Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting Held in Public
To be held on Tuesday 25 October 2022 at 09:30
Via MS Teams

Enc		Purpose	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*		5
A2	Actions from previous meeting *Suzy Brain England OBE, Chair*	*Review*	
B	**True North SA1 - QUALITY AND EFFECTIVENESS**		**09:35**
B1	Maternity Update *Lois Mellor, Director of Midwifery*	*Assurance*	15
B2	Learning from Prevention of Future Deaths Report Response ***(verbal)*** *Richard Parker OBE, Chief Executive*	*Note*	10
C	**True North SA4 – FINANCE & PERFORMANCE**		**10:00**
C1	Ambulance Handovers *George Briggs, Interim Chief Operating Officer*	*Assurance*	15
D	**STRATEGY**		**10:15**
D1	Q2 2022-23 Update Corporate Director Objectives *Richard Parker OBE, Chief Executive*	*Assurance*	10
E	**GOVERNANCE**		**10:25**
E1	Annual Emergency Preparedness, Resilience and Response Core Standards Compliance *George Briggs, Interim Chief Operating Officer*	*Approval*	10

F	**OTHER ITEMS**		**10:35**
F1	Any other business (to be agreed with the Chair prior to the meeting) *Suzy Brain England OBE, Chair*	*Discussion*	
F2	Governor questions regarding the business of the meeting (10 minutes)* *Suzy Brain England OBE, Chair*	*Discussion*	10
F3	Minutes of the meeting held on 27 September 2022 Suzy Brain England OBE, Chair	*Approval*	5
F4	**Date and time of next meeting:** **Date:** Tuesday 29 November 2022 **Time:** 09:30 **Venue:** MS Teams	*Information*	
G	**MEETING CLOSE**		**10:50**

***Governor Questions**

The Board of Directors meetings are held in public but they are not 'public meetings' and, as such the meetings, will be conducted strictly in line with the above agenda.

For Governors in attendance, the agenda provides the opportunity for questions to be received at an appointed time. Due to the anticipated number of governors attending the virtual meeting, Lynne Schuller, 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 by 5pm the day before 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

Action notes prepared by: Angela O'Mara
Updated: 27 September 2022

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Action Log

Meeting:	Public Board of Directors
Date of latest meeting:	27 September 2022

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

No.	Minute No.	Action	Lead	Target Date	Update
1.	**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**	**27.9.2022** - updated Board Assurance Framework @ C1 – **action to close.**
2.	**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**	**27.9.2022** - included within E2 – Finance Update – **action to close**
3.	**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**~~ **November 2022**	**27.9.2022 –** Risk Management Board stood down on 19.9.2022 due to national bank holiday for the Queen's funeral. Next meeting due 17.10.2022 – Executive Medical Director to provide an update at November's full board meeting

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Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	25 October 2022	**Agenda Reference:**	**B1**		
Report Title:	**Maternity Update**				
Sponsor:	Richard Parker, Chief Executive				
Author:	Lois Mellor, Director of Midwifery				
Appendices:	Perinatal Surveillance Dashboard				

Report Summary	
Purpose of report:	To update the Board of Directors on performance, key issues, and developments in Maternity Service
Summary of key issues/positive highlights:	• Update on current Perinatal Mortality Review Tool (PMRT) reviews for the month and quarter 4 findings • Current Healthcare Safety Investigation Branch (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 Clinical Negligence Scheme for Trusts (CNST) standards recommenced 7 May 2022
Recommendation:	Board to note the content of the report and supporting dashboard.

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:	SA1 – To provide outstanding care & improve patient experience
Corporate risk register:	Risk ID6,16,1412
Regulation:	CQC – Safe Care and Treatment and Patient Centred Care.
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:	All parts of this report have been discussed at all levels in the Children & Families Division.		
Date:		**Decision:**	

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

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Monthly Board Report

September 2022

Additional information in support of this report is provided 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

The latest Mothers and Babies; Reducing Risk through Audits and Confidential Enquiries (MBRRACE) Report for births 2019 gives a national stillbirth rate of 3.35 per 1000, a decrease from the 3.51 figure for 2018 births. This figure is calculated from births at 24 weeks or over, excluding terminations of pregnancy.

The Trust stillbirth rate for 2021 **from 24 weeks** of pregnancy onwards across both sites for this period are 16 which equates to 3.54 per 1,000. This figure is adjusted and reduced to 13 when termination of pregnancies (TOP) over 24 weeks are excluded (3), making the adjusted rate 2.88 per 1,000.

During this same period from **22 weeks of pregnancy to full term** there were: 13 stillbirths and 6 late fetal losses, 4 terminations of pregnancy above 22 weeks of gestation, and 2 stillbirths which occurred out of area (non-hospitalised transfer). The adjusted annual stillbirth rate is 4.20 per 1000 births in 2021.

The annual statistic is recorded to the end of each quarterly report to identify any rising trends in a timely manner, however this is the crude, and not adjusted and stabilised figure.

During the second quarter from 1st July 2022 to 30th August 2022 there have been **7** stillbirths, excluding 2 Medical TOP.

There have been **0** late miscarriages between 22+0-23+6 during this quarter, excluding 2 MTOP.

There has been a total of **7** stillbirths from 24 weeks during this quarter. Of the total number of stillbirths above 24 weeks gestation, **5** have been above 37 weeks of pregnancy. This does include 3 in one day on the 18th August 2022.

This provides a trust adjusted stillbirth rate of **5.49** per 1000 births from 24 weeks gestation.

This provides a combined quarter 1 and 2 adjusted stillbirth rate of **5.24** per 1000 births from 24 weeks of gestation. This equates to **13** stillbirths above 24 weeks gestation and **1** late miscarriage between 22+0 - 23+6 weeks gestation since the 1st April 2022.

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1.2 Neonatal Deaths

No update available.

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 is sequenced as part of the refurbishment of level 3, creating a bereavement suite.

An initial pilot showed nearly all of the trusts reported a significant decrease in stillbirth rates whist the wallets were in use. Midwives noticed that women regularly read the information printed on their wallet whilst waiting for appointments and they made women act on concerns rather than ignore them, citing three cases where, acting on the information had undoubtedly saved babies lives. From September pregnant women are now being given the MAMA academy wallet

As a result of the rise in stillbirth rates which have been reported in quarterly stillbirth rates, and may be related to Covid 19 the service has begun to liaise with our area's specialised perinatal pathologists to see if there are any links from a pathological viewpoint

There is also analysis being undertaken regionally as this trend has been seen across the region.

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	2 ↓ 1
Exception reporting	0

2.1 Reports Received since last report

HSIB case number: MI-006325
HSIB criteria: HIE/ Cooling
Trust site: Doncaster
Incident date: 25.01.22
Referral date: 28.01.22

Safety Recommendation
To ensure that the process for sending placentas for histology is embedded.

2.2 Current investigations

HSIB case number: MI-009360
HSIB criteria: HIE/ Cooling
Trust site: Doncaster
Incident date: 11.05.22
Referral date: 18.05.22

Three staff meetings undertaken
Further staff meetings required
SMART 2 meeting on 12 October 2022

HSIB case number: MI-010419
HSIB criteria: Stillbirth
Trust site: Doncaster
Incident date: 10.06.22
Referral date: 21.06.22

On staff meeting outstanding
SMART 2 arranged for 20 October 2022

3. Serious Incident Investigations (Internal)

No new incidents.

4. Training Compliance

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

CTG Study Day

- The training 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 Cognitive Abilities Test (CAT) at the end of this study day.
- 90% of all staff have to have attended the fetal monitoring study day by the 5th January 2023. Including the numbers that have attended and booked to attend, the trajectory up to the end of September 2022 will be :

Consultants	84.6% ↓
Doctors	81% (not currently inc GP trainees. Plan in place). ↑
Midwives	77.1% (including all NQM's starting Oct 22). ↑

In mitigation the K2 CTG compliance (online) training compliance is good.

The current training position is:

MDT Role	Number	Number Compliant	K2 CTG Compliance	Number of Staff Undertaken Fetal Monitoring Study Day	Study Day Compliance
Consultants	13	9	**69.2%**	9	**69.2%**
Doctors	21	4	**19.0%**	6	**28.6%**
Midwives	210	164	**78.1%**	125	**59.5%**
NHSP Midwives	20	12	**60.0%**	6	**30.0%**
Divisional	**264**	**189**	**71.6%**	**146**	**55.3%**

Which has improved from 42.1 % last month

Practical Obstetric Multi Professional Training (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.

MDT Role	Number	Number Compliant	Prompt Compliance
Consultants	13	5	**38.5%**
Doctors	20	12	**60.0%**
Midwives	194	123	**63.4%**
NHSP Midwives	18	4	**22.2%**
Support Workers	76	17	**22.4%**
Theatre Staff	82	34	**41.5%**
Anaesthetists	32	8	**25.0%**
Divisional	**435**	**203**	**46.7%**

Training was paused over the summer and recommenced on 1st 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 hospitals training will be accepted if this has been completed within the last rolling year.

5. Service User Feedback

The Maternity Voices Partnership (MVP) are due to meet on 26 October 2022, and the Director of Midwifery will attend a face-to-face meeting at the request of the members.

The MVP work plan has been agreed between the two Integrated Care Boards (ICB), and the Director of Midwifery. This will be monitored through the MVP meetings and the LMNS.

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

Work towards Year 4 CNST standards is ongoing.

A project manager has been recruited to assist the service with collating the evidence.
A review of safety actions 3 and 5 has been undertaken by 360 and feedback is expected in late October.

Currently compliance with two standards remains a risk:
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 Maternity 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 three building blocks described in the letter from Ruth May in September 2022 are in place:

- Adequate midwifery staffing
- Education and training
- Engagement of staff

10. Board Level Safety Champion staff feedback from walkabout

Until the new Chief Nurse commences in post a new board level safety champion will be identified.

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)

	MW to birth ratio : BR+ recommendation 1::28.25	Vacancy rate (MW)	LW co-ordinator supernumerary (%)
July	1:31.4		< 100%
Aug	1:30.6		<100%
Sept	1:29.9	15%	<100%

Maternity unit DBTH – Doncaster

KPI (see slide 4)	Measurement / Target		Doncaster Rate		
			July	Aug	Sept
Caesarean Section rate	Elective	**<13.2 %**	14.4%	18.3%	17.8%
	Emergency	<15.2 %	27.8%	27.8%	24.2%
Preterm birth rate	≤26+6 weeks	0	0.4%	0.3%	0.4%
	≤36+6 weeks	**<6%**	9.1%	10%	7.81%
Massive Obstetric Haemorrhage	**≥1.5l**	<2.9%	2.7%	2.8%	5.6%
Term admissions to NICU		<6%	3%	3.38%	4.04%
3rd & 4th degree tear	SVD (unassist'd)	<2.8%	1.5%	1.8%	2.9%
	Instrumental (assisted)	<6.05 %	0%	8.3%	8.6%
Right place of birth		95%	99.6%	99.7%	99.6%
Smoking at time of delivery		<11%	14.2%	9.6%	12.1%
Percentage of women placed on CoC pathway			0%	0%	0%
Percentage of women on CoC pathway: BAME / areas of deprivation	**BAME**		0%	0%	0%
	Area of deprivation		0%	0%	0%

Month/Quarter		Red flag alert	Open > 30 days	Unactioned Datix	Maternity Serious Incidents	Maternity Never Events	HSIB cases	Still Births (All / Term / Intrapartum)			HIE cases (2 or3)	Neonatal Deaths Early	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**	**0**
	Aug	0	**76**	**0**	**1**	**0**	**2**	**2**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	Sept	43	**83**	**0**	**0**	**0**	**0**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	Q2															

Maternity Red Flags (NICE 2015)

		July	Aug	Sept
1	Delay in commencing/continuing IOL process	43	26	41
2	Delay in elective work	1	0	0
3	Unable to give 1-1 care in labour	1	0	2
4	Missed/delayed care for > 60 minutes	3	0	0
5	Delay of 30 minutes or more between presentation and triage (LWAU)	0	0	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 1::28.25	Vacancy rate (MW)	LW co-ordinator supernumerary (%)
Apr			
May			
June			

KPI (see slide 4)3.9%	Measurement / Target		Bassetlaw Rate		
			July	Aug	Sept
Caesarean Section rate	Elective	<13.2 %	10.1%	8.1%	8.4%
	Emergency	<16.9 %	37%	30.4%	30.1%
Preterm birth rate	≤26+6 weeks	0	0	0	0
	≤36+6 weeks	<6%	8.4%	7.1%	9.79%
Massive Obstetric Haemorrhage	≥1.5l	<2.9%	4.20%	3.7%	4.2%
Term admissions to NICU		<6%	2.77%	2.5%	3.12%
3rd & 4th degree tear	SVD (unassist'd)	<2.8%	0.0%	0.0%	5.6%
	Instrumental (assisted)	<6.06 %	11.1%	0.0%	0.0%
Right place of birth		95%	100%	97.36%	100%
Smoking at time of delivery		<11%	5.2%	11.5%	13.5%
Percentage of women placed on CoC pathway		35%	0	0	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	July	7	34	0	0	0	0	0	0	0	0	0	0	0	0	0
	Aug	1	76	0	0	0	1	1	0	0	0	0	0	0	0	0
	Sept	0	35	0	0	0	0	1	0	0	0	0	0	0	0	0
	Q2															

Maternity Red Flags (NICE 2015)

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

Assessed compliance with10 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

NHS

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			

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	None	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	Communication Staff attitude	Communication Staff attitude	Communication Staff attitude
Listening to women (sources, engagement / activities undertaken) CQC Women's Experience	CNST still suspended MVP ongoing and engaging with patient leaflets and guidelines	Working with MVP Complaints feedback Proactive support by senior midwives Care opinion feedback	Working with MVP
Evidence of co-production	MVP meetings	MVP meetings	MVP meetings
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	OCR meetings NED / safety champion walkabout Engagement sessions FTSU walkabouts Staff survey action plan developed	OCR meetings Staff survey action plan shared via email to all staff Recruitment & retention team in place FTSU sessions in clinical area Board level safety champion walkabout
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	WHATS HOT Ward briefs and emails Face to face discussions with staff LMNS meetings Safety summit in June went well for sharing across the LMNS good turn out for DBTH	WHATS HOT Ward briefs and emails Face to face discussions with staff 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)

Doncaster and Bassetlaw Teaching Hospitals
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Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	25 October 2022	**Agenda Reference:**	**C1**
Report Title:	**Patients waiting less than 15 minutes for ambulance handover from time of arrival**		
Sponsor:	George Briggs, Interim Chief Operating Officer		
Author:	Andrea Squires, Divisional Director of Operations for Urgent & Emergency Care		
Appendices:			
Report Summary			
Purpose of report:	To provide information and assurance in relation to actions ongoing to improve the number of patients waiting more than 15 minutes for ambulance handover from time of arrival.		
Summary of key issues/positive highlights:	• NHSE (2020) guidance states that ambulance handovers should reliably be completed within 15 minutes and that a handover escalation process should be enacted where time to handover exceeds or is likely to exceed 30 minutes. • The current national standards state that all patients should be handed over within 15 minutes with none waiting over 60 minutes for handover. • The month of 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 highlighted in purple. • 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. • This paper will provide a monthly update against national standards and highlight improvements moving forwards.		
Recommendation:	For information/assurance purposes only		

Action Required:	~~Approval~~	**Information**	~~Discussion~~	**Assurance**	~~Review~~

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

Implications	
Board assurance framework:	Changes made to SA1 to reflect risk and related to winter planning & also planning mitigation
Corporate risk register:	Report regards Risks ID 6 and 2349 on the Risk Register - F&P 6 • Failure to achieve compliance with performance and delivery aspects of the SOF, CQC and other regulatory standards Report outlines actions plan to make progress on this specific requirement related to ambulance handovers, no change to risks on CRR
Regulation:	NHS England (2020) Reducing Ambulance Handover Delays: key lines of enquiry
Legal:	N/A
Resources:	N/A

Assurance Route			
Previously considered by:	Divisional Management Board for Medicine		
Date:	22/09/22	**Decision:**	
Next Steps:	Continued monitoring of recovery and associated action plans at Divisional Management Board for Medicine, Finance & Performance Committee and monthly escalation to Board. Work forms part of Urgent and Emergency Care Programme.		
Previously circulated reports to supplement this paper:	N/A		

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

Problem Statement: Performance against the Ambulance handover within 15 minutes standard is currently 43.20% for Doncaster.

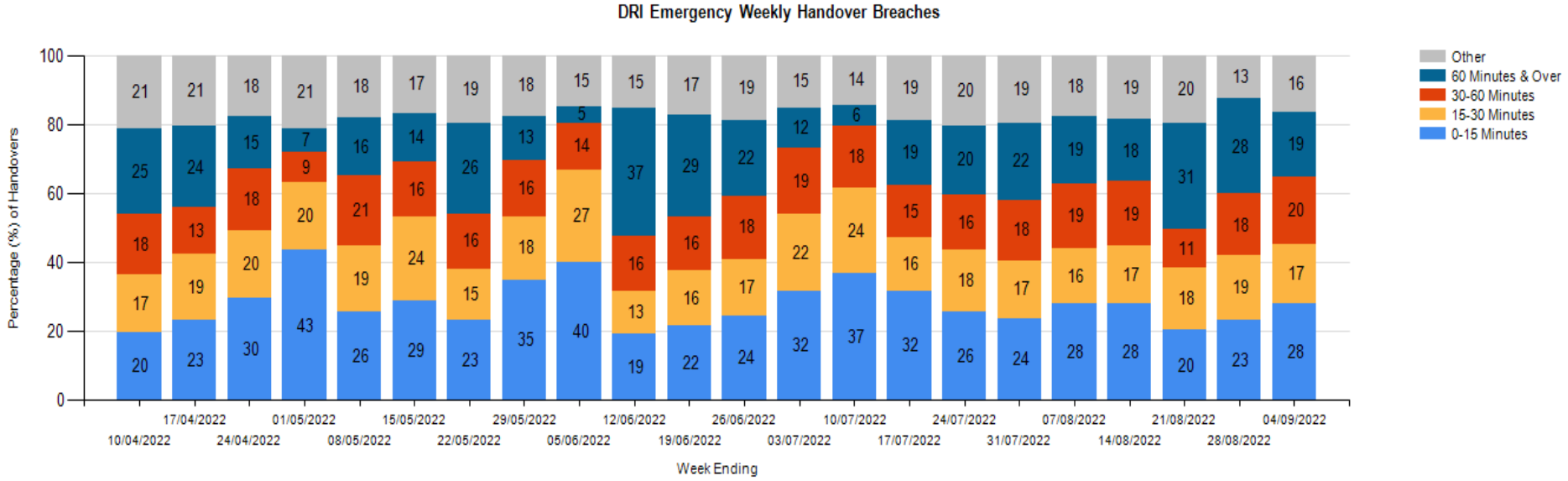
Current Trend: Performance against the Ambulance handover within 15 minutes improved slightly over the month of August, increasing to 43.20% compared to 43.03% in June.

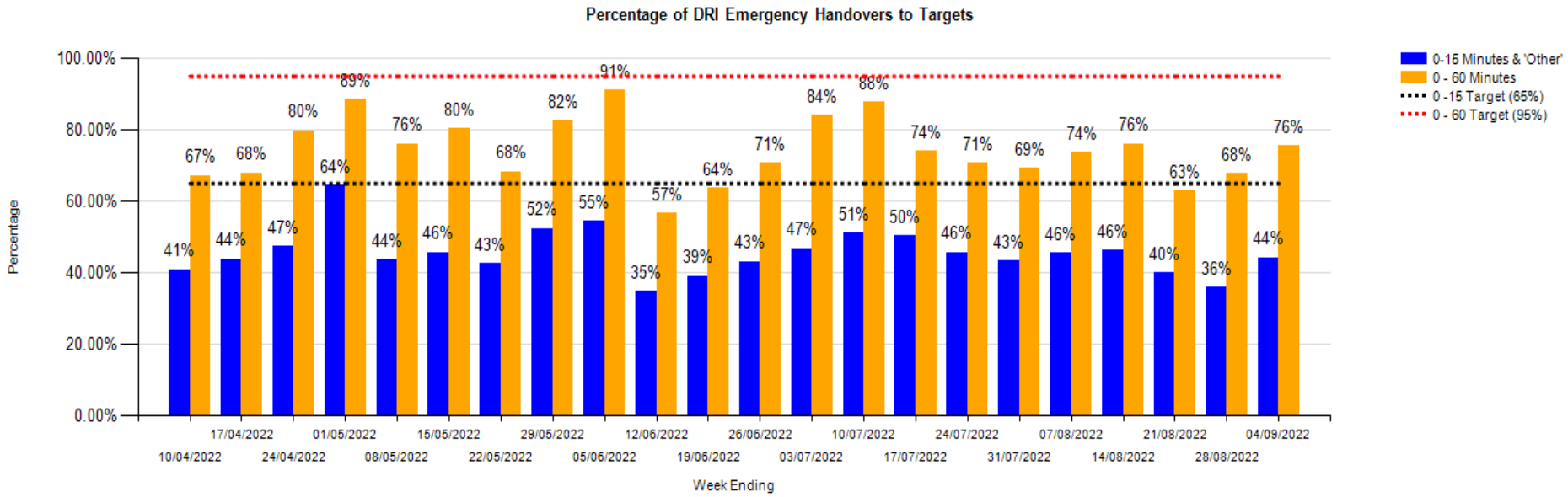
Metric Owner: Divisional Director of Operations (DDO) for Urgent & Emergency Care

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

Desired Trend:

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





Handover performance by focused site

Choose metric: Total breaches 30-60 mins

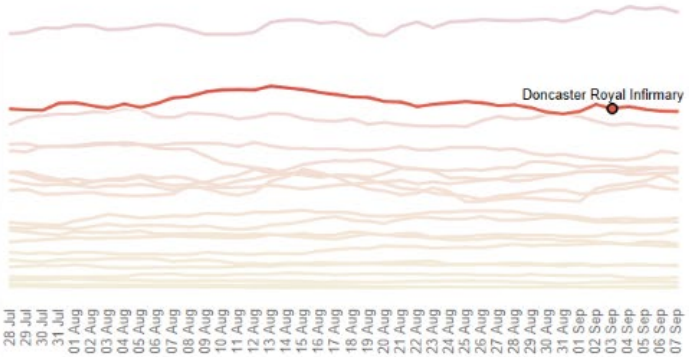
Total breaches 30-60 mins

Rolling 30-day position as at **07 Sep 22**

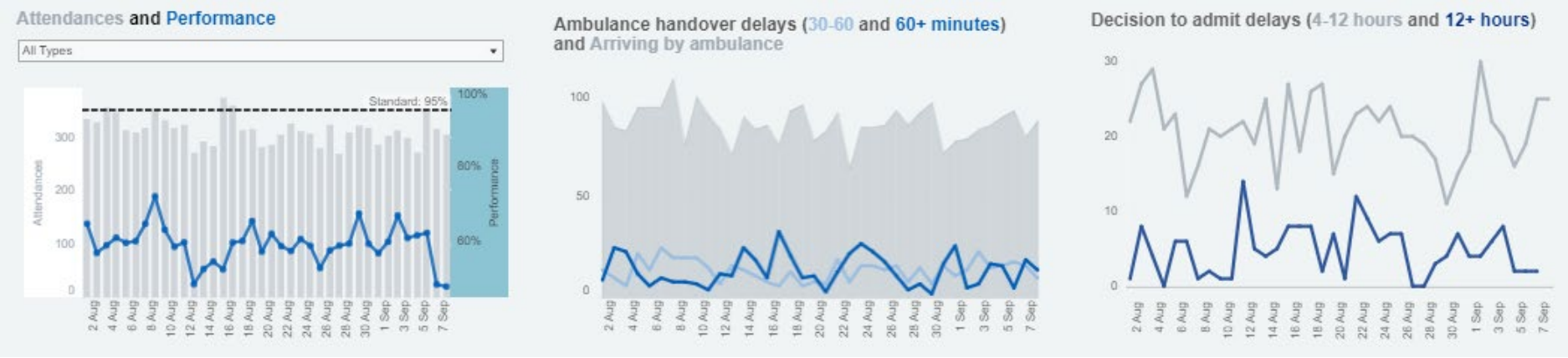
click on a bar to highlight focused site on the trend chart

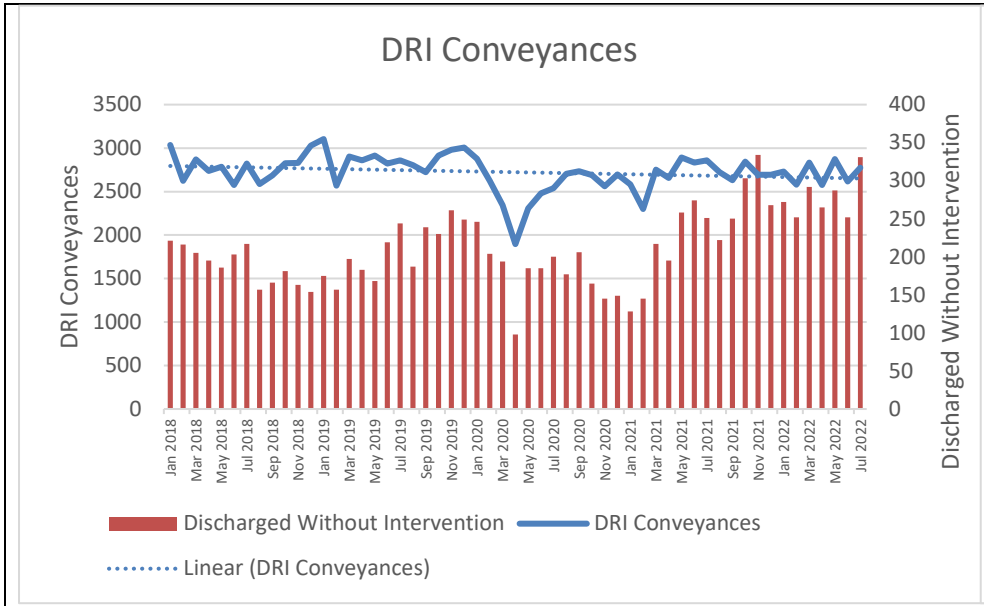
Ambulance..	Focused Site	
Yorkshire	Northern General Hospital	668
Yorkshire	Doncaster Royal Infirmary	428
Yorkshire	Hull Royal Infirmary	388
Yorkshire	Bradford Royal Infirmary	327
Yorkshire	York Hospital	292
Yorkshire	Scarborough General Hospital	290
Yorkshire	Barnsley Hospital	281
Yorkshire	Pinderfields 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

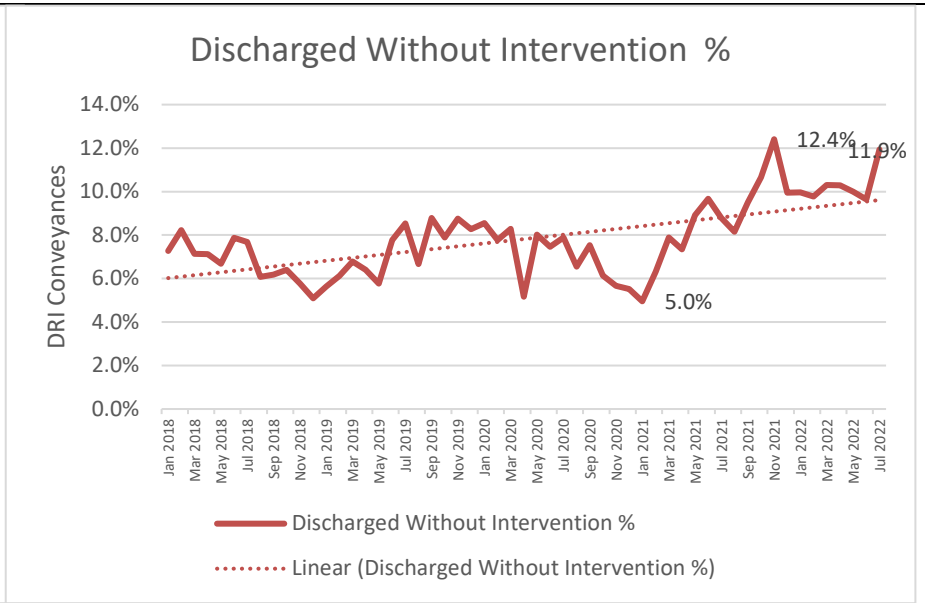
Rolling 30-day **Trend**



Key associated metrics that also support the standard:







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.

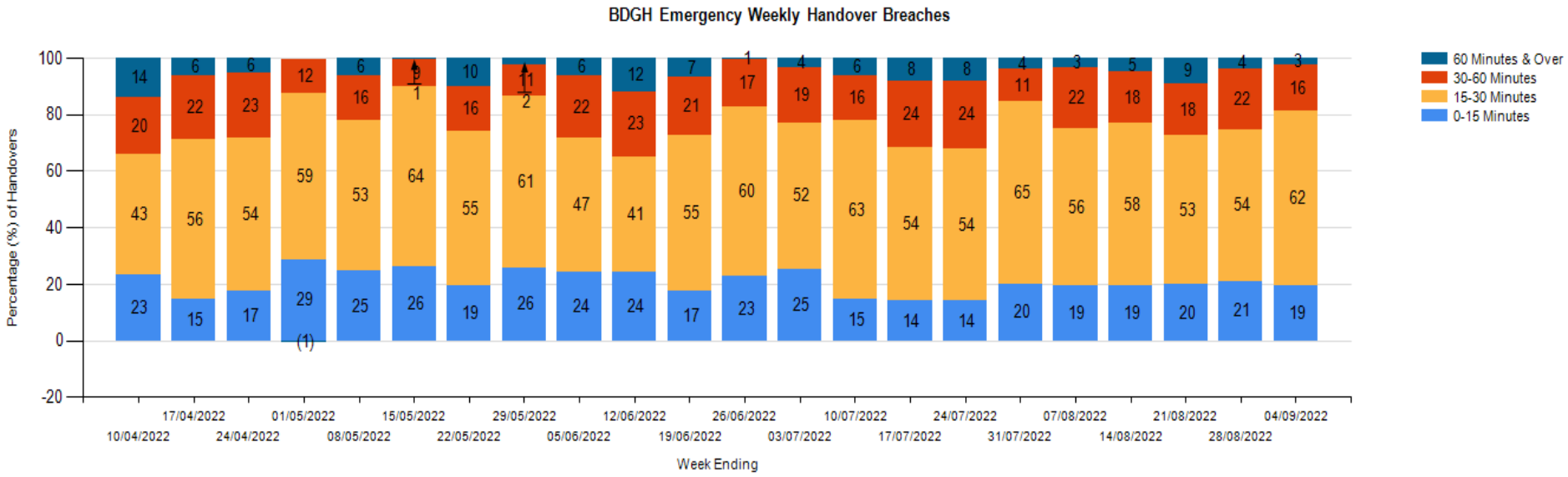
Over the past 5 years, the percentage of patients that have been discharged without intervention/treatment is showing an increase in trend, with the main growth being from March 2021, peaking at 12.4% in November 2021 and 11.9% in July 2022. 2022 has the highest percentage for the time period. Prior 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.

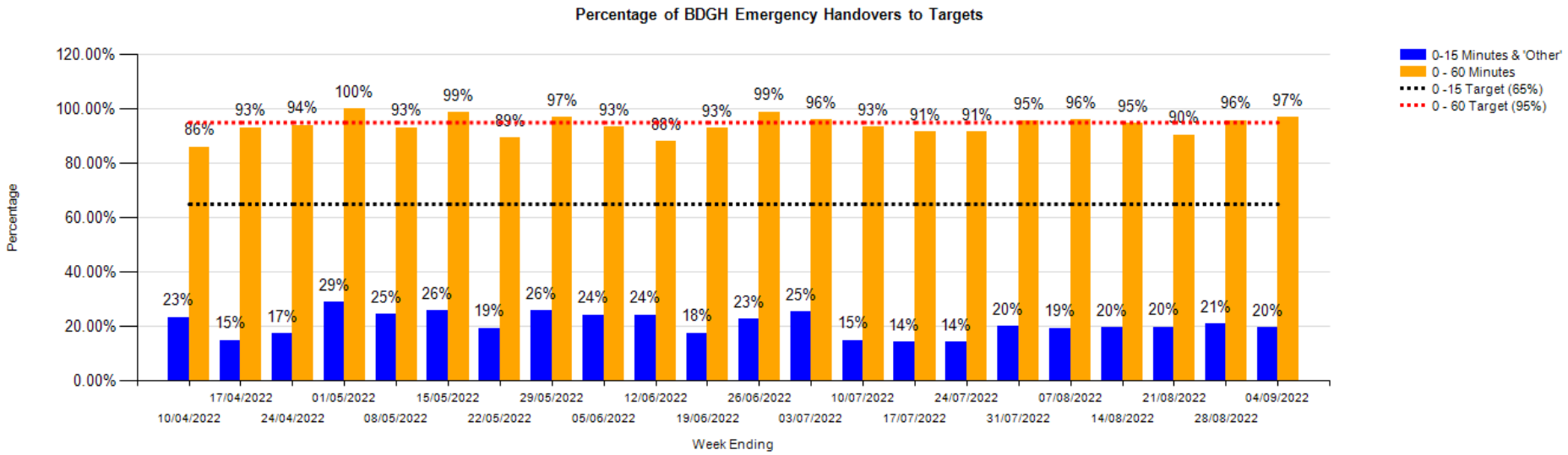
Shortness of breath, Fever and Abdominal pain are the 3 highest presenting complaints for patients discharged without an intervention or treatment.

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

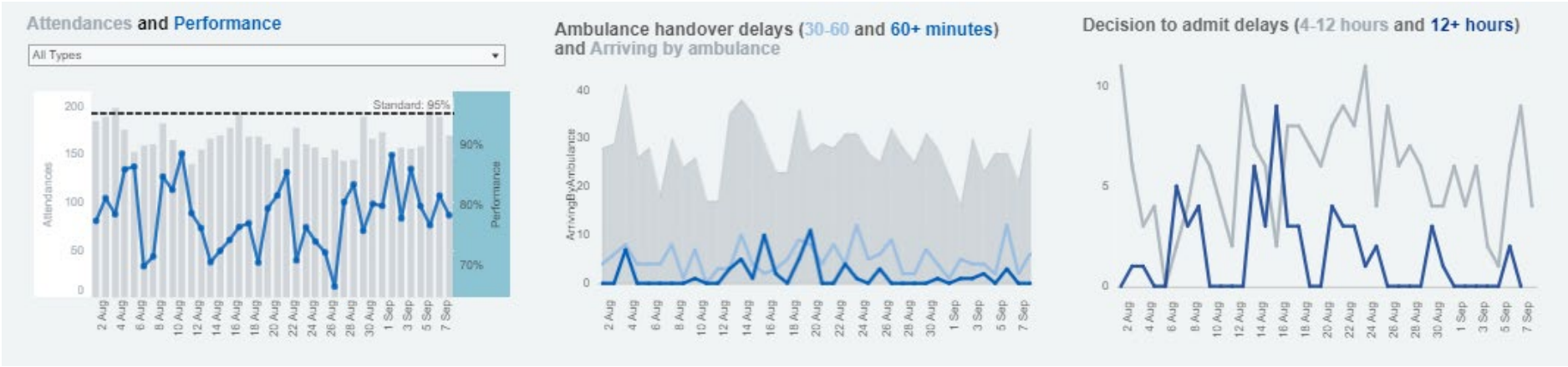
Problem Statement: Performance against the Ambulance handover within 15 minutes standard is currently 19.82% for Bassetlaw. **Current Trend:** Performance against the Ambulance handover within 15 minutes has deteriorated over the month of August decreasing to 19.82% compared to 22.17% in June.	**Metric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

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



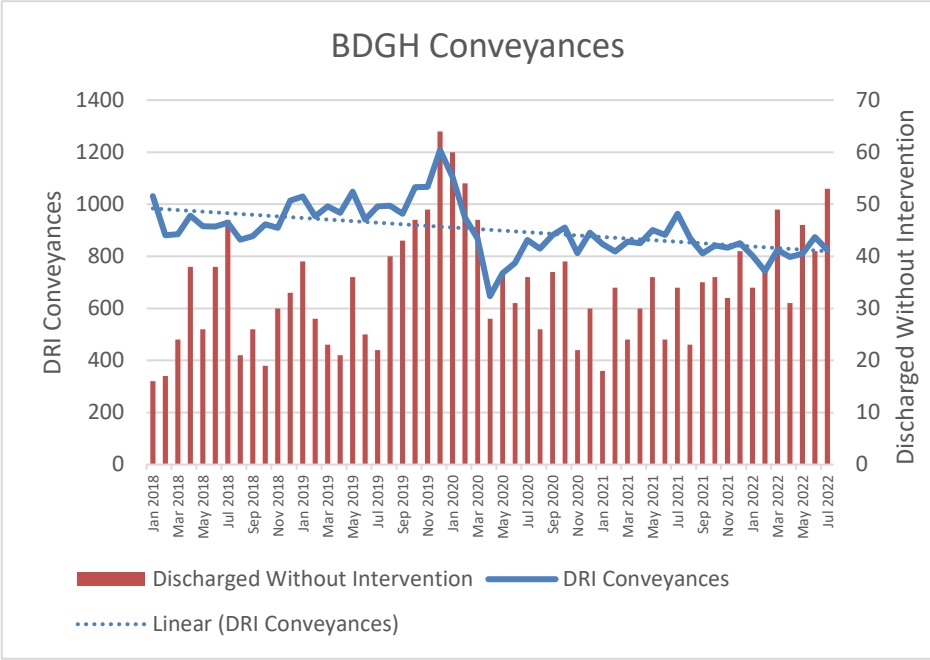


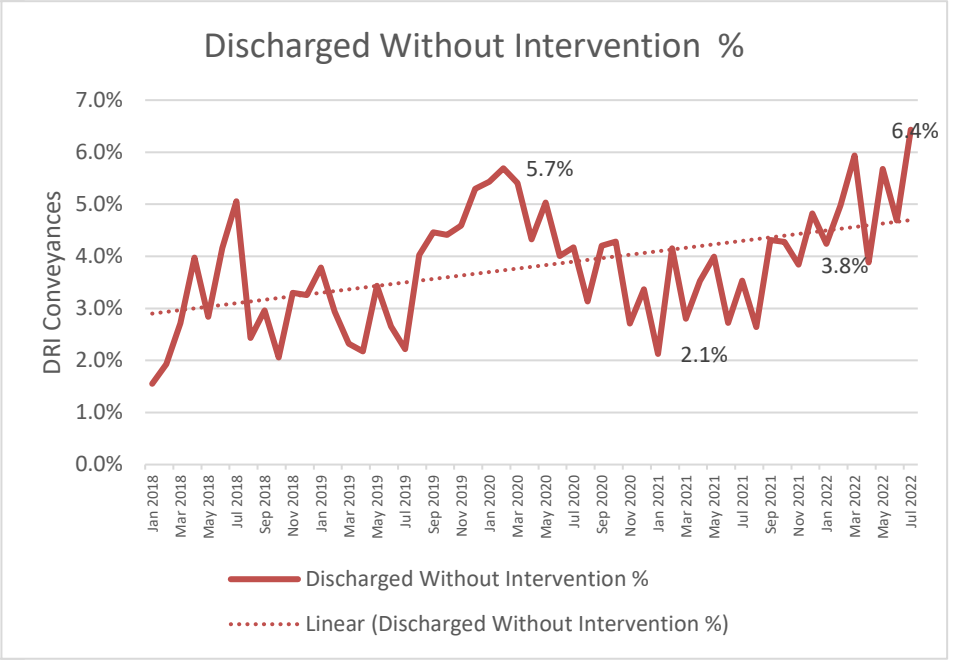
Key associated metrics that also support the standard:




Escalation beds, core beds and bed occupancy
Beds
Bed occupancy
100.0%
98.0%
96.0%
94.0%
92.0%
100
50
0
2 Aug
4 Aug
6 Aug
8 Aug
10 Aug
12 Aug
14 Aug
16 Aug
18 Aug
20 Aug
22 Aug
24 Aug
26 Aug
28 Aug
30 Aug
1 Sep
3 Sep
5 Sep
7 Sep

7+, 14+ and 21+ day long stays
% of beds occupied by long stay patients
% of beds occupied by long stay patients
60%
40%
20%
2 Aug
4 Aug
6 Aug
8 Aug
10 Aug
12 Aug
14 Aug
16 Aug
18 Aug
20 Aug
22 Aug
24 Aug
26 Aug
28 Aug
30 Aug
1 Sep
3 Sep
5 Sep
7 Sep


BDGH Conveyances
DRI Conveyances
Discharged Without Intervention
1400
1200
1000
800
600
400
200
0
70
60
50
40
30
20
10
0
Jan 2018
Mar 2018
May 2018
Jul 2018
Sep 2018
Nov 2018
Jan 2019
Mar 2019
May 2019
Jul 2019
Sep 2019
Nov 2019
Jan 2020
Mar 2020
May 2020
Jul 2020
Sep 2020
Nov 2020
Jan 2021
Mar 2021
May 2021
Jul 2021
Sep 2021
Nov 2021
Jan 2022
Mar 2022
May 2022
Jul 2022
Discharged Without Intervention
DRI Conveyances
Linear (DRI Conveyances)


Discharged Without Intervention %
DRI Conveyances
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
5.7%
2.1%
3.8%
6.4%
Jan 2018
Mar 2018
May 2018
Jul 2018
Sep 2018
Nov 2018
Jan 2019
Mar 2019
May 2019
Jul 2019
Sep 2019
Nov 2019
Jan 2020
Mar 2020
May 2020
Jul 2020
Sep 2020
Nov 2020
Jan 2021
Mar 2021
May 2021
Jul 2021
Sep 2021
Nov 2021
Jan 2022
Mar 2022
May 2022
Jul 2022
Discharged Without Intervention %
Linear (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 Summary & Actions: Patients waiting less than 15 minutes for ambulance handover from time of arrival

Top contributor	Potential Root Cause	Countermeasure	Owner	Status
Pre-hospital / Front Door Issues	• Difficulty accessing primary care services for advice and guidance • Difficulty accessing assessment services for advice and guidance • Difficulty accessing community response services	• Additional GP hours in urgent primary care to support ambulance crews where discussion needed with GP • Extend Same Day Health Centre offer to YAS and South Yorkshire Police for patients that need minor injuries support • Extended pilot with new geriatrician at DRI to support conveyance avoidance particularly around frailty • Work underway to promote the Rapid Response service with ambulance crews • YAS direct pathway to medical and surgical same day emergency care services now implemented, to be duplicated at Bassetlaw • Single point of access for GPs to facilitate direct admission to medical and surgical same day emergency care services • Early senior review in ambulance bay to identify patients suitable for medical and surgical same day emergency care services and fit to sit • Implement 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	• 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	DDO for UEC / CD DDN for UEC / COO DDN for Medicine	Delivery Delivery Delivery

	community	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)	DDNO (new post) COO COO	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	• Delays in entering handover pin to confirm handover has been completed due to competing	• Daily validation of ambulance handovers to re-commence with a monthly report to highlight	DDO for UEC	Monitoring

handover data between YAS / DBTH	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	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	YAS/DDO DDO for UEC YAS DDO for UEC	Monitoring Monitoring Monitoring Closed

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	25 October 2022	**Agenda Reference:**	**D1**		
Report Title:	**Q2 2022-23 Update Corporate Director Objectives**				
Sponsor:	Richard Parker, Chief Executive				
Author:	Richard Parker, Chief Executive				
Appendices:	Appendix 1 – spreadsheet of objectives detail				
Report Summary					
Purpose of report:	This report updates the Board of Directors on the progress made in quarter 2 on the delivery of the Breakthrough and Corporate Objectives for 2022/ 2023 through work being undertaken by Executive Directors. Progress to date reflects the challenges of the on-going pandemic and demands of the elective recovery programme.				
Summary of key issues/positive highlights	The updates identify that there have been challenges with accelerating the pace of recovery from the pandemic due to the ongoing operational pressures but that work towards the delivery of the Trusts Strategic Objectives and True North is being maintained.				
Recommendation:	The Board of Directors is asked to note the contents of the updates and advise on any changes and amendments to the suggested objectives to ensure that actions through 2022/2023 continue to mitigate risks to the delivery of the Strategic Vision.				
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:	The Corporate objectives reflect the work needed to deliver the Board of Directors strategic direction and mitigate known and reasonably foreseeable risks.
Corporate risk register:	Delivery of the Corporate Objectives for 2022/2023 will support the reduction in known and reasonably foreseeable risks.
Regulation:	The Corporate Objectives for 2022/2023 identify actions which will be taken to maintain and ideally improve, the Trusts CQC Good rating at the next assessment. Demonstrating compliance with the standards expected

	to be achieved for a Good rating in the Safe Domain and an Outstanding rating in the Caring Domain.		
Legal:	The Corporate Objectives for 2022/2023 aim to maintain the Trusts progress and compliance with statutory responsibilities.		
Resources:	The resources required to deliver the Corporate Objectives for 2021/2022 are identified as part of the planning processes for 2022/2023.		
Assurance Route			
Previously considered by:	Executive Team		
Date:		**Decision:**	To be presented to the Board of Directors on 25 October 2022
Next Steps:	Specific Objectives will be reviewed at Board Sub Committees with overall progress reported to the Board of Directors in: • July 2022 • October 2022 • January 2023 • April 2023		
Previously circulated reports to supplement this paper:	2022/2023 Corporate Objectives, True North and Breakthrough Objectives, Board of Directors Papers and Performance Reports.		

1. INTRODUCTION

This paper updates the Board of Directors (BoD) on the progress which has been made by the Executive Team towards the delivery of the Corporate Objectives. The impact of the Covid pandemic on the Trusts patients and staff continues to result in significant pressure on the emergency and elective pathways. As a result, the Trusts performance in Q2, and the ability to deliver the Strategic aims and objectives has been slower than originally anticipated.

Measures and actions to mitigate the risks and restore the Trust progress towards the 'True North' were taken with the creation of the Directorate of Recovery, Innovation and Transformation. However, due to the continuing pressures and workforce gaps across the Trust the benefits of concentrating dedicated time and resources on the key elements of recovery; quality, safety, efficiency, and effectiveness are still to be fully realised.

2. BACKGROUND

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

During 2021/ 2022 progress on the revitalisation of previous programmes of work and delivery continued to be affected by the sustained pressures within the South Yorkshire and Bassetlaw system related to the ongoing Covid pandemic. In 2022/ 2023 the full impact of the pandemic on planned care is now visible creating significant challenges in recovery with extended waits for diagnostic and elective services.

Therefore, the focus of the 2022/ 2023 objectives is related to the ongoing management of pandemic pressures, the recovery of waiting list and waiting time performance, and the delivery of safe, sustainable, effective, and efficient care.

As the gaps in the Executive Team are now reducing it is expected that enhanced support will be available to the Trusts Operational Teams to allow a renewed focus on the delivery of the Trusts operational and winter plans and on additional steps which can be taken to better support staff to recover previous performance levels and restore services.

Lessons learnt during the pandemic are being embedded as we seek to further innovate and transform services in and out of hospital care.

3. CORPORATE OBJECTIVES

The contribution each Director has made towards the delivery of the agreed objectives at the end of quarter 2 are identified in appendix 1.

Board sub-committees have agreed the specific objectives and undertake assurance on the delivery of the specific elements to assure the delivery of the Trusts performance.

4. RECOMMENDATIONS

The BOD is asked to discuss the contents of this paper, advise upon any necessary amendments to improve the Trust delivery of the True North.

EXECUTIVE OBJECTIVES 2022/2023

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Deputy CEO / Director of RIT

Name	Deputy CEO / Director of RIT	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status	Q3 Update	Q3 Status	Q4 Update	Q4 Status
Take a lead role in working with Partners in Bassetlaw Place and the Nottingham Integrated Care System to achieve the Place and Systems Objectives and Outcomes objectives for 2022/ 23.		Jon Sargeant	RIT01	BOD	DBTH to be an active partner in Nottinghamshire Care System and for any elements of the Nottinghamshire ICS system plan to be delivered as necessary. Monitored through Board report updates and via regular report into Finance and Performance Committee (F&P).	2022-10-17	Attending meetings with the provider alliance, last report to board being the nominations paper re the Notts ICB. Taking part, with other Executive Directors, in a KPMG review on behalf of Notts Provider Alliance regarding direction of travel.	Working on it	Attending a number of N&N ICS Executive level meetings as well as Bassetlaw Place Partnership meetings or ensuring cover at these where needed. Regular contact with locality Director and planned Place visits in October and November. Partnership working linked in with RDaSH working and presented to September Board and October F&P.	Working on it				
Engage at Place and ICS to identify transformation and development opportunities which enhance the services for our communities and staff		Jon Sargeant	RIT02	BOD	Plans will be in place for services which reduce inequalities and improve outcomes.	2022-10-17	Work ongoing	Working on it	work ongoing. scheduled meeting with RDaSH to explore transfomraton joint working cancelled at short notice due to ill health. looking to reschedule.	Working on it				
Establish a Trust Wide plan to drive Recovery, Transformation and Improvement opportunities across the Trust to improve quality and safety, reduce inequality and improve efficiency and effectiveness.		Jon Sargeant	RIT03	F&P / A&R / PC / QEC	Plan for recovery of elective and emergency performance has been developed, and amended to reflect higher than expected Covid 19 and emergency activity. Wider plan to be produced by October 2022.	2022-10-17	Work ongoing	Working on it	A Trust transformation board has been established to drive progress across a number of key workstreams. Workstreams have also been set up with programmes of work focussing on the key Trust priorities across quality, elective recovery and workforce amongst others. These are all being managed through monday.com	Working on it				
Complete the Service Line reporting work utilising the results to drive the Trusts Strategic Direction		Jon Sargeant	RIT04	F&P	Plan to be presented to TEG, F&P, Quality and Effectiveness Committee (QEC) and onto Board in October 2022	2022-10-17	Specialty reports largely completed, additional workshops held with Trust Executive Group(TEG) and Executive Team. Regular report made to F+P	Working on it	Clinical specialty strategies complete for all divisions except for childrens and families. additional follow workshops being held with C&F specialties with final specialty clinical strategy document to be completed in November.	Working on it				
Support the delivery of a robust learning and development programme to maximise the capacity and capability for improvement		Jon Sargeant	RIT05	PC	Plan to be presented to TEG, F&P, QEC and onto Board in October 2022	2022-10-17	Work ongoing	Working on it	Work ongoing	Working on it				
Support the Board of Directors to champion Quality Improvement as the vehicle for transformation		Jon Sargeant	RIT06	BOD	Plan to be presented to TEG, F&P, QEC and onto Board in October 2022	2022-10-17	Work ongoing	Working on it	Communication plan being worked on with Communications to highlight the engagement & successes of Qi. Bi-monthly repot out sessions being set up (17th November 10-11 next one – for 3 Level 2 Graduations') – to invite NEDs and Executive team representative. Key Performance indicators for Qi being developed and trialled – ongoing. Annual update to QEC – completed October 2022. All improvement projects now being managed via Monday.com and reported into the transformation board – completed. Improvement regular updates into TEG – started September 2022.	Working on it				
Lead the development of the New Hospital Business Case and once funding has been approved ensure the deliver of the Trust major capital programmes; Bassetlaw Emergency Care Village, Mexborough Surgical Care Hub, Mexborough Community Diagnostic Centre		Jon Sargeant	RIT07	BOD / F&P	Monitored through project plans, and agreed budgets into F&P and onwards to the BOD as required.	2022-10-17	BEV case to be presented to F&P and Trust Board in July, CDC case completed and submitted, work on going on other schemes	Working on it	There is an ICB/DMBC/DBTH meeting on 10/1 to discuss way forward for new build. BEV OBC - RFIs have been recived and responded to. Awating further feedback. RAAC - project commenced, due to complete March 23. MEOC - short form BC being developed for Dec. Approval Feb 23. Open - Autumn/Winter 23.	Working on it				
Ensure the delivery of the Trust Information and Technology Strategy maximising the benefits of Information Technology to safety, efficiency and effectiveness		Jon Sargeant	RIT08	F&P / QEC / ARC	Monitored through project plans, and agreed budgets into F&P and onwards to the BOD as required.	2022-10-17	EPR case presented to the FP and Trust board and submitted to NHSE	Working on it	Currently awaiting central sign off of the OBC in advance of going out to procurement. We continue to deploy Neurve Centre modules eg. Clinical Photography, and case notes.	Working on it				
Maximise the benefits and opportunities of the Wholly Owned Subsidiary (WOS)		Jon Sargeant	RIT09	F&P / A&R	The WOS is making an increasing contribution to the Trusts plans	2022-10-17	Good progress made with Quality Medical Education and Training (QMET), and the WOS is looking at feasibility of putting a small pharmacy on BDGH site	Working on it	Work ongoing with WOS opportunities	Working on it				
Ensure that the Board of Directors, Board Sub Committees and Trust Operational Management Groups have quality assured information by which to assess and assure that delivery of the Trusts Strategic and Operations Objectives.		Jon Sargeant	RIT10	ALL	Monitored against project plan for data improvement, and the introduction of data quality kitemarks. Reporting into F&P and other BOD sub-committees as required.	2022-10-17	Derrick Scorecard system now live and Project Management processes via Monday.com software being implemented	Working on it	Project management processes and reporting embedded and feeding into transformation board and programme steering groups	Working on it				

Medical Director

Name	Medical Director	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status	Q3 Update	Q3 Status	Q4 Update	Q4 Status
Fully implement the job planning process. Ensuring that job plans support the delivery of safe, sustainable, efficient and effective services Ensure that the internal audit recommendations are completed		Tim Noble	MD01	F&P / QEC	100% of senior medical staff job plans reviewed, agreed and signed off on the Allocate system Ensure the job planning review process is established to have an annual job plan cycle Job Plan Audit Recommendations Action Progress Meeting established to progress and monitor actions against internal audit recommendations through to completion	2022-10-17	Job Plan Action Progress Meeting established. 14 out of 20 actions and sub-actions now complete and closed by internal auditors The first of a series of job planning workshops for clinical directors held 05/07/2022	Working on it	One remaining action open, update submitted to October's Audit and Risk Committee.	Working on it			
Support specialties and Divisions to optimise recruitment and retention processes with a specific focus on smaller services and difficult to recruit to areas.		Tim Noble	MD02	QEC	Targeted workforce meetings with specialties/divisions to be established to optimise recruitment and retention processes, with Medical Director, Medical HR, Divisional Director, Divisional Director of Operations, Clinical Directors, Education Department Share good practice and learning across specialties	2022-10-17	MD with responsibility for workforce, working with Medical HR, Education Department and Divisional/Specialty leads to identify specialties with difficulty in recruitment	Working on it	Medical Director for workforce working with target specialties	Working on it				
Following the completion of the reviews of Corporate, Divisional and Directorate Governance arrangements embed the clinical governance and risk management process changes		Tim Noble	MD03	QEC	In line with the recommendations from the external review, ensure governance arrangements and risk management processes are revised and a change management plan developed Communication and engagement with divisional and corporate areas to embed recommended changes through the robust governance framework	2022-10-17	External review complete and report awaited.	Working on it	External peer review report now received. This has been analysed and in concert with PSIRF will help re-shape our governance review. There is a recommendation for an "implementation team" for PSIRF which will assist in producing the changes.	Working on it				

Name	Deputy CEO / Director of RIT	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status	Q3 Update	Q3 Status	Q4 Update	Q4 Status
In conjunction with the Chief Nurse ensure that the Trust is able to demonstrate evidence of compliance with the standards required to achieve a CQC Good rating in the Safe Domain and an Outstanding rating in the Caring Domain.		Tim Noble	MD04	QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet and exceed the CQC standards.	2022-10-17	Working with Chief Nurse to complete the development and implementation of the Trust's Quality Strategy	Working on it	There are effective Clinical Governance processes in the Trust. Further work will continue with the Chief Nurse.	Working on it				
Jointly lead the maternity improvement plan in line with national recommendation from the Ockenden report, clinical Negligence Scheme for Trusts (CNST) year 3 and any further related reports		Tim Noble	MD05	BOD / QEC	Work closely with Chief Nurse and Director of Midwifery to deliver the action plans developed in line with national recommendation from the Ockenden report. Review of safety culture within maternity, work closely with Chief Nurse and Director of Midwifery to review findings, agree recommendations and develop action plans. The 2022/ 2023 Assurance Framework will ensure the Trusts plans are being delivered. Milestone outcomes to be jointly agreed with Chief Nurse and Director of Midwifery.	2022-10-17	Working closely with Chief Nurse and Director of Midwifery to jointly agree action plans in line with national recommendation from the Ockenden report.	Working on it	Having regular meetings with the Maternity team.	Working on it				
Ensure that learning from incidents, complaints, claims and the Learning from Death Reviews are used to improve the quality and sustainability of services; maintaining and improving outcomes and a reduction in HSMR & SHMI		Tim Noble	MD06	BOD / QEC	Medical Examiner Learning from Death Reviews and lessons learnt will be used to maintain and improve outcomes and reduce HSMR and SHMI Learning from incidents, complaints, claims demonstrated in the integrated quality and performance report, with targeted interventions as needed	2022-10-17	Medical Examiner Team scrutinising non-coronial deaths in acute Trust Trust Board reports produced to provide assurance of recommendations and implemented actions. Trust Mortality Group reviewing HSMR performance and trends.	Working on it	The Medical Examiner service continues to assess all adult hospital deaths. the learning from deaths nurse is assisting in the delivery of change and has presented to the Senior medical staff at MAC. Mortality data is under regular review.	Working on it				
Work with the Chief People Officer to maximise the benefit of the Senior Doctor Leadership Development Programme to develop senior leaders across the Trust.		Tim Noble	MD07	PC	Senior doctor leadership development programme in place Proactively encourage senior medical workforce to engage with the programme Encourage the use of study leave to allow protected time for leadership development	2022-10-17	Senior doctor leadership development programme planned for 2022/23	Working on it	The Medical Directors Directorate have collaborated with the leadership team and delivered workshops for senior medical leaders in the organisation.	Working on it				
Fully embed the Medical Advisory Committee (MAC) as the vehicle for engagement and communication with the wider senior medical workforce.		Tim Noble	MD08	PC	Establish bi-monthly Medical Advisory Committee meetings with agreed Terms of Reference Establish bi-monthly MAC planning meetings to cover a range of subject matter as requested by the senior medical workforce Invite Executive Directors and Non-Executive Directors to attend each meeting as a means of engaging and having two-way communication between the senior medical workforce and Trust Board members	2022-10-17	Medical Advisory Committee meetings established monthly Senior medical staff surveyed for input into topics and themes for discussion Process in place to forward plan agenda	Working on it	MAC is fully embedded and continues to have a wide mix of presentations and topics. Surveys have helped with topic selection with both internal and external speakers. Feedback is very good.	Done				
Support the delivery of the Trust Strategic Direction through the delivery of safe, resilient, efficient clinical pathways which are compliant with NICE guidance and evidence based practice and aligned to the Place, ICS and Acute Fed clinical networks		Tim Noble	MD09	ALL	Engage with divisions and specialties through Service Strategy Reviews, incorporating GIRFT recommendations, in line with Trust Strategy Oversight of priorities in terms of short, medium and longer term strategic plans Support pathway redesign to ensure services are delivering efficient clinical pathways that are evidence based and aligned to wider clinical networks	2022-10-17	GIRFT review in specialities to produce up-to-date position re: GIRFT recommendations.	Working on it	The Medical Director for Operational Stability and Optimisation has progressed this work, using GIRFT and Model hospital tools.	Working on it				

Director of Finance

Name	Director of Finance	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status	Q3 Update	Q3 Status	Q4 Update	Q4 Status
Work with the Corporate and Divisional Directors to ensure the delivery of the Trust revenue plan		Alex Crickmar	DOF01	F&P / A&R	Improved support to Divisions to support delivery of the Trust's financial plan. This will be reported monthly to F&P, with the year end accounts presented to ARC.	2022-10-17	Year end accounts signed off at the end of June with unqualified audit opinion for 21/22. Currently off track against financial plan by £1.1m. Financial assurance framework in place for 22/23 with escalation and support offer through POSM meetings with Divisions to improve financial position.	Working on it	The Trust is currently behind financial plan at the end of Q2 as reported to Trust Board. Budgets have been set and agreed with budget holders and financial framework put in place with Divisions with controls in place to support delivery of plan.	Working on it				
Work with the Corporate and Divisional Directors to ensure the delivery of the Trusts Capital Plan		Alex Crickmar	DOF02	F&P / A&R	Improved support to Divisions to support delivery of the Trust's financial plan. This will be reported monthly to F&P, with the year end accounts presented to ARC.	2022-10-17	Corporate Investment Group (CIG) re-introduced from beginning of financial year, with significant number of capital cases now approved, especially in Estates. Capital plan currently on track to be delivered by year end.	Working on it	Whilst the Trust is behind plan on capital, this is a phasing issue with the expectation that plans will be delivered by year end. The finance team has been fully involved in supporting the operational capital plan along with a number of significant capital developments including ePR, BEV etc.	Working on it				
Support the work on the large scale business cases; the New Hospital Strategic Outline Business Case, Bassetlaw Emergency Care Village, Community Diagnostic Centre and the Elective Surgical Hub.		Alex Crickmar	DOF03	F&P / A&R	Approval of business cases. The development of cases will be monitored through business cases to F&P and onwards to the BOD as required.	2022-10-17	Finance team continued to support all significant business cases. EPRR approved at Board in Q1. CDC Phase 2 now approved by national team. Currently working on BECV ahead of presentation to Board in July.	Working on it	The finance team has been fully involved in supporting the significant capital developments including ePR, BEV etc. with an updated LTFM being used to support financial modelling. A number of the business cases has received Board and F&P approval, with CDC receiving national approval.	Working on it				
Ensure the delivery of the Estates Strategy and Plans		Alex Crickmar	DOF04	F&P / A&R	Annual objectives for Estates will be delivered in line with plan (e.g. Granger Report). This will be monitored through project plans and reported through to F&P and ARC.	2022-10-17	Estates plans and objectives are all currently on plan to be delivered including good progress on the Granger report actions which was reported on at the July F&P Committee.	Working on it	The Estates team are currently delivering against its annual plan, with some good progress made in a number of areas including actions relating to the Granger report as reported to F&P.	Working on it				
Deliver an improved management accounts function including systems and training		Alex Crickmar	DOF05	F&P / A&R	Roll out of training programme to Divisions, development of systems (including finance dashboard as part of data warehouse project), development programme for the team and review of structure including roles and responsibilities. This will be monitored through project plans.	2022-10-17	Training Programme videos are in the last stages of completion, ledger information now linked into Datawarehouse and finance dashboards are developed in draft and are in the process of being signed off over the next month, FBP development programme being reviewed, and roles and responsibilities work has now started.	Working on it	The Finance and Procurement team have developed a suite of online training videos for use by Divisions. The team have also developed online financial dashboards through the datawarehouse and this is now being tested with Divisions for sign off. A full review of tasks undertaken within management accounts has been undertaken with improvements made in processes. This includes the month end timetable is now 2-3 days reported earlier than it was pre-COVID. Further work on reviewing roles and responsibilities is needed.	Working on it				

Chief People Officer

Name	Chief People Officer	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status	Q3 Update	Q3 Status	Q4 Update	Q4 Status
Develop and launch revised People Strategy aligned with national NHS People Plan, People Promise and priorities.		Zoe Lintin	CPO01	BOD / PC	Engagement with colleagues to author the revised People Strategy, which will demonstrate the DBTH interpretation and delivery against the national plan and priorities. Work to begin in Q2/Q3, to launch Q4.	2022-10-17	Planned for work to begin Q2	Working on it	Initial engagement started at committees, agreed to align with NHS People Plan with 4 pillars	Working on it				

Name	Deputy CEO / Director of RIT	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status	Q3 Update	Q3 Status	Q4 Update	Q4 Status
Design and implement a Trust wide approach to engagement in the national staff survey, including developing plans to improve participation, feedback on the results and corporate/ local action planning to improve results.		Zoe Lintin	CPO02	BOD / PC	Approach defined for the 2022 staff survey defined and communicated in Q2 prior to survey launch. Engagement sessions booked ready for lifting of embargo in Q4, with consistent approach to action planning at Trust-wide and local level. 63% response rate or better in the survey (Q3).	2022-10-17	Tender for provider for 2022 survey underway and approach to engagement in the survey results being communicated. Update at July PC.	Working on it	Approach designed to cover the whole survey life cycle, supported at TEG, People Committee, Board & Partnership Forum. Implemented and communicated for 2 survey. Expectations set for engagement in survey results	Done				
Actively support and further develop the Trust Leadership and Organisational Development opportunities. Consolidate/strengthen links with Education and Research Team		Zoe Lintin	CPO03	PC	Leadership development prospectus in place and offer expanded throughout the year. Roll-out of the Team Engagement and Development (TED) tool to support teams, as part of the national pilot. Improvements in leadership questions in staff survey. Embed role as new Exec lead for Education and Research, maximising opportunities for working with the People and Organisational Development (P&OD) team.	2022-10-17	Leadership prospectus launched. TED tool workshop held in June with c80 participants, first teams using the tool. Exec lead for Education and Research confirmed in June.	Working on it	Closer working with Education & Research team, now with same Exec lead across People & OD and E&R. New Head of Leadership, OD, EDI & Wellbeing started on secondment Sept 22. Overall offer to be reviewed again once leadership behaviours framework developed	Working on it				
Build on the Health and wellbeing offer to ensure a sustainable and holistic offer for our people making best use of system opportunities.		Zoe Lintin	CPO04	BOD / PC	Comprehensive, proactive and holistic health and wellbeing (H&W) offer in place which is well understood and accessible by our people. Improvements in H&W questions in staff survey. Increase in number of H&W Champions. Increase in preventative aspects of the overall offer. Positive impact on sickness absence (recognising impact of other factors). Review of Occupational Health capacity undertaken and decisions made on resource requirements.	2022-10-17	Wellbeing offer continues to be expanded e.g. smear clinics. OH business case previously submitted. H&W update at July PC.	Working on it	Health & Wellbeing offer continues to be embedded. Work underway on a proposal for more sustainable funding model (Oct)	Working on it				
Working with the Executive Team and other colleagues, develop and implement a leadership behaviours framework building upon the Develop, Belong, Thrive Here at DBTH.		Zoe Lintin	CPO05	PC	Engagement with colleagues to develop the framework, linked to existing DBTH ethos and national resources (Q3). Plan in place for launch, implementation and future embedding of the framework linked to all aspects of the employee life cycle. Staff survey impact in future years.	2022-10-17	Plan for engagement to begin in Q3 after the summer period.	Working on it	Initial discussions held with colleagues, planning for wider engagement in Q3	Working on it				
Review recruitment and retention processes to maximise efficiencies, improve timescales and enhance applicants experience. Developing and strengthening the recruitment and retention team, and the use of technology.		Zoe Lintin	CPO06	PC	Completion of Quality and Improvement (QI) project on end to end recruitment process, from vacancy approval to 'first day ready'. Improvement action plan developed and delivered with PMO support. Improvements seen in length of process and candidate experience. Recruitment team capacity explored and decisions made on resource requirements. Automation options explored.	2022-10-17	QI project scoped and workshop arranged for 19 July with stakeholders. Recruitment business case previously submitted. Update on recruitment KPIs and plans at July PC.	Working on it	QI improvement project underway with launch and follow-up workshops. Actions identified and progress being monitored on Monday.com. Several changes made quickly to streamline the recruitment process. KPIs being reviewed	Working on it				
Review the approach to casework including the implementation of technology to improve experiences.		Zoe Lintin	CPO07	PC	Casework database implemented. Improvement in length of time taken on individual casework. Further roll-out of 'just culture' approach to managing casework, working with Staff Side colleagues.	2022-10-17	Casework database implemented. Update at July PC.	Working on it	Allocate ER Tracker implemented, all cases from 01.04.22 on the system. KPIs on timescales being monitored. 99% positive feedback from managers to date. 'Just Culture' ethos being explored, starting with reviewing tone of all template letters	Working on it				

Chief Operating Officer

Name	Chief Operating Officer	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status	Q3 Update	Q3 Status	Q4 Update	Q4 Status
Ensure that EPRR plans and assurances are in place to respond to all reasonably foreseeable incidents		George Briggs	COO01	ARC	Plans being updated post Covid business continuity and emergency plans. Training offer has been updated and is being rolled out across on call teams.	2022-10-17	Training being booked. Monthly EPRR updates booked with COO	Working on it	The EPRR compliance plan was presented to BoD in September and the plan is going to Audit Commitee on the 14th October	Done				
Ensure the delivery of the National, ICS and Local standards for Urgent and Emergency Care, Elective Care and cancer care, and diagnostics ensuring that wherever possible reduce inequalities in access.		George Briggs	COO02	F&P	Business as usual plans in place and emergency recovery board set up July 22 Elective recovery board set up August 22	2022-10-17	Monthly review and weekly updates agreed	Working on it	Daily operational teview taking place performance has been stubbornly resistant to improvement the major changes to the AMDY ASU in October are on plan	Working on it				
Ensure wherever possible that the delivery of the recovery and restoration plans reduce inequality		George Briggs	COO03	QEC	Emergency recovery and Elective recovery boards setup with review monthly	2022-10-17	ICB monthly review	Working on it	Recovery plan for electives is in train with twice monthly updates	Done				
Ensure arrangement are in place to maintain and improve patient flow to maximise efficiency and effectiveness		George Briggs	COO04	F&P	Performance which related to patient flow will be at 2019/ 2020 levels.	2022-10-17	Plan to be updated	Working on it	As ICS and local standards we are performing below the national average the complex improvement and winter plans are in place but reliant on ICB and place #! #! #!	Working on it				
Ensure that services deliver the required levels of transformation to allow access to enhanced funding		George Briggs	COO05	F&P	Services will be linked into QI program and transformation board. Transformation board will meet monthly with feed in from elective and emergency programs	2022-10-17	First boards to be held in Q2	Working on it	Transformation plansd developed and reviewed during Q2	Working on it				
Develop, agree and implement robust plans to manage winter pressures and enhanced IPC measures		George Briggs	COO06	F&P / PC	Winter plans will be in place by Q3 to reflect divisional plans Winter plans linked to the Integrated Care System and PLACE plans.	2022-10-17	Initial plan shows bed reduction latest version to include ward 22 beds	Working on it	winter plan has been developed and costed the ICB and place are agreeing the overall plan and partial implementation gas commenced without further community support we will not be able to maintain performance at safe levels and care for staff and patients will suffer	Stuck				

Chief Nurse

Name	Chief Nurse	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status	Q3 Update	Q3 Status	Q4 Update	Q4 Status
Working with the Executive Medical Director to embed a 'Quality Framework' define the characteristics and evidence that will define and support the Trust to be 'Outstanding in all that we do		Abigail Trainer	CN01	QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet and exceed the CQC standards	2022-10-17	Implementation now commenced, project team working question set on trial areas , this will feed into newly formed quality steering group then Transformation board. 'Perfect Ward' audit and accreditation tool across all in patient areas to ensure we have a robust mechanism to measure quality metrics including, patient falls, hospital acquired pressure ulcers, medication incidents.	Working on it	Work in progress. Accrediation audites now being transferred to the new Tendable Audit Solution. Just gone live, to be presented to Nov Board.	Working on it				

Name	Deputy CEO / Director of RIT	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status	Q3 Update	Q3 Status	Q4 Update	Q4 Status
In conjunction with the Executive Medical Director ensure that the Trust is able to demonstrate evidence of compliance with the standards required to achieve a CQC Good rating in the Safe Domain and an Outstanding rating in the Caring Domain		Abigail Trainer	CN02	QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet and exceed the CQC standards	2022-10-17	Working with The Executive Medical Director to complete the development and implementation of the Trust's Quality Strategy Work underway to ensure the Trust and Division can demonstrate compliance with the CQC standards.	Working on it	Awaiting new CQC quality assessment framework which will replace current KLOEs and will link in with Trust Quality framework. Walk around maternity in place against current KLOEs as risk of inspection due for maternity.	Working on it				
Jointly lead the maternity improvement plan in line with national recommendation from the Ockenden report, clinical Negligence Scheme for Trusts (CNST) year 3 and any further related reports		Abigail Trainer	CN03	BOD / QEC	Work closely with Medical Director and Director of Midwifery to deliver the action plans developed in line with national recommendation from the Ockenden report. Review of safety culture within maternity, work closely with Medical Director and Director of Midwifery to review findings, agree recommendations and develop action plan. The 2022/ 2023 Assurance Framework will ensure the Trusts plans are being delivered.	2022-10-17	Ockenden action plan in place and reported to the BOD Additional resources being put in place to proactively collect and catalogue CNST evidence Birth rate plus review completed. Report to be provided to QEC Work underway to strengthen the midwifery management structure	Working on it	Ockenden and CNST action plans in place. Project manager recruited to support CNST & Ockenden workload – date to start to be agreed. 2 x 8b posts recruited to support DoM (operational and strategic) start dates Dec 2022 & Jan 2023 Regular progress reports given to QEC and BOD	Working on it				
Ensure the patient/carer voice is listened to by delivering increasing evidence of co-produced outcomes		Abigail Trainer	CN04	QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet and exceed the CQC standards	2022-10-17	Work is underway to implement a revised patient experience service.	Working on it	Work continuing to develop strategy.	Working on it				
Ensure safe and benchmarked staffing levels through the Trust, Safer Nursing Care Tool (SNCT) undertaken n May 2022, full feedback will be presented at board in September 2022.		Abigail Trainer	CN05	BOD / QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet and exceed the CQC standards	2022-10-17	Safe staffing assessments and recommendation will be presented to BOD in September	Working on it	Sept Board - latest data collection May 22 identified the need to refresh trainign for some colleagues as well as new starters. THis work will be delivered by the Shelford Group in Oct. Next data collection land Nov 22.	Working on it				
Implementation of the Patient Safety Incident Response Framework (PSIRF) and development of patient safety specialist roles across the organisation. Awaiting further national guidance on next steps , patients safety champions identified and in place		Abigail Trainer	CN06	F&P / QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet and exceed the CQC standards	2022-10-17	Work is underway and will be finalised once the external reviews of risk and governance are completed.	Working on it	External review of risk and governance completed. Report being reviewed to identify recomendations. Timeline for PSIRF implementation to be present to QEC in Oct, as guidance has now been received.	Working on it				
Celebrate, share and promote good practice		Abigail Trainer	CN07	QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet and exceed the CQC standards	2022-10-17	Individaul opportunities to celebrate good pratcice and patient care are reported through established communication channels and celebration events are being planned. Listening events with senior nurses are underway.	Working on it	Individaul opportunities to celebrate good pratcice and patient care are reported through established communication channels and celebration events are being planned. Listening events with senior nurses are underway	Working on it				

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	25 October 2022	**Agenda Reference:**	**E1**
Report Title:	**Annual Emergency Preparedness Resilience & Response Core Standards Compliance**		
Sponsor:	George Briggs, Interim Chief Operating Officer		
Author:	Jeannette Reay, Emergency Planning Officer George Briggs, Interim Chief Operating Officer		
Appendices:	Appendix A - Statement of Compliance Appendix B - Improvement Plan - Actions Arising from 2022/23 Assurance Process		
Report Summary			
Purpose of report:	• To provide the Board with information on the Trust's self-assessment for 2022/23: - Self-Assessment Process - Performance Against the Core Standards - Performance Against the Deep Dive (Evacuation and Shelter) Standards - Declaration of Compliance - Approval Process - Recommendations - Next Steps - Statement of Compliance - Improvement Plan • To allow the Board to approve the Statement of Compliance at Appendix A. • To allow the Board to approve the Improvement Plan at Appendix B for submission to NHS England.		
Summary of key issues/positive highlights:	• The declaration for 2022-23 will be of partial compliance, as the Trust is 77% compliant with the Core Standards that it is expected to achieve.		

Recommendations:	As recommended by the Trust's Audit and Risk Committee (14 October 2022): • To approve the statement of compliance at Appendix A for submission to NHS England (Yorkshire and the Humber). • To approve the Improvement Plan at Appendix B for submission to NHS England (Yorkshire and the Humber).				
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:	Compliance with NHS England and Improvement Emergency Preparedness, Resilience and Response (EPRR) Framework – annual statutory requirement for self-assessment.
Legal:	The Civil Contingencies Act (CCA) 2004 places statutory duties on Category One Responders, and the Core Standards assess the Trust's preparedness and response capabilities to those duties and also to other statutory and regulatory requirements.
Resources:	

Assurance Route			
Previously considered by:		Trust Executive Group Audit and Risk Committee	
Date:	10 October 14 October 2022	**Decision:**	The Audit and Risk Committee has made a recommendation to the Board for its approval of the Declaration and Action Plan.
Next Steps:	• The statement and improvement plan will be submitted to NHS South Yorkshire ICB following the approval by the Board of Directors (no later than the deadline of 28 October 2022). • By 11 November 2022 NHS South Yorkshire ICB will undertake and complete its local assurance processes with providers. • By 18 November 2022 NHS South Yorkshire ICB will submit the submissions to NHS England (North East and Yorkshire). • By 25 November 2022 the submissions from the four North East Yorkshire ICBs will have been reviewed by NHS England (North East and Yorkshire).		

	• By 30 November 2022, NHS England (North East and Yorkshire) will submit the assurance ratings to NHS England's Director of Emergency Preparedness, Resilience and Response (National). • The Trust's confirmed level of compliance will be included in its Annual Report and Accounts for 2022-23.
Previously circulated reports to supplement this paper:	None.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS – 25 OCTOBER 2022

ANNUAL STATEMENT OF COMPLIANCE

AGAINST

NHS ENGLAND'S CORE STANDARDS FOR EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE

2022-23

Jeannette Reay - Emergency Planning Officer
George Briggs - Chief Operating Officer

1. Introduction

As part of NHS England's Emergency Preparedness, Resilience and Response (EPRR) Framework, providers and commissioners of NHS funded services must show that they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients.

NHS England has an annual statutory requirement to formally assure its own, and the NHS in England's, EPRR readiness. To do this NHS England asks providers of NHS funded care to complete an annual assurance process. The first step in this process is organisational self-assessment.

The NHS England Core Standards for (EPRR) are the minimum requirements commissioners and providers of NHS funded services must meet. The number of standards for organisations is dependent on function and statutory requirements. For acute Trusts the number of reportable Core Standards to NHS England in 2022-23 is 64.

Declaration is via a self-assessment of fully compliant, partially compliant or not compliant against each Core Standard. An overall assurance rating is then assigned to the organisation on the percentage of reportable Core Standards for EPRR which the organisation has assessed itself as being 'fully compliant' with (see section 3 below).

Each year a 'deep dive' is conducted to gain additional assurance into a specific area. The 'deep dive' area of focus for 2022-23 is on Evacuation and Shelter. The self-assessment against the deep dive standards does not contribute to the organisation's overall EPRR assurance rating and is reported separately to NHS England (see section 5 below).

2. Statutes and Guidance Underpinning EPRR

The Civil Contingencies Act (CCA) 2004 places statutory duties on Category One Responders, and the Core Standards assess the Trust's preparedness and response capabilities to those duties and also to other statutory and regulatory requirements.

The key requirements for compliance are with:

- Civil Contingencies Act 2004;
- NHS Act 2006 (as amended by Health and Social Care Act 2012);
- NHS England Emergency Preparedness Framework 2015;
- National Standard Contract SC30;
- NHS Improvement;
- Care Quality Commission.

3. Self-Assessment Process – Compliance and Assurance Ratings

Process

The process for self-assessment was a review of the standards by the Trust's Emergency Planning Officer and the Interim Chief Operating Officer.

The details of each standard and evidence required were considered in detail and a peer review of the assessment was undertaken with the EPRR Team from Barnsley Hospital NHS Foundation Trust on 4 October 2022.

Compliance Ratings

Organisations rate their compliance for each reportable standard as:

Compliance Level	Definition
Fully compliant	Fully compliant with the Core Standard.
Partially compliant	Not compliant with the Core Standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months.
Not compliant	Not compliant with the Core Standard. In line with the organisation's EPRR work programme, compliance will not be reached in the next 12 months.

Assurance Ratings

An overall assurance rating is assigned to the organisation on the percentage of reportable Core Standards for EPRR.

The possible overall assurance ratings are:

Compliance Level	Evaluation and Testing Conclusion
Fully	The organisation is 100% complaint with all standards it is expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the Core Standards it is expected to achieve. For each non-compliant Core Standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the Core Standards it is expected to achieve. For each non-compliant Core Standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation is compliant with 76% or less of the Core Standards the organisation is expected to achieve. For each non-compliant Core Standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

4. Performance Against the Core Standards for 2022-23

The 64 Core Standards reportable by Acute Trusts are based on the duties of Category One Responders under the Civil Contingencies Act (CCA) 2004. They are split into ten domains (seen in the table below).

Performance Statement on reportable Core Standards (All)

Domain	No of Standards	Fully Compliant	Partially Compliant	Not Compliant
Governance	6	5	1	0
Duty to Assess Risk	2	2	0	0
Duty to Maintain Plans	11	7	4	0
Command and Control	2	2	0	0
Training and Exercising	4	2	2	0
Response	7	6	1	0
Warning and Informing	4	4	0	0
Co-operation	4	4	0	0
Business Continuity	10	3	7	0
CBRNe	14	14	0	0
Total	**64**	**49**	**15**	**0**

In total the Trust has assessed itself as fully compliant with 49 of the reportable Core Standards.

In total there are 15 standards which have been assessed as amber.

This equates to 77% compliance, meaning that the Trust will be reporting its compliance for 2022-23 as 'Partial'.

The details relating to non-compliance and actions for improvement are presented in the Improvement Plan at Appendix B.

5. Performance Against the Deep Dive Standards for 2022-23

Each year a 'deep dive' is conducted to gain additional assurance into a specific area. The 'deep dive' area of focus for 2022-23 is on Evacuation and Shelter.

The self-assessment against the deep dive standards does not contribute to the organisation's overall EPRR assurance rating and is reported separately to NHS England for use as an information gathering exercise.

Performance Statement on Evacuation and Shelter Standards

The Trust has assessed itself as fully compliant with eight of the 13 Evacuation and Shelter.

There are five deep dive standards which have been assessed as amber and on which actions will be taken.

Evacuation and Shelter has been a focus for the Trust's Estates and Facilities and EPRR teams during 2021-22 and work will continue to improve Trust processes – including working with Regional partners – during 2022-23.

6. Declaration of Compliance

The Accountable Emergency Officer is required to declare, on behalf of the Trust, the overall level of compliance against NHS England's Evaluation and Testing Conclusion (Appendix A).

The declaration for 2022-23 will be of partial compliance as the Trust is 77% compliant with the reportable Core Standards that it is expected to achieve.

The Board of Directors is required to approve the declaration.

7. Approval Process – Audit and Risk Committee, 14 October 2022

A report outlining the process and self-assessment was provided to the Trust's Audit and Risk Committee at its meeting on 14 October 2022.

The report was supported by a link to the full self-assessment working paper (excel spreadsheet) which Audit and Risk Committee Members were invite to access and view.

The Audit and Risk Committee:

- **Noted the self-assessment process undertaken for 2022-23.**

A number of queries were raised by Audit and Risk Committee Members, and the following points were noted:

- ***An Emergency Planning Support Officer had commenced in post in mid-May 2022***
  Although later than planned (due to repeated recruitment processes), this was extremely positive and would support the implementation of actions contained with the Improvement Plan (Appendix B).

- ***A direct comparison from the 2021-22 process and submission was not possible as the standards had been subject to a full review between periods***
  The submission for 2021-22 had been against 46 measurable standards (64 for 2022-23).
  There had been nine individual standards scored as 'amber' in 2021-22 which equated to a score of 80% (15 in 2022-23, equating to 77%).
  Both year statements provided a rating of 'Partial Compliance'.

- ***The percentage score for the year was one point above 'Non-Compliant'***
  The process for submission had been to score on a standard by standard basis – only computed to an overall score once all standards had been examined.
  It was a coincidence that the score of 77% aligned to the minimal available score to provide 'Partial Compliance'.
  The actions within the Improvement Plan (Appendix B) had been designed to close the gaps in assurance in achievable timeframes. Some of the actions were more straightforward than others and, as their completion was achieved, it would move the Trust's score into an increasingly favourable position.

- ***Focus was required on Business Continuity***
  A number of actions were included to redesign and implement the Trust's processes for Business Continuity.
  Business Continuity champions for all Divisions would be instrumental in ensuring the implementation of these actions throughout the organisation.

- ***Integrated Care Board and NHS England's Understanding of the Trust's position***
  The Trust's EPRR Team had worked with colleagues from NHS England throughout the year and, more recently with Integrated Care Board colleagues.
  Partner staff were aware of the Trust's position in terms of EPRR and would be anticipating a return at a 'Partial' level of compliance.

- ***Risks to Highlight to the Board of Directors***
  The Estates risks arising from the Trust's aged infrastructure were included on the Risk Register and were well rehearsed at the Board of Directors.
  The deadlines in the Improvement Plan were based on the information known, and resources available to the EPRR Team, at the time of the self-assessment. As such they were sensitive to changes, or additional pressures which might occur in the future.
  Any adverse impacts on the plan would be confirmed by the Trust's Chief Operating Officer, and reported to the Audit and Risk Committee.

- ***Reporting to the Audit and Risk Committee***
  A mid-year report on progress of the Implementation Plan would be provided to the Audit and Risk Committee.

The Audit and Risk Committee agreed to recommend that, at its meeting on 25 October 2022, the Board of Directors:

- **Approve the statement of compliance at Appendix A for submission to NHS England (North East and Yorkshire).**

- **Approve the Improvement Plan at Appendix B for submission to NHS England (North East and Yorkshire).**

8. Recommendations

The Board of Directors is requested to:

- **Approve the statement of compliance at Appendix A for submission to NHS England (North East and Yorkshire).**

- **Approve the Improvement Plan at Appendix B for submission to NHS England (North East and Yorkshire).**

9. Next Steps

- The statement and improvement plan will be submitted to NHS South Yorkshire ICB following the approval by the Board of Directors (no later than the deadline of 28 October 2022).

- By 11 November 2022 NHS South Yorkshire ICB will undertake and complete its local assurance processes with providers.

- By 18 November 2022 NHS South Yorkshire ICB will submit the submissions to NHS England (North East and Yorkshire).

- By 25 November 2022 the submissions from the four North East Yorkshire ICBs will have been reviewed by NHS England (North East and Yorkshire).

- By 30 November 2022, NHS England (North East and Yorkshire) will submit the assurance ratings to NHS England's Director of Emergency Preparedness, Resilience and Response (National).

- The Trust's confirmed level of compliance will be included in its Annual Report and Accounts for 2022-23.

APPENDIX A

North East & Yorkshire Emergency Preparedness, Resilience and Response (EPRR) Assurance 2022-23

STATEMENT OF COMPLIANCE

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Partial against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board/governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

Date signed

Date of Board/Governing Body meeting	Date presented at Public Board	Date published in Organisation's Annual Report

APPENDIX B

ACTIONS ARISING FROM 2022-23 ASSURANCE PROCESS (CORE STANDARDS)

Ref	Core standard description	Improvement required to achieve compliance	Actions to deliver improvement	Lead	Target date
5	Governance / EPRR Resource The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	The current structure is sufficient to fulfil 'BAU' requirements for EPRR. No additional resource has been identified to address the backlog of EPRR work (arising from the long term vacancy of the EPSO, the focus on EU Exit and Covid-19), or to support projects (eg Estates Risks and Evacuation). There is no defined budget for EPRR.	Consideration of resource requirements by the substantive COO (in post from January 2023).	Chief Operating Officer (Substantive)	31 March 2023
10	Duty to Maintain Plans / Incident Response In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	The Trust's EPRR policies and plans are in date, but not all are subject to annual review.	Update Trust EPRR policies and plans in line with stated review dates - and add an annual refresh date.	Emergency Planning Officer	31 March 2023

Ref	Core standard description	Improvement required to achieve compliance	Actions to deliver improvement	Lead	Target date
12	<u>Duty to Maintain Plans / Infectious Disease</u> In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Plans for the system response to Infectious diseases are led Public Health (DMBC). DBTH IPC policies are in place for the prevention and management and incident outbreaks – these would be tailored for specific circumstances (when known). Enhanced guidance on FFP3 requires the Trust to fit test relevant staff on at least two different masks, every two years.	Consider the need for a specific Trust Plan on infectious disease outbreaks. Determine, and implement, resource requirements to comply with FFP guidance: - Substantive team, - Equipment, - Processes, - Rolling programme.	Emergency Planning Officer Chief Nurse	31 March 2023 31 March 2023
13	<u>Duty to Maintain Plans / New and Emerging Pandemics</u> In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Plans for the system response to Infectious diseases are led Public Health (DMBC).	Consider the need for a specific Trust Plan on New and Emerging Pandemics.	Emergency Planning Officer	31 March 2023

Ref	Core standard description	Improvement required to achieve compliance	Actions to deliver improvement	Lead	Target date
16	Duty to Maintain Plans / Evacuation and Shelter In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	DRI identified as a high risk site for evacuation. Work with partners currently in place to agree dispersal of patients in the event of a partial or full site evacuation.	Progress work with partners on evacuation.	Chief Operating Officer / Emergency Planning Officer	31 March 2023
23	Training and Exercising / EPRR Exercising and Testing Programme In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Exercise and testing frequency not fully compliant with requirements during 2021/22.	Produce a training and exercise schedule for 2022/223.	Emergency Planning Officer	30 June 2023
24	Training and Exercising / Responder Training The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training.	Staff portfolios - for EPRR training and exercising – are not currently in place. NHSE/I is leading on a standard format.	Provide a format for personal records (NHSE/I is leading on a standard format for this work).	Emergency Planning Officer / Chief People Officer	31 March 2023

Ref	Core standard description	Improvement required to achieve compliance	Actions to deliver improvement	Lead	Target date
28	Response / Management of Business Continuity Incidents In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	The Trust's Business Continuity Strategy and Policy is due for update by 31 March 2023. A full review will be undertaken – with a view to the simplification of processes and implementation.	Review and republish the Trust's Business Continuity Strategy and Policy.	Emergency Planning Officer	31 March 2023
44	Business Continuity / BC Policy Statement The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.				
45	Business Continuity / Business Continuity Management Systems Scope and Objectives The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.				

Ref	Core standard description	Improvement required to achieve compliance	Actions to deliver improvement	Lead	Target date
46	<u>Business Continuity / Business Impact Analysis / Assessment</u> The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Annual refresh of all BIAs not completed during 2021/22.	• Conduct Business Continuity plan audit. • Finalise the update of the processes for business continuity plans (BCPs). • Provide training on BCP processes. • Facilitate workshops with divisions and departments to update BCPs. • Undertake exercises to test BCPs - locally and Trust wide. • Report on BCP matters to Board.	Emergency Planning Officer	30 June 2023
47	<u>Business Continuity / Business Continuity Plans</u> The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people, • information and data, • premises • suppliers and contractors, • IT and infrastructure.	Audit, to confirm availability of business continuity plans, required.			
48	<u>Business Continuity / Testing and Exercising</u> The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum.	Annual testing of business continuity plans – and reporting - not completed during 2021/22.			
50	<u>Business Continuity / Business Continuity Monitoring System Monitoring and Evaluation</u> The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.				

Ref	Core standard description	Improvement required to achieve compliance	Actions to deliver improvement	Lead	Target date
52	Business Continuity / Business Continuity Management System Continuous Improvement Process There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Requires review once BCMS has been developed and implemented.	Review of processes for BCMS effectiveness and reporting. Review scrutiny process for business continuity plans. All plans to be updated in light of the updated risk environment.	Emergency Planning Officer	30 June 2023

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 27 September 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
George Briggs - Interim Chief Operating Officer
Alex Crickmar - Acting Director of Finance
Mark Day - Non-executive Director
Joanne Gander - Non-executive Director
Zoe Lintin - Chief People Officer
Dr Tim Noble - Executive Medical Director
Richard Parker OBE - Chief Executive
Neil Rhodes - Non-executive Director
Kath Smart - Non-executive Director
Abigail Trainer - Acting Chief Nurse

In attendance:
Lesley Barnett - Deputy Director of Nursing for Cancer (agenda item B1)
Fiona Dunn - Director of Corporate Affairs / Company Secretary
Angela O'Mara - Deputy Company Secretary (Minutes)
Toni Peet - Personalised Care Manager (agenda item B1)
Dr Anna Pryce - Guardian of Safe Working (agenda item D3)
Adam Tingle - Acting Director of Communications & Engagement

Public in attendance:
Peter Abell - Public Governor Bassetlaw
Helen Best - Member of the Public
Laura Brookshaw - 360 Assurance
Tina Harrison - Partner Governor
Georgina Holmes - Staff Side Chair
Heather Jackson - Director of Allied Health Professionals (observer)
Lynne Logan - Public Governor Doncaster
Andrew Middleton - Public Governor Bassetlaw
Pauline Riley - Public Governor Doncaster
Sophie Strong - Graduate Management Trainee (observer)

Apologies:
Lois Mellor - Director of Midwifery
Jon Sargeant - Interim Director of Recovery, Innovation & Transformation

P22/09/A1 **Welcome, apologies for absence and declaration of interest (Verbal)**

The Deputy Chair of the Board welcomed everyone to the virtual Board of Directors meeting, including governors and members of public in attendance.
The above apologies for absence were noted and no declarations were made.

P22/09/A2 **Actions from Previous Meetings (Enclosure A2)**

Action 1 – Principles for 2022/2023
Action has now been closed.

Action 2 - Board Assurance Framework – Strategic Aim 1
An updated Board Assurance Framework was provided at agenda item C1. Action to be closed.

Action 3 - Impact of Pay Award
The impact had been included within the Finance Update provided at agenda item E2. Action to be closed.

Action 4 – Risk Management
The inaugural meeting of the Risk Management Board, scheduled for 19 September 2022 had been stood down in view of the national bank holiday for the Queen's funeral. The next meeting would take place on 17 October 2022 and an update provided to the Board of Directors meeting to take place on 29 November 2022.

The Board:

- ***Noted the update to the action log.***

P22/09/B1 **The National Cancer Patient Experience Survey 2021 Presentation (Enclosure B1)**

The Deputy Chair welcomed the Deputy Director of Nursing for Cancer and the Personal Care Manager to the meeting, to present the outcomes of the 2021 National Cancer Patient Experience Survey.

The presentation provided an overview of the survey, designed to monitor progress in delivery of cancer care, drive local improvements and inform the work of the various charities and stakeholder groups supporting cancer patients. The survey demonstrated the Trust's performance, as compared to the national average and identified strengths and development opportunities in the service provided.

The survey, commissioned by NHS England, and administered by Picker included NHS adult patients who had received a confirmed primary cancer diagnosis and were subsequently discharged following treatment between April and June 2021. A total of 116 patient responses had been received, representing a 58% response rate, the highest number of responses being from breast and colorectal patients.

Overall, 79% of the responses were above the national average and the Deputy Director of Nursing for Cancer recognised this positive outcome. This good news story had been shared within the team and with the support of the Communications Team would be made publically available and included in Trust wide internal communications.

Responses that fell below the national average had been carefully considered, where the level of service was impacted by partner service provision the Deputy Director of Nursing for Cancer confirmed the Trusts would work together to deliver improvements. Colleagues were actively involved in the development of an action plan to address the feedback.

Jo Gander thanked the Deputy Director of Nursing for Cancer for the presentation and shared her appreciation with all colleagues involved in the service, noting the review period coincided with the continued presence of Covid-19. It was confirmed that the areas from which the greatest response had been seen directly related to patient numbers.

Hazel Brand welcomed the development of the action plan but recognised the challenging timeframe to implement and see an impact considering the next survey would take place in October 2022. Post meeting the possibility of the report being received in a timelier manner was raised with the Deputy Director of Nursing for Cancer who agreed to provide that feedback to the national survey provider, Picker.

Kath Smart acknowledged the negative feedback and nationally low response rate with regards to the quality of patient food and confirmed nutrition and hydration had been subject to discussion at the Quality & Effectiveness Committee. Whilst no overarching themes had been identified it was helpful to receive feedback for discussion at the relevant forum.

The Executive Medical Director acknowledged the positive outcome and shared his appreciation with the Deputy Director of Nursing for Cancer and the wider team.

The Chair thanked the Deputy Director of Nursing for Cancer for the comprehensive update to Board.

The Board

- ***Noted the National Cancer Patient Experience Survey 2021 presentation***

P22/09/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 Acting Chief Nurse confirmed all updates were highlighted for ease of reference. Guidance on implementation of the Patient Safety Incident Response Framework (PSIRF) had been received, delivery of which was expected within 12 months and would be considered alongside the patient safety peer review and the governance restructure. The revised Infection, Prevention and Control Board Assurance Framework remained outstanding.

The Executive Medical Director confirmed the National Institute for Health and Care Excellence (NICE) clinical effectiveness audits and Tendable audits were included as new measures. Risk stratification, validation and clinical prioritisation of patient pathway work continued and ongoing development/improvements would be progressed by the Outstanding Outpatients Forum, to include digital transformation.

Kath Smart welcomed the addition of the risk appetite to the Board Assurance Framework and the incorporation of Strategic Aim 1 (Covid). A conversation with regards to the implementation of the Patient Safety Incident Response Framework was expected at next week's Quality & Effectiveness Committee, including the impact of the actions on the target risk rating.

The Chief Executive acknowledged the change to systems, process and controls arising from PSIRF, however, a need to improve current performance levels as well as a focus of the future was required; with safe and sustainable urgent and emergency care, elective recovery and winter plans required.

In response to a question from Mark Bailey, the Acting Chief Nurse confirmed that in the absence of an updated Infection, Prevention & Control Board Assurance Framework the existing guidance was being followed, no change had been identified to the Trust's position by the Lead IPC Nurse and the Director of Infection Prevention and Control.

In respect of the Ockenden assurance, Mark Bailey asked that the date be amended to reflect the peer review visit of July 2022.

With the expected return of influenza and norovirus this winter, whilst learning to live with Covid, the Chief Executive stressed the importance of public support in respect of adopting hands, face, space and ventilation and key public health communications would be required to this effect.

The Board:

- ***Noted and took assurance from the Board Assurance Framework***

P22/09/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 safer nursing data collection in May a need to provide additional training in the use of the safer staffing tool was identified, due to staff turnover. The next data collection would take place in November 2022 and would support the business planning process.

A summary of new recruits by division identified new starters over the coming months, due to the impact of Covid on placement hours a slight delay to start dates had been seen for some newly qualified nurses. Funding for a Royal College of Nursing leadership development programme had been secured for 75 staff nurses.

A focus on agency usage continued, including choice of supplier and the approval process for high cost providers.

The Chief People Officer requested an early conversation with the Acting Chief Nurse to ensure a joined up approach to just culture.

Kath Smart recognised the potential of Tendable, feedback on audit outcomes would be presented to the Quality & Effectiveness Committee with a focused conversation on learning.

Mark Day noted the review of moderate and severe harm falls and enquired if a wider review to include no and low harm falls was undertaken. The Acting Chief Nurse confirmed that falls work focused primarily on prevention, an example of which was the "see yellow think falls" initiative. The nursing team and the Director of Allied Health Professionals

would work closely to further develop falls prevention, evidence of which had been observed on a recent ward visit by the Interim Chief Operating Officer and Mark Bailey as part of a therapist led quality improvement.

In response to a question from Mark Day, the Acting Chief Nurse confirmed that despite difficulties recruiting, the safe care pilot had continued with manual data collection. The Chief Executive acknowledged that due to the relocation of colleagues during the pandemic there may be a need to review and refresh the Allocate system to ensure the establishment and associated budget accurately reflected workforce needs.

Mark Bailey welcomed the extension of the RCN leadership programme, in terms of wider learning and development needs the Acting Chief Nurse confirmed they would be considered as part of the appraisal process.

The Board:

- ***Noted and took assurance from the Chief Nurse Update.***

P22/09/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 Acting Chief Nurse confirmed a recent visit of maternity services had taken place, supported by the non-executive maternity safety champion. Staffing continued to be challenging, although a number of newly qualified and experienced midwifes had now been recruited.

The Director of Midwifery had recently presented to the Council of Governors on maternity safety reviews and their impact and the Chair of the Board acknowledged the contribution of the Director of Midwifery and her team.

The Board:

- ***Noted and took assurance from the Maternity Update***

P22/09/C4 **Executive Medical Director Update, including Q4 2021/2022 Learning from Deaths Report (Enclosure C4)**

The Executive Medical Director Update provided a summary of key areas of work within the directorate, including the Hospital Standardised Mortality Ratio (HSMR), Summary Hospital-level Mortality Indicator (SHMI) and the Learning from Deaths Report Quarter 4 2021/22.

Kath Smart noted the inclusion of SHMI in the CQC Insight report recently received at the Quality & Effectiveness Committee and stressed the importance of being sighted on this performance indicator, noting the limiting factors in its calculation identified by the Executive Medical Director.

Recruitment to some specialities was difficult and where additional sessions were a consistent feature, the Executive Medical Director confirmed they would be subject to review by the Medical Director for Workforce and Specialty Development.

In response to a question from Neil Rhodes, with regards to the high number of programmed activities (PAs) carried out by some consultants, the Executive Medical Director clarified that outside of 7am-7pm Monday to Friday the PA equated to three rather than four hours. In addition a PA could relate to the discharge of a specific duty, rather than a time commitment. However, as a responsible employer, there was a duty of care to employees to be considered alongside the delivery of a safe, efficient and sustainable service. The Chief Executive suggested it would be appropriate as an organisation to determine an upper limit for PAs, the monitoring of which would be undertaken by the Medical Directors Office and benchmarked via model hospital.

In response to a question from Jo Gander, the Executive Medical Director confirmed that a diagnosis of autism was not always included in care records, as a result of patient choice and as such autism could not always be identified within the learning from deaths reports.

Mark Day highlighted the issue of missing patient wristbands, the Acting Chief Nurse confirmed a planned programme of work to address this was underway, the monitoring of which could be included within a Tendable audit.

The Board:

- ***Noted and took assurance from the Executive Medical Director Update.***

P22/09/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 Chief People Officer confirmed updates from this month's People Committee had been incorporated, highlighted for ease of reference. A discussion had taken place in respect of strategic aim 3's target risk rating relating to workforce, which had resulted in an amendment to the in-year rating of 12 with the overall ambition remaining at 8. In addition, a corporate risk had been added to the risk register to reflect the impact of the current cost of living crisis on our workforce and the potential for industrial action.

The programme of Board visits had commenced in September and the Chair of the Board enquired how the Board could be assured that outputs requiring action were addressed. The Chief People Officer confirmed the key purpose of the visits was to raise visibility, improve connections with the workforce and observe first-hand the staff and patient experience. Colleagues were to be signposted for appropriate support, unless the matter was able to be resolved by the visiting board members. The executive board member would feedback to the host and send a thank you card and the non-executive member would complete the template for return to the Trust Board Office.

An engagement plan would support the launch of the staff survey this week, including the sharing of previous year's improvements, it would be helpful for board members to

promote completion as part of their visits. A yearly cycle of engagement would be planned going forwards to ensure timely action once the embargo was lifted.

The Board:

- ***Noted and took assurance from the Board Assurance Framework***

P22/09/D2 **People Update (Enclosure D2)**

The People Update provided information on developments relating to staff engagement and experience, board development, buddying and non-executive "champion" roles.

A total of 69% of non-medical colleague appraisals had been recorded, the completion rate was expected to be slightly higher due to delays in updating ESR. A review of the appraisal process had taken place and a shortened form would be developed for use next year; it was expected the season would start in April 2023.

A communications programme to support the national Speak Up campaign would take place In October. In her capacity as Freedom to Speak Up Non-executive Director, Hazel Brand encouraged board members to share their pledge.

In response to a question from Kath Smart with regards to assessing the impact of the health and wellbeing offer, the Chief People Officer confirmed the offer had been reviewed at the recent People Committee from a sustainability perspective and whilst the take up rates indicated the level of interest, feedback from a qualitative perspective was also required. A briefing paper with regards to the future of the schemes would be developed with a view to establish funding support.

The Board:

- ***Noted and took assurance from the People Update.***

P22/09/D3 **Guardian of Safe Working Quarterly Report (Enclosure D3)**

The Chair of the Board welcomed the Guardian of Safe Working, Dr Anna Pryce, to the meeting.

The report provided an overview of reporting during the period May to July 2022, when a low level of exception reporting was noted, mostly related to medical specialities with rota gaps, arising due to vacancies and/or sickness absence. An anomaly in reporting was highlighted during May and June where multiple exceptions were reported retrospectively by a junior doctor. A programme of engagement to raise awareness of exception reporting and its purpose was ongoing.

Over the last 12 months an increase in the number of exception reports relating to missed educational opportunities was noted, reflective of high workloads. The Executive Medical Director confirmed educational training should be stood down only in exceptional circumstances and he encouraged increased awareness of this matter.

The Guardian of Safe Working reported higher than usual trainee vacancies during August which may impact on future reports. It was agreed that an updated position would be received at November's Board of Directors.

The Board:

- ***Noted and took assurance from the Guardian of Safe Working Quarterly Report***

P22/09/D4 **Workforce Race & Disability Equality Standards (Enclosure D4)**

The Chief People Officer brought the Board's attention to this year's data submissions in respect of workforce race and disability equality standards. The report highlighted the positive improvements and key areas of focus, which included a lack of disabled and Black, Asian and Minority Ethnic (BAME) representation at board level and a largely static BAME non-clinical representation in Agenda for Change bands 8a and above.

Neil Rhodes acknowledged the positive BAME representation across the NHS below band 8a and reflected that analysis of the top 5% of earners may be a helpful indicator of positive representation. He recognised that disability equality standards were more challenging, however, an increase in the number of appointments had been seen, particularly in Agenda for Change bands 5 to 7.

A number of initiatives to improve representation at a Board level, including the Black on Board programme and board apprentices, provided opportunities to specifically target groups to support executive and non-executive appointments and the Chief People Officer agreed to discuss with Neil Rhodes outside of the meeting. **ZL**

The Chair of the Board confirmed a previous pre-pandemic approach to increase the Board's diversity had met with limited success and the newly appointed Chief People Officer was currently undertaking an options appraisal which would be presented to a future board for consideration.

The Board:

- ***Noted and took assurance from the Workforce Race & Disability Equality Standards***

P22/09/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 related to the deterioration of the income and expenditure position in month five, which he summarised as part of agenda item E2 – Financial Update.

The Board:

- ***Noted and took assurance from the Board Assurance Framework***

P22/09/E2 **Finance Update (Enclosure E2)**

The Acting Director of Finance provided a high-level overview of the month five position. The Board were asked to note an in-month deficit of £2.7m, £1.0m adverse to plan and a year-to-date deficit of £7.9m, £1.4m adverse to plan. The deficit was largely driven by a pay overspend of £4.7m due to high temporary staffing usage. The reported position included Q1/2 Elective Recovery Funding, which if removed would result in a deficit variance of c£7-8m.

Capital spend in-month was £1m against a plan of £1.7m, year-to- date capital spend was £3.6m against a plan of £7.3m.

At the end of August the cash balance was £27m, an increase of £2.8m from the previous month. This increase related to quarterly income from Health Education England and limited capital expenditure. Due to the planned income and expenditure deficit and a back loaded capital plan, the cash balance was expected to fall throughout the rest of the year and would be subject to close monitoring.

£2.2m of savings had been delivered in month against the plan of £1.1m, with a year to date savings of £8.1m against a planned £5.7m.

As requested at the last Board meeting the Acting Director of Finance confirmed the estimated annual cost of the 2022/23 pay award was c£13.9m. Taking into account additional funding since planning, initial calculations indicated an annual cost pressure in year of c£0.3m.

In addition to the actions taken at an organisational level in respect of agency spend, the Chief People Officer confirmed the Trust was also part of a system wide working group.

In his capacity as Chair of the Finance & Performance Committee Neil Rhodes recognised the challenging income and expenditure position and confirmed an additional single agenda meeting of the Committee had supported a focused discussion on the increased reliance and associated cost of temporary staffing. The discussion considered workforce and operational pressures, the financial impact and relevant controls and mitigating actions.

In response to a question from Kath Smart with regards to plans to address the increased agency spend, the Chief Executive confirmed the plan would be based on forecasted activity, elective recovery funding assumptions, bed base and anticipated Covid infection rates. The situation was recognised to be challenging at a local, regional and national level. The Trust had not delivered the required enhanced levels of activity and there was the potential for future funding to be linked to delivery of patient initiated follow up and virtual wards. The plan had to be predicated on increased recruitment and reflect new ways of working, the revised plan and refreshed trajectories would then allow a financial position to be established, and the Integrated Care Board would be sighted on these plans and associated challenges. The work would be co-ordinated by the Directorate of Recovery, Innovation & Transformation and tracked via Monday.com, allowing operational staff the time to focus on delivery.

The Acing Chief Nurse highlighted that the majority of additional shifts sourced via NHS Professionals were fulfilled by Trust colleague and reinforced the need to achieve a balance

between offering a safely staffed service and colleagues' health and wellbeing. In addition, as the majority of new recruits were newly qualified registrants, a settling in period was required before they become part of the hands per shift.

The Board:

- ***Noted the Finance Update.***

P22/09/E3 **Operational Performance Update including Ambulance Handover Delays (Enclosure E3)**

The Interim Chief Operating Officer provided an insight into the current operational performance.

Demand for emergency services remained high; a reconfiguration of services to improve triage and streaming at the front door including enhanced pathways for same day emergency care had taken place and overnight/out of hours GP capacity had been increased.

The ambulance handovers position continued to be challenging, with increased numbers and continuing flow issues resulting in delays. The Trust was working proactively with partners to educate and improve direct referrals to Same Day Emergency Care and had initiated changes to reinstate the Emergency Assessment Unit and increase the capacity for Early Senior Assessment.

A second draft of the winter plan had been prepared and use of the modular theatre finalised to be implemented following the relocation of the central delivery suite.

The Chief Executive recognised the need to improve emergency performance, both internally and with partners, ensuring patients were seen in the right place and at the right time and to manage flow out of the department via a place-based approach.

Kath Smart sought assurance that the plans to address ambulance handover delays and elective recovery were appropriate, the Interim Chief Operating Officer confirmed his confidence in the urgent and emergency care plans but highlighted the impact would be realised over a period of time and with the support of the Trust's partners. In response to a question from Hazel Brand, it was confirmed that delivery was monitored via Monday.com and the Project Management Office and reported to the Finance & Performance Committee.

The Trust would work with the independent sector to recover elective backlogs with the process and budgets carefully managed by the Interim Chief Operating Officer, Interim Director of Recovery, Innovation & Transformation and Acting Director of Finance.

The Interim Chief Operating Officer clarified the process of waiting list validation, currently completed by an external provider, Source, with a view to completing the work in house.

The Board:

- Noted and took assurance from the Operational Performance Update

P22/09/E4 **Update on Covid-19 Public Enquiry (Enclosure E4)**

The Company Secretary provided an overview of the Covid-19 public enquiry, noting its modular approach, procedural and public hearings and associated timeline. A summary of the implications and considerations for the Board were highlighted. In accordance with the terms of reference the Trust was not expected to be a core participant and to date no request for information had been received. The necessary provisions for the retention of data and documents was in place.

The Interim Chief Operating Officer, was the Trust's executive lead, supported by the Emergency Planning Team.

In response to a question from Hazel Brand, the Company Secretary confirmed the focus on discharge to care homes/social care settings was expected to be considered as part of Module 3.

Risk ID 3103 - the Trust's ability to comply with National COVID-19 Inquiry had been added to the corporate risk register and future updates would be provided to Board, as required.

The Board:

- ***Noted the Update on Covid-19 Public Enquiry***

P22/09/E5 **Directorate of Recovery, Innovation & Transformation Update (Enclosure E5)**

In the absence of the Interim Director of Recovery, Innovation & Transformation the Chief Executive introduced the report which provided an insight into the directorate's work.

The importance of the Montagu Elective Orthopaedic Centre project was highlighted. Working in partnership with The Rotherham NHS Foundation Trust and Barnsley Hospital Foundation Trust, the Trust was developing a business case on behalf of the Integrated Care System to create a centre of excellence to support orthopaedic elective recovery.

In his capacity as Chair of the Finance & Performance Committee Neil Rhodes confirmed a substantial update had been provided at this month's Committee meeting, which included an in-depth assessment of the capital projects and governance structure implemented to ensure appropriate oversight of key developments. The Committee were appropriately assured and welcomed the positive impact of the new directorate.

The Board:

- ***Noted and took assurance from the Directorate of Recovery, Innovation & Transformation Update.***

P22/09/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.

Risk ID 3103, the Trust's ability to comply with the National COVID-19 public inquiry had been added to the register by the Interim Chief Operating Officer.

Risk ID 2472 - Covid-19 had seen a reduction in the rating assigned to the management of the world-wide Corona virus pandemic from 20 to 15.

The independent peer review of risk management had been completed and the key enabler for the implementation of the report recommendations would be the newly created Risk Management Board.

Kath Smart welcomed the updates to the corporate risk register, further updates to Estates & Facilities risks were required and the Company Secretary agreed to follow these up with the team. **FD**

In response to a question from Neil Rhodes, the Executive Medical Director confirmed that ahead of the Risk Management Board colleagues would be asked to review the current 15+ risks to ensure the risk and mitigating actions were still relevant and current.

The Board:

- ***Noted the Corporate Risk Register.***

P22/09/G2 **Approval of Risk Management Policy & Risk Appetite Statement (Enclosure G2)**

The policy and supporting risk appetite statement were received for approval. The papers had been circulated for comment to executive and non-executive colleagues, the Trust's internal auditors and presented to the Trust Executive Group, comments from which had been incorporated.

Updates to the policy included: risk appetite, risk tolerance, risk grading, roles and responsibilities, a review of the risk governance structure and process and the development of Risk Management Board Terms of Reference. All of which addressed the recommendations in the internal audit risk management review.

In response to a question from the Executive Medical Director, the Chief Executive confirmed as the substantive director with responsibility for clinical governance and patient safety, his role as Chair of the Risk Management Board was appropriate and no revision to the policy review date was necessary.

The Board

- ***Approved the Risk Management Policy & Risk Appetite Statement***

P22/09/G3 **Trust Board Directors Register of Interests & Fit & Proper Person Annual Review (Enclosure G3)**

In accordance with the NHS Code of Accountability and NHS England's guidance on managing conflicts of interest, board members were required to declare an interest which had the potential to conflict the impartial discharge of their duties. A current register of interests as at 1 August 2022 was provided for information, should there be any future change this should be declared to the Chair of the Board prior to the business of the meeting.

The Board

- ***Noted the Trust Board Directors Register of Interests & Fit & Proper Person Annual Review***

P22/09/G4 **DBTH Constitution – Review Update (G4)**

A review of the Trust's Constitution had been completed by the Company Secretary to reflect changes following the introduction of the Health and Care Act 2022, specifically the formal adoption of Integrated Care Systems and the subsequent abolition of Clinical Commissioning Groups (CCG).

Other changes included clarity in respect of volunteer membership rights, the role of a governor in system working and following legislative changes the opportunity to replace CCG partner governors to improve diversity and reflect the community served by the Trust.

Feedback from executive, non-executive and governors had been incorporated and subject to approval by the Board, the Constitution would be presented to the Council of Governors on 29 September for ratification.

In response to a question from Hazel Brand, the Company Secretary confirmed the suspension of a governor subject to a conduct/disciplinary investigation was referenced at 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)".*** Further guidance, including actions to terminate a governors tenure could be found in Annex 5 and in response to a question from the Chief Executive it was confirmed post meeting that where a governor resigned or their tenure terminated they would not be eligible to stand for re-election for a period of three years from the date of resignation/removal.

Subject to the above clarification the Board confirmed their approval of the Constitution.

The Board

- ***Approved the Trust's Constitution***

P22/09/H1 **Information Items (Enclosure H1 – H9)**

The Board noted:

- H1 Chair and NEDs Report
- H2 Chief Executives Report
- H3 Performance Update Appendices
- H4 Minutes of the Finance and Performance Committee 26 May & 30 June 2022
- H5 Minutes of the People Committee 3 May 2022
- H6 Minutes of the Audit & Risk Committee 17 June 2022
- H7 Minutes of the Quality & Effectiveness Committee 8 February, 5 April & 7 June 2022

- H8 – Minutes of the Charitable Funds Committee 9 December 2021 & 24 March 2022
- H9 Minutes of the Trust Executive Group 11 July & 15 August 2022

P22/09/I1 **Minutes of the meeting held on 26 July 2022 (Enclosure I1)**

The Board:

- ***Approved the minutes of the meeting held on 26 July 2022.***

P22/09/I2 **Any other business (to be agreed with the Chair prior to the meeting)**

No items of other business were raised.

P22/09/I3 **Governor Questions regarding the business of the meeting (10 minutes) ***

The following questions were raised by the Deputy Lead Governor, on behalf of the governors:

The Board Assurance Framework cites workforce as the top risk to sustainable performance. Accepting that the Trust is constantly pursuing a range of mitigation actions, workforce shortages remain a significant challenge. Much of the cause lies at the door of national decisions on training places, pay, pensions, etc., over which we have little influence. **In respect of elements within the "control" of the Trust, are there further actions being taken or planned to be taken to further improve the workforce situation, particularly in respect of retention? Which of these is working? Additionally, what collaborative actions are being taken with partners within the ICBs (SY and Notts.) to secure longer-term improvement in workforce supply and retention, and which of these is expected to have an early positive impact?"**

"The Chief Executive has emphasised the necessity of system working with partners in primary care, community services, social care, etc., in order to reduce avoidable attendances at ED and other departments and to improve flow of patients to and from our hospitals. The governors would welcome a presentation and discussion on what actions have been taken or planned within this chain of collaboration, and how effective they have been or are expected to be."

In order to fully respond to the above, it was agreed that individual governor briefing sessions would be arranged, to be led by the Chief People Officer and Chief Executive respectively.

The Chair of the Board thanked those in attendance for their contribution.

The Board:

- ***Noted the governor question and the agreed approach***

P22/09/I4 **Date and time of next meeting (Verbal)**

Date: Tuesday 25 October 2022
Time: 09:30am
Venue: MS Teams

P22/09/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.***

P22/09/J **Close of meeting (Verbal)**

The meeting closed at 12.55