role with unregistered nurses. The Acting Chief Nurse explained that on the acute wards this wasn't a model that could work however, it had been looked at within different areas.

Mark Day asked whether this staffing data was also sited at another committee and whether data around ward staffing planning (planned versus actual) - when does it translate in to being a risk for patients to be able to tease out areas of concern?
The Acting Deputy Chief Nurse confirmed that the data was the difference between the planned and actual bed occupancy and could balance out dependent on patients on the ward. The Acting Chief Nurse explained that years ago the report was simplified with very little detail. Staffing was a high risk and had an impact of everything that the Trust does. Once the safer nursing tool was being used then information could be used to more effectively to assess safe staffing levels and and manage the risks shift by shift and keep track on how they were evidenced. Further work was required on this tool.

Sheena McDonnell asked for assurance om the following areas:-

	- timescale for the implementation of the tool and how would it help the Trust with not requiring agency staff; - How the Trust retains staff within healthcare assistant vacancies, & make the positions more attractive; The Acting Deputy Chief Nurse advised a matron had been appointed to assist with help with safe care tool (Allocate), and the tool would be able to be rolled out in July 2022 at Bassetlaw, then followed by Doncaster and Mexborough. The healthcare assistant recruitment was being investigated, although the positions were being promoted it was difficult to keep staff within the post due to the salary, with no experience this means that staff were either paid at either apprentice level or 75% of a band 2 salary. The salary does put people off when applying although they are able to earn more by working weekends and nights, and progression was possible. The Acting Chief Nurse added that the Trust offers flexible working, ward areas and supporting people. One issue was that private sector business were offering more money and flexible shifts. The Deputy Director of Education and Research added that there was a lot of work in the community around health and social care. Also, the Dome "We Care Into The Future" event was happening next month. E-roster was also to be trialled within the student nurses.	
	The Committee: - **Noted and took assurance from the Safer Staffing Update**	
QEC22/06/C 5	**Maternity, Transformation & Ockenden Update** This item was taken as to note only, much of the data has previously been seen at Board. It was noted the gap analysis has started following publication of Ockenden 2, and this was a starting point. Questions to be fed back to the Director of Midwifery were: • Information was still due from observations, neo-natal and anaesthesia colleagues. • Timeline and frequency for when this information would be brought back to QEC Mark Bailey offered to feedback once a conversation had taken place between himself and the Director of Midwifery.	
	Action – - ***MB to discuss the report with the Director of Midwifery and feedback to QEC***	**MB**
	The Committee: - ***Noted the Maternity, Transformation and Ockenden Update***	
QEC22/06/C 6	**Mental Health Strategy** The Divisional Director of Nursing for Medicine provided an update on the previously circulated paper. Key issues discussed: • Implementation of the Use of Force in Mental Health Act • Receipting of section papers at Bassetlaw Hospital. • CAMHS pts and long waits in ED- needs review	

- De-escalation training for certain areas.
- Educational - MH awareness/education/ core skills are prioritised by ICS
- Require further engagement from Notts healthcare around MH input in the MH Forum.

Partner orgs were having difficulties with recruitment of mental health staff was difficult as this was a 24/7 service, however, there are posts to be filled over the next couple of months from the latest recruitment initiatives.

The one notable vacancy is the MH Consultant for the hospital liaison service which is out to advert for the second time. It is currently covered by the on-call psychiatrist at RDaSH.

There is a MH forum every month that is an MDT meeting to review MH services, issues, good practices and developments within the Trust and to share knowledge. Minutes and action logs are generated from each meeting.

Current issues that had been raised were in the new Mental Health Units (use of force) Act (restraining patients). Beth Cotton was leading on this and working with the mental health team. The Acting Chief Nurse added that Beth Cotton would be asked to attend a Quality and Effectiveness meeting to provide a further update on the progress of this work.

The Divisional Director of Nursing for Medicine raised the issues around the process of receipting of section papers policy and working with Rotherham Doncaster and South Humber Trust, scan them through and they collect them. Work was underway to look at Notts healthcare and the way in which they receipt the papers.

De-escalation training had been well received as issues with violence and aggression was a main issue on the staff surveys, charitable funds were continuing to support this training. A lot of work had been put into Mental Health awareness, working with the education team and with the ICS, looking at the core skills training for acute staff.

Sheena McDonnell commented that there was a lot of work with our partners across the board and building relationships. Were ambulance services engaged with continuity of care and redirecting them before going to hospital? The Divisional Director of Nursing for Medicine has links with the Yorkshire ambulance service, the police and with Rotherham Doncaster and South Humber Trust, and were only seen at Doncaster ED if they have an injury, otherwise they would be transferred/ conveyed directly to the Section 136 suite at RDaSH.

The Chair asked the Divisional Director of Nursing for Medicine what support was needed from the committee as the strategy was brought a while ago and she wondered if there were any gaps in the work plan and strategy. The Divisional Director of Nursing for Medicine confirmed that the last time this had been presented was 2019 and confirmed it required reviewing with education being a large part of the strategy.

The Chair also raised about the mental health and the use of force, it had been raised via Audit and Risk regarding suitable and appropriate rooms in the ED areas. It was confirmed that a room was allocated within the emergency department for mental health patients and was fit for purpose at both Bassetlaw and Doncaster sites.

	Action: *Bring an update/refresh on the mental health strategy back to QEC for further review at a time to be agreed with the new Chair*	**KC**

	The Committee: - *Noted the Mental Health Strategy update*	
QEC22/06/C7	**Tendable Update** Head of Nursing for Corporate Services provided an update on the new digital audit tool – "Tendable" formerly known as 'Perfect Ward'. Training was now being delivered into clinical areas and was live. Training had been provided at Bassetlaw and Doncaster with positive feedback received. There would be an official launch date on how to use the system with a further update being provided to QEC. The Chair requested that further updates were reported back to QEC along with the outcomes and timelines. The Acting Chief Nurse praised the tool and that you can look at low level of live data, easy to use and user friendly for staff. Build on this to use as ward accreditation, change in how audits were carried out in clinical areas.	
	Action: - *Come back with progress updates, timelines, and outcomes from Tendable*	**MH**
	The Committee: - **Noted and took assurance from the Tendable App Update**	
QEC22/06/C8	**QPIA Report (Verbal)** No update was provided for this item	
QEC21/06/C9	**QEC Annual Report** The Chair invited any additional comments on the draft QEC annual report to be sent to the Corporate Governance Officer before the end of June 2022, noting a number had already come from Sheena and Mark, before the report can be finalised.	**CG**
	The Committee: - *Noted the QEC Annual Report*	
QEC22/06/C10	**Patient Safety Review Group Annual Report** Head of Nursing for Corporate Services provided an update on the PSRG annual report and that it looks at insights around the incidents and the shared learning and what to do next. It also reviews the national patient safety alerts, resus updates, safeguarding, child deaths, medication safety, falls and manual handling updates. A lot of detail was within the reports and provides detail with the work and help from divisional teams. The Chair asked about the Respect Audit with concern that this hadn't been received between May 2021 and March 2022, the Acting Deputy Chief Nurse shared concerns and was progressing work with this to bring back upto standard, and would feed into future reports.	
	The Committee: - *Noted the Patient Safety Review Group Annual Report;* - *Requested that a future QEC report contained information on progress with the Respect Audit.*	

QEC22/06/D 1	**Patient Experience Update**	
	The Deputy Director of Nursing (Patient Experience) presented the Patient Experience report to provide assurance on the complaints process and delivery of the True North Objective SA1.	
	Looking at the key areas within complaints report, a discussion was had about the themes and how they were recorded. In response, it was noted that at present when complaints are logged, only the main areas and issues are looked at within the department and the overall theme wasn't then recorded. It was acknowledged that the themes from the complaints required further scrutinisation.	
	The report summarised the complaint outcomes; 11 complaints were upheld, 29 not up held and a further 29 were partly upheld. The report focussed on an action plan that medicine had developed (put together for over the next 12months to show how the areas had learnt from their complaints and experience.) Fours key areas had been identified; - attitude and behaviours, - communication, - lost property, - patient discharge. How this was monitored and what actions were being taken forward was now being investigated and would be monitored once a quarter.	
	The recent Maternity survey presented previously highlighted that many patients couldn't bring anyone to the appointment with them. This would be highlighted at the maternity voice partners meeting at the end of May. Inpatient survey results had been received and would be provided at the next QEC meeting.	
	Sheena McDonnell commented about the action that referred to a KPMG audit report on complaints and that there had been an update at Audit and Risk Committee. It was acknowledged that things had moved on but not Sheena was not fully assured that the Trust is where it was required to be and wondered on the timescales and where were the outcomes reported back to. There was an action plan moving forward within the emergency department but was it timely enough. How can the committee assist with this? The Acting Deputy Chief Nurse responded to the concerns and explained that plans were in place to further investigate into the work with the patient experience agenda. Work had also started with the deaf community and the LD agenda as well as using quality improvement events, so patient experience and how do the Trust deliver this would be a key focus. A patient experience strategy was required prior to looking at the quality strategy. The Acting Chief Nurse added that the team would be looking at the objectives within the areas, strategy, the complaints, and the patient agenda.	
	Mark Bailey raised a question about the previous KPMG audit and if the updated actions could be presented back to Quality and Effectiveness, this was confirmed. All actions had been transferred across to 360 assurance and were complete, but assurance needed on how these actions have been implemented. The Chair agreed a high-level patient engagement patient experience strategy was required to look at all aspects of the area rather that the complaints feedback trends but to involve the Board in this high level engagement strategy.	

	Sheena McDonnell added that the committee had been seeing the focus on this and the patient experience isn't just about the complaints process. Looking at what the Trust know and how do we close any gaps on this. The Executive Medical Director commented about the patient story within the report and that the people involved within the oncology service was due to them being moved and were employed via Weston Park which had an impact on the Trust. How do the Trust support the patients? The Deputy Director of Nursing (Patient Experience) provided reassurance that this issue had been escalated and feedback provided to both Trusts. Sheena McDonnell raised that the Trust had a responsibility to investigate into this and support patients to access the services that were required.	
	Action: - ***To provide a Patient Engagement strategy to QEC (to involve the Board in some high level engagement to this development).*** - ***To review the previous KPMG audit and ensure all actions complete and bring back to QEC with assurance and evidence of implementation of the actions closed.***	**SN/AT** **SN/AT**
	The Committee: - ***Noted and took assurance from the Patient Experience Update***	
QEC22/06/D2	**NHS Food Strategy (Annual)** The Deputy Director of Nursing (Patient Experience) introduced the Head of Dietetics, to present the NHS Food & Drink strategy due to be launched across the trust in summer 2022. It was required by the NHS contract and was developed using the department of health toolkit and covers nutritious food for patients, healthier food for patients and staff and sustainable food for all. The strategy was developed in partnership with Sodexo, our catering providers, by undertaking a gap analysis against the standards. Progression of the key objectives of the strategy have been worked on with some complete. Key objectives that have been achieved were inclusion of nutrition in to care plans, easy to follow guides had been created and accessible via the with regular updates. • Elements of the strategy had been the food allergy and Hygiene awareness, there was a hot and cold food provision for out of hours with awareness of this being raised. • There was an ongoing bi-annual menu design and redesigning this with Sodexo, looking at the challenges around the nutritional analysis. • A roll out had begun on Nutritional screening in outpatients. • Continued work with the steering committee and Sodexo to resolve any food and drink issues. • Ward based care was continuing with staff observing mealtimes, this had been funded by charitable funds. • Hope to include service users with learning difficulties and once it meets nutritional standards, they would then take part in a food tasting and provide feedback. • The next steps were to continue to work through the objectives and form part of the wider Nutritional action plan 2021 – 2024.	

	The Chair asked if the Trust still had a quality contract monitoring officers who, pre COVID, would taste the food on the trolleys etc, does this still happen and was quality control still in place? The Head of Dietetics explained that Sodexo were in the process of putting dates together to now be called "mini PLACE" audits where outcomes would be fed back via the Nutritional Steering Group.	
	The Committee: - ***Noted the NHS Food Strategy***	
QEC22/06/E1	**Annual research paper (Deliveries from 21/22 and plans for 22/23)** The Deputy Director of Education and Research provided a summary paper for the committee. There has been a stable recovery from Covid-19 into the research studies both in breadth and depth of the studies and also complexity for which we are recognised financially for. There had been two research studies supported via charitable funds; • Born, and Bred in Doncaster (Babi-D) –the partnership across Doncaster • Magnet for Europe – about raising standards. Other key points: • The Teaching Hospital board was now established with Mark Bailey chairing the meeting looking at the broader workforce and is a fantastic opportunity to work with our partners across the region. • The research, education and clinical academic hub had opened. • New research strategy was in progress and would be presented at July 2022 Board. • Recruited to our first Professor of Nursing. Mark Bailey provided an observation regarding the awareness of the research and the links between the innovation, research training and promoting the relationship with safer care. The Company Secretary added that annual members lectures were in the process of being filmed and suggested that the work of the Research team would be a great topic to share within these series of lectures. Details of how to share would be sent after the meeting.	
	The Committee: - ***Noted and took assurance from the Annual research paper (Deliveries from 21/22 and plans for 22/23)***	
QEC22/06/E2	**Self-Assessment of the NHS funded knowledge and library services** The Deputy Director of Education and Research explained that the Trust was one of the organisations that had a level 4 assessments against the 6 standards. A business case would be presented for the library services to be reinstated back in house. Also allow further work to build on the foundations of research and knowledge.	
	The Committee: - ***Noted the* Self-Assessment of the NHS funded knowledge and library services;**	

	- *Agreed for the Chair to pass QEC thanks on for a great outcome with the assessment and acknowledge the hard work which had gone into this*	
QEC22/06/F 1	**Corporate Risk Register** The Company Secretary updated that nothing had changed since Board The Chair commented that the committee were still awaiting implementation of the recommendations from Internal Audit, plus the KPMG review which would be presented once agreed with the Executive team. It was noted the deadlines for implementation of the changes was 31 July 2022.	
	The Committee: - *Noted the Corporate Risk Register*	
QEC22/06/F 2	**CQC and Regulatory Compliance Update (Verbal)** The Acting Chief Nurse explained that there had been information from neighbouring Trusts that they had received CQC visits. Regular meetings had taken place with the CQC via the Trust engagement meetings. A formal governance group will be set up within the Trust to cover the CQC and compliance agenda in the near future. The Company Secretary mentioned that the CQC Inspection Manager was the same for the SYB System. The CQC were changing their regulation approach, to be more risk focussed and proactive. The Trust keeps the CQC updates and sending information across. The Acting Chief Nurse added that plans were required, and that staff were confident with any questions they may be asked. The Chair added that the CQC was an opportunity to showcase what we do well and was also positive and not all negative and the Trust should motivate and encourage staff to highlight positive areas too, alongside any risk areas.	
	The Committee: - *Noted the CQC and Regulatory Compliance Update*	
QEC22/06/F 3	**Corporate Objectives** The Acting Chief Nurse provided an update at board but had added in expected outcomes to tie them in with items that had been discussed within the meeting today. The Company Secretary added that this was an action from the Chief Executive after Board to provide an outcome, then provide an oversight on a regular basis before final sign off at Board in July.	
	The Committee: - *Noted and approved the Corporate Objectives relating to the Chief Nurse Area*	
QEC22/06/H 1	*Governor Observations* Lynne Logan didn't have any observations but praised the meeting	
QEC22/06/G 1	*Data Quality Audit – Divisional Performance Scorecard* The Chair explained that this had been referred in from ARC to ensure that Quality and Effectiveness Committee are sighted on those recommendations which involved data which was key to QEC; including Falls, hospital acquired pressure ulcers (HAPU's) and	

	mortality data. There was a formal action plan for the recommendations and would be monitored by the internal auditors (360 assurance) and would be presented to Audit and Risk Committee to ensure were implemented. Mark Bailey asked about the dashboards and any issues with the clinical coding, including training of staff. The Executive Medical Director replied that coding covers all information services and regular training was in place as required.	
	The Committee: - ***Noted the Data Quality – Divisional Performance Scorecard***	
QEC22/06/I1	**Sub-Committee Meetings (Enclosure I1):**	
	- Clinical Governance Committee Minutes - March & April 2022 - Research and Innovation Committee Minutes – 28th April 2022	
QEC22/06/J1	**Any Other Business**	
	The Chair referenced items that were deferred to the August meeting as follows:- -Infection Prevention Control assurance paper (if the new guidance was available for this to be provided in August QEC). -Health and Equalities update -Clinical Audit Annual Report The Chair referenced an action that was raised at an Audit and Risk committee meeting in May to be referred into QEC for consideration as follows:- Sheena McDonnell had raised the concerns around the violence and aggression standards that were raised at the previous Audit and Risk meeting, especially in relation to appropriate training when helping those that have an illness and require assistance with violence and aggression. The Acting Chief Nurse clarified that concerns had been raised previously around bed watch and the use of security staff and what training they have had. A dementia and mental health lead had been seconded into looking at the training. A lot of the violence and aggression issues were relating to those patients that had a condition for example dementia and delirium. Agreed by the committee that Beth Cotton - Mental Health and Dementia lead would provide a written update to QEC to assure of the on-gojng work. The Chair agreed to go on the October meeting.	
	Action: Include Review of V&A Training onto QEC workplan for October	
QEC22/06/J2	**Minutes of the meeting held on 5th April 2022** Move Suzy Brain England into the membership section on the minutes, as she Chaired the last meeting	
	The Committee: - ***Noted and approved the minutes from the meeting held on 5th April 2022.***	
QEC22/06/J3	***Issues escalated from/to:*** i) QEC Sub-Committees	

	ii) Board Sub-Committees **iii)** Audit & Risk Committee	
QEC22/06/J4	**<u>Assurance Summary</u>** 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, - Are there any emerging new risks identified?	
	<u>The Committee were assured on behalf of the Board of Directors on:</u> - ***Matters discussed at this meeting.*** - ***Progress against committee associated Executive's objectives,*** - ***No new emerging risks identified***	
	The Chair noted this was Sheena's last QEC and thanked Sheena McDonnell for all her help, support and contributions to the Quality agenda	
QEC22/06/J5	**<u>Date and time of next meeting (Verbal)</u>**	
	Date: **Time:** **Venue:**	**Monday 5th September 2022** **2pm** **Microsoft Teams**	
	Meeting End time	16:40	

FINAL

| | CHARITABLE FUNDS COMMITTEE | |

Minutes of the meeting of the Charitable Funds Committee
Held on Thursday 9ᵗʰ December 2021 at 13.30 via Microsoft Teams Videoconferencing

Trustees:	Mark Bailey – Non-Executive Director (Chair) Suzy Brain England – Chair of the Board Richard Parker – Chief Executive Neil Rhodes - Non-Executive Director Jon Sargeant – Director of Finance Kath Smart – Non-Executive Director Alex Crickmar – Acting Director of Finance	
In attendance:	Matthew Bancroft – Head of Financial Control Peter Brindley and Norma Brindley - Executors and Representatives of the Fred & Ann Green Legacy Emma Shaheen – Head of Communications and Engagement Rhian Morris – Specialist Midwife for Bereavement Services (item B2) Matthew Proctor – Specialist Midwife for Bereavement Services (Item B2) Sarah Ayre – Deputy Head of Midwifery (Item B2) Dan Spiller – Ernst & Young (Item D1 and D2) Charlene Chen – Ernst & Young (item D1 and D2)	
To Observe:	Sheila Walsh - Governor Susan McCreadie - Governor	
Apologies:	Dr T J Noble – Medical Director	
		ACTION
CFC21/12/A1	**Welcome and Apologies for Absence (Verbal)** David Purdue – Chief Nurse Pat Drake – Non-Executive Director Sheena McDonnell – Non-Executive Director	
	The Chair welcomed the members and attendees	
CFC21/12/A2	**Conflicts of Interest (Verbal)**	
	No conflicts of interest were declared.	
CFC21/12/A3	**Actions from previous meeting** Actions 1, 2, 3, 4 and 5 – were closed Action 6 - Investment Update To be deferred to March 2022 meeting	

	Action: Matthew Bancroft would update the Action Log.	
	The Committee: - *Noted the updates and agreed as above, which actions would be closed.*	
CFC21/12/B1	**Review of Fund Balances** Head of Financial Control discussed that we had broadly broken even in the 7 months up to October 2021 from an operational point of view, but there was gains on investments totalling £395k in the period. The total funds carried forward to the end of October 2021 were £9.739 Million. The balance anticipated potential support requests from candidate projects such as the Digital Innovation Hub, Bereavement Suite (discussed later in the meeting) and patient and staff experiences which would take the total to £8.8m. There was a discussed surrounding the Community Diagnostic Hub and the fact there was ongoing discussions as to if/when the project would take place. It was felt that whilst the Hub would be funded through NHS funds, there could be a desire to enhance the patient experience. This would mean charitable funds could be suitably used, namely the Fred and Ann Green fund, given that the Hub is likely to be based at Mexborough.	
	The Committee: - *Noted the approved update for Fund Balances.*	
CFC21/12/B2	**Approval of Expenditure** **Bereavement Suite / Serenity Suite** The Chair welcomed Rhian Morris, Matthew Proctor and Sarah Ayre to discuss the Bereavement Suite business case. It was explained that the case was to cost in the region of £100k, and fundraising totalling £36k had already taken place. The business case had already been to Corporate Investment Group who had approved the case in principle, subject to Charitable Funds funding the case. The presentation outlined the desire to make the experience more dignified for parents who were going through the death of their baby. This was outlined in patient feedback, but also as part of the National Bereavement Care Pathway, that the Trust had signed up to 2 years ago. The presentation showed the Committee the current physical environment for parents and outlined how the proposed Suite would be more appropriate and inclusive, including a dedicated counselling room, quiet soundproofed area and additional facilities meaning the suite was fully self contained.	

In addition to the Suite, the presentation showed some of the work that the staff do with bereaved parents, ensuring parents experience a high level of dignity and support during an extremely difficult time.

Emma Shaheen commented that it is hoped that a focused fundraising appeal would generate in the region of £50k, and as such, the likely ask from existing Charitable Funds would be in the region of £50k via matched funding.

It was acknowledged by the Committee that such a project was an ideal way of utilising charitable funds and it was agreed that the full cost of the project would be underwritten by Charitable Funds to allow the project to commence, with the fundraising appeal to backfill.

The Committee thanked the Bereavement Team for their excellent and passionate presentation and work in the area.

Staff Vouchers

Richard Parker verbally presented the case to Committee to fund a £25 gift voucher to staff as a "thank you" to staff. This was along the same lines as had been funded by Charitable Funds in the previous year and it was felt appropriate given the fact a high number of donations are as a thank you to staff.

Suzy Brain-England commented that there had been difficulties in the previous year with some members of staff finding it difficult to access the voucher for a number of different reasons. Emma Shaheen commented that some of the teething difficulties from the previous year had been learned from and as such, the process should be much smother.

The Committee agreed to fund the vouchers from Charitable Funds.

	The Committee:	
	- *Noted the update for Approval of Expenditure*	
CFC21/12/B3	**Charitable Funds Development Committee (Above and Beyond Committee)**	

In the Chief Nurses absence, the Chair asked Matthew Bancroft to present the paper

It was noted that the Committee had received 31 bids since 1st April 2021, to a total value of £286k.

These bids had been received from every Division and each site and it was clear that the Committee was being more widely known. It was also noted that the pace of the bids had picked up during the year, after a slow start, presumably due to the operational pressures.

The Chair questioned whether more could be done around staff environments, for example staff kitchens. However, Jon Sargeant commented that the Estates team are facing pressure to ensure Trust capital projects are finished in time for the year-end, which means projects which are felt to be above and beyond, have to take a back seat.

	The Committee: - *Noted the Above and Beyond Committee Report.*	
CFC21/12/C1	**Fundraising Strategy Update** Emma Shaheen verbally presented the paper, which included an update on the Christmas Star appeal, which was successful, but attracted fewer sponsors that the previous year. It was felt that this was as a result of Sheffield Children's Hospital Charity doing outreach campaigns this year, which meant the Frenchgate Shopping Centre in Doncaster and the Alhambra Theatre in Barnsley were utilised by them for their campaigns. The Committee were informed that the charity had agreed to be part of the North Notts Bee Trail. Although like Wild in Art projects, this is on a much smaller scale through a provider called Making Trails. The Charity is a partner to the project, partnering with the North Notts BID and Bassetlaw District Council and has contributed £25k to the project. As the sole charity partner, any fundraising will solely be for DBTH Charity, but it is felt that the main benefits will be to allow DBTH Charity to make better contacts in the Bassetlaw area and generate income in that way. Suzy Brain-England commented on the similar event that took place in Sheffield and the staff time it takes to run such an event and the need to ensure it is managed appropriately. It was also noted that the auction at the end of the event was particularly important in terms of fundraising. The proposal for future strategy was also discussed, given that the current Corporate Fundraiser had been in post for 12 months and they were due a review. Neil Rhodes commented that there was an opportunity to develop a legacy donation strategy, although it was a more longer term strategy. A discussion also took place with regards to the long term contractual status of the Corporate Fundraiser, which the Committee agreed was appropriate to take forward with Emma Shaheen.	 **ES**
	The Committee: - *Noted the Fundraising Strategy Update.*	
CFC21/12/D1	**Annual Report and Accounts** It was confirmed that the Annual Report and Accounts had been substantially audited by Ernst & Young. Since they were presented at the previous Charitable Funds Committee, they had been updated for minor presentational adjustments, with no amendments to the figures within the accounts. Subject to the conclusion of the audit, the Annual Report and Accounts would be filed with the Charity Commission.	
	The Committee: - *Noted the update with regards to the Annual Report and Accounts*	

CFC21/12/D2	**ISA 260 Workplans** Dan Spiller presented the ISA 260 to the Committee, and noted that because of the nature of the charity, its format was substantially different to that of the Trust's ISA 260. There was an observation regarding expenditure from the previous year had been recognised in the current year accounts. However, it was noted that substantive work had taken place with regards to cut-off for this year, and because of this, a level of assurance could be obtained.	
	The Committee: - ***Noted the ISA 260 from external audit.***	
CFC21/12/E1	**Governor Observations (Verbal)** Susan McCreadie commented that the presentation by the Bereavement Team was excellent and the project was an excellent one. Sheila Walsh commented that the Serenity Suite project was extremely moving. A question was raised around the donations received from the Bee Trail and which fund it would go into. Emma Shaheen responded that it would go into a General Fund at present, but there are options if there are Bassetlaw specific projects, particularly around the Front Door project.	
CFC21/12/F1	**Minutes of the Sub-Committee Meeting:** - Above and Beyond Committee – 6th September, 4th October	
	The Committee noted: - ***Noted the update for the minutes of the Above and Beyond Sub Committee***	
CFC21/09/F2	**Minutes of the Charitable Funds Committee Meeting held on 16th September 2021**	
	The Committee: - ***Approved the minutes from the Charitable Funds Committee on the 16th September 2021***	
CFC21/12/F3	**Any Other Business** None	
CFC21/09/F5	**Date and time of next meeting – To be confirmed**	
	Meeting End time	15:30	

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

CHARITABLE FUNDS COMMITTEE

Minutes of the meeting of the Charitable Funds Committee
Held on Thursday 24ᵗʰ March 2022 at 13.30 via Microsoft Teams Videoconferencing

Trustees:	Mark Bailey – Non-Executive Director (Chair) Suzy Brain England – Chair of the Board Sheena McDonnell – Non-Executive Director Neil Rhodes - Non-Executive Director Jon Sargeant – Director of Recovery, Innovation and Transformation Kath Smart – Non-Executive Director Alex Crickmar – Acting Director of Finance	
In attendance:	Emma Shaheen – Head of Communications and Engagement Sarah Dunning – Corporate Fundraiser Julie Butler - deputising for Dr T Noble Jayne Collingwood – Head of Leadership and Organisational Development (For Garden Wellbeing room bid)	
To Observe:	Sheila Walsh – Governor	
Apologies:	Richard Parker – Chief Executive Dr T J Noble – Medical Director Fiona Dunn – Company Secretary David Purdue – Chief Nurse Matthew Bancroft – Head of Financial Control Peter Brindley and Norma Brindley - Executors and Representatives of the Fred & Ann Green Legacy Susan McCreadie – Governor	
		ACTION
CFC22/03/A1	**Welcome and Apologies for Absence (Verbal)** Richard Parker – Chief Executive Dr T J Noble – Medical Director Fiona Dunn – Company Secretary David Purdue – Chief Nurse Matthew Bancroft – Head of Financial Control Peter Brindley and Norma Brindley - Executors and Representatives of the Fred & Ann Green Legacy Susan McCreadie – Governor	
	The Chair welcomed the members and attendees. Kath Smart raised a query as to whether the meeting was quorate and it was believed that there was no restriction as to the number of members attending the meeting.	
CFC22/03/A2	**Conflicts of Interest (Verbal)**	

	No conflicts of interest were declared.	
CFC22/03/A3	**Actions from previous meeting** Action 1 to be covered later in the meeting. Action 2 has been closed.	
	Action: Matthew Bancroft would update the Action Log.	**MB**
	The Committee: - ***Noted the updates and agreed as above, which actions would be closed.***	
CFC22/03/B1	**Review of Fund Balances** The Director of Finance presented the paper and confirmed that the position to the end of February 2022 included a £716k gain on investment and he had met with Aberdeen Standard investment managers to discuss the portfolio. Kath Smart commented about the desire to increase charitable expenditure as a result of the healthy fund balances and this would be covered within the later agenda item.	
	The Committee: - ***Noted the approved update for Fund Balances.***	
CFC22/03/B2	**Approval of Expenditure** The Director of Finance outlined that the Magseed, Garden Wellbeing Room and the Perfect Ward projects had been through the Trust internal approval processes prior to being presented to the Committee. **Magseed** A discussion took place around how the scheme benefitted patient care over and above standard NHS provision, which was confirmed by the Director of Finance. Kath Smart questioned the support of the revenue costs, which led to a detailed discussion around the history of the business case and how the kit would be funded and utilised in both the event that the trail was and was not successful. Suzy Brain-England queried whether the project was deemed to be suitable for charitable funding, but the Director of Recovery, Innovation and Transformation confirmed that there is an existing way of treating patients with the condition and as such, this project can be seen as being enhancing patient care. **Action – The Director of Finance was asked to clarify the funding of the revenue costs of the project.**	**AC**

	It was agreed that the project is to be funded via Charitable Funds, should Executives be satisfied with regards to the funding of the revenue costs. **Garden Wellbeing Room** The Head of Leadership and Organisational Development outlined the case, to provide a dedicated space to promote staff wellbeing. The Committee agreed to fund the project. **Perfect Ward** The bid originally received Chairs approval outside of the Committee meetings as a result of the length of time between meetings and the desire to get the bid actioned. The Director of Finance outlined the steps that the bid went through to get approved and updated the Committee that the work had already started on the case. **Montagu Elective Centre** The Director of Recovery, Innovation and Transformation gave a verbal update with regards to the case, where the Trust had made plans to bid for central capital monies for the project, which is likely to involve mainly Orthopaedic elective cases. It was hoped that the case would be approved so that the Centre would become operational towards the end of 2022/23. It was felt that there was a possibility of Fred and Ann Green fund being utilised to support and enhanced the case, depending on the availability of central funding. Suzy Brain-England commented that the proposal would be extremely suitable for the Fred and Ann Green fund given the fact that the overall case would support the Montagu site as a whole. It was agreed that the Director of Recovery, Innovation and Transformation would update the Committee when costs have been finalised. The Director of Recovery, Innovation and Transformation also commented that the Community Diagnostic Centre service for 2022/23 had been reviewed by NHS England and there were additional questions around the cost, in particular with the staffing costs around the Crash Trolley. Given the benefit to patients in having a local, flexible service, the Director of Recovery, Innovation and Transformation agreed to circulate a paper to Committee members should the need to consider charitable funding arise. **Action - The Director of Recovery, Innovation and Transformation is to circulate a paper to Committee members should the need to consider charitable funding arise.**	 **JS**
	The Committee: - *Noted the update for Approval of Expenditure*	
CFC22/03/B3	**Charitable Funds Development Committee (Above and Beyond Committee)** In the Chief Nurses absence, the Director of Finance presented the paper	

	It was noted that the Committee had received 50 bids since 1st April 2021, to a total value of £420k.

It was also noted that the pace of the bids had picked up during the year, after a slow start, and there was good momentum with the number of bids within the process which hadn't yet been presented to the Committee.

Kath Smart commented that there was a number of staff bids through the Committee and that was a positive trend and whether or not there should be a target in place for the Committee for staff benefits. The Head of Communications and Engagement commented that there are a number of different routes for staff benefit schemes and making a target on a particular Committee would be difficult.

Action – The Director of Finance was asked to split the charitable activities expenditure between staff and patient activities. | **AC** |
| | *The Committee:*

- *Noted the Above and Beyond Committee Report.* | |
| **CFC22/03/B4** | **Presentation from fund-holder on funded scheme**

The Head of Communications and Engagement updated the Committee that the planned video around the Butterfield Suite in ED was unable to be completed due to operational pressures within ED.

Action – The Head of Communications and Engagement was to circulate the video at the next meeting | **ES** |
| **CFC22/03/C1** | **Overview of Current and Planned Fundraising Activities**

The Head of Communications and Engagement verbally presented the paper, which included an update in the North Notts Bee Trail, which is due to commence in late March to promote wellbeing, public health and the local economy.

Following the presentation at the previous meeting, the Serenity Suite fundraising project has commenced with £30k already received, with additional commitments over £10k, against the stretch target of £150k, which was extremely positive given the short length of time the fundraising project has been ongoing. With additional pledges, the overall amount raised is £92k.

The Hearts of Doncaster project is ongoing and agreement with the Council is being reached with regards to the location, although any public announcement may be delayed due to Purdah. | |
| | *The Committee:*
- *Noted the Current and Planned Fundraising Activities Update.* | |

CFC22/03/D1	**Annual Review of Charitable Funds Policy (including Committee Terms of Reference)**	
	The Director of Finance outlined the minimal updates with regards to the Policy, as outlined within the paper. It was also proposed that the membership of the Committee should include all Executive Directors, although it is accepted that not all will attend the meeting	
	The Head of Communications and Engagement asked whether consideration should be given in the Policy for guidance to be set out around the interaction between the Trust, Charity and external charities who wish to fundraise on DBTH property or utilise other aspects of DBTH (such as social media)	
	Action – The Head of Communications and Engagement is to construct suitable wording for inclusion within the Policy for consideration at a future Committee meeting.	**ES**
	The Committee: - *Agreed to include all Executive Directors as members of the Committee* - *Noted the updated Charitable Funds Policy*	
CFC22/03/D2	**Annual Review of Expenditure Policy**	
	The Director of Finance outlined the minimal updates with regards to the Policy, as outlined within the paper.	
	The Chair raised a query around funding innovative projects and whether it was covered within the Policy. The Director of Finance suggested that it was covered, but there was a need to communicate this across the Trust and emphasise this within the Policy	
	Action – The Director of Finance was to ensure the Policy emphasised the ability to utilise Charitable Funds for innovative projects.	**AC**
	The Committee: - *Noted the updated Expenditure Policy*	
CFC22/03/D3	**Monitoring Compliance with the Reserves Policy**	
	The Director of Finance outlined the paper and its interlinking with the Annual Review of the Investment Partner. It was commented that the aspirational nature of the expenditure levels means that the Investment Partner is recommending that the investments are liquidated and kept as cash, to reduce the risk held.	
	However, given the fact that any significant levels of expenditure are known well in advance and there is an annual review of liquidity levels, the current investment strategy and reserves policy should continue as it is.	
	The Committee: - *Approved the Reserves Policy*	

CFC22/03/D4	**Annual Review of Investment Partner**	
	The Director of Finance outlined the ethical restrictions around the current (and any future) portfolio, particularly around investments with connections to Russia and Belarus and the fact the situation is relatively fluid. The Committee noted that the situation is ongoing and it will be brought back to the next Committee meeting.	
	Action – The Director of Finance is to contact the Investment Partner to gain additional information and advice around the ongoing ethical restrictions.	**AC**
	The Committee: - *Noted the review of the Investment Partner*	
CFC21/12/E1	**Governor Observations (Verbal)** Sheila Walsh commented that the Wellbeing Room at DRI is a wonderful idea and questioned whether there are similar plans for the other sites and it was felt that there was not any space constraints at the other sites.	
CFC21/12/F1	**Minutes of the Sub-Committee Meeting:** - Above and Beyond Committee – None have been produced	
CFC21/09/F2	**Minutes of the Charitable Funds Committee Meeting held on 9 December 2021**	
	The Committee: - *Approved the minutes from the Charitable Funds Committee on the 9 December 2021*	
CFC21/12/F3	**Any Other Business** None	
CFC21/09/F5	**Date and time of next meeting** Thursday 9th June 2022 Via Videoconferencing Time 13:30	
	Meeting End time	15:30	

FINAL

	TRUST EXECUTIVE GROUP	

Minutes of the Meeting of the Trust Executive Group
Held on Monday 11th July 2022 via Microsoft Teams

Present:	Anurag Agrawal - Divisional Director – Medicine Ken Agwuh - Interim Divisional Director Clinical Specialties (KA) Ken Anderson - Chief Information Officer (KAn) George Briggs - Interim Chief Operating Officer Kirsty Edmondson Jones – Director of Innovation & Infrastructure Eki Emovon - Divisional Director - Children and Families Zoe Lintin – Chief People Officer Richard Parker - Chief Executive (Chair) Emma Shaheen – Head of Communications and Engagement Tim Noble - Executive Medical Director Alasdair Strachan - Director of Education & Research Abigail Trainer – Acting Chief Nurse	
In attendance:	Laura Brookshaw - 360 Assurance Gill Marsden – Deputy Chief Operating Officer – Elective Jenny Marsh – Acting Deputy Director of Finance Angela O'Mara – Deputy Company Secretary Howard Timms – Acting Operational Director of Estates and Facilities Ruth Vernon – 360 Assurance	
Apologies:	Alex Crickmar - Acting Director of Finance Fiona Dunn - Deputy Director Corporate Governance / Company Secretary Antonia Durham-Hall – Divisional Director – Surgery and Cancer Jon Sargeant – Interim Director of Recovery, Innovation & Transformation (Chair)	
		ACTION
TEG22/07/A1	**Welcome and Apologies for Absence (Verbal)**	
	The Chief Executive welcomed members and those in attendance to today's meeting; the above apologies for absence were noted. The Acting Deputy Director of Finance and the Interim Chief Operating Officer (COO) were welcomed to their first meeting of the Trust Executive Group. The Chief Executive confirmed the appointment of the substantive Chief Operating Officer would be formally communicated today. Denise Smith would commence in post in January 2023, following a period of notice. To ensure a smooth transition the Interim COO would remain in post for a number of weeks after her start date. The Trust's internal auditors joined the meeting to present agenda items C6 (Head of Internal Audit Opinion Terms of Reference) and C7 (Internal Audit Action Log); the Chief	

	Executive agreed to take these items prior to the remaining business of the meeting, after which 360 Assurance colleagues would leave the meeting.	
TEG22/07/A2	**Matters Arising / Action Log**	
	The following updates to the action log were noted: **Action 1. Division/Directorate Quality Framework** – The Acting Chief Nurse confirmed work was ongoing in respect of the framework, including the incorporation of the Patient Safety Incident Response Framework (PSIRF). With the support of the Executive Medical Director, it was agreed that the action could be closed. **Action 2. Clinical Update** – was not yet due. **Action 3. Education and Research Update** – was included on today's agenda.	
	The Committee: - *Noted the updates to the action log.*	
TEG22/07/A3	**Conflict of Interest (Verbal)** No conflicts of interest were declared.	
TEG22/07/A4	**Requests for any other business (Verbal)** No items of other business were raised.	
TEG22/07/A5	**CEO Update**	
	NHS South Yorkshire and Nottingham and Nottinghamshire Integrated Care Systems were established on a statutory basis with effect from 1 July 2022. The Trust would now operate across two integrated care systems. Both organisations had established their governance arrangements and their boards to include partner representation for acute and mental health services. The Chief Executive confirmed he had been nominated as the acute representative to sit on NHS South Yorkshire's Integrated Care Board for a term of three years, it should be noted this was an independent role not as a representative of the Trust, nor the Acute Federation. Mark Brooks from South West Yorkshire Partnership was the mental health representative. NHS Nottingham & Nottinghamshire's acute representation was from Nottingham University Hospitals and the mental health representative from Nottinghamshire Healthcare. The first meeting of NHS South Yorkshire's Integrated Care Board took place on 1 July 2022, the business of which mostly related to the acceptance of governance arrangements and terms of reference. The Place Directors were confirmed as, Anthony Fitzgerald for Doncaster and Victoria McGregor Riley Place for Bassetlaw, both of whom would be required to set up their respective Place boards to drive performance, finance	

	and through the Acute Federation to ensure the Places organisations work together constructively and in collaboration (now a statutory duty). A 100-day challenge had been set by NHSE/I for integrated care systems to reduce delayed transfers of care and right to reside. The Chief Executive confirmed he had reached out to both place directors to stress the importance of addressing this in view of the number of patients who were medically fit for discharge but remained in hospital. Considering South Yorkshire's financial position South Yorkshire ICB's Chief Finance Officer, Lee Outhwaite, would undertake a piece of work to better understand individual trust's positions, this was very much welcomed by DBTH. National feedback indicated a meeting with NHSE/I had taken place to consider NHS pay, ambulance handover delays and the associated risks and delivery of the elective recovery programme. It was recognised that elective recovery had stalled nationally, due to the covid position, but there remained a drive to improve and return to 2019/20 levels. The average performance against these levels was 90%, the trust's performance was in the lower quartile and there was a need to improve this for the benefit of our patients. The Interim COO was working closely with the divisions to address this.	
	The Committee: - ***Noted the CEO Update***	
TEG22/07/C1	**Clinical Update**	
	The Acting Chief Nurse confirmed the review of the patient safety team, including PALS and Legal Services, was nearing completion and the written report was expected next week. Work continued with finance and the wider nursing team in respect of nurse staffing and the roll out of Tendable had commenced at Bassetlaw, initial feedback had been positive. The Datix upgrade paper summarised the current system and data issues being experienced and the resultant impact on dashboards, due to the dual running of data in a test and live system. Approval was sought from Trust Executive Group to delete the live data in the test system, records would be preserved, should they be required for future interrogation. With the support of the Chief Information Officer, Trust Executive Group confirmed its approval to proceed. The Quality Impact Assessment had been completed and would be signed off by the Executive Medical Director and Acting Chief Nurse. The Executive Medical Director provided an update on Covid, which highlighted an increase in both patient and staff numbers. As outbreaks had been seen on wards, the Director of Infection, Prevention & Control had agreed to consider visiting arrangements and due to the prevalence of Covid amongst anaesthetists the potential use of FFP3 masks would be reviewed. The Chief Executive welcomed the reviews in view of the potential for infection rates to increase to levels seen in January 2022 by the end of July. With a current sickness absence of 10% and as the peak of annual leave approached, the Chief Executive acknowledged the coming weeks would be challenging.	**KA**

	Divisional colleagues had no clinical matters for discussion.	
	The Committee: - *Noted the Clinical Update.*	
TEG22/07/C2	<u>**Finance Update**</u>	
	The Acting Deputy Director of Finance confirmed that the paper provided a mid-planning position, with a view against the original deficit plan of £25m, as well as the revised £10m deficit plan. An adverse variance of £1m to the £10m deficit plan was noted, largely related to pay and the continued high temporary staffing spend. Opportunities to reduce the reliance on temporary workforce and associated costs would continue to be a key focus. Following the legislative changes of 1 July, the Chief Executive highlighted that an increased level of awareness, and scrutiny would be seen, with the opportunity for benchmarking across Place, the Acute Federation and NHS South Yorkshire. The Acting Deputy Director of Finance confirmed that the corporate benchmarking return was currently being compiled, as the deadline for submission was 13 July, colleagues were encouraged to support timely responses from their respective areas. A late paper had been circulated, which provided the key outputs and comparisons to the previous submission. Once submitted the data would be validated prior to its publication in Autumn 2022. In response to a question from the Chief People Officer, the Acting Deputy Director of Finance agreed to consult the guidance to establish the need to include international recruitment interview expenses ahead of its submission. The Chief Executive requested that sign off in respect of the governance and risk submission should be the dual responsibility of the Acting Chief Nurse and Executive Medical Director. Final approval by the Acting Director of Finance or the Chief Executive would be required on submission.	**JM**
	The Committee - *Noted the Finance Update*	
TEG22/07/C3	<u>**Operational Update**</u>	
	An increase in the prevalence of Covid was reported in both patient and staff groups, despite this the Interim Chief Operating Officer confirmed there had been minimal demand for critical care beds. The focus of work in Critical Care was to ensure the timely movement of patients out of the Unit, where enhanced care was no longer required. Improvements had been seen with emergency flow and ambulance handovers. Flow out of the department continued to be affected by those patients who had extended lengths	

of stay and the significant number of patients who were medically fit for discharge but had no supporting care provision in the community.

The 104 week wait performance had been maintained, but there remained work to do to reduce the 52 week wait position, which stood at 1369 on 12 June 2022.

Elective capacity continued to be a cause for concern, particularly in view of the current level of covid infection and staff absence. The Elective Recovery Board would be re-introduced and the Trust would continue to work closely with the independent sector as part of the planned recovery.

The Interim Chief Operating Officer indicated that with the help of the ICS a discrepancy relating to the Elective Recovery Fund (ERF) calculator for outpatients was being investigated.

Over the next few weeks a programme of work would commence in respect of winter planning, including the potential for further covid surges.

On a positive note, the radiology backlog was expected to return to the required national levels within the next 3-6 months.

The impact of covid on the anaesthetics workforce was noted and the potential for this to affect surgical capacity, the Director of Infection, Prevention & Control had agreed to discuss the suggested introduction of FFP3 masks as a preventative step with the Infection Control Lead Nurse.

	The Committee - *Noted the Operational Update*	
TEG22/07/C4	**Maternity Update – all sites**	
	With the support of the Executive Medical Director and the Acting Chief Nurse, the Interim Chief Operating Officer confirmed the plans in place to support delivery of safe maternity services. Staffing levels over the summer months, and prior to commencement of the newly qualified midwives would be challenging and a working party had been formed to closely monitor this. The group meet on a weekly basis, more frequently if required, to assess staffing levels; the need for additional agency staff would be supported but limited to two per shift. Flexibility from existing colleagues, in adjusting existing work commitments and leave arrangements was being sourced. The difficulties were not unique to the Trust, with neighbouring trusts in both South Yorkshire and Nottinghamshire facing similar challenges. When staffing levels cannot be maintained discussions have already taken place with the commissioners to transfer patients, with closure being considered only when all other opportunities had been exhausted. The Children & Families Divisional Director acknowledged the resultant impact on medical staff who may be called upon to support maternity colleagues in the Central Delivery Suite from their clinics.	

	The Director of Education & Research encouraged clear communication with students and trainees, being mindful of their experience and the potential for this to impact on their future choice of employer. The Acting Chief Nurse shared with colleagues the proactive engagement with the next cohort of midwives, maintaining regular contact and keeping communication channels with the recruitment and educational midwives open. The Chief Executive sought colleagues' agreement with the proposed plan and moving forwards recognised the need to consider the proposed maternity/obstetrics model to deliver transformed services in light of the maternity safety reviews.	
	The Committee - *Noted the Maternity Update*	
TEG22/07/C5	**People Update**	
	The Chief People Officer highlighted the following points from the presented paper: • **Pay award** - no further information was available, early indications signalled the predicted award may not meet with union expectations. • **National terms and condition relating to Covid sick pay** – the government announcement of the phased withdrawal of sick pay would be implemented over coming months. Limited notice had been received and work to present a consistent system-wide communication was in hand. The rationale for change was to remove disparity between the approach to long term absence and that relating to covid. In addition, the initial introduction had been seen as a short-term infection, prevention and control measure which had continued for longer than expected. Guidance and support for managers would be provided. In response to a question from the Director of Infection, Prevention & Control, the Chief People Officer acknowledged his concern with regards to the potential impact on colleagues attending work when Covid positive. Similar concerns had been expressed and a collective response was being considered across the ICS. In view of the recent warm weather the Chief Executive sought colleague's views on the need for a lighter/summer uniform. The Acting Chief Nurse confirmed she had been approached and thought it sensible to formulate a case to be presented to the Charitable Funds Committee.	**AT**
	The Committee: - *Noted and approved the People Update*	
TEG22/07/C6	**Head of Internal Audit Opinion Work Programme Terms of Reference**	
	The Terms of Reference set out the programme of work throughout the year which would inform the year-end Head of Internal Audit Opinion. As part of this work, the following areas would be considered:	

	Board Assurance Framework (BAF) - to ensure ongoing review and updates to the live document, including the evidence of progress against mitigating actions, evidenced by reference to the BAF and through observing public board and sub-committee meetings. I**mplementation of audit actions -** consider the organisation's culture and grip on the timely closure of audit actions. **Internal Audit Plan Outturn -** consider audit opinions, key themes and the volume of high-risk actions. **Third Party Assurance** - to take into account third party feedback such as CQC actions, external audit opinion, external well led reviews. As the first stage Head of Internal Audit Opinion would be taken to the Audit & Risk Committee in October the Chief Executive agreed it would be helpful to receive this as part of the internal audit update in October to ensure colleagues were sighted on progress.	
	The Committee: - *Noted the Head of Internal Audit Opinion Terms of Reference*	
TEG22/07/C7	**Internal Audit Action Log**	
	A first response rate of 73% was reported for internal audit actions, 360 Assurance would continue to offer support to maintain and improve closure rates. In the year to date, four actions had missed their due dates. Two related to Medicines Management, evidence for which was being collated, and discussions were ongoing with the Interim Director of Recovery, Innovation & Transformation. The remaining two related to job planning and 360 Assurance confirmed that constructive discussions with the Executive Medical Director and his team had taken place and progress with closure of audit actions was evidenced. Seven historic actions remained open, six of which were due by the end of July 2022 and related to risk management and the Head of Internal Audit Opinion work programme and would be pertinent to this year's work. Further detail to support the highlight report within the papers was available via the Pentana portal. The Chief Executive reminded colleagues of the importance of the internal audit follow up rate, reasonable performance was expected to be in the high 80s and the Trust's performance would be monitored against this.	
	The Committee: - *Noted the internal audit action log update.*	

TEG22/07/D1	**CIG Update**	
	Trust Executive Group received an update on the business cases reviewed by the Corporate Investment Group on 27 June 2022. The majority of the cases were included within the capital programme, except for two, and two cases required further work and would be reconsidered following the update. The validation business case had been approved outside of the Corporate Investment Group and was the first call on the cost pressure funding, which the Trust was currently over committed against. The position would be carefully monitored going forwards. The Chief Executive confirmed that the case had been presented as an unavoidable cost, as a matter of urgency to avoid further deterioration in the overall performance without the involvement of the external validators. Returning to business as usual the Trust would avoid this through good planning. In respect of the items which required further work, the Chief Executive highlighted that earlier support had been agreed by the Executive Team for the additional intensivist, so the outstanding matters would require a resolution.	JM
	The Committee: - *Noted the CIG Update*	
TEG22/07/E1	**Validation Management Business Case**	
	Trust Executive Group received the validation management business case for completeness, following a decision to approve outside of the Corporate Investment Group. The Chief Information Officer confirmed the significant change in process required to support the validation work, which was a critical part of the Trust's recovery programme. The Deputy Chief Operating Officer added her support for the need to move at pace to improve inhouse capability, as evidenced in a recent audit; extensive training would be required to implement and embed a sustainable solution. Over time, a technical solution to assist validation could be explored to further improve capacity. The Deputy Chief Operating Officer expressed her appreciation of the Chief Information Officer's support in progressing this work.	
	The Committee: - *Noted the Validation Management Business Case, approved by the Executive Team*	
TEG22/07/E2	**Programme Management Procedure**	
	The Efficiency Director outlined the proposed changes to project management governance for 2022/23, which included the deployment of Monday.com, a project management workflow tool, and the refresh and alignment of programme management approaches across the Trust.	

	A summary of the benefits arising from the change included: improved visibility, automation, prioritisation and standardisation, all of which would ensure effective programme delivery. If colleagues had not already received a demo of the system, or had any questions, the team were happy to support requests, which should be routed via Angie Lawson. The Chief Executive confirmed this work had been commissioned to support delivery of the major schemes of work required to deliver 2022/23 objectives. Effective use of the system and project management approaches would enable the identification and prioritisation of those projects which would generate the greatest outcomes. In response to a question from the Deputy Chief Operating Officer, the Efficiency Director confirmed funding for Monday.com had been secured in 2021/ 2022 for a period of two years with the option to extend for a further year and as such would provide a consistent solution going forwards. In response to a question from the Executive Medical Director regarding the risk that the system could stifle innovation, the use of Monday.com was felt to offer an agile approach which would aid rather than hinder, whilst ensuring that innovation was progressed where a clear benefit was identified which would improve outcomes and be delivered within an identified resource. Funding for the system had been discussed at Board as part of the creation of the Recovery, Innovation & Transformation directorate at the end of the 2021/2022 financial year to enable a strong start to 2022/23. The Director of Innovation & Infrastructure and the Chief Information Officer offered their support of this intuitive system, recognising the benefits gained from improved accessibility and its structured approach. However, as with any new system it was recognised that the true benefits would only be realised through use and the Director of Efficiency encouraged use of the system be embedded into practice.	
	The Committee: - *Noted the Programme Management Procedure*	
TEG22/07/E3	**Strategy Update**	
	The Director of Innovation & Infrastructure summarised the content of the paper which provided an update on the service strategy development and strategic programmes. Three of the four service strategy workshops had now taken place, Children & Families division remained outstanding but was planned in. Feedback from the sessions indicated a good level of attendance and engagement and thanks were shared with the divisional colleagues and their teams. The business case for Phase 2 of the Community Diagnostics Centre (CDC) was approved last week. This phase included the provision of an enhanced endoscopy suite, two ultrasound rooms, a multi-function clinical room, training facilities and the relocation of pain management service.	

	An opportunity to bring forward the bid for fixed CT and MRI provision into phase 2 had arisen due to a slippage in the spend of CDC monies at a neighbouring trust and the team would begin to scope the viability of this option for consideration by the national team. Funding for the provision of alternative winter care had been confirmed for South Yorkshire Integrated Care System, trust plans had been submitted and following review, the Chief Executive confirmed that where plans were approved funding was expected to be received soon afterwards, to support the timely implementation of plans ahead of winter. The Chief Executive took the opportunity to confirm funding for the Laboratory Information System (LIMS) and digital pathology proposal for South Yorkshire & Bassetlaw had been approved, which equated to an IT investment of £22.5m and would support the reduction in the pressures associated with histopathologist recruitment. Approval of the Laboratory Information Management System (LIMS) business case was also awaiting approval. In respect of the training room referenced in the CDC phase 2 bid, the Director of Education & Research enquired of plans to agree the workforce and required training programmes to populate the CDC. As the facility would be a South Yorkshire solution the Chief Executive confirmed that discussion would progress through the relevant hosted networks. Where a project was system wide, the Managing Director of the Acute Federation Board had a small team responsible for cross cutting projects, which would be managed by the System Delivery Group.	
	The Committee: - *Noted the Strategy Update*	
TEG22/07/E4	**Innovation Update (Presentation)**	
	The Director of Innovation & Infrastructure brought colleagues attention to the following highlights within the update: • Demand - 40 projects were currently in train • Increased Qi capacity was required, via Qi Business Partners and the creation of a Qi Faculty to support Qi as a tool for everyday practice • Robust post project evaluation and monthly reporting • Development of Qi KPIS and evaluation tools - progress against which would be reported at the Transformation Board / Trust Executive Group The Chief Executive recognised the intention to return to pre-Covid focus on driving forward improvements, drawing on the experience of staff and allowing colleagues to be actively engaged in system change. The Chief People Officer fully supported colleague engagement and recognised where training was undertaken there was a need to facilitate this being put into practice, whilst managing operational pressures. In respect of cultural change and staff engagement the Chief People Officer suggested she work closely with the Director of Innovation & Infrastructure to manage the overlap between this work and organisational development to avoid duplication.	

	In terms of the capacity to deliver, it was agreed that an assessment of the best use of practitioners would need to be assessed and considered against organisational priorities, to deliver safe, sustainable, effective and efficient services. In terms of the next steps colleagues were supportive of the direction of travel and recognised that further detail would be required, including where appropriate the costs of backfill when the business case was developed.	
	The Committee: - ***Noted the Innovation Update***	
TEG22/07/E3	**Infrastructure Update (Presentation)**	
	The Director of Innovation & infrastructure presented an overview of the projects contained within her presentation, which included: • Removal of the Reinforced Autoclaved Aerated Concrete at Bassetlaw • Community Diagnostic Centre Phase 2 Bid • Bassetlaw Emergency Village Outline Business Case • Montagu Elective Orthopaedic Centre The Chief Executive highlighted that the Montagu Elective Orthopaedic Centre would consist of two laminar flow theatres and would be developed as a centre of excellence, which could in the future be utilised flexibly as a surgical centre, adapting to the pressures which at the present time related to the orthopaedic backlog. In respect of the digital capital project for Critical Care, the Chief Executive asked the Chief Information Officer to look into an issue that had been raised with him in respect of the interface between this and the electronic prescribing system. Clarification of the challenges to be picked up with the Chief Pharmacist to ensure medicines management procedures were not impacted.	**KAn (CIO)**
	The Committee: - ***Noted the Capital Update***	
TEG22/07/F1	**Risk Management Board Update**	
	The Executive Medical Director identified the work required to progress the implementation of the Risk Management Board, which included a policy refresh and training provision. The Executive Medical Director felt that the appointment of a Risk Manager and the identification of administrative support were crucial elements in ensuring success. A meeting would take place with the Deputy Director of Corporate Governance, following her return from leave and at that time the process for the delivery of all elements of the required action and their timelines would be clarified.	

	The Chief Executive identified that as this work was an action arising from an internal audit review it was required to be completed within the agreed timeline, as specified by the Trust's internal auditors.	
TEG22/07/G1	**Education and Research Update**	
	The Director of Education & Research presented the SET report for medical and dental staff, which identified a reduced completion rate of 60.43% , as compared to the Trust level compliance of 85.12% and proposed actions to recover the compliance level.

Recommendations to recover the position were documented and a lengthy discussion took place across the group to understand the reasons for the difference in compliance, how compliance should be monitored and the actions which needed to be taken if training was not completed.

The Chief People Officer observed that generally, as a point of experience, medical colleague's compliance rates tended to be lower, and in addition to considering how this was monitored and who had oversight of this, the training and education team were exploring ways of observing training in practice, as part of everyday work, as opposed to classroom or e-learning based training.

Importantly, what was clear was that a pre-determined level of training was required by colleagues to carry out their role and responsibilities in a safe and effective manner and there was a professional responsibility to undertake the training. Compliance should also be viewed as a protective measure for colleagues.

From an information governance perspective, the Chief Information Officer expressed his concern with regards to non-compliance from a Data Protection Toolkit perspective, which was key measure against which the Trust was monitored.

The Director of Education & Research confirmed plans to support learning in practice which would be progressed by a business case for additional resource. The allocated time was felt to be reasonable for completion and in his opinion what needed to change was the organisation's culture/ approach within medical teams to completion. The situation was not unique to the Trust but did require enforcement by clinical and divisional leadership.

The Chief Executive asked the Executive Medical Director, through discussions with colleagues, to understand the obstacles and what measures would to be taken to improve medical staff's SET compliance. | **TN** |
| | *The Committee:*

- *Noted the* Education and Research Update | |
| **TEG22/07/G2** | **Proposal for a New Foundation School in Health with Retford Academy in Bassetlaw.** | |
| | Trust Executive Group received the paper, requesting approval of Retford Oaks Academy as a Foundation School in Health in Bassetlaw. This followed the successful formation of the Foundation School in Health in Doncaster, with Hall Cross Academy in 2018. | |

	Trust Executive Group welcomed the positive development in the relationship with Retford Oaks and welcomed the opportunity to formalise the partnership.	
	The Committee: - *Noted and approved the* **Proposal for a New Foundation School in Health with Retford Academy in Bassetlaw.**	
TEG22/07/H1	**ICS Update**	
	The Chief Executive confirmed there was nothing to add to his update provided at agenda item A5 (CEO Update).	
TEG22/07/I1	**Place Update**	
	The Chief Executive confirmed there was nothing to add to his update provided at agenda item A5 (CEO Update).	
TEG22/07/J1	**Any other Business (Verbal)**	
	The Director of Education & Research identified the Magnet for Europe study which looked at the health and wellbeing of clinical staff, as part of a European wide study. The first part of the study was to encourage completion of a short survey via a QR code. The Director of Education & Research proposed to distribute to members for dissemination to clinical colleagues. The Executive Medical Director confirmed the circulation.	
TEG22/07/J2	**Minutes of the Trust Executive Group meeting dated Monday 13th June 2022**	
	The Committee: - *Noted and approved the minutes of the meeting dated Monday 13th June 2022.*	
TEG22/07/J3	**Date and time of next meeting (Verbal)**	
	Date: Monday 15th August 2022 Time: 14:00 – 17:00 Venue: Via Microsoft Teams	
	The meeting closed at – 17:05	

FINAL

**Doncaster and Bassetlaw
Teaching Hospitals**
NHS Foundation Trust

TRUST EXECUTIVE GROUP

**Minutes of the Meeting of the Trust Executive Group
Held on Monday 15th August 2022 @ 2pm via Microsoft Teams**

Present:	Anurag Agrawal - Divisional Director – Medicine Ken Anderson - Chief Information Officer George Briggs - Interim Chief Operating Officer Fiona Dunn - Director of Corporate Affairs / Company Secretary Eki Emovon - Divisional Director - Children and Families Joseph John - Medical Director for Operational Stability and Optimisation Zoe Lintin - Chief People Officer Nick Mallaband - Medical Director for Workforce and Specialty Development Richard Parker - Chief Executive (Chair) Jon Sargeant - Interim Director of Recovery, Innovation & Transformation Emma Shaheen - Director of Communications and Engagement Alasdair Strachan - Director of Education & Research Abigail Trainer - Acting Chief Nurse	
In attendance:	Laura Brookshaw - 360 Assurance Claudia Gammon - Corporate Governance Officer (Minutes) Gill Marsden - Deputy Chief Operating Officer – Elective Jenny Marsh - Acting Deputy Director of Finance Howard Timms - Acting Operational Director of Estates and Facilities Ruth Vernon - 360 Assurance	
Apologies:	Alex Crickmar - Acting Director of Finance Antonia Durham-Hall - Divisional Director – Surgery and Cancer Tim Noble - Executive Medical Director	
		ACTION
TEG22/08/A1	**Welcome and Apologies for Absence (Verbal)**	
	The Chief Executive welcomed members and those in attendance to today's meeting; the above apologies for absence were noted.	
TEG22/08/A2	**Matters Arising / Action Log**	
	The following updates to the action log were noted: **Action 1 – TEG22/06/C1 – Discharge Letters** The Chief Information Officer confirmed the Trust had contacted two GP practices, via the CCG, to obtain examples, the numbers were greater than anticipated. It appeared the issue was due to working practice, with letters being dispatched when the consultants/doctors were reviewing cases. Investigations were ongoing and a further update would be brought to the September meeting.	

	Action 2 – TEG22/07/G1 – SET Compliance – Medical Workforce	
	Statutory and Essential Training was essential to role and was required to be completed. It would be included within the clinical update going forwards and this action would be closed.	
	The Committee: - *Noted the updates to the action log.*	
TEG22/08/A3	**Conflict of Interest (Verbal)** No conflicts of interest were declared.	
TEG22/08/A4	**Requests for any other business (Verbal)** No items of other business were raised.	
TEG22/08/A5	**CEO Update**	
	The Chief Executive highlighted the following areas of local and national interest: o Workforce issues, including staff retention and health and wellbeing o The pay award hadn't been well received. Senior medical staff and junior doctors were reviewing their pay and the Royal College of Nursing and Unison had proceeded to ballot for strike action later in the year. o In Q1/2 there would be no clawback of Elective Recovery Funding, Quarter 3/4 funding would be dependent on performance. The Trust was in the lower quartile at 82%, if this didn't increase the Trust wouldn't receive any ERF funding which would cause a financial challenge. o Emergency care relating to ambulance handovers and 100-day challenge, this was for the Trust to implement 10 best practice measures to reduce the number of patients staying at the hospital. The Secretary of State's office had contacted the Trust to ensure the system was investigating discharges. o The ambulance handover delay pattern hadn't changed over the past 5 years, however, internal processes had and the wait times to see emergency department medics. o Significant pressures on the 62-day cancer waits were being investigated. o The ICS formed on the 1st of July and the transfer of staff from system to acute federation had commenced. Understanding the key issues was important and continuing to work on the new hospital bid, orthopaedic and surgical centres. The ICS resources were being awarded to other organisations and give each a chance to deliver. o Continued work around travel allowances would be discussed within the meeting.	
	The Committee: - *Noted the CEO Update*	

TEG22/08/B1	**Civica Declare – Standard of Business Conduct & Employee Declarations Update**	
	The Company Secretary explained that a web based software solution, Civica Declare, had been procured to provide an electronic central repository of declarations of interest, including the supporting policy, standards of business conduct. Previously, directors and decision makers had submitted manual declarations. The web based solution would enable staff to log on and submit their interest for approval, which would subsequently be publicly accessible via the website. The system was currently being tested using information from ESR and had been checked via fraud protection and data security. The plan was to roll the system out at the end of August/early September starting with decision makers. The Trust would be compliant if the policy was followed, and all declarations added. The Chief People Officer observed that there was framing around this and that nothing was changing as it had always been required but in a different way. It was added that a demonstration had been conducted showing the policy was easier to follow and less time consuming. The Medical Director for Operational Stability and Optimisation praised the idea of having a single platform where all declarations of interest were held. The Chair added that private practice consultants' declarations of interest could be viewed previously.	
	The Committee: - *Noted the Clinical Update.*	
TEG22/08/C1	**Internal Audit Action Log**	
	Ruth Vernon provided an update on the Internal Audit and the actions from the previous year. Currently the Trust had 7 open historic actions, 6 of which related to the Board Assurance Framework/risk management and the other related to job planning. The deadlines for which were the end of October 2022. Closed actions within their original due date were also investigated, this year 65% of these were implemented by their due date. The internal audit action log would be presented at every Trust Executive Group meeting, all executives were also able to view progress on the 360 Assurance portal. The Company Secretary added that evidence was also required for each action to be updated. The Risk Management Board would commence shortly to ensure all 15+ risks were appropriate and relevant mitigating actions in place.	
	The Committee - *Noted the Internal Audit Action Log*	
TEG22/08/C2	**Clinical Update**	
	The Medical Director for Operational Stability and Optimisation highlighted a few areas within the clinical update:	

- o Workforce requirements were being considered, with a view to increase the number of junior doctors by liaising with the education leaders within the deanery
- o Improve consultant recruitment
- o 78% of the workforce was now on allocate for job planning
- o New consultant recruitment would have a forum to ensure staff feel welcome and arrange informal mentorship when starting with the Trust.
- o Medical directorates were working with the Covid Medicine Delivery Unit work and the demand for CT scans.
- o Progress was being made with the revalidation process.
- o SET training was discussed with senior medical staff and that it wasn't an optional requirement and was a part of their terms and conditions. Communications would be circulated stipulating the importance. On the agendas for medical and divisional directors meeting to be raised.

The Divisional Director of Medicine added that consultants and medics set training was behind, ongoing discussions to improve were taking place. Following a question regarding appraisals and if it could be raised as part of the job plan. It could be part of the appraisal process but couldn't be used for revalidation. This was to be investigated.

In response to a question from the Divisional Director of Children and Families , the Chair confirmed that non completion would be challenged.

The Divisional Director of Medicine queried if the issue of mandatory SET training was to be raised in job planning discussions and approached differently. The Chair stated that the essential and statutory training was included within the contract and was therefore mandatory.

Staff were concerned that currently the offer that the Trust were proposing wasn't the same as the British Medical Association, unless this was decided some staff would stop any additional work within their specialties. The Chair agreed that rates would be considered across the system. At present no Trusts across South Yorkshire were paying the British Medical Association rates. A mandate to reduce agency spend by 10% had been received by all Chief Executives via letter.

The British Medical Association rate wasn't supported by NHS employers and was part of ongoing national negotiations.

Although there had been an incremented rate elsewhere in the Trust, the emergency department weren't seeing this and had raised concerns. The out of hours rate hadn't changed. The Chair explained that they had a differential rate and was required to be covered in a way that was good use of public money.

The Acting Chief Nurse also provided a clinical update.
- o Providing an extra Finance and Performance meeting regarding agency and bank spending within nursing.
- o Workstreams and working together
- o Second stage of the agency/bank spend meeting to be held on 1st September with the divisional nurses, looking at newly recruited staff, international nurses, and the impact on spend.

	o Safeguarding was a significant challenge; review took place last year with concerns around leadership. The clinical commissioning group provided recommendations and was on the risk register.	
	The Committee - *Noted the Operational Update*	
TEG22/08/C3	<u>**Finance Update**</u>	
	The Acting Deputy Director of Finance explained the figures for month 3 o Year to date the deficit was £4.3m on revenue, this was £1.1m worse than plan and was driven by pay o A £2.4m overspend driven by temporary staffing, sickness, Covid and operational pressures. o The Division of Medicine and Children & Families were receiving enhanced financial support, regular meetings were held to review action plans. o Capital was behind plan, with medical equipment being an area of concern o Estates plans were all via CIG o Cash was in line with plan at month 3, along with CIP The medical equipment areas would be investigated by the Executive Medical Director and the Acting Director of Finance after the meeting. In month 6 there would be a look at where the Trust was, key areas of focus for the next 6 months and appropriate divisional plans put in place. This would be cascaded to the divisions ahead of winter pressures.	
	The Committee - *Noted the Finance Update*	
TEG22/08/C4	<u>**Operational Update**</u>	
	• Missing Discharge Letters • Business Resilience Steering Group Terms of Reference • RTT & PTL Pathway Management The Interim Chief Operating Officer provided the following updates: <u>Missing Discharge Letters</u> o No further comments to add to the earlier update. <u>Business Resilience Steering Group Terms of Reference</u> o The regional team had requested that the terms of reference were seen by all and were signed off by the business resilience steering group. <u>Operational Update</u> o There were currently 35 Covid-19 inpatients	

- National drive for Covid-19 and other infections for winter
- Improvement had been seen within South Yorkshire and Nottinghamshire regarding flow in July
- Within the last 2 weeks there had been numerous diverts.
- Ambulance handovers remain high, however, the numbers were similar to those in previous years. There were more walk-ins, especially at Bassetlaw
- A meeting had been set up with the emergency department doctors to investigate the issues across South Yorkshire
- Further work was taking place in respect of patients with stays in excess of 21 days
- 800 lost bed days from the previous month
- Bassetlaw would be sharing their data with Nottinghamshire hospitals, this was a trial
- Emergency department recovery programme had started and looking at long and complex patients reviewing them as soon as possible.

There were plans to close the Acute Medical Unit at Doncaster in the future which would mean a loss of 12 medical beds, this may have an effect on patients coming into medicine.

Ambulance handovers were like the previous year however, there was a 6% increase in minors, with 3% increase of that being prior to Covid-19. The issues were about what was going on within the Trust and not the handovers.

Elective

- Two weekly elective recovery meeting set up, looking at the data
- Diagnostics had seen a slight improvement of 2/3% ahead of the previous month
- Drive the waiting time down including those waiting longer than six weeks, this should be at 99%. The Trust were currently at 58%
- The next stages of the elective programme with cancellations in July due to staff sickness and Covid-19.
- Validation of the waiting lists was to be investigated to reduce the number of patients.
- Focus work was being carried out within maternity services which had resulted in no diverts and seen a positive uptake of midwives supporting.

The Chair summarised the Trust was in a difficult position, recovery had been slower than expected, how the Trust increased performance was key. Need plans and systems to deliver in the way patients require the Trust to. Job planning needs to be transformational rather than transactionally, with opportunities to do this in some areas. If the Trust was struggling on elective work, then they were expected to move that work to other areas or Trusts that had capacity.

RTT & PTL Pathway Management

The Chief Information Officer confirmed that work had been carried out on an options appraisal, the extended source group was extended by 6 months. 20 different options were worked through. 3 enablers and 5 options.

Three recommendations:

	1) Move forward with two of the enablers with immediate effect, work with the medical secretaries was the most important. Look at sourcing a digital pathway system, this would only be until identified 2) Should the Trust continue to support for a short period of time, the idea was to move to a more sustainable view. A dedicated team that only assists with deals with outpatient's validation one team. 3) Do nothing, centralise everything, outsource all validation activities but there was a monetary issue with this. System support was available for validation, work to understand this, before taking forward to CIG was required. The Chair provided an overview that medical secretaries were to engage more in the validation process. Divisional directors all supported this.	
	The Committee: - ***Noted and approved the Operational Update***	
TEG22/08/C5	**People Update**	
	The Chief People Officer provided a people update: o Appraisal season was in progress and emphasised the quality of conversations and that staff feel valued and asked about their wellbeing. This was more important than the paperwork. o Clinical Excellence Awards were previously done in line with the equal distribution model, this was a national option during Covid-19. The recommendation to the Trust Executive Group was that the Trust continue with this equal distribution. The national awards would not recommence until January 2023. o Mileage rates had been discussed in June with an agreement to increase, with a 6-monthly review s. This was to achieve consistency across the ICB. This would be considered due to changes within other organisations. The Chair added that as the Trust didn't achieve complete consistency further talks were to be had. It was likely to incur cost pressures but was a requirement if other Trusts agreed. Colleagues that were within the first 3,500 miles the rate would be 61p per mile and then 35p after this subject to review clauses. If the cost of petrol reduces this would be subject to further review. The Trust Executive group agreed with this.	
	The Committee: - ***Noted the People Update***	
TEG22/08/D1	**CIG Update**	
	The Acting Deputy Director of Finance provided an update on the capital investment group papers.	

	o Business cases were presented, the aesthetics specialty business case wasn't approved and would be investigated further outside of the meeting. o Cost pressures were currently oversubscribed. Since the original review on the areas there had been a further list: • Validation of waiting lists • Trusts travel rates • Nurse endoscopists • DCC rehab coordinators • DCC technicians • Increased additional session rates • Covid vaccinations • AHP international recruitment • Ward 19 – opening 1 week early The Interim Director of Recovery, Innovation & Transformation questioned that although the cost pressure was phased for plan was there an allowance for slippage. It was answered that it would over time, reassessed at certain points and would be reviewed monthly. The Acting Operational Director of Estates and Facilities clarified the updated digital priorities proposals list required approval. The Acting Deputy Director of Finance added that this was funded, it had been brought to the Capital Investment Group previously but not all divisional directors were there to approve so it had been presented at the Trust Executive Group. The Chair added that the schemes were approved and within budget and if the divisions had any issues that the estates and finance teams needed to be aware.	
	The Committee: - ***Noted the CIG Update.***	
TEG22/08/E1	**Strategy Update**	
	The Interim Director of Recovery, Innovation & Transformation shared the update, noting the Community Diagnostics Centre phase 2bid had been signed off. Permanent scanners were being looked at alongside a substation at Montagu. Bids via the imaging network were made for various items. The public health consultant had been appointed. More work was required around the place in Nottinghamshire and Doncaster. Alternate care bid for winter had been supported.	

	Health and inequalities work was being carried out, working alongside the new public health consultant, the Council and RDaSH.	
	The Committee: - *Noted the Strategy Update*	
TEG22/08/E2	**Innovation Update**	
	Work was being carried out with the Quality Improvement team to ensure involvement with Trust crucial projects. Also work on the virtual ward which was a larger opportunity than anticipated. Paper to come back to the September meeting looking at the quality and improvement and how we utilise people to roll it out.	
	The Committee: - *Noted the Innovation Update*	
TEG22/08/E3	**Capital Update**	
	The infrastructure update: o Case submitted for the Reinforced Autoclaved Aerated Concrete (RAAC) work in July 2022, there was a large shortfall on costs, with the Trust receiving a further £5m to be completed this year. o The Bassetlaw Emergency Village business case was submitted, going to plan, and looking at working towards the final business case, awaiting NHSE to sign off. o Montagu Elective Orthopaedic Centre (MEOC) draft memorandum of understanding was in place, however, partners required more time. All agreed that a wider piece of work would be in place to look at what the unit would be used for. Wider orthopaedic centre was also an option, meetings to discuss further. Some funds had been drawn down to assist with the business case. o No further update on the new hospital at Doncaster, early Autumn. Starting work for the final business case had been looked at via the ICS and ICB. Digital capital was in a good place compared to previous years, business case for the new bleep system would be raised at the next capital investment group. Recruiting a project manager for the scan for safety group.	
	The Committee: - *Noted the Capital Update*	
TEG22/08/F1	**Risk Management Board Update**	
	The Medical Director for Operational Stability and Optimisation explained that the new Risk Management Board would look at the risk register, including provision of improved training and coordination across the groups. Matrix guidance would be provided throughout. The first meeting would be held in September, with a task and finish group to be established.	

	The Chair confirmed that the Executive Medical Director had oversight of risk management and that there wasn't a conflict of interest within the portfolio. Once a substantive Chief Nurse was in post then a way forward would be discussed.	
	The Committee: - ***Noted the Risk Management Board Update***	
TEG22/08/G1	**Education and Research Update**	
	The Director of Education & Research shared feedback from the national General Medical Council survey, and the challenges faced due to workforce gaps. The Trust was working with the college tutors to establish the required areas for improvement. The Trust had been approached for extra junior doctor posts with the help from the divisional directors 120 new doctor inductions had gone well, one challenge with students was around electronic door access. A new innovation and research strategy was taking place via the Teaching Hospital Board.	
	The Committee: - ***Noted the Education and Research Update***	
TEG22/08/H1	**ICS Update**	
	There was no further update from the Chair	
TEG22/08/I1	**Place Update**	
	The Chair explained that governance arrangements were moving towards more operational issues, first Doncaster place-based meeting had taken place.	
TEG22/08/J1	**Any other Business (Verbal)**	
	The Chief People Officer wished to bring a verbal update on annual leave and if staff could carry days over. The outcome was that staff were encouraged to take their annual leave for health and wellbeing reasons, however, staff can apply within there divisions to carry days over up to 5 days. The Acting Deputy Director of Finance added that a staff survey maybe required to check holidays financially.	
TEG22/08/J2	**Children & Families Board Update – April & June 2022**	
	The Committee: - ***Noted the Children & Families Board Update April & June 2022*** The Chair raised the amount of staffing and the risks at Bassetlaw, out of hours cover over night hadn't been reopened. Work was required for this to ensure the Trust produces the safest care.	

TEG22/08/J3	**Minutes of the Trust Executive Group meeting dated Monday 11th July 2022**		
	The Committee:		
	- *Noted and approved the minutes of the meeting dated Monday 11th July 2022.*		
TEG22/08/J4	**Date and time of next meeting (Verbal)**		
	Date: Time: Venue:	Monday 12th September 2022 14:00 – 17:00 Via Microsoft Teams The Chair gave his apologies for the next meeting and the Deputy Chief Executive would Chair.	
	The meeting closed at: 16:45		

NHS
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 July 2022 at 09:30
via MS Teams

Present:	Mark Bailey - Non-executive Director
	Suzy Brain England OBE - Chair of the Board (Chair)
	Hazel Brand - Non-executive Director
	Alex Crickmar - Acting Director of Finance
	Mark Day - Non-executive Director
	Joanne Gander - Non-executive Director
	George Briggs - Interim Chief Operating Officer
	Dr Tim Noble - Executive Medical Director
	Richard Parker OBE - Chief Executive
	Neil Rhodes - Non-executive Director
	Jon Sargeant - Interim Director of Recovery, Innovation & Transformation
	Kath Smart - Non-executive Director
	Abigail Trainer - Acting Chief Nurse
In attendance:	Kirsty Clarke - Acting Deputy Chief Nurse (agenda item B1)
	Sam Debbage - Deputy Director of Education & Research (agenda item F2)
	Fiona Dunn - Director of Corporate Affairs / Company Secretary
	Kirsty Edmondson-Jones - Director of Innovation & Infrastructure (agenda item F3)
	Anna Fawcett - Regional Associate Director – Operations, Archus (agenda item F3)
	Mathew Gleadall - Acting Deputy Director of Estates & Facilities (agenda item E3)
	Anouska Huggins - Associate Director, Archus
	Jenny Hunt - Lead Professional Nurse Advocate (agenda item B1)
	Anthony Jones - Deputy Director of People & Organisational Development
	Lois Mellor - Director of Midwifery
	Angela O'Mara - Deputy Company Secretary (Minutes)
	Emma Shaheen - Director of Communications & Engagement
	Tim Wilson - Deputy Director of Research & Innovation (agenda item F2)
Public in attendance:	Peter Abell - Public Governor Bassetlaw
	Dennis Atkin - Public Governor Doncaster
	Mark Bright - Public Governor Doncaster
	Georgina Holmes - Staff Side Chair
	Jordan Howard - Member of the Public
	Lynne Logan - Public Governor Doncaster
	Richard Mangolles - Member of the Public
	Paul Mapley - Efficiency Director (observer)
	Andrew Middleton - Member of the Public
	Dave Northwood - Public Governor Doncaster
	Pauline Riley - Public Governor Doncaster
	Lynne Schuller - Public Governor Bassetlaw
	Lewis Swann - Member of the Public

Andy Tibbs – Member of the Public
Sheila Walsh - Public Governor Bassetlaw
John Williamson - Member of the Public

Apologies: Zoe Lintin, Chief People Officer

P22/07/A1   **Welcome, apologies for absence and declaration of interest (Verbal)**

The Chair of the Board welcomed everyone to the virtual Board of Directors meeting, including governors and members of public in attendance. A warm welcome was extended to George Briggs, Interim Chief Operating Officer and Non-executive Directors, Hazel Brand and Joanne (Jo) Gander who join their first Board meeting following their appointment.

The above apology for absence was noted and no declarations were made.

P22/07/A2   **Actions from Previous Meetings (Enclosure A2)**

Action 1 – Principles for 2022/2023

The Corporate Objectives would be received at agenda item F1 for approval, a Q1 update had been incorporated within the paper for information and assurance.

The Board:

- *Noted the update to the action log.*

P22/07/B1   **The Professional Nurse Advocate (PNA) Presentation (Enclosure B1)**

The Chair of the Board welcomed the Lead Professional Nurse Advocate (PNA) to the meeting, as one of the first PNAs to qualify, she commenced in post in January 2022, on a joint secondment with the University of Sheffield. Leadership and collaborative working were key areas of focus and the Lead PNA worked closely with the Trust's Maternity Professional Advocate, raising their profile regionally and nationally and sharing good practice, academic work and learning. A total of 13 PNAs had qualified since January, who undertake their substantive posts on a sessional basis.

The presentation provided an insight into the role of a PNA, it's contribution to the Trust's vision, progress of implementation and the impact and benefits of the sessions taking place. To fully achieve its aims the project was expected to take up to three years to implement, Health Education England funding for the PNA programme was currently available until 2024. Going forwards a range of options to adopt PNAs within the Trust were suggested, subject to costing.

In response to a question from Neil Rhodes, with regards to the benefits that would be seen from a Trust and patient perspective, the Lead PNA envisaged the structured support and compassionate leadership would drive a reduction in sickness absence and improve resilience, which would improve recruitment and retention opportunities and impact positively on the level of care.

Mark Day acknowledged the focus on ensuring the most appropriate deployment of PNAs,

as required by the new NHS standard contract, in response to what partnership work was taking place, the Lead PNA confirmed her role on the regional group and connections across the Integrated Care System.

Jo Gander welcomed the improvement opportunities afforded by the PNA role and enquired what metrics were in place to assess the impact on patient experience, the Lead PNA advised the focus was currently staff centric, but as the role developed, she expected the impact on the patient to be a programme outcome.

Kath Smart recognised the similarity to the supportive Stay & Thrive Matron post and enquired if support extended to other staff groups, such as Allied Health Professionals. The Lead PNA advised at present the remit did not extend to more specialised roles.

The Chair thanked the Lead Professional Nurse Advocate for the comprehensive update to Board.

The Board

- ***Noted the Professional Nurse Advocate Presentation***

P22/07/C1 **Board Assurance Framework – SA1 (Enclosure C1)**

The Board received an updated Board Assurance Framework (BAF) in respect of risks to the achievement of the Trust's strategic aim 1 – to provide outstanding care and improve patient experience. The BAF was considered in detail, in line with internal audit recommendations.

The Executive Medical Director highlighted an increase to the risk rating of SA1 Covid as a result of increased levels of infection within the community and hospital setting. Despite an increase in the number of patients with Covid, very few required critical care. The continuation of the Covid Medicines Delivery Unit was noted, and the expected NHSE/I updates to the Infection, Prevention Control Board Assurance Framework had not yet been received.

In respect of SA1, the Acting Chief Nurse informed Board of the introduction of a Quality Steering Group which would be responsible for oversight of a range of quality matters including Tendable, Datix, the Quality Strategy and the Patient Safety Incident Response Framework.

Development of the Urgent & Emergency Care improvement programme continued, and the peer review of patient safety and clinical governance was expected by the end of the month. Once received this would be reviewed and adapted into practice.

Kath Smart suggested outcomes from the Quality & Effectiveness Committee, in respect of safer staffing and the audit reports for Data Quality and Medicines Management should be included in the corrective actions. The process of sharing learning via Sharing How We Care should also be referenced in the framework. There was a need to include risk appetite within the BAF, as stated in the Stage 2 Head of Internal Audit Opinion.

In respect of SA1 (Covid 19), Kath Smart recognised that whilst infection rates were not directly within the Trust's control, those mitigating actions taken by the Trust should be captured in the corrective actions. The Chief Executive confirmed that as we moved into a

phase of learning to live with Covid and away from a declared major incident thought would need to be given to circumstances which may present a higher than expected level of infection, such as the World Cup 2022.

In response to a question from Jo Gander, the Executive Medical Director agreed to include narrative in respect of benchmarking of Getting It Right First Time and CQC Insights into the BAF. Kath Smart advised the Board that CQC insights would be considered as part of September's Quality & Effectiveness Committee agenda and Getting it Right First Time was included within the 2022/23 Internal Audit Plan. **TN**

Neil Rhodes recognised the challenge of delivering an elective recovery programme, whilst living with Covid, the Chief Executive acknowledged capacity was a key challenge, and there was a need to ensure a suitably staffed and experienced workforce to deliver a safe, sustainable, effective and efficient service. A need to explore all opportunities to innovate and transform service delivery, working at pace to drive forward a reduction in health inequalities.

The Board:

- ***Noted and took assurance from the Board Assurance Framework***

P22/07/C2   **Chief Nurse Update (Enclosure C2)**

The Chief Nurse Update provided information, outcomes, and assurance on the key deliverables for patient safety and experience and safe staffing numbers. The following highlights were brought to the Board's attention

- Following the introduction of a quality improvement initiative, Mallard Ward had experienced no serious harm falls within a two-year period.

- Place assessments would recommence in September 2022 and patient representatives would be secured to support the work across the divisions.

- The Tendable accreditation application (previously known as Perfect Ward) had gone live and ward and departments were able to undertake audits on handheld devices. Staff engagement sessions would ensure evaluation and feedback was acted upon.

In response to a question from Jo Gander relating to the complaints data, the Acting Chief Nurse confirmed that the two main categories of complaints related to communication and staff attitude. A review of complaint descriptors was underway and was expected to be implemented in September. A more in-depth review of customer complaints took place at the Quality & Effectiveness Committee.

In respect of the quality improvement work which had positively impacted falls on Mallard ward, the Acting Chief Nurse informed Mark Day that the initiative would be shared via the holistic care team. In response to the wider implementation of the Allocate SafeCare Model it was confirmed this was expected to take place in September.

In response to a question from Hazel Brand, the Acting Chief Nurse confirmed that all patients who come into hospital have a falls assessment and the level of risk was then

appropriately aligned to the level of care provided. The use of yellow socks and blankets was recognised as a good visual aid to raise awareness of those at risk of a fall.

Mark Bailey welcomed the implementation of Tendable and looked forward to receiving further detail as the roll out of audits was extended. Together with Nerve Centre the Acting Chief Nurse reinforced the richer evidence base available by technological solutions.

In view of the continued workforce challenges and recent press coverage of safe staffing levels Kath Smart requested the Acting Chief Nurse incorporate measures taken to mitigate the risks for the next meeting of the Quality & Effectiveness Committee in September.

The Board:

- *Noted and took assurance from the Chief Nurse Update.*

P22/07/C3 **Maternity Update (Enclosure C3)**

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 compliance in respect of the Clinical Negligence Scheme for Trusts (CNST) 10.

The Director of Midwifery confirmed, in line with the national picture, a number of stillbirths, potentially linked to Covid 19 had been reported during quarter one. Along with Public Health, the Trust continued to promote the vaccination programme and for those presenting with Covid an enhanced pathway was provided. In addition, and in view of an increased risk of stillbirths, smoking cessation support was provided as part of antenatal care.

Three of the Clinical Negligence Scheme for Trusts safety actions were reported to be at risk and a meeting with the board level safety champion had been arranged to review plans.

In respect of the reported caesarean section rate on the perinatal surveillance report, the Director of Midwifery confirmed this was no longer monitored but received for information only.

In response to a question from Mark Bailey, the Director of Midwifery confirmed that training requirements were carefully managed to ensure the provision of a safe, effective and efficient service, recognising the picture on ESR did not always reflect the role specific requirements.

The Chief Executive confirmed the capacity of the senior leadership team in maternity services was under review, to ensure an appropriate structure to provide inspirational leadership over the coming years.

The Board:

- *Noted and took assurance from the Maternity Update*

P22/07/C4   **Executive Medical Director Update(Enclosure C4)**

The Executive Medical Director Update reported a continuing downward trend in the Hospital Standardised Mortality Ratio (HSMR) of 103.78 in March, as compared to 107.84 in the previous month.

Significant progress was reported in respect of the job planning audit, with 14 of the 20 actions implemented and 78% of all job plans were now held in the Allocate central repository. Short term funding for administrative support had been sourced and the post recruited to. In order to strengthen job planning capacity a training package had been incorporated as part of the Leading to Outstanding Programme and job planning sessions, led by the Medical Director for Workforce, had taken place with a further session planned in September with external facilitation.

The monthly Medical Advisory Committee continued its development. A planning committee had been established to develop a 12 month programme which would include external speakers, including GPs, to provide a positive engagement opportunity between primary and secondary care, and in addition recently appointed consultants would reflect on their experience of joining DBTH. Executive and non-executive colleagues were welcome to observe or contribute to the agenda.

At the end of quarter one, the 12 month rolling position indicated 77% of appraisals had been completed, the national measure would be reported as at 31 March and based on current completion rates was expected to be approximately 96%.

By way of an update to the report, the Executive Medical Director confirmed the appointment to the joint Public Health consultant post with Rotherham Doncaster & South Humber NHS FT; the successful candidate was expected to start in October 2022.

Neil Rhodes acknowledged the improved job planning position and welcomed this being embedded into business as usual, which signified a positive cultural shift. The Executive Medical Director identified there were a number of matters to be addressed due to service redesign which would require individual and team job planning to be assessed but expected all of the work to be completed by December 2022.

Kath Smart confirmed a detailed update had been provided to the Audit & Risk Committee earlier in the month and the Committee were appropriately assured on progress and plans going forwards. The Executive Medical Director had agreed to return to the October meeting of the Audit & Risk Committee to provide a further update.

In respect of the approach to addressing health inequalities and the Trusts duty to collaborate, the Trust would be working closely at place via the Public Health consultant, the Chief Executive confirmed emergency department performance and elective waits represented two areas of inequality and the Trust's ambition was to move this and diagnostic recovery to at least the NHS England average. In order to be safe, sustainable, effective and efficient there would be a need to move away from transactional process into transformational change.

The Board:

- *Noted and took assurance from the Executive Medical Director Update.*

P22/07/D1   **Board Assurance Framework – SA2 & 3 (Enclosure D1)**

The Board received an updated Board Assurance Framework, which included risks to the achievement of the Trust's strategic aim 2 – everybody knows their role in achieving the vision and strategic aim 3 - feedback from staff and learning in top 10% in UK.

The Deputy Director of People & Organisational Development shared the updates to the Board Assurance Framework for SA2, highlighted for ease of reference. The appraisal season was currently mid-cycle and completion of meaningful appraisals was considered as part of the Performance, Overview and Support meetings. As a top-down pyramid approach had been taken an increase in the percentage completed was expected in the latter part of the season.

Actions arising from the staff survey were also a focus of discussion at the Performance, Overview and Support meetings, to ensure outputs and action plans were in place and where required support was available and successes celebrated.

In respect of the numbers of colleagues accessing the leadership development programme, it was noted this was reflective of the staffing challenges due to vacancies and sickness absence levels.

The Board Assurance Framework for SA3 identified the positive impact of the Freedom to Speak Up champions, which had seen good levels of engagement and the provision of training and support.

The RACE Code audit had now been completed and would be progressed through the Board sub-committees.

A downward trend was reported for sickness absence, the current absence rate stood at 7.39%, 1.89% of which related to Covid. In terms of reasons for absence, musculo skeletal and stress/anxiety continued to report the highest levels. An improvement to the occupational health referral process to facilitate e-referrals and a fast-track option was hoped to positively impact on long term absence levels.

No comments or questions were received.

The Board:

- *Noted and took assurance from the Board Assurance Framework*

P22/07/D2   **People Update (Enclosure D2)**

The Board received the People Update, the content of which was summarised by the Deputy Director of People & Organisational Development.

Planning in respect of the 2022 staff survey had commenced to ensure that immediately the embargo was lifted in Spring 2023 active communication and engagement could begin. Efforts would be focused on celebrating success and understanding and responding to

those areas which required improvement. Where common themes were identified trust wide initiatives would take place.

In respect of the findings of the Messenger Review, many of the recommendations would be progressed as a national programme of work, to ensure consistency of standards with oversight arrangements yet to be confirmed. The Chief People Officer would be actively engaged through regional and national networks, consideration would be given to potential national changes and alignment to national resources when developing our approach to leadership and culture at the Trust.

Recommendations included: a simplified, national standard appraisal process, a new career and talent management function and effective recruitment & development of non-executive directors. Recognition of the difference first class leadership could make to both the staff and patient experience was noted, as well as the need to strengthen the culture of collaboration.

Following the government's decision to withdraw the national terms and conditions relating to Covid 19 sick pay, the People & Organisational Development team had been preparing for the change, ensuring clarity in communications and supporting colleagues with the impact of the change.

Mark Day welcomed the update and the work in progressing this. In response to his request for non-executive directors to be involved in the Reciprocal Mentoring Programme, the Deputy Director of People & Organisational Development confirmed this would be considered as part of the planning of the second cohort.

The Chief Executive acknowledged the learning from cohort one of the Reciprocal Mentoring Programme and the importance of senior management and board level representation in line with its community. The Chair of the Board highlighted the efforts taken to achieve an appropriately balanced board which had not translated to the required outcomes and in due course there may be a need to consider the reintroduction of an associate non-executive director programme. Kath Smart shared an example of a community-based recruitment approach, the benefits of which were recognised either at place or system level.

The Board:

- ***Noted and took assurance from the People Update.***

P22/07/E1   **Board Assurance Framework – SA4 (Enclosure E1)**

The Board received an updated Board Assurance Framework (BAF) which identified risks to the achievement of the Trust's strategic aim 4 – in recurrent surplus to invest in improving patient care.

The Acting Director of Finance summarised the changes to the BAF, highlighted for ease of reference, which reflected the revised deficit financial plan of £10m, the impact of inflationary pressures on capital projects, increasing utility costs and high temporary staffing spend. Delivery of the 4% CIP target would be challenging, elective performance standards which assumed elective recovery would be delivered was likely to be impacted by higher than planned Covid levels. The overall risk score remained at 16.

Action: In respect of the recently announced pay award, work would be undertaken to establish the costs and likely impact on the Trust's financial position once the funding had been established.

Finally, in respect of corrective actions, the Acting Director of Finance confirmed all audit recommendations had been implemented within the agreed deadline.

No comments or questions were received.

The Board:

> - *Noted and took assurance from the Board Assurance Framework*

P22/07/E2   Finance Update (Enclosure E2)

The Acting Director of Finance's report provided a high-level overview of the month three position. A deficit of £1.5m was reported, in line with plan, with a year-to-date position of £4.3m, £1.1m adverse to plan, this was largely driven by a pay overspend and operational pressures, including vacancy levels.

Agency spend remained high with an in month spend of £1.8m, an increase had been seen from the previous month and compared to pre-pandemic levels was approximately double. A single item agenda meeting of the Finance & Performance Committee would consider the background to this, mitigating actions and next steps.

Where a need for enhanced support had been identified, additional support meetings had been established, chaired by the Acting Director of Finance. These were in place for the Division of Medicine and Children & Families.

In respect of capital, an in month spend of £759K was reported against a plan of £2,802k; the year to date position was £2,114k against the £4,601K plan. Cases for both estates and IT were progressing through the Corporate Investment Group, business case dates and deadlines for submissions had been shared in respect of medical equipment requests. The memorandum of understanding for the preliminary Reinforced Autoclaved Aerated Concrete (RAAC) work had been signed off by Board and funding was expected this month.

The cash balance at the end of June 2022 was £27.7m, an increase of £1.1m from month two.

The year-to-date CIP target was broadly on plan, an update was provided at this month's Finance & Performance Committee, where colleagues were adequately assured of the reporting and planning and a further update would be provided by the Efficiency Director at the September meeting.

Having considered the report and from discussions at the Finance & Performance Committee Neil Rhodes confirmed he was content with the capital and cash position. In respect of nursing agency spend, he acknowledged this was a cause for concern and would be considered at the extraordinary meeting on 12 August.

In response to a question from the Chair of the Board in respect of savings linked to reducing the length of stay, the Chief Executive acknowledged the increasing number of patients who were medically fit for discharge who had no care package within the community. This impacted upon the Trust's ability to deliver services and increased accommodation and staffing costs. The solution was a place and system matter and not solely under the control of the Trust.

In view of the current position and the plans being formulated by divisions, Hazel Brand asked if delivery of the plan was expected. The Acting Director of Finance noted the risk around the unidentified gap but reflected positively on the engagement and rigour in monitoring and oversight of the plans and welcomed the return of financial grip.

The Board:

- *Noted and took assurance from the Finance Update.*

P22/07/E3   **The Premises Assurance Model Assessment Report 2021/22 (Enclosure E3)**

The Board received the Premises Assurance Model Assessment Report 2021/22 , a national assurance tool to report on those regulatory and statutory requirements linked to the Trust's estate and its related services, against five mandated domains.

The intention of the report was to provide assurance that appropriate systems and processes were in place to mitigate the risks associated with non-compliant infrastructure and major systems.

In response to a question from Kath Smart, the Acting Deputy Director of Estates & Facilities confirmed that the element rated as inadequate in *figure 1: Overall Summary Position of Self-Assessment Question Scores,* related to the lack of a policy/procedure in respect of air pollution, this was being addressed via one of the supporting workstreams for the Green Plan.

In response to a question from Mark Day, with regards to the cost consequences associated with the requirement to achieve planned preventative maintenance, the Acting Deputy Director of Estates & Facilities confirmed the Premises Assurance Model Assessment required a costed action plan to achieve a good rating which could be based on an estimate or quotation and as such this was a value, rather than a commitment to spend.

Board noted the information contained within the report and approved the submission of the report.

The Board:

- *Approved the Premises Assurance Model Assessment Report 2021/22*

P22/07/E4   **Operational Update – Looking Forward (Enclosure E4)**

The Interim Chief Operating Officer's Operational Update noted increasing Covid levels through June, plans for a continued presence of the virus and a revised focus going forwards on living with Covid was noted. Despite increasing numbers, there continued to be a limited need for those requiring critical care support; a current focus of the Critical

Care Unit was on the timely discharge of patients no longer requiring intensive care to more appropriate facilities.

Attendances in the Emergency Department, both by ambulance and walk-ins continued to be high, due to high bed occupancy flow out of the department was challenging. A number of improvement initiatives to support activity were in place.

In respect of elective recovery, further improvement was required, and a refreshed plan would be developed.

Discussions with regards to winter planning had taken place with the Executive Medical Director and a briefing session for clinicians would be scheduled.

Neil Rhodes invited the Interim Chief Operating Officer to share his thoughts on elective recovery and looked forward to subsequent discussions at the Finance & Performance Committee. A need for an innovative approach across the divisions was required. The Interim Chief Operating Officer reflected on the current situation and acknowledged a change in what had worked well pre to post pandemic. Whilst regional performance was on plan, locally and nationally there remained continued challenges. There were a number of key areas of focus , including a sustainable reduction in outpatient numbers, to increase patient initiated follow up appointments and the reintroduction of weekly patient tracking list meeting. Alongside this, the Trust needed to work closely with the independent sector, with a marked improvement in elective recovery required from September /October.

The Chief Executive acknowledged that the challenge to recover had been much greater than expected. A clear focus on fit for purpose plans to drive recovery was required, including use of the independent sector. There was a need to work though issues including the use of theatres and outpatient delivery, in order to move towards at least the average national position, higher if possible.

The Interim Director of Recovery, Innovation & Transformation advised that elective recovery funding had been confirmed for the first half of the year. In order to support the Division of Surgery & Cancer enhanced support would be provided to develop recovery at pace.

In order to achieve a reduced length of stay across all three sites extensive support from partners would be required, to ensure care package availability. The situation would be reviewed on at least a fortnightly, possibly weekly basis.

The Board:

- *Noted and took assurance from the Operational Update – Looking Forward*

P22/07/E5   **Performance Update (Enclosure E5)**

The Board received the Interim Chief Operating Officer's Performance Update which provided performance headlines from June 2022, operational context and next steps. Supporting performance appendices were included at H3 for information/review.

The Board:

- *Noted and took assurance from the Performance Update.*

P22/07/E6   **Ambulance Handover Delays (Enclosure E6)**

The Board received the Interim Chief Operating Officer's mandated monthly report on ambulance handovers.

It was reported that Yorkshire Ambulance Services NHS FT would cohort patients to allow ambulances to leave the hospital site and return to the community. A review of processes to facilitate timely movement out of the emergency department was in train and included the use and location of the Same Day Emergency Care Centre, the introduction of an early senior assessment, extended opening hours of the discharge lounge and a review of the structure and function of the operational site team to ensure a more timely cascade of information.

The Chair of the Board thanked the Interim Chief Operating Officer for his knowledge and insight.

In response to a question from Mark Bailey with regards to working with neighbouring trusts, the Interim Chief Operating Office shared daily interactions with fellow Chief Operating Officer across both NHS South Yorkshire and Nottingham and Nottinghamshire to establish more effective ways of working, ensuring that Bassetlaw was firmly embedded into the new system. National pressures relating to ambulance handovers and waits would continue to remain a focus.

The Chief Executive considered the three-tiered approach, from a Trust perspective remaining committed to tackling internal issues with enthusiasm, supported by inspirational management and delivery of appropriate resource. To facilitate, at Place, the most appropriate admission and discharge opportunities and across the system to ensure appropriate conveyance and a focus on partners delivering their responsibilities.

In response to a question from Neil Rhodes regarding waits in the emergency department for doctors, the Interim Chief Operating recognised the challenged staffing position due to vacancies and rota gaps, arising from a reduced ability to fill gaps via additional sessions. Plans to address this would include development of middle grade doctors, through speciality training and consideration of a change to the consultants working pattern, to include cover beyond midnight.

The Board:

- *Noted and took assurance from the Ambulance Handover Delays Report*

P22/07/F1   **2022/2023 True North, Breakthrough & Corporate Objectives, including Q1 Update (Enclosure F1)**

Following consideration at the relevant sub committees of Board, the corporate objectives were received by Board for final approval, along with a quarter one update.

Performance against the objectives would be monitored throughout the year and reported to Board on a quarterly basis.

In response to a question from Kath Smart in respect of the Executive Medical Director's objective *"Following the completion of the reviews of Corporate, Divisional and*

Directorate Governance arrangements embed the clinical governance and risk management process changes" it was confirmed that the risk management element would be considered by the Executive Team and the Audit & Risk Committee.

The Board noted the quarter one update and confirmed their approval of the corporate objectives.

The Board

- ***Approved the 2021/2022 Corporate Objective Outcome***

P22/07/F2   **Research Strategy (Enclosure F2)**

The Chair of the Board welcomed the Deputy Director of Education & Research and Jane Fearnside, Research Fellow to the meeting.

In 2017 the Trust secured Teaching Hospital status and held a clear commitment to deliver a quality, patient centred research programme, communicated in its Research & Development Strategy 2017-2022.

In order to continue to drive forward its commitment, a new Education & Research Directorate was established in 2020 and in 2021 a Teaching Hospital Board was formed to work closely with the Trust's strategic partners in order to grow capacity and capability.

Recognising the key drivers for research and innovation, the areas of greatest need were identified, with a focus on reducing the widening health inequalities gap. A whole life, whole system approach would be followed, around starting well, living well and ageing well.

Currently research studies were led by other organisation with the Trust working in partnership and as such were not driven by the Trust's strategic priorities. The Trust would work closely with its place partners and academic partners to ensure the research strategy would be closely aligned to the other Trust strategies.

Consultation with the public and stakeholders would take place in September/October, with the strategy developed ready for sign off at the Quality & Effectiveness Committee in December 2022.

A summary of the challenges and a review of the current strategic focus and strengths of the Trust and our academic partners, the University of Sheffield and Sheffield Hallam University were mapped out in respect of starting, living and ageing well.

Kath Smart welcomed the ambitious plans and provided feedback from consultant interviews of the interest expressed in participating in research and enquired how the specialities and divisions were engaged in research matters to strengthen the trust's position as an employer of choice. The Deputy Director of Research and Education confirmed the close links with the Trust's academic partners and internally via the Clinical Directors and Senior Nursing Teams. Whilst research was not remunerated in the same way as other professional activities, the Divisional Directors and Clinical Directors were supportive and offered the flexibility to allow colleagues involvement .

Mark Bailey recognised the positive impact of education and research in the provision of safer patient care and commended the collaborative work of the education and research colleagues and academic partners. A timeline of actions over the remainder of the year would be helpful when communicating further with the Teaching Hospital Board or via other Board sub committees.

The Board

- ***Noted the Research Strategy***

P22/07/F3   <u>**Bassetlaw Emergency Village Outline Business Case**</u> *(Enclosure F3)*

The Director of Innovation & Infrastructure, supported by consultants from Archus, were welcomed to the meeting to present the Bassetlaw Emergency Village Outline Business Case (OBC). The Finance & Performance Committee had scrutinised the OBC last week and had commended the business case to Board for approval.

The purpose of the Bassetlaw Emergency Village (BEV) project was to deliver a modern, fit-for-purpose emergency care facility at Bassetlaw Hospital, which delivered the paediatric model which had been subject to public consultation and an appropriately sized emergency department.

The project had involved an extensive programme of work to determine appropriate plans, based on activity, demand and capacity and input from clinical engagement sessions. An options appraisal identified four possible approaches: business as usual, do minimum, preferred way forward and a more ambitious way forward. Funding of £17.6m had been secured and considering the financial envelope the assessment and treatment centre and the fracture clinic work would not be incorporated into this business plan.

An economic appraisal had identified the preferred way forward as the best value for money. The cost of £17.98m would be largely covered by the funding and work to address the gap, through other schemes, or value engineering were being considered. The plan was affordable over the long term due to cash releasing benefits but was dependent upon the development of a workforce model to support this.

In terms of next steps and due to a change in leadership, there was a need to identify a clinical lead for the project, approval was sought for submission of the OBC to NHSE/I, which would be considered at its October Board meeting. Subject to its approval this would then proceed to full business case, the deadline for the funding to be spent was within the 2023/24 financial year.

In respect of the timetable contained in section 11 – Project Programme, the Chief Executive requested clarity on the dates assigned to stage 4 of the enabling/construction works which was prior to the approval of the full business case . The Interim Director of Recovery, Innovation & Transformation confirmed this would take place only via the support of a memorandum of understanding.

Hazel Brand welcomed the counselling and mental health facilities and in response to a question with regards to the needs to relocate services whilst the enabling work was underway the Director of Innovation & Infrastructure confirmed this was not required, although the reprovision of parking would need to be considered.

The Chair of the Board recognised the significant improvement to delivery of services at Bassetlaw and sought Board's approval for submission of the OBC, which received unanimous support.

Presenting colleagues were thanked for the work to date on the project, including today's presentation.

The Board

- *Approved the Bassetlaw Emergency Village Outline Business Case*

P22/07/G1 **Corporate Risk Register (Enclosure G1)**

The Board received the Corporate Risk Register and supporting paper.

No new corporate risks, rated 15+ had been added to the register. The change to the rating of risk ID2472 – Covid had been increased from 15 to 20 due to increasing infection levels.

The independent review of the risk management system was reported within the action required and progress against the report recommendations would be monitored via software solution, Monday.com.

The key enabler for the implementation of the report recommendations would be the newly created Risk Management Board, to be chaired by the Executive Medical Director. The Terms of Reference for the board had been agreed by the Trust Executive Group.

In response to a question from Kath Smart with regards to when the impact would be seen on the Corporate Risk Register, the Company Secretary recognised the importance of this piece of work and the potential impact on the Head of Internal Audit Opinion, the terms of reference of the Risk Board had been agreed and the policy was in the process of being updated. The Executive Medical Director confirmed that a schedule of meeting dates would be discussed with the executive directors this week, with a view to starting in September and on a monthly basis thereafter. The work to assess the risk and mitigating actions could then commence, it was difficult to provide a completion date at this point until the scale of the task was known.

The Chair requested that an update be provided at the next board meeting to provide a timeline for the revised policy and plan of work. **TN**

The Board:

- *Noted the Corporate Risk Register.*

P22/07/G2 **Trust Annual Report & Accounts 2021/22, including Annual Governance Statement Quality Accounts 2021/22 (Enclosure G2)**

The Annual Report & Accounts 2021/22 had been approved by the Audit & Risk Committee with delegated authority from the Board and were received today for completeness.

A final copy would be presented at the Trust's Annual Members Meeting on 29 September 2022.

The Board

- Noted the Trust Annual Report & Accounts 2021/22, including Annual Governance Statement & Quality Accounts 2021/22

P22/07/G3 <u>**Standing Financial Instructions, Standing Orders and Scheme of Delegation (Enclosure G3)**</u>
The Board received the above policy documents for approval, which had been updated in line with best practice and previously considered by the Audit & Risk Committee.

The minor adjustments were highlighted within the report summary, in addition the introduction of new lease accounting standards was included within the Capital section and the procurement tendering limits updated, following harmonisation across the ICS.

In respect of 3.4 (b) and (c) of the Standing Orders, the Acting Director of Finance highlighted a correction that should read 7 non-executive directors and 7 executive directors respectively.

As the draft addendum had not yet been finalised following consultation by NHSE/I, the Company Secretary confirmed further updates would be required in due course.

Subject to the above change, the Board approved the Standing Financial Instructions, Standing Orders and Scheme of Delegation.

The Board

- ***Approved the Standing Financial Instructions, Standing Orders and Scheme of Delegation***

P22/07/G4 <u>**Audit & Risk Committee Annual Report (G4)**</u>

The Audit & Risk Committee Annual Report was received for information, the Committee Chair brought the following highlights to the Board's attention:

External Auditors, Ernst & Young provided a clean opinion on the 2021/2022 accounts, recommendations contained within the ISA 260 progress would be reviewed in October 2022.

The Head of Internal Audit Opinion for 2021/2022 provided moderate assurance, which related to improvements required to strategic risk management and the follow up of audit actions.

The Chair of the Board thanked Kath Smart for her work as Chair of the Audit & Risk Committee.

The Board

- *Noted and took assurance from the Audit & Risk Committee Annual Report*

P22/07/H1 **Information Items (Enclosure H1 – H7)**

The Board noted:

- H1 Chair and NEDs Report
- H2 Chief Executives Report
- H3 Performance Update Appendices
- H4 Minutes of the Finance and Performance Committee 25 April & 26 May 2022
- H5 Minutes of the People Committee 3 May 2022
- H6 Minutes of the Audit & Risk Committee 19 April & 27 May 2022
- H7 Minutes of the Trust Executive Group 14 March, 9 May & 13 June 2022
- H8 South Yorkshire & Bassetlaw Acute Federation Annal Report 2021/22

P22/07/I1 **Minutes of the meeting held on 26 April 2022 (Enclosure I1)**

The Board:

- *Approved the minutes of the meeting held on 28 June 2022.*

P22/07/I2 **Any other business (to be agreed with the Chair prior to the meeting)**

No items of other business were raised.

P22/07/I3 **Governor Questions regarding the business of the meeting (10 minutes) ***

The Lead Governor shared governors' congratulations with colleagues on Mallard Ward for achieving no serious harm falls within the last two years.

The following questions were shared on behalf of the governors:

What resource provision is readily available in terms of addressing communication difficulties between staff and patients. How many staff have accessed training in British Sign Language and Makaton and how do we assess a person's need, accessing suitable communication?

The Director of Communications and Engagement confirmed that the Deputy Director of Nursing (Patient Experience) had sourced an opportunity for patient facing colleagues to enrol on a British Sign Language workshop, 80 staff were currently registered with further spaces available. The Trust was also working closely with Doncaster Deaf Trust to understand further challenges around service provision.

In addition, the Acting Deputy Chief Nurse has developed a network of learning disability ambassadors, approximately 300 colleagues strong, the ambassadors act as advocates for patients with disabilities and their carers. Plans to raise awareness of support for patients with learning disabilities, via Oliver's Campaign was planned for the coming weeks.

In relation to the Professional Nurse Associate presentation, 80% of colleagues surveyed felt that the initiative improved staff well-being. **Do we explore the reasoning behind the 20% not feeling supported?**

As the Professional Nurse Advocate role develops and more learning can be shared it was agreed to run a briefing and development session for the governors to have an opportunity to understand more about the role and its impact.

The presentation on the research strategy, identified plans to hold public and stakeholder consultations, would this be across place and could the consultation be widened?

Stakeholder engagement would take place in the widest context, including the general public, academic partners and potentially Healthwatch. As the Deputy Director of Education and Research was no longer on the call should governors wish to receive further information a governor briefing and development session could be arranged.

The Lead Governor reflected on the recent governor workshop in which the draft addendum was considered and in view of the revision in respect of governors holding non-executives to account for the board's duty to collaborate, it was helpful for governor observers to observe board members identifying collaboration at place and system level.

The Chair of the Board shared her appreciation for the continued governor contribution and engagement and thanked those in attendance today for the reports and input.

The Board:

- *Noted the governor observations, question and feedback provided.*

P22/07/I4   **Date and time of next meeting (Verbal)**

         Date: Tuesday 27 September 2022
         Time: 09:30am
         Venue: MS Teams

P22/07/I5   **Withdrawal of Press and Public (Verbal)**

The Board:
- *Resolved that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.*

P22/07/J   **Close of meeting (Verbal)**

The meeting closed at 13.47