Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting Held in Public
To be held on Tuesday 29 November 2022 at 09:30
Via MS Teams

Enc		Purpose	Page	Time
A	**MEETING BUSINESS**			**09:30**
A1	Welcome, apologies for absence and declarations of interest *Suzy Brain England OBE, Chair* *Members of the Board and others present are reminded that they are required to declare any pecuniary or other interests which they have in relation to any business under consideration at the meeting and to withdraw at the appropriate time. Such a declaration may be made under this item or at such time when the interest becomes known* *Members of the public and governor observers will have both their camera and microphone disabled for the duration of the meeting*			10
A2	Actions from previous meeting *Suzy Brain England OBE, Chair*	*Review*		
B	**PRESENTATION**			**09:40**
B1	Tendable *Marie Hardacre, Head of Nursing for Corporate Services*	*Note*		15
C	**True North SA1 - QUALITY AND EFFECTIVENESS**			**09:55**
C1	Board Assurance Framework *Dr Tim Noble, Executive Medical Director* *Kirsty Clarke, Acting Deputy Chief Nurse* *Simon Brown, Acting Deputy Chief Nurse*	*Assurance*		10
C2	Chief Nurse Update *Kirsty Clarke, Acting Deputy Chief Nurse* *Simon Brown, Acting Deputy Chief Nurse*	*Assurance*		15
C3	Maternity Update *Lois Mellor, Director of Midwifery*	*Assurance*		10
C4	Executive Medical Director Update • to include Q1 2022/23 Learning from Deaths *Dr Tim Noble, Executive Medical Director*	*Assurance*		15

D	**True North SA2 & 3- PEOPLE AND ORGANISATIONAL DEVELOPMENT**			**10:45**
D1	Board Assurance Framework *Zoe Lintin, Chief People Officer*	*Assurance*		10
D2	People Update *Zoe Lintin, Chief People Officer*	*Assurance*		10
D3	Guardian of Safe Working Quarterly Report *Dr Anna Pryce, Guardian for Safe Working & Consultant in Sexual Health* *Zoe Lintin, Chief People Officer & Dr Tim Noble, Executive Medical Director*	*Assurance*		10
	BREAK 11:15 – 11:25			
E	**True North SA4 - FINANCE AND PERFORMANCE**			**11:25**
E1	Board Assurance Framework *Alex Crickmar, Acting Director of Finance (SA4 Finance)*	*Assurance*		10
E2	Finance Update *Alex Crickmar, Acting Director of Finance*	*Note*		10
E3	Board Assurance Framework *George Briggs, Interim Chief Operating Officer (SA1/SA4) Performance*	*Assurance*		10
E4	Operational Performance Update to include Ambulance Handovers *George Briggs, Interim Chief Operating Officer*	*Assurance*		20
E5	Directorate of Recovery, Innovation & Transformation Update *Jon Sargeant, Interim Director of Recovery, Innovation & Transformation*	*Assurance*		10
F	**STRATEGY**			**12:25**
F1	Community Diagnostic Centre Business Case *Jon Sargeant, Interim Director of Recovery, Innovation & Transformation*	*Approve*		15
G	**GOVERNANCE AND ASSURANCE**			**12:40**
G1	Corporate Risk Register *Fiona Dunn, Director Corporate Affairs/Company Secretary*	*Review*		5
G2	Use of Trust Seal *Fiona Dunn, Director Corporate Affairs/Company Secretary*	*Assurance*		10
G3	NHSE Consultation • NHS Enforcement Guidance • Provider Licence *Fiona Dunn, Director Corporate Affairs/Company Secretary*	*Information*		10
H	**INFORMATION ITEMS (To be taken as read)**			**13:05**
H1	Chair and NEDs Report *Suzy Brain England OBE, Chair*	*Information*		
H2	Chief Executives Report *Richard Parker OBE, Chief Executive*	*Information*		

H3	Performance Update Appendices *George Briggs, Interim Chief Operating Officer*	*Information*		
H4	Minutes of the Finance and Performance Committee - 21 July, 12 August & 26 September 2022 *Neil Rhodes, Non-executive Director*	*Information*		
H5	Minutes of the People Committee - 5 July & 6 September 2022 *Mark Day, Non-executive Director*	*Information*		
H6	Minutes of the Quality & Effectiveness Committee - 5 September 2022 *Jo Gander, Non-executive Director*	*Information*		
H7	Minutes of the Audit & Risk Committee - 14 July 2022 *Kath Smart, Non-executive Director*	*Information*		
H8	Minutes of the Charitable Funds Committee – 20 June 2022 *Mark Bailey, Non-executive Director*	*Information*		
H9	Minutes of the Trust Executive Group – 12 September 2022 *Richard Parker OBE, Chief Executive*	*Information*		
I	**OTHER ITEMS**			**13:05**
I1	Minutes of the meeting held on 25 October 2022 *Suzy Brain England OBE, Chair*	*Approval*		5
I2	Any other business (to be agreed with the Chair prior to the meeting) *Suzy Brain England OBE, Chair*	*Discussion*		
I3	Governor questions regarding the business of the meeting (10 minutes)* *Suzy Brain England OBE, Chair*	*Discussion*		10
I4	**Date and time of next meeting:** **Date:** Tuesday 20 December 2022 **Time:** 9:30 **Venue:** MS Teams	*Information*		
I5	**Withdrawal of Press and Public** Board to resolve: That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. *Suzy Brain England OBE, Chair*	*Note*		

J	MEETING CLOSE	13:20

***Governor Questions**

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

For Governors in attendance, the agenda provides the opportunity for questions to be received at an appointed time. Due to the anticipated number of governors attending the virtual meeting, Lynne Schuller, as Lead Governor will be able to make a point or ask a question on governors' behalf. If any governor wants Lynne to raise a matter at the Board meeting relating to the papers being presented on the day, they should contact Lynne directly by 5pm day prior to the meeting to express this. All other queries from governors arising from the papers or other matters should be emailed to Fiona Dunn for a written response.

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

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

Suzy Brain England OBE
Chair of the Board

Action notes prepared by: Claudia Gammon
Updated: 25 October 2022

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Action Log

Meeting:	Public Board of Directors
Date of latest meeting:	25 October 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/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 **Included within Executive Medical Director Update (C4)**
2.	**P22/10/D1**	**Medical Advisory Committee and Risk Management Board** To provide a visual governance structure to show the reporting structure of the Medical Advisory Committee and the Risk Management Board.	**TN**	**November 2022**	**Included within Executive Medical Director Update (C4)**
3.	**P22/10/D1**	**Corporate Director Objectives** Mid-year review and discussion of corporate objectives to commence with the Executive Directors and the Chairs at the relevant Board Sub-Committees. Review if workshop required once process reviewed	**All**	**November 2022**	**Post meeting update** – the Chief Executive & Chair of the Board agreed that each executive director would meet with the non-executive directors to talk through their objectives, highlighting successes and challenges. Meetings were in the diary, with the exception off the Chief Operating Officer and Chief Nurse which would take place by the end of Q4 2022/2023, following their substantive appointments in January 2023.

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DBTH a vision for quality and improvement

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Tendable is a company that has delivered a software application that improves the effectiveness and efficiency of healthcare providers.

The Tendable application is a smart quality inspection tool that empowers frontline staff to improve quality in any healthcare setting. One simple audit process that can cover both internal needs and regulatory requirements.

The DBTH journey started in May 2022. The key aims of the launch of the project at DBTH is to give a real time view of quality assurance. Providing the reports, analytics and insights to improve performance and compliance, so our teams can spend more time in providing care.

Tendable has already improved our ability to audit the quality of care we provide, and gives the frontline teams the tools and information they need to continually improve.

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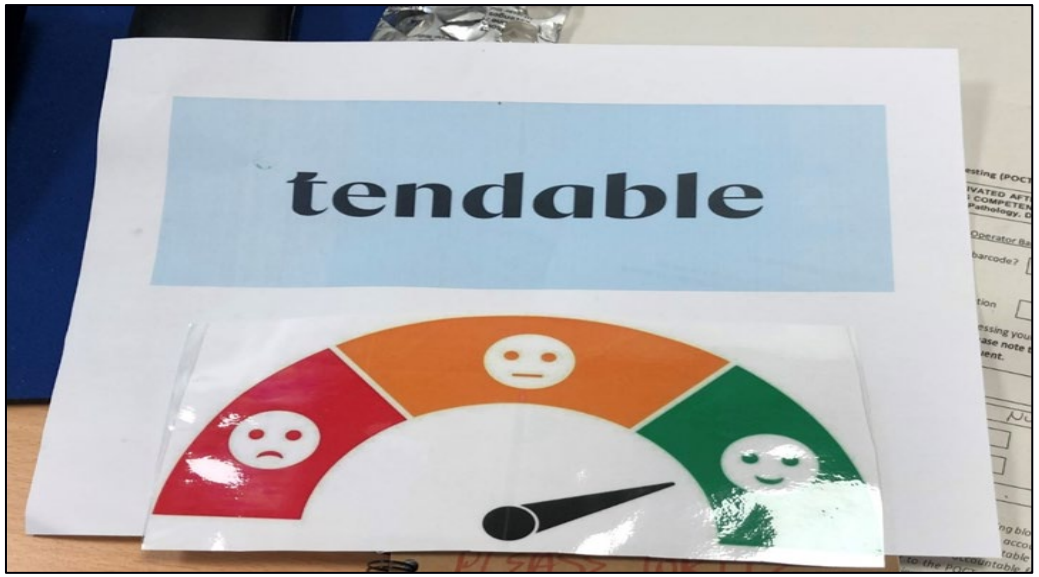
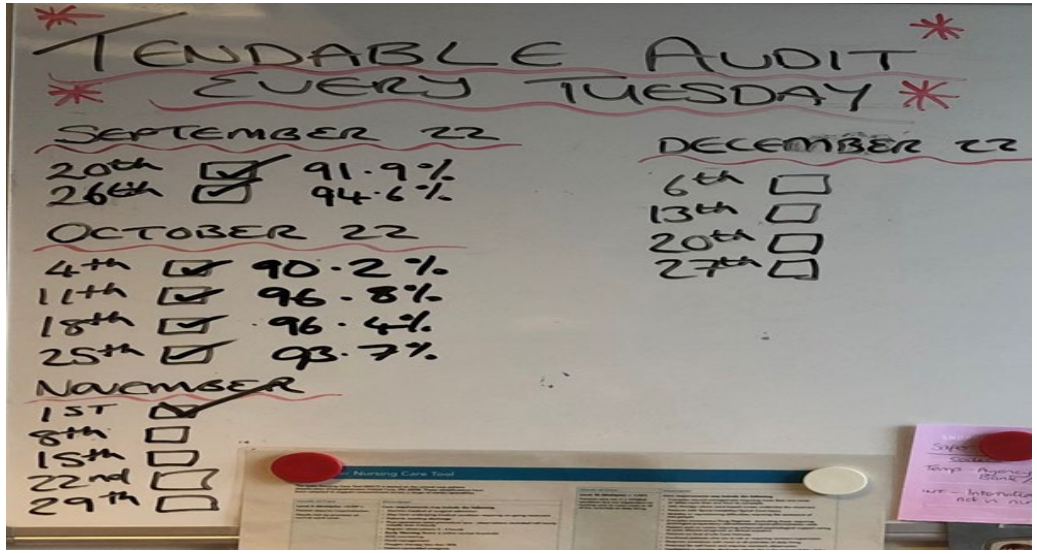
At DBTH the Tendable inspection question sets have been tailored to meet DBTH specific needs and to show our teams what good practice looks like.

The mobile application is easy to use, saves time and makes quality audits effective. Our teams can own quality and it provides them with the tools for tracking quality performance.

Our frontline teams are empowered to take actions effective to improve the quality of care we strive for.

Engagement sessions on all 3 sites have taken place and all the teams have been enthusiastic in embracing this new way of working. Images show how some managers have shared good work.





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A weekly Ward/Department Manager inspection and a monthly Matron inspection was launched for all inpatient wards. Inspections started in July 2022 on all our inpatient wards. This allowed education and support before compliance monitoring. The official compliance monitoring was launched in October.

Next steps at DBTH is that our Accreditation Lead Nurse is supporting Maternity and Paediatric wards with education and how to undertake inspections, inspections are live on the system.

Outpatients and Theatres all now have access to inspections and are assessing what question sets are relevant for their areas and what specialist questions are required to monitor compliance.

The full project plan is tracked via Monday.com. and is monitored through the Quality Steering Group. The Tendable Steering Group has also commenced, this is a cross divisional group supporting all stakeholders to shape progress.

Work is progressing at pace and we are continuing to liaise with other Trusts for support with lessons learnt from implementation.

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Feedback following engagement session and how the wards have celebrated improvement

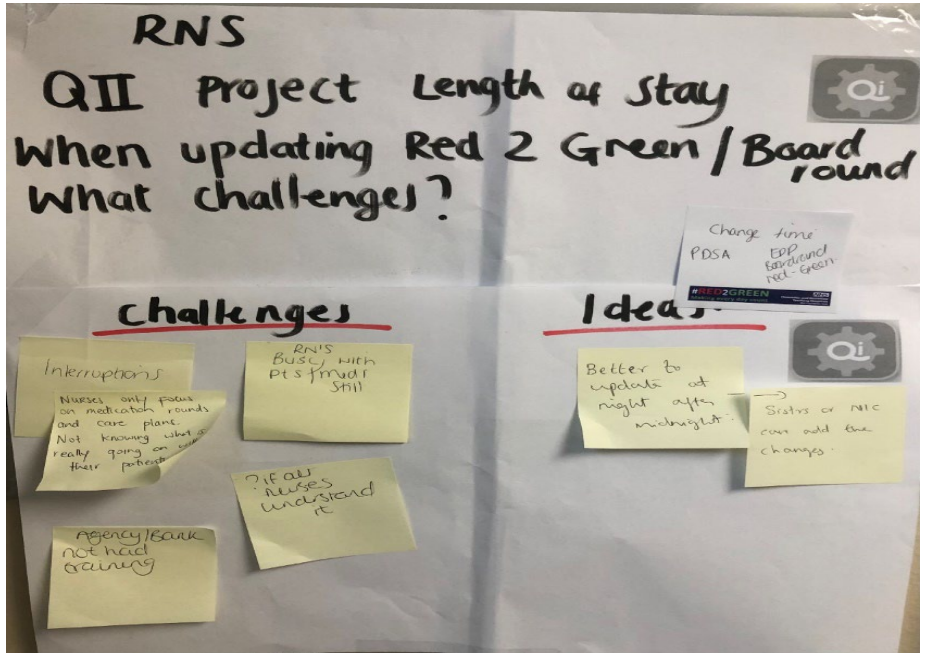
"I can now really see the improvement at a glance - you can see where there is an issue or improvement to be made and also what we do well" (CCU)

"I love Tendable, it makes auditing so much more simpler and easier. Also allows other staff members to have an angle on what we audit on the wards, helps them understand…" (W20)

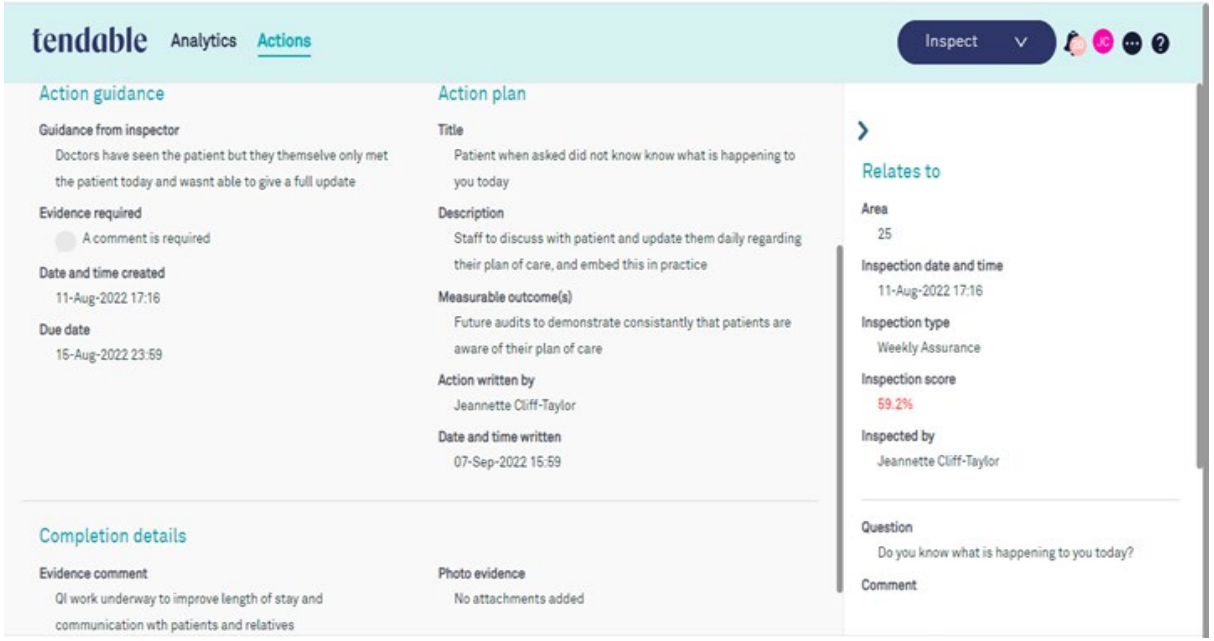
Improvements Demonstrated

Inpatient wards are using their Actions and Analytics to support improvements, adopting Qi methodology to engage with their teams and sustain improvement plans.
Specific patient experience feedback below highlighted necessary areas of improvement.

"Do you know what's happening to you today?" Score 89%, now increased score of 92% in October



"Do you know when you're going to be discharged?" 71% now increased compliance demonstrated in 78%



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Action plans following audits highlighting areas for improvement

"Wrist bands are now in place for every patient following Action Plan and improvement work." (CCU)

"CDA checks have improved since we set an Action Plan, if not completed by the night staff they hand it over and day staff then check them…" (W20) (Scored positively last 6 weeks)

Action plan

Title dirty commode

Description commode found dirty. Photo taken as evidence. Sluice/commodes shared with CCU. No patients on ward 18 currently using commodes. Photo shared with staff on CCU and haematology using ward group apps.

Measurable outcome(s) future audits to show improvement in this area

Action written by TRACEY BROOKES

Date and time written 25-Oct-2022 13:24

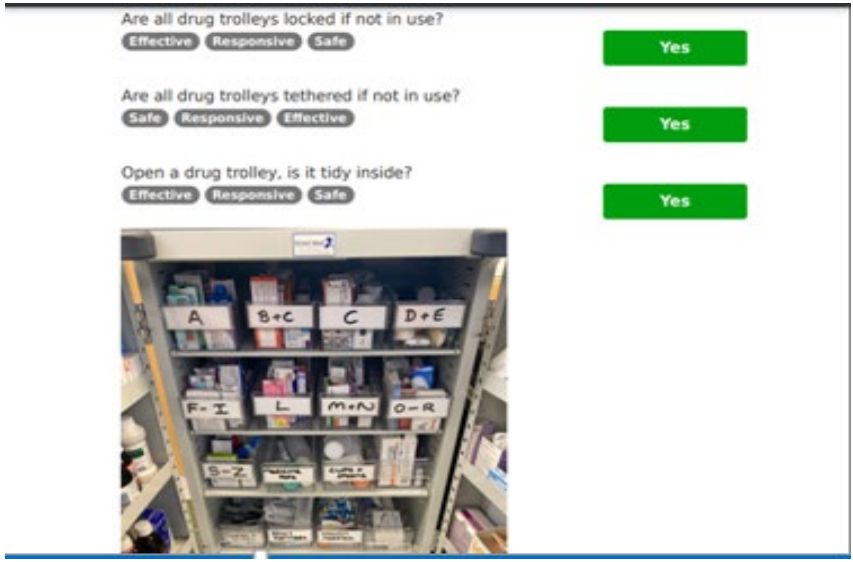
Action plan **Title** CD checks

Description Coord to check daily

Measurable outcome(s) WM and nurse in charge to check daily

Action written by Dawn Murray

Date and time written 30-Sep-2022 11:28



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October analyse of themes

Inspection Section Category Score this month / Score last 12

1. Hand Hygiene 99% (216) 99% (604)
2. Falls/Enhanced Supervision 96% (465) 95% (1406)
3. Staff Experience 95% (750) 96% (2103)
4. Clinical Area Safety 95% (933) 96% (2659)
5. Infection Prevention & Control 95% (1437) 94% (4105)
6. Information Governance 94% (207) 94% (585)
7. Skin Integrity 93% (395) 93% (1168)
8. Nutrition 92% (286) 92% (818)
9. Nursing Documentation 92% (917) 91% (2429)
10. Patient Experience 92% (555) 89% (1611)
11. Safe and Secure Management of Medicines 85% (1075) 86% (3038)

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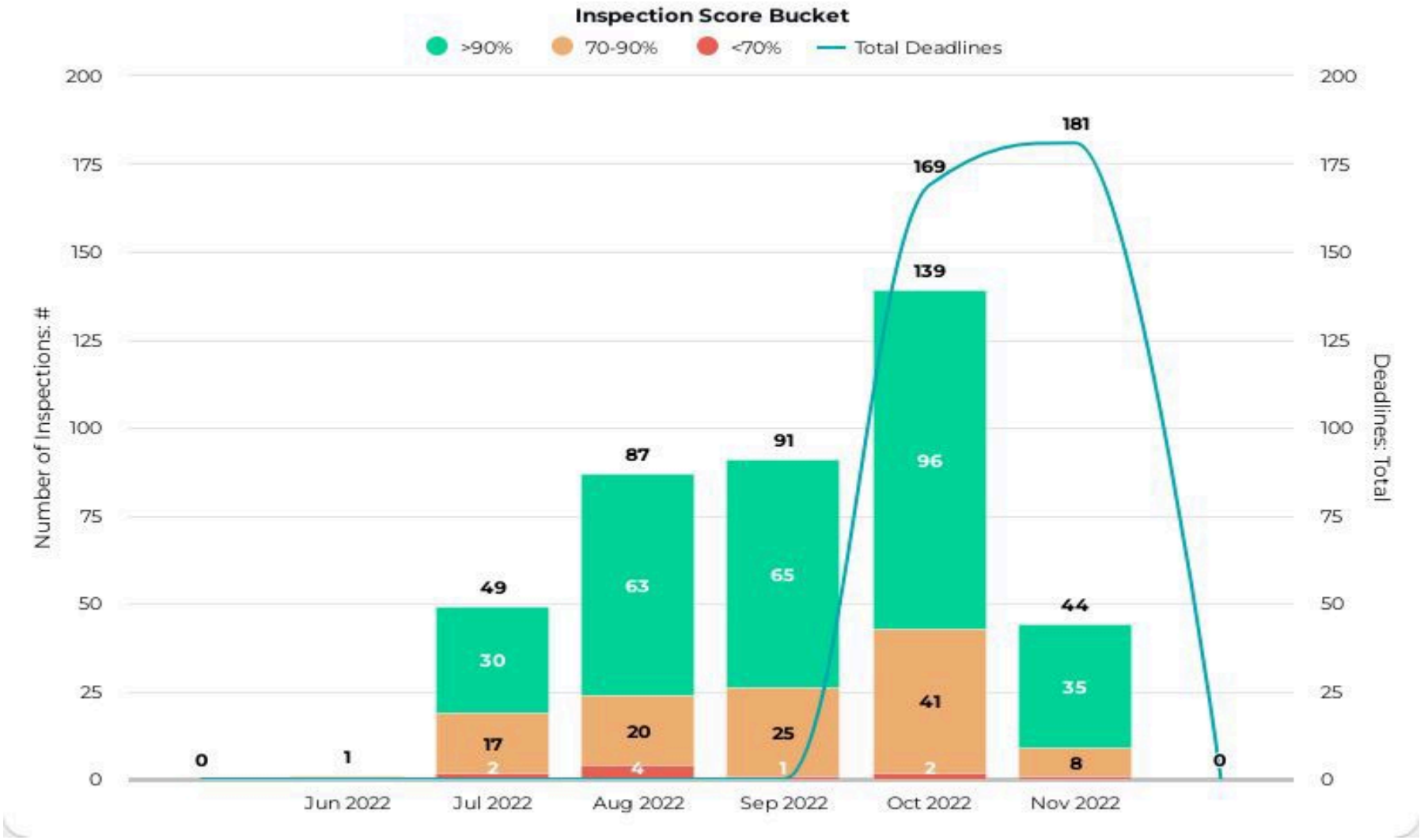
Analytics dashboards

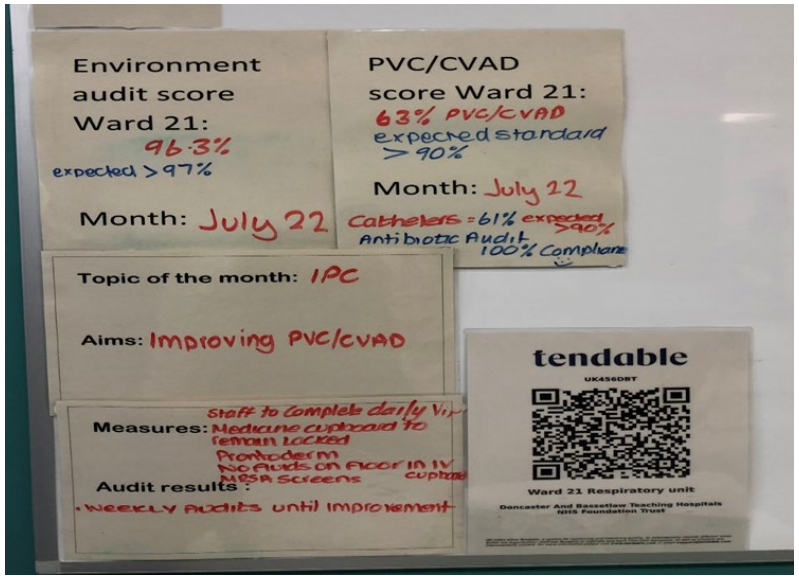


This graph is a screen shot of the live executive dashboard.

This demonstrates that in November so far 44 inspections have been undertaken
(as of 10 November)

In October, 139 inspections out of 169 were undertaken.
96 inspections were positive scores, 43 inspections highlighted issues that required an Action Plan and improvement work.

Improvements Demonstrated



"Cleanliness of commodes has improved following our Action Plan…." (Orthopaedic team)

Action plan

Title Fire warden checks not completed - winter ward newly opened

Description Forms ordered to be put in place for monthly checks. Staff informed

Measurable outcome(s) Future audit to demonstrate completion

Action written by Gaynor Wigley

Date and time written03-Nov-2022 16:49

"Monthly Fire warden checks now in place following Action Plan and weekly audit…" (W22)

"Lock repaired on setting up room door as part of our action plan.." (W16)

Action plan

Title Hand gel

Description Hand gel not being available at patient's bed side.

Measurable outcome(s) 1 week, I have put a hand gel on all patients' beds and asked staff to take them off when patients are moved.

Action written by Sarah Yemm

Date and time written25-Aug-2022 13:29

"Hand gel at point of care following Action Plan, moving them from bottom of bed to patient locker as identified missing following transfer…" (W20)

"Setting up room fridge now locked on repeat audits" (W16)

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Next steps

Tendable Steering Group to explore ongoing changes and developments.

Develop the Trusts Nursing and Midwifery Clinical Governance Framework.

Accreditation Program, triangulating Tendable data with incidents, complaints and claims.

Support Quality Improvement and shared learning.

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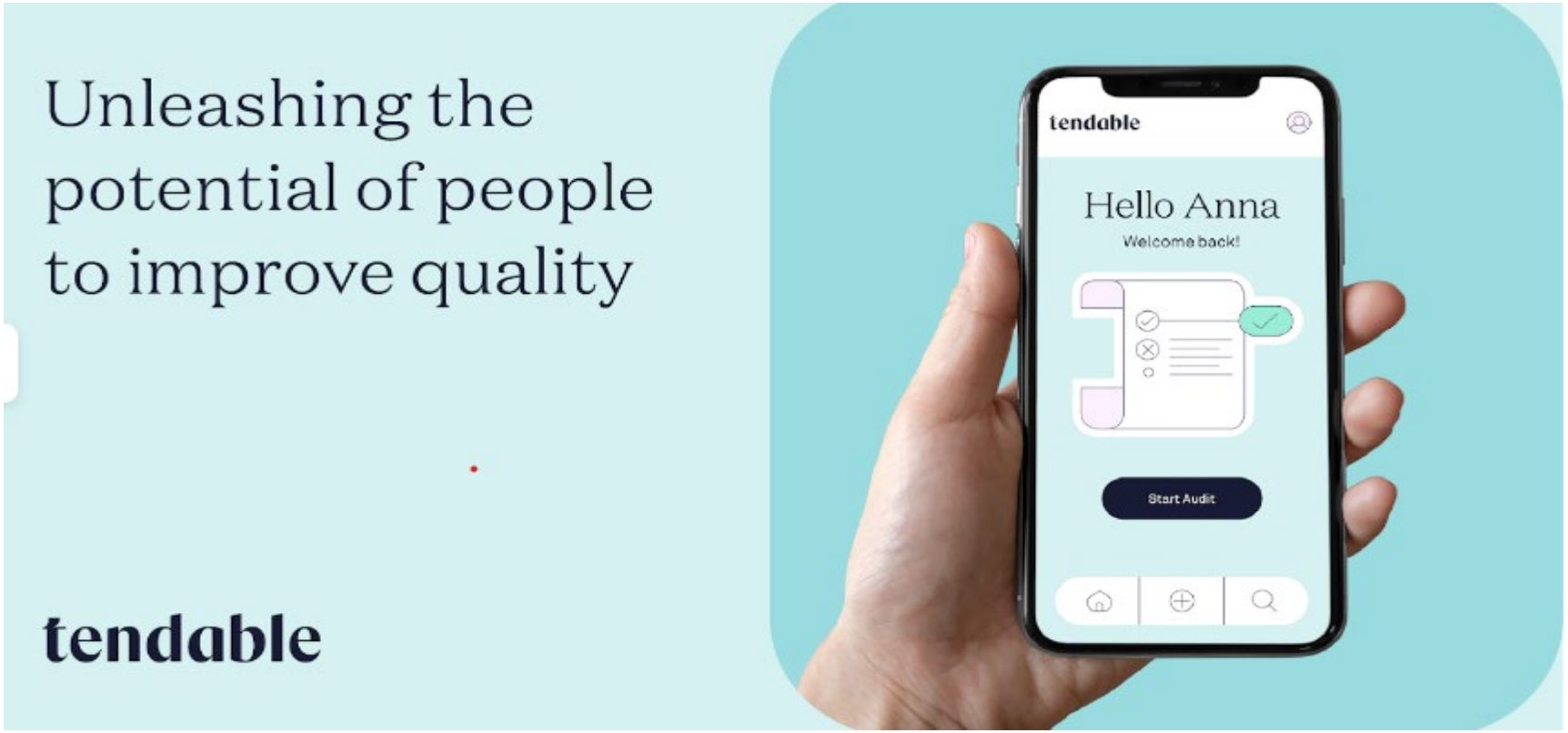
Any Questions?



Board Assurance Framework – Risks to achievement of Strategic Aims

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

True North Strategic Aim 1	True North Strategic Aim 2	True North Strategic Aim 3	True North Strategic Aim 4
To provide outstanding care and improve patient experience	**Everybody knows their role in achieving the vision**	**Team DBTH feel valued and feedback from staff and learners in top 10% in UK**	**In recurrent surplus to invest in improving patient care.**
Breakthrough Objective: Achieve measurable improvements in our quality standards & patient experience	**Breakthrough Objective:** At least 90% of colleagues have an appraisal linked to the Trusts Values and feel able to contribute to the delivery of the Trust vision.	**Breakthrough Objective:** Team DBTH feel valued and the Trust is within the top 25% for staff & learner feedback	**Breakthrough Objective:** Every team achieves their financial plan for the year

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

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

Current Risk Level Summary

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

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

Additional assurance continues to be sought internally and the evidence of this is referenced in the respective director reports to the Oct/Nov Sub Committees and Trust Board. The individual BAF sheet SA1-COVID has now been incorporated within BAF SA1 Sheet for Sept.

The BAF continues to be further developed to ensure strategic risks impacting on delivering the strategic aims are captured, assessed and well articulated within each BAF area. The rationale for the overall risk score for each risk is discussed and captured at each meeting.

The Audit and Risk committee has oversights for all four strategic aims/objectives and the Non-Executive Directors confirm overall compliance and assurance at this committee for this BAF process.

The key risks to achieving outstanding patient experience remains workforce, the key risk to financial sustainability is underperformance against income plan, cost improvement plan and the underlying financial sustainability and the key risk to operational excellence remains RTT 18 and the 52 week breach position. Additional assurance continues to be sought internally and the evidence of this is referenced in the respective director reports to the Nov Trust Board and its subcommittees.
No other changes have been recorded in the overall BAF risk scores for SA1-SA4.
New sections within the individual BAF sheets SA1-SA4 now include reference to the individual risks that contribute to the BAF explanations

There has been no change in the overall BAF risk levels during quarter 3 of 2022/2023.

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

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

Overall change per Strategic Aim (SA)						
	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2021/22	No of risks/SA	Change
SA1	⟺	⟺	⟺		5	⟺
SA2	⟺	⟺	⟺		3	⟺
SA3	⟺	⟺	⟺		3	⟺
SA4	⟺	⟺	⟺		4	⟺
COVID	↑	↓	Merged into SA1			↑

Appendix Level1

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

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

Risk Owner: Trust Board – Medical Director/Chief Nurse
Committee: QEC

People, Partners, Performance, Patients, Prevention

Date last reviewed : November 2022

Strategic Objective
To provide outstanding care and improve patient experience

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

Measures:

- *Covid risk SA1* ID 2472 incorporated into SA1*
- *Updated existing Board Assurance Framework for IPC as new guidance due in May 2022 still not produced by NHSE*
- *Review and utilisation of PSIRF (patient safety incident framework) and the focus on embedded learning*
- *NICE – delivery of statutory audits of clinical effectiveness*
- *Evidence of "closing the loop", through sharing of learning from incidents and follow up from QI processes*
- *Focus on key safety risks – IPC Outbreaks - waits, falls, milestones set through business planning for each division aligned to the division's breakthrough objectives*
- *Clinical effectiveness, processes to include the following of NICE guidance*
- *IQPR measures*
- *Feedback from patients via compliments and complaints, to include learning and engagement with stakeholders*
- *Patient survey outputs and effectiveness of action plans*
- ~~*Urgent and Emergency care programme in place , includes, relocation of AMU back to AMU , and the opening of EAU*~~
- ~~*Increase in trolley capacity in emergency department to support ambulance handovers*~~
- *Patient Safety Incident Response Framework (PSIRF) compliance*

Opportunities:

- Change in practices, new ways of working, regional Integrated Care Boards established for South Yorkshire and Nottingham & Nottinghamshire.
- Advent of more digital care –digital transformation including electronic patient record and virtual ward
- Greater opportunity for collaboration at place / system level
- Implementation of national patient safety strategies that improve patient care
- Restructure to focus on patient experience
- Quality improvement processes focused on Falls in the 10 high risk areas

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

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

Risks:

- *Risk of patient harm if we do not listen to feedback and fail to learn*
- *Risk of not using available quality assurance data to best effect in order to identify areas to improve or manage patient care.*
- *Risk to safety and poor patient experience as a result of failure to improve the estate and infrastructure.*
- *Risk of non-delivery of national performance standards that support timely, high quality care*
- *Risk to safety and poor patient experience if we do not improve emergency flow in our capacity constrained environment*
- *Current gaps in registered workforce whilst new registrants and international nurse's complete preceptorship with increased reliance on agency staff.*
- *Risks to patient both in terms of flow and communication as a result of the pathways relating to Infection, Prevention and Control measures due to uncertain covid pandemic pattern*

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

CRR Risk cross reference	Q&E9 1517	F&P 6 7	F&P 8 16	Q&E F&P 2472	QEC-PSIRF 3112		
Risk area	Medicine supply	Regulatory Stds	workforce	COVID	PSIRF		
Current CRR Risk Rating	15	16	16	15	12		
Risk Appetite Type	Qual	Reg	Qual Peop	Qual Peop Finance	Qual		
Risk Appetite Level	Open	Minimal	Open	Open	Open		
Target Risk Rating	12	9	8	10	3		

Overall Risk Scores for Strategic Objective

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

In assessing rationale for the overall strategic risk current score, please articulate the individual strategic risks clearly, by considering the prompts below:

- *Is the target risk score realistic/when will it be achieved and is this date reflected in action completion dates?*
- *Are the controls in place effective – are they driving the risk score down? Are there any gaps in controls? Are any of the controls not having an impact – do they need removing from the BAF?*
- *Have actions to address gaps been identified and are these on track?*
- *Is there a need to seek additional assurance – either additional board scrutiny or independent assurance?*
- *Do the controls mitigate high level operational risks noted on the BAF?*

Rationale for overall strategic risk current score:
Impact:

- Impact on performance
- Impact on Trust reputation
- Impact on safety of patients
- Impact on patient experience
- Potential delays to treatment
- Possible Regulatory action

Future risks:

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

Comments:

- Need to ensure Trust Values are effective
- Need to develop quality/patient safety strategy
- Need to sustain improvements in QI initiatives
- Need to widen the focus on patient and user feedback

Controls (mitigation to lead to evidence of making impact):	Last Review date	Next review date	Reviewed by	Gaps in Control
Accountability Framework & Quality framework process Risk Stratification, Validation and Clinical Prioritisation of Patient Pathways.	September 2022	December 2022	Med Director (TN) & COO	Action plans in place, reviews on going Processes embedded within admitted pathways and diagnostics. Current PAS system unable to provide full view of follow-up patients on non-active pathways. Further work to support the processes for non-

KPMG work complete and business as usual continues through the Outstanding Outpatients forum in terms of ongoing developments, improvements and digital transformation.					admitted pathways underway within Digital Transformation and operationally, including the development of a patient pathway management system
~~Awaiting completion of external patient safety and governance review prior to implementation~~ External peer review of patient safety and governance complete and report received - now aligned to the PSIRF project plan.		~~May 2022~~ November 2022	~~November 2022~~ March 2023	Med Director (TN)	~~Awaiting outcome of recommendations to understand gaps In control, not currently mitigated~~ Business Case includes details of the required workforce structure to deliver PSIRF. Project Plan developed with milestones to deliver the recommendations, needs a dedicated implementation team
Urgent and Emergency Care Improvement Programme – ongoing		~~April 2022~~ November 2022	~~November 2022~~ April 2023	Med Director (TN) & COO	Actions & plans in place monitored through Urgent and Emergency Care Programme Board
Action plans to respond to CQC patient surveys		~~April 2022~~ November 2022	~~November 2022~~ March 2023	Chief Nurse & Med Director (TN)	Action plans in place in response to CQC recommendations, monitored through PEEC via regular reporting. ~~Due to departure of current post holder time frame delayed. Recruitment process taking place currently~~
Patient Experience, Patient and Public Involvement and Accessible Standards in place which form part of the patient experience pathway		~~June 2022~~ November 2022	~~November 2022~~ March 2023	Chief Nurse	Work plan and strategy to be enhanced to improve patient experience, will be driven by new Chief Nurse when in post January 2023.
Assurances received (L1 – Operational L2-Board Oversight L3 External) **		**Last received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
L3	Internal Audit reviews on quality outcomes, falls documentation compliance 20/21, ~~DToC 2019/20,~~ Complaint process 2020/21. Action plans completed against internal audit and reviewed at QEC in June.	June21	ARC, Board	Full	None
L1,L2	SNCT undertaken to ensure safe staffing completed in June2022, report outcome will be expected at board in September 2022.	Jan 22	QEC, Board	Full	Awaiting completion of SNCT data collection which is taking place in May 2022. Audit completed , data analysis taking place and will be presented at September 2022 Board
L2,L3	Okenden feedback received from the LMNS, action plans developed to achieve 7 key actions	Dec 21	Board	Full	Action plan in place
L1,L2,L3	BAF completion on specific areas, evaluated by CQC, IPC BAF reviewed at Board of Directors December 2020. BAF reassessed 14th July 2021, to be reassessed with latest guidance. Updated BAF shared with Board on the 25th January 2022	Jan 22	Board	Full	
L2	Nurse Staffing Assurance Framework shared at Board on the 25th of January 2022	Jan 22	Board	Full	
L3	National Getting It Right First Time (GIRFT) reviews across specialties on a rolling programme of work.	September 2022	Board	Full	~~Medical Director undertaking a full review of all recommendations and actions and links to Specialty level and Divisional Strategic plans.~~ Medical Director supporting implementation of recommendations

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

Appendix Level1

The PSIRF is a contractual requirement under the NHS Standard Contract. Workforce structure to be resourced to ensure compliance. Dedicated PSIRF implementation team required to ensure each phase and transition timescales are achieved.				

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

Areas in yellow highlight indicate change from last version

NHS
Doncaster and Bassetlaw Teaching Hospitals
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Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	29 November 2022	**Agenda Reference:**	**C2**		
Report Title:	**Chief Nurse Update**				
Sponsor:	Richard Parker, Chief Executive				
Author:	Kirsty Clarke, Acting Deputy Chief Nurse Simon Brown, Acting Deputy Chief Nurse				
Appendices:	None				
Report Summary					
Purpose of report:	The Board are asked to approve the ongoing work to improve patient quality against the True North Objectives				
Summary of key issues/positive highlights:	The paper outlines the August and September outcomes in relation to the key patient safety measures in falls, hospital acquired pressure ulcers, infection prevention and control and serious incidents, highlighting what learning has been undertaken and how this is shared across the Trust. The paper highlights patient experiences, focused on the effectiveness of the complaints procedures, themes of complaints and how we evidence learning. The paper also gives an insight into the current position on safe staffing, highlighting the mitigations in place and the future developments to support safety.				
Recommendation:	To note and take assurance.				
Action Require:	~~Approve~~	**Information**	~~Discussion~~	**Assurance**	~~Review~~
Link to True North Objectives:	**TN SA1:** ***To provide outstanding care for our patients***	**TN SA2:** ***Everybody knows their role in achieving the vision***	**TN SA3:** *Feedback from staff and learners is in the top 10% in the UK*	**TN SA4:** *The Trust is in recurrent surplus to invest in improving patient care*	

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

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

Chief Nurse Report November 2022

The national patient safety strategy defines patient safety as maximising the things that go right and minimising the things that go wrong. It is integral to the NHS' definition of quality in healthcare, alongside effectiveness and patient experience.

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

The Patient Safety Incident Response Framework (PSIRF) was published on 16 August 2022, as a major piece of guidance on how NHS organisations respond to patient safety incidents and ensure compassionate engagement with those affected. All providers contracted under the NHS standard contract have been asked to begin preparing to transition to PSIRF from 1 September 2023. Preparation is expected to take 12 months with organisations transitioning to PSIRF by autumn 2023. A project plan will be presented to QEC in December 2022 and work is ongoing to pull together a PSIRF implementation team.

Insight

Serious Incidents
There were eight serious incidents logged across August and September. These relate to:

- Aggressive/violent behaviour meeting serious incident criteria.
- Medication error.
- Lost to follow-up, following request for a chest x-ray.
- Lost to follow-up, missed opportunities for earlier diagnosis.
- Ectopic Pregnancy Management.
- Maternity; term intrauterine foetal death
- Radiology; out of hours service missed spinal fractures.
- Fall resulting in severe harm; fractured Neck of Femur.

This is a total of **23** Serious Incidents reported, year to date for 2022-23. Of these, 18 are for care issues including one never event, one related to aggressive behaviour, two HSIB investigations and two falls. Work is underway to understand what learning can be gleamed, and how we can improve in future.

Healthcare Safety Investigation Branch (HSIB) Investigations
There have been no new referrals for HSIB investigations.

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

The current key priorities are listed below:

- Skin integrity.
- Falls.
- Discharge.
- Recognition of deteriorating patient.
- Medication Safety Officer.

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

Patient Safety Specialists
The Trust patient safety specialists are Dr Juan Ballesteros (Associate Medical Director for Clinical Safety), Marie Hardacre (Head of Nursing for Patient Safety and Corporate Services) and Nicola Severein-Kirk (Lead Nurse for Patient Safety and Quality).

There is significant change surrounding how we investigate, learn and develop a safety 'Just Culture'. The transition to PSIRF will need a system wide change and will need to incorporate the 'Just Culture' approach.

Falls
There were 143 falls in August and 109 in September. 213, out of 252, of these 177 resulted in no harm and 68 in low harm. There were 10 non inpatient falls in August and September.

There were two moderate harms, and five severe harms throughout August and September.

The Falls Safety Improvement Panel meet monthly and analyse all moderate and severe harm from falls and any themes identified for learning. The themes are communicated to the wider DBTH team and shared in a monthly newsletter, the learning identified across the months of August and September include:

- Promoting the implementation of 5 for falls.
- The communication of the next best option for supervision and escalation of care.
- To adhere to lying and standing Blood Pressure recording and the prompt identification of postural blood pressure drop.
- Promote patients to have a vision assessment to be undertaken, ie. Have you had an eye test recently?
- Provision of early walking aids and education of HCA and nursing teams to provide timely aids and intervention.
- To raise awareness amongst ward teams in relation to toileting needs.

Hospital Acquired Pressure Ulcers (HAPU)
There were 42 HAPU's in August and 69 in September. This has affected 92 patients in total. Of these patients, zero were classified as category four HAPUs, eight were category three

HAPUs and nine were unstageable HAPUs. There were three mucosal pressure ulcers and one uncategorisable (ear).

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

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

Infection Prevention and Control (IPC)

Clostridium difficile (C.diff) There were two cases of Clostridium difficile in August and six in September. Six of these were Hospital Onset, Hospital Associated (HOHA) infections, and two were Community Onset, Hospital Associated infections (COHA).

This takes the total number of cases of Clostridium difficile for the current financial year to eighteen, against a trajectory of 48.

E-Coli bacteraemia: In August there were six cases and September five cases of E-Coli bacteraemia reported. Ten cases were classed as Hospital Onset, Hospital Associated and one case was Community Onset, Hospital Associated (COHA). This is a total of 39 cases with a current trajectory of 87 for the financial year.

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

MRSA colonisation: There was one reported in August and two in September. This is a total of 11 cases and is being closely monitored by the divisional teams and IPC.

The roll out of TENDABLE has improved performance against some key IPC measures. There has been improvement across a number of metrics including commode cleaning and hand gel availability.

Overall hand hygiene results are positive with an average for the September at 98%.

A revised infection prevention and control board assurance framework was received from NHS England at the end of September. This is currently being completed and will be presented to the Quality and Effectiveness Committee in December and come to Board in January 2023.

Involvement

The framework for involving patients in patient safety

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

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

Patient Safety Syllabus

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

Improvement

Shared Learning

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

Patient Experience

Complaints

In October the number of complaints received was 66, consisting of 52 '40 working days', 12 '60 working days' and two MP complaints. This was a slight increase compared to the 57 received in September.

When split by division, Medicine had 30 complaints, Surgery and Cancer had 27, Children's and Families had 5, Clinical Specialties 3 and 1 other (corporate areas).

The number of concerns registered were 95 which was a slight reduction compared to September (104).

Compliance with acknowledging formal complaints within 3 working days sits at 93% which is consistent with previous months.
The number of complaints closed in October was 62, with a total of 39% meeting the timeframe for closure. There were significant challenges throughout October due to an increase in Covid activity within the Trust, and also within PALS due to staffing shortages. This had a significant impact on complaints resolution performance.

Of the 62 complaints closed, 9 were upheld, 26 partly upheld and 27 not upheld.

Top themes of complaints in October were diagnostics (including tests delays, missed) patient care (including hydration, nutrition and maternity) values and behaviours (staff) and access to treatments (drugs, equipment or appliances).

In October there were two contacts from the PHSO both of which requested information to be provided prior to a decision being made with the intent to investigate. All information was provided within the timescales requested.

A further case was closed in October with final recommendations advised by the PHSO and financial remedy agreed. All recommendations have been actioned and a full response detailing these have been sent to the PHSO including a written apology to the complainant.

Friends and Family Test (FFT)
In September there was a 7.2% inpatient response rate to FFT. Of those who responded, 98.5% rated their care as very good or good. Of the attendances in outpatients, 97% rated their care as very good or good.

Nursing and Midwifery staffing

All NHS Trust providers are required to publish Nursing and Midwifery staffing data on a monthly basis. The data describes planned hours for staffing based against the actual hours worked. In addition to this the care hours per day (CHPPD) are reported as a monthly metric. DBTH submitted data within the submission timeframe for the months of September 2022 and October 2022, with no exceptions.

September 2022 data submission
There were 40 inpatient wards open throughout September 2022.

16 (40%) wards were on green for planned v actual staffing, 7 (17.5%) wards were on amber for being 5% under planned v actual staffing (S10, A5, C1, AMU, HAEM, 17, 32). There were 5 (12.5%) wards (A2L, St Leger, 25, Mallard, Gresley) which were on amber for being 5% over planned v actual staffing.

7 (17.5%) wards were red for being 10% under planned v actual staffing (A4, CDS, M1, NNU, B6, ITU, 21). There were 5 (12.5%) wards (Rehab 1, B5, S12, CHOU, 16) which were rated red for being over 10% of their planned v actual staffing during September.

Care Hours per Patient Day:

CHPPD	RN (Actual)	HCA (Actual)	Reg NA (Actual)	Non Reg NA (Actual)	Total (Act)
BDH	4.73	3.33	0.08	0.12	8.27
DRI	4.15	3.27	0.18	0.13	7.73
MMH	2.35	4.17	0.21	0.00	6.73
Total	**4.15**	**3.33**	**0.16**	**0.12**	**7.77**

October 2022 data submission
There were 41 inpatient wards were open throughout October 2022.

18 (43.9%) wards were on green for planned v actual staffing, 8 (19.5%) wards were on amber for being 5% under planned v actual staffing (S10, A5, C1, C2/CCU, REHAB 2, CHOU, G5, 17). There were 3 (7.3%) wards (S11, REHAB 1, A2L) which were on amber for being 5% over planned v actual staffing.

10 (24.3%) wards were red for being 10% under planned v actual staffing (AMU, 22, HAEM, 21, DCC, ITU, B6/ESSU, NNU, M1, CDS). There were 2 (4.8%) wards (B5, ST LEGER) which were rated red for being over 10% of their planned v actual staffing during October.

Care Hours per Patient Day:

CHPPD	RN (Actual)	HCA (Actual)	Reg NA (Actual)	Non Reg NA (Actual)	Total (Act)	Total (Planned)
BDH	5.03	3.28	0.06	0.10	8.47	8.80
DRI	4.25	3.17	0.12	0.09	7.63	7.02
MMH	2.28	3.46	0.17	0.00	5.91	5.89
Total	4.25	3.21	0.11	0.08	7.66	0.00

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

- adult inpatient wards in acute hospitals
- adult acute assessment units
- children and young people's inpatient wards in acute hospitals

The Trust also has a licence to use the SNCT for Emergency departments, this is a new tool and the senior nursing have completed the training and assessments required to utilise the tool.

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

The last data collection was undertaken in May 2022, during which time it was identified that those undertaking the process including peer review process had not been provided with recent training on the tool. It is recognised that this can affect the validity of the data and the ability to reference it with any confidence in decisions relating to staffing requirements at ward level.

To address this training has been commissioned with the Shelford Group across November, delivered virtually to both ward managers and matrons for Adult and Paediatric areas. This approach will then enable a train the trainer approach to be undertaken through a core group of SNCT champions at DBTH and will be led by safe staffing matron.

Data collection has commenced week commencing 15th November 2022 across Adult Inpatient areas, which will also support use of the data in annual planning processes. Data collection is planned across November and December using the ED and Children's & Young Peoples tools.

Update on Staff Nurse Recruitment & Retention

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

NQ Autumn 2022 Recruitment Update

Division	Headcount accepted	Started in Trust supernumerary period (Sept / Oct)	Placement start delay - headcount
Medicine	36	30	6
Surgery (plus G5)	18	13	5
CSS	3	2	1
Paediatric	6	6	N/A
Total	63	51	12

It is important to note that due to reduction in student nurse placement availability during Covid pandemic (2020 to 2021) and subsequently into 2022, combined with sickness absence episodes, a number of healthcare students have not achieved the required placement hours to proceed to register with their professional body. At DBTH 12 out of 63 NQ new starters are currently affected with 10 being delayed beyond November 2022. These students where possible will be supported to undertake some of their make-up placement hours within DBTH.

International Nurse Update

DBTH continues to progress with recruitment of internationally educated nurses to complement our existing workforce. In addition to the planned recruitment of 70 adult nurses and 5 paediatric nurses across 2022/2023, DBTH was further awarded funding to support with recruitment of an additional 12 internationally educated nurses to arrive before the end of March 2023. From a recruitment perspective this will provide DBTH with an additional 82 adults nurses and 5 paediatric nurses from the recruitment work stream.

Cohort's 2022/2023	Number (WTE)
6 - arrived April	11 adult
7 - arrived May	9 adult
8 - arrived Aug	10 adult
9 - arrived Sept	10 adult
10 - arrived Oct	5 adult

11a - arrive Nov 17	5 paediatric
11b - arrive Nov 24	13
12 - arrive Mid Jan	12
13 - arrive Mid Feb	12

All internationally educated nurses are required to pass an objective structured clinical examination (OSCE) to enable them to transition on to the Nursing & Midwifery (NMC) UK register. DBTH has a 100% pass rate to date (on 1st or 2nd attempt). As previously mentioned there have been changes by the NMC to the OSCE process and there is a possibility the first time pass rate may be affected.

Work continues led by the Stay and Thrive Matron to support international recruits to consider and access ongoing professional development both in terms of clinical and leadership role requirements. Career development at DBTH for international educated nurses across leadership and clinical education role continues with successful career development across a range of positions.

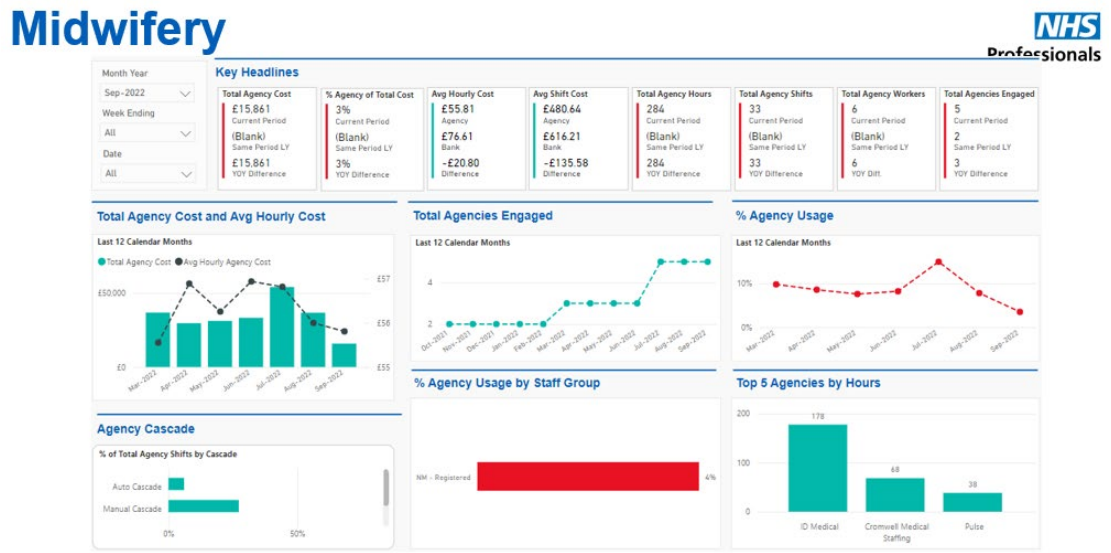
Agency Summary

September agency usage summary - Adult Nursing
The September 2022 agency trend position demonstrated below shows the continued use of agency against a fairly static vacancy position. Whilst NQ and international educated nurses remain within their supernumerary phase, reliance on temporary staffing solutions remains a requirement to support delivery of safe care. The majority of autumn recruited Newly Qualified and Internationally educated nurse's transition into the registered hands per shift across October and November. Other drivers for agency usage across September included opening of a 16 bedded winter ward at DRI, Elective modular ward DRI and frequent use of unfunded beds on Trauma & Ambulatory Care Unit DRI and B5 at BDGH for medical outliers. It is recognised that in view of the vacancy position, compounded by maternity leave and sickness absence, it is necessary to further mitigate the risks to patient care delivery.

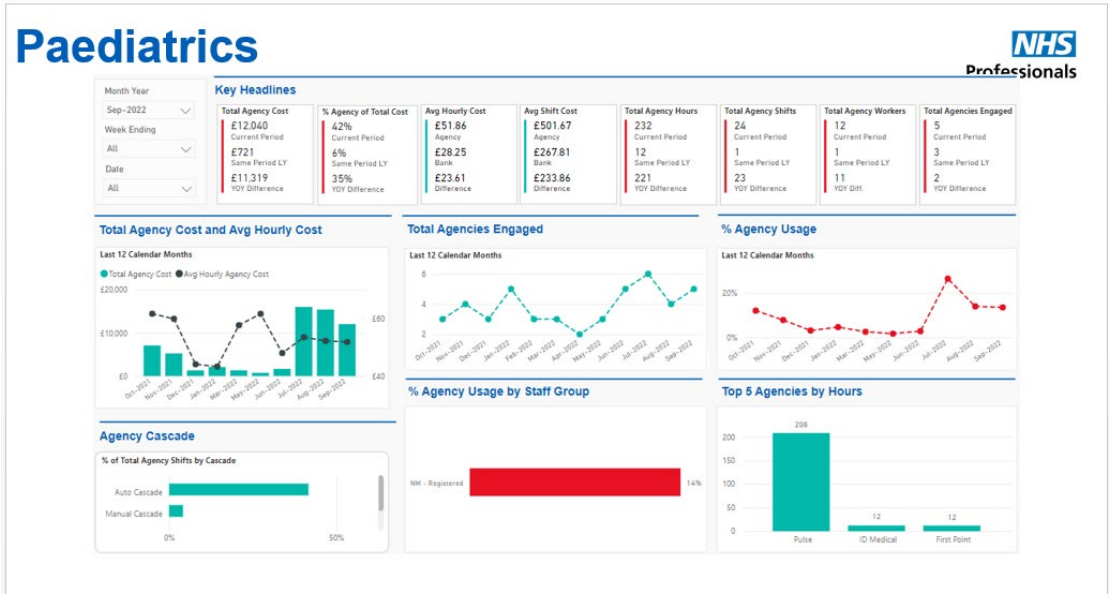
Agency spend has reduced across September and higher cost agency reliance patterns have shifted. Several of the high cost agencies no longer appear in the top 5 agency chart. Work is now ongoing locally and across the ICB to further reduce enhanced rate agency costs with temporary workforce suppliers.

In comparison to July and August position this demonstrates a slight reduction in spend of £21’599 in month.

September agency usage summary - Midwifery

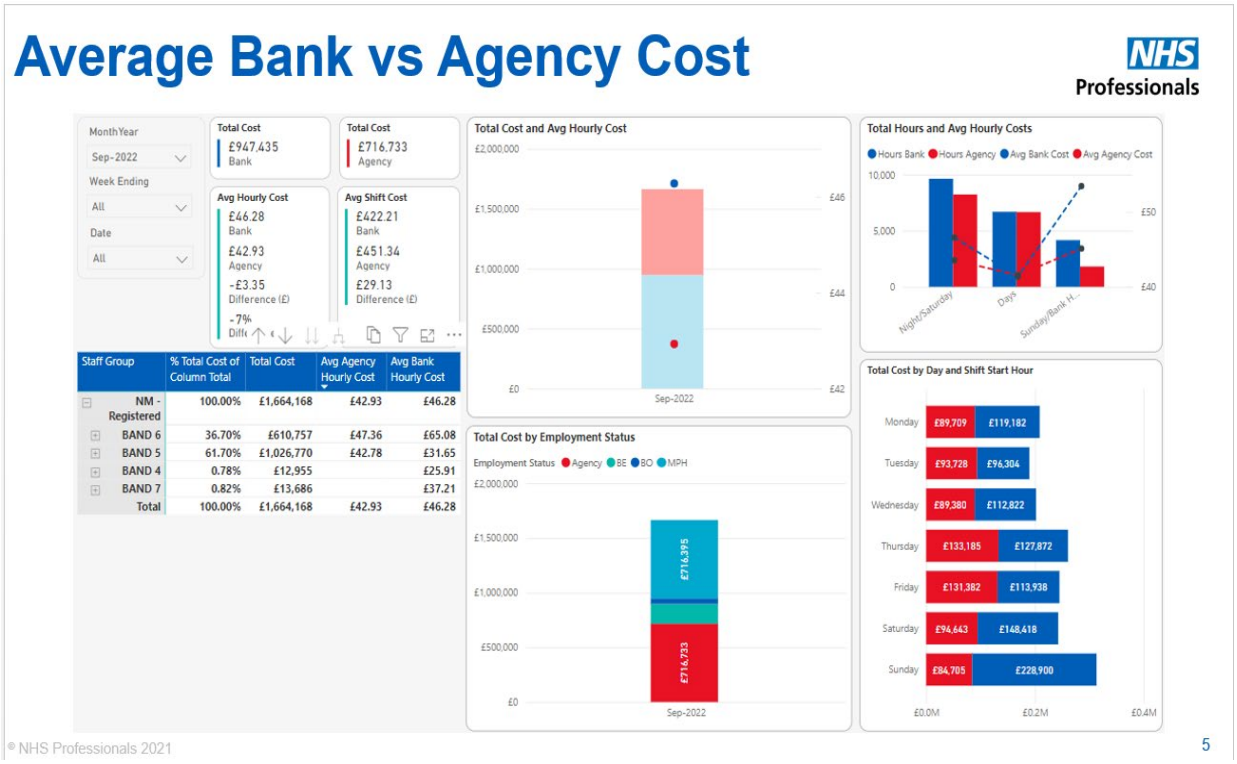


In comparison to July 2022 there has been a reduction in spend of £38,201 across midwifery, however NHSP fill and pay rates were increased during this same time period.



In comparison to July 2022 there has been a slight reduction in agency costs within Paediatrics of under £4000.

The below tables illustrate agency and bank costs across September 2022. The hourly bank cost is inflated across September due to bank incentives that remained in place for Midwifery services.



Safe Care

Daily safe staffing meetings

The embedding of daily staffing meetings has continued throughout September at DRI with Surgery and Medicine areas now attending daily meetings, progression of the roll out at DRI will bring on board Critical Care and Paediatric areas by the end of November 2022.

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

NHSP colleagues join these daily meetings to provide rapid response to areas of need and also support housekeeping of shifts on the temporary workforce booking system / ERoster interface, including cancellation of surplus shifts.

The above process has commenced using a manual data collection process for panned V actual at DRI & MMH sites and the safe care pilot using the Allocate system is planned to roll out at Bassetlaw from December 2022. The work stream continues to report through to the Trust Quality Strategy Group and by exception to the Quality and effectiveness committee.

Staff Retention

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

Staff nurse development
A total of 45 Staff Nurses from across Adult and Paediatric Specialities have now completed the Royal College of Nursing Staff leadership programme. A Further 30 staff nurses will be enrolled onto the programme commencing March 2023, with plans to support further cohorts planned for 23/24.

Professional Nurse Advocate update
As part of the 3 year Chief Nurse Strategy to have 1 professional nurse advocate (PNA) to 20 registered nurses the Trust seconded a senior nurse to lead on the PNA role out Trust wide and ensure DBTH were engaged in the local, regional and national PNA journey.

The below table illustrates the current DBTH Professional Advocate position.

DBTH Qualified PNA	DBTH PNA awaiting entry on register	PNA in training	Allocated places	Awaiting place	Predicted by March 2023
13	8	8	2	1	32

Due to the current recruitment position and winter pressures a decision was made to avoid releasing staff during December to end of March 2023 due to the high demand on clinical

staff and the anticipated higher than usual bed pressures anticipated. This avoids staff being released and then pulled back from an academic development programme into clinical duty's and ensure that the risk of staff burnout doesn't impact on achievement of the qualification and academic programme. There is a healthy reserve list to recommence the trainee PNA recruitment drive from April 2023.

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Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	29 November 2022	**Agenda Reference:**	**C3**		
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:	None				
Action Require:	~~Approval~~	**Information**	~~Discussion~~	**Assurance**	~~Review~~

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

Implications	
Board assurance framework:	*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

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		

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Previously circulated reports to supplement this paper:	none

Monthly Board Report (October 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

In October 2022 there were 5 stillbirths, there were 3 at Doncaster and 2 at Bassetlaw. One of the stillbirths was a term (> 37 weeks pregnant).

The cases are currently under review by a multidisciplinary team using the perinatal mortality review tool. The term stillbirth team is undertaking a comprehensive review to identify any possible learning from this case, with the family contributing to the investigation.

1.2 Neonatal Deaths

There were no neonatal deaths in October

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.

The service has commenced a deep dive review into the stillbirths that have occurred during the last year. This is in light of the increase in stillbirths in August and October. An external research fellow has been asked to contribute to this work as well as liaison with our area's specialised perinatal pathologists to see if there are any links with COVID from a pathological viewpoint

There remains a national increase in stillbirths, and national guidance is being followed within DBTH.

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
Current active cases	2
Exception reporting	0

2.1 Reports Received since last report

No reports in the last month.

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
Draft report received for factual accuracy checking

HSIB case number: MI-010419
HSIB criteria: Stillbirth
Trust site: Doncaster
Incident date: 10.06.22
Referral date: 21.06.22
Draft report received for factual accuracy checking

3. Serious Incident Investigations (Internal)

There is one ongoing SI investigation related to the term stillbirth described above, which is also being reviewed via PMRT.

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.
- 90% of all staff have to have attended the fetal monitoring study day by 5th January 2023. Including the numbers that have attended and booked to attend, the trajectory will be:

Consultants	100%
Doctors	75% (not currently inc GP trainees. Plan in place)
Midwives	77.1% (including all NQM's starting Oct 22)

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	20	9	**45.0%**	5	**25.0%**
Midwives	210	173	**82.4%**	129	**61.4%**
NHSP Midwives	21	12	**57.1%**	6	**28.6%**
Divisional	**264**	**203**	**76.9%**	**149**	**56.4%**

Which has improved from 55.3% to 56.4%

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 46.7 % (Divisional) to 55.1 % this month.

MDT Role	Number	Number Compliant	Prompt Compliance
Consultants	12	9	**75.0%**
Doctors	32	15	**46.9%**
Midwives	205	163	**79.5%**
NHSP Midwives	22	8	**36.4%**
Support Workers	70	17	**60.0%**
Theatre Staff	82	34	**41.5%**
Anaesthetists	38	8	**21.1%**
Divisional	**461**	**254**	**55.1%**

5. Service User Feedback

Several midwives met on the with the MVP service users in the first face to face meeting. There was honest and rich feedback from recent service users.

The areas that were decided to address and develop plans on are:

- Language used by professionals - using a more positive approach to discuss options, and risk related to care
- Forms of information and signposting to information. The maternity website is under development and the MVP will assist us with this
- Consultants approaches to discussions about plans of care in maternity
- The triage service, staff attitudes and waiting times

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. This review has assessed partial compliance with the evidence submitted. Full compliance can be submitted for some elements using different types of evidence.

   Currently compliance with three standards remains a risk:

   Safety Action 3 - ATAIN
   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**

    Dr Tim Noble with undertake this role in the interim until the new Chief Nurse has commenced in post.

    A walkabout will be planned before December 2022.

NE&Y Regional Perinatal Quality Oversight Group Highlight Report

LMNS: South Yorkshire and Bassetlaw

Reporting period: October 2022 – December 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 (%)
Oct	1:27.4	14%	
Nov			
Dec			

Maternity unit: DBTH – Doncaster

KPI (see slide 4)	Measurement / Target		Doncaster Rate		
			October	Nov	Dec
Caesarean Section rate	Elective	<13.2 %	18.3%		
	Emergency	<15.2 %	20.1%		
Preterm birth rate	≤26+6 weeks	0	0.37%		
	≤36+6 weeks	<6%	8.4%		
Massive Obstetric Haemorrhage	≥1.5l	<2.9%	4%		
Term admissions to NICU		<6%	3.3%		
3rd & 4th degree tear	SVD (unassist'd)	<2.8%	0.7%		
	Instrumental (assisted)	<6.05 %	0%		
Right place of birth		95%	95.37%		
Smoking at time of delivery		<11%	13.1%		
Percentage of women placed on CoC pathway		35%	0%		
Percentage of women on CoC pathway: BAME / areas of deprivation	BAME	75%	0%		
	Area of deprivation		0%	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	Oct	48	163	0	0	0	0	2	1	0	0	0	0	0	0	0
	Nov	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Dec	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Q3															

Maternity Red Flags (NICE 2015)

		Oct	Nov	Dec
1	Delay in commencing/continuing IOL process	37	0	0
2	Delay in elective work	0	0	0
3	Unable to give 1-1 care in labour	0	0	
4	Missed/delayed care for > 60 minutes	0	0	0
5	Delay of 30 minutes or more between presentation and triage (LWAU)	1	0	0

NE&Y Regional Perinatal Quality Oversight Group
Highlight Report

LMNS: South Yorkshire and Bassetlaw

Reporting period: October 2022 – December 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		
			October	Nov	Dec
Caesarean Section rate	Elective	**<13.2 %**	8.3%		
	Emergency	<16.9 %	27.3%		
Preterm birth rate	≤26+6 weeks	0	0.76%		
	≤36+6 weeks	**<6%**	5.3%		
Massive Obstetric Haemorrhage	**≥1.5l**	<2.9%	2.3%		
Term admissions to NICU		<6%	3.03%		
3rd & 4th degree tear	SVD (unassist'd)	<2.8%	2.8%		
	Instrumental (assisted)	<6.06 %	15.4%		
Right place of birth		95%	95.76%		
Smoking at time of delivery		<11%	7.6%		
Percentage of women placed on CoC pathway		35%	0		
Percentage of women on CoC pathway: BAME / areas of deprivation	**BAME**	75%			
	Area of deprivation				

Month/Quarter		Red flag alert	Open > 30 days	Unactioned Datix	Maternity Serious Incidents	Maternity Never Events	HSIB cases	Still Births (All / Term / Intrapartum)			HIE cases (2 or3)	Neonatal Deaths (Early / Late)		Notification to ENS	Maternal Mortality (direct / indirect)	
2020/2021	Oct	0	**41**	**0**	**0**	**0**	**0**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	Nov	0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	Dec	0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	Q3															

Maternity Red Flags (NICE 2015)

		Oct	Nov	Dec
1	Delay in commencing/continuing IOL process	4	0	0
2	Delay in elective work	0	0	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

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

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

Evidence of SBLCB V2 Compliance

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

Assessment against Ockenden Immediate and Essential Action (IEA)

	Oct	Nov	Dec
Audit of consultant led labour ward rounds twice daily			
Audit of Named Consultant lead for complex pregnancies			
Audit of risk assessment at each antenatal visit			
Lead CTG Midwife and Obstetrician in post			
Non Exec and Exec Director identified for Perinatal Safety			
Multidisciplinary training – PrOMPT, CTG, Obstetric Emergencies (90% of Staff)	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	Oct	Nov	Dec
Freedom to speak up / Whistle blowing themes	None		
Themes from Datix (to include top 5 reported incidents/ frequently occurring)	Weight unexpectedly below the 10th centile PPH Shoulder dystocia Unexpected admission to NNU Staffing		
Themes from Maternity Serious Incidents (Sis)	Guidance needed when professional opinions differ		
Themes arising from Perinatal Mortality Review Tool	Increased SB rate No themes on toll further review being undertaken Bereavement facilities poor		
Themes / main areas from complaints	Communication Delays in care		
Listening to women (sources, engagement / activities undertaken) CQC Women's Experience	MVP ongoing, workplan in place CQC survey action plan to be developed		
Evidence of co-production	New CDS		
Listening to staff (eg activities undertaken, surveys and actions taken as a result)	Ongoing OCR meeting Ongoing skills and drills scenarios Education lead now back in post supporting education needs of staff PROMPT going back to face to face in August		
Embedding learning (changes made as a result of incidents / activities / shared learning/ national reports)	WHATS HOT Ward briefs and emails Face to face discussions with staff LMNS meetings Trust meeting		

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
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	29 November 2022	**Agenda Reference:**	**C4**
Report Title:	**Executive Medical Director's Clinical Update including Quarter 1 2022/23 Learning from Deaths Report**		
Sponsor:	Dr Tim Noble, Executive Medical Director		
Author:	Julie Butler, Senior Manager		
Appendices:	Appendix 1: Quarter 1 2022/23 Learning from Deaths Report Appendix 2: Reporting Structure for Risk Management Board and Medical Advisory Committee Appendix 3: Risk Management Timeline		

Report Summary	
Purpose of report:	To provide a clinical update on the areas within the EMD portfolio of work
Summary of key issues/positive highlights:	This is a comprehensive report covering a number of aspects of work within the Executive Medical Director Directorate portfolio of work. • The Quarter 1 (2022/23) Learning from Deaths report, in accordance with the National Guidance on Learning from Deaths (March 2017), shows a decrease in numbers from 568 in Q4 to 505 in Q1. • The Medical Examiner team continue to scrutinise 100% of all non-coronial adult hospital deaths and have been able to speak to 99% of families. • In Q1 16 structured judgement reviews were requested. • There was 1 death of an adult patient with a learning disability and 1 death of a patient with a diagnosis of autism. Both cases have been referred to the Learning Disabilities Mortality Review Programme and concluded to have received good care. • The clinical update provides an overview of the work being undertaken by the medical director team including the newly established Risk Management Board.
Recommendation:	The Board of Directors is asked be assured by the content of the report.

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

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

Implications			
Board assurance framework:	*No changes made*		
Corporate risk register:	N/A		
Regulation:	National Guidance on Learning from Deaths (March 2017),		
Legal:	N/A		
Resources:	N/A		
Assurance Route			
Previously considered by:		Clinical Governance Committee Quality and Effectiveness Committee	
Date:	October 2022	**Decision:**	For information and assurance
Next Steps:	Presentation to Board of Directors		
Previously circulated reports to supplement this paper:			

1. INTRODUCTION

This report provides a clinical update from the Executive Medical Director's office, summarising key areas of work.

2. WORKFORCE AND SPECIALTY DEVELOPMENT

2.1 Workforce

Working collaboratively between the medical director's office, divisional directors, clinical directors, medical HR, leadership and development team and education, the Medical Director for Workforce has explored a number of options to increase the number of medical training places with the aim of developing a substantive consultant workforce.

The General Professional Skills business case to provide training placements for UK citizens who have trained abroad and are looking for work back in the UK/NHS was approved at October's CIG. The business case for expansion of the CESR programme supported by SAS Advocate, Tutor and CESR Lead roles should be complete for submission to November's CIG for consideration.

Foundation programme expansion – following a successful bid, co-developed by the MD team and education lead, the deanery are planning an additional 3 FY1 and 6 FY2 doctor placements at DBTH in August next year, with further expansion expected in following years.

2.2 Job Planning

The rolling programme of Clinical Directors' development workshops are being planned for 2023. The format and agenda for future sessions is currently under development. The dates of 2023 workshops are 7 February, 6 June, and 12 September.

As at 31 October, 2022, there are 101 job plans signed off on the Allocate system, this fluctuates as job plans on the system become due an annual review.

Process	No. Completed 30/9/22	No. Completed 31/10/22
signed off	104	101
awaiting clinician 1st / 2nd sign off	43	62
in discussion	191	175

The planned milestones and trajectories at divisional level will be monitored through the Performance, Outcomes and Support Meetings (POSM).

2.3 Newly Appointed Consultants

A Trust wide 'New Consultants Forum' has been developed which will help new consultants integrate into the organisation, the culture, build effective relationships and provide support and signposting for informal mentorship.

The next forum is scheduled for Tuesday 20 December 2022.

2.4 Medical Advisory Committee (MAC)

The MAC held its November meeting on Monday 7th. Items for discussion included:

- Introduction to the Chief People Officer, with Zoe Lintin attending.
- Medical workforce updates from Dr Nick Mallaband.
- Dr Nabeel Alsindi, GP and Doncaster Place Medical Director, attended to discuss organisational pressures, challenges, workload and how we work collaboratively across primary and secondary care.

The MAC reports to Trust Executive Group in the form of an annual report on its activities, which will be submitted at the end of the financial year.

3. OPERATIONAL STABILITY AND OPTIMISATION

3.1 Getting It Right First Time (GIRFT)

The national GIRFT team have requested, through the regional implementation lead, that we host 2 days of GIRFT presentations. This will give specialties within the Trust an opportunity to present the work that has been undertaken following their initial GIRFT reviews and recommendations, share benchmarking data on current performance and make recommendations for future improvements and developments.

The first of these events is being planned for Tuesday 17 January.

3.2 Risk Stratification, Clinical Validation and Prioritisation

The main risk continues to lie with patients on non-admitted pathways, particularly for those patients who have had some initial treatment and no longer on an active pathway, but clinically need further review and/or follow up.

The Digital Transformation team are leading on procurement of a patient pathway management system to enable visibility of the patients in a single tracker, risk stratification and clinical priority of review patients as well as those on an active pathways, supporting a much more robust process of clinical prioritisation of those patients.

3.3 Virtual Ward (VW)

Dr Joseph John has established a Trust wide Virtual Ward Steering Group bringing together a multi-professional group of senior staff, to lead the VW programme, have an overview of regional and national plans, and to provide support and direction to local teams.

The Steering Group will provide oversight, scrutiny and support for the implementation of local schemes, which in the first phase are frailty and respiratory, and be a forum for teams and individuals to raise key challenges, escalate issues and requests for help.

4. REVALIDATION AND APPRAISAL

The following data extract from the appraisal system covers the 2022/23 financial year period. In comparison to the Agenda for Change appraisal season, medical staff compliance is appraised throughout the year and forms part of the revalidation process.

The team are supporting individuals that require further help and support and continue to chase outstanding appraisals that need to be scheduled.

Appraisal Status	Q3 01/10/2021	Q4 01/01/2022	Q1 01/04/2022	Q2 01/07/2022
No of doctors due to hold an appraisal (month part of their yearly appraisal date falls in this quarter)	156	39	107	99
No of doctors with appraisals scheduled	100	49	87	79
Total Completed Appraisals	**92 (92%)**	**44 (89.8%)**	**30 (34.48%)**	**31(39.24%)**

5. CLINICAL GOVERNANCE/PATIENT SAFETY

5.1 Peer Review of Governance and Patient Safety

The independent peer review of the Trust's governance and patient safety processes has concluded and the report received. The recommendations from this report, along with the new governance framework, will be incorporated into the broader project plan for the implementation of the Patient Safety Incident Response Framework (PSIRF). The Executive Medical Director will support the Chief Nurse to achieve this objective.

5.2 Support for Clinical Governance Leads

The establishment of quarterly meetings as a forum to support the Divisional Clinical Governance Leads and are now being set up. These provide an informal setting to discuss a range of issues that may not necessarily be covered within the formal governance meeting or that need further in-depth discussion outside the governance arena.

5.3 Wellsky Missing Discharge Letters

Quality improvement (QI) work has commenced in respect of the Wellsky changes with the aim of ensuring that GPs receive 100% of discharge letters.

The actions identified during the first QI session are being taken forward at ward level and the improvement work is being tested using Plan, Do, Study, Act (PDSA) methodology.

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

The information and tables below have previously been presented to October's Clinical Governance Committee.

6.1 Crude Mortality

The Trust figure for September 2022, is 1.72%, with the ratio at DRI 1.69 and Bassetlaw 1.81 which remains relatively stable. As previously reported this is not a very precise indicator being simply a ratio of the number of deaths versus number of patients discharged.

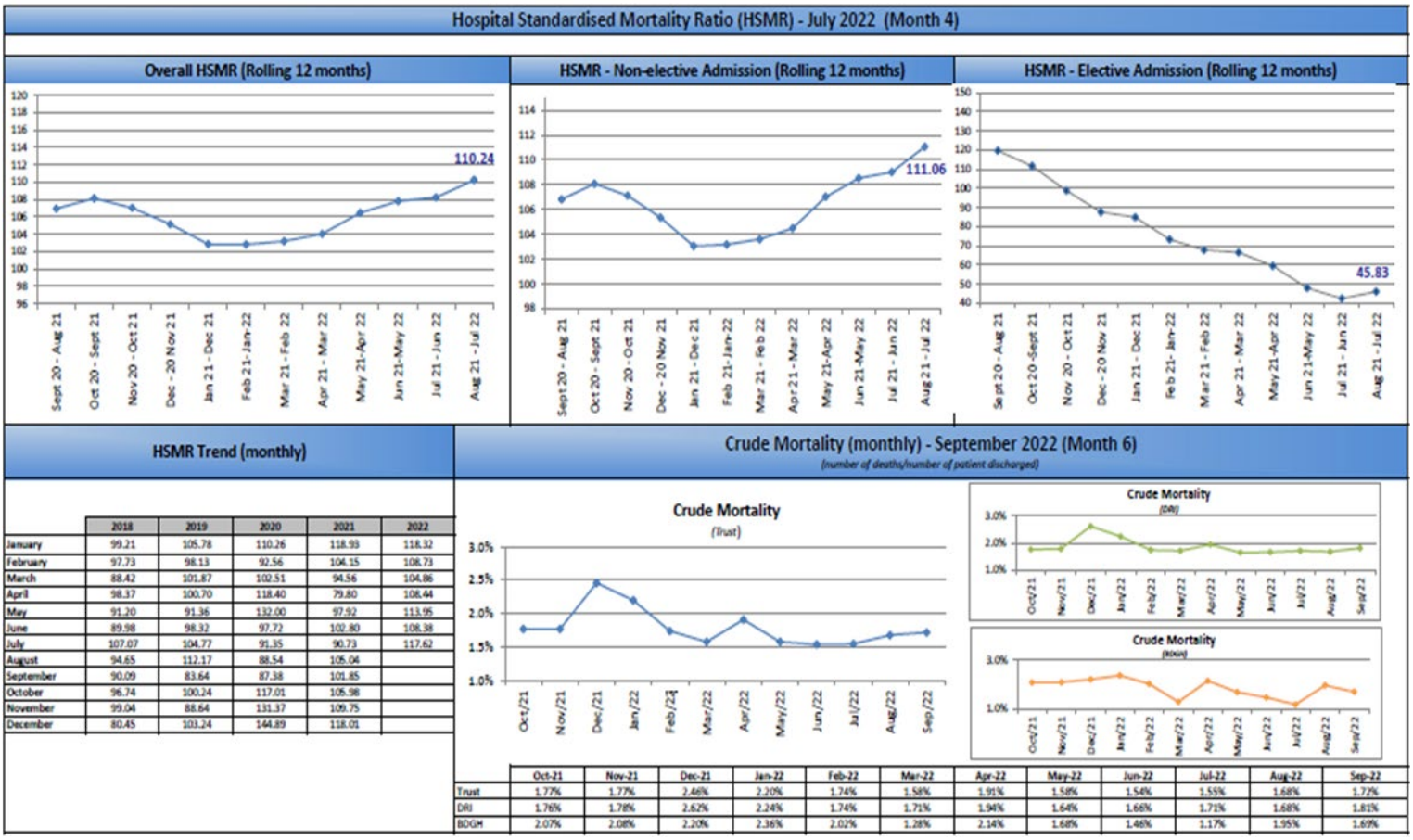
6.2 Hospital Standardised Mortality Ratio (HSMR)

HSMR month on month for January was 118.32 and for July 117.62. Overall HSMR (rolling 12 months) for August 21 to July 22 was 110.24. The ratio for this result is number of observed deaths versus number of expected deaths (as prescribed by Dr Foster).

In terms of elective admissions, there has been several months in the last 12 month period where there have been no deaths, demonstrating a downward trend. The Board of Directors can be assured that the recent slight increase raised no cause for concern as excess deaths are all scrutinised.

As the number of excess deaths has increased by over 5 points this has triggered further investigation. This investigation has revealed excess deaths recorded for non-elective admissions relate to cancer patients, complex cases, late presentation, stroke and multi-organ failure.

The Trust's increase in elective HSMR reflects the national picture.



	2018	2019	2020	2021	2022
January	99.21	105.78	110.26	118.93	118.32
February	97.73	98.13	92.56	104.15	108.73
March	88.42	101.87	102.51	94.56	104.86
April	98.37	100.70	118.40	79.80	108.44
May	91.20	91.36	132.00	97.92	113.95
June	89.98	98.32	97.72	102.80	108.38
July	107.07	104.77	91.35	90.73	117.62
August	94.65	112.17	88.54	105.04	
September	90.09	83.64	87.38	101.85	
October	96.74	100.24	117.01	105.98	
November	99.04	88.64	131.37	109.75	
December	80.45	103.24	144.89	118.01	

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Trust	1.77%	1.77%	2.46%	2.20%	1.74%	1.58%	1.91%	1.58%	1.54%	1.55%	1.68%	1.72%
DRI	1.76%	1.78%	2.62%	2.24%	1.74%	1.71%	1.94%	1.64%	1.66%	1.71%	1.68%	1.81%
RDGH	2.07%	2.08%	2.20%	2.36%	2.02%	1.28%	2.14%	1.68%	1.46%	1.17%	1.95%	1.69%

Month 4 Hospital Standardised Mortality Ratio (HSMR)

6.3 Summary Hospital-level Mortality Indicator (SHMI)

SHMI is due to be reported in November 2022.

Given the scrutiny of the Medical Examiner concluding there are no issues with the quality of care in the Trust, the Associate Medical Director (AMD) responsible for patient safety and governance contacted NHS Digital to query whether the elevation of SHMI was due to post discharge issues and if this could be both quantified and qualified.

In response, the Higher Information Analyst at NHS Digital, provided the following comment regarding this measure:

"I would like to impress that the SHMI does not represent a quality of care indicator, but is a ratio of patients who die following hospitalisation at a trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated at that trust (age, sex, method and month of admission, current and underlying medical condition(s) and birthweight (for babies)."

6.4 Medical Examiner Update

As detailed in the Quarter 1 (2022/23) Learning from Deaths Report, (Appendix 1) the Medical Examiners (ME) Office continues to review 100% of all adult deaths in the Trust and highlight the identification of any potential care issues. The role of these offices is to examine deaths to:

- agree the proposed cause of death and the overall accuracy of the medical certificate of cause of death (MCCD) with the doctor completing it
- discuss the cause of death with bereaved people and establish if they have questions or any concerns with care before death
- act as a medical advice resource for the local coroner
- identify cases for further review under local mortality arrangements and contribute to other clinical governance processes

6.5 ME scrutiny of all non-coronial deaths

The National Medical Examiner, Graham Cooper, attended the Trust along with the Regional Medical Examiner on 11th November, 2022. The aim of this visit was to meet the medical examiner team, walk round the department, and review their processes and data. Feedback from the visitors was very complimentary and they congratulated the team on achieving and maintaining 100% scrutiny of deaths for the acute Trust.

In terms of extending scrutiny to the community in accordance with new legislation, it was acknowledged by the National ME that the team were prepared pending access to Systmone and EMIS. He reinforced the requirement to ensure access was up and running by the beginning of January 2023 and that this was time critical in order to achieve compliance with the system becoming statutory in April next year.

In July 2022, NHS England advised that ministers had announced their intention for the statutory ME system to start from April 2023. In preparation for this, all NHS organisations should have processes in place to facilitate the work of medical examiners in place by 31 March 2023.

It is recognised nationally that extending the ME system to all non-coronial deaths is complex and implementation should proceed carefully, through an agreed incremental process made possible by the non-statutory period.

Following approval of a business case in October 2022, to fund licences and set up costs for access to Systmone and EMIS GP practice systems, the ME team in collaboration with the Digital Transformation team and primary care colleagues can commence work on a local implementation plan to ensure that by March 2023, the ME system is in place to scrutinise all community deaths, as per the new legislation.

7. RISK MANAGEMENT BOARD

The Risk Management Board held its inaugural meeting on 17 October 2022. This committee, currently Chaired by the Executive Medical Director, had been established in response to the recommendations from an internal audit review of the Trust's risk management processes during 2021/22. The internal auditors highlighted the following key risks:

1. *The Trust does not have a clear and consistent policy in place to manage risks at all levels of the organisation and this policy is not understood by staff.*

2. *The process for managing Local-level risks is not understood by staff and is not followed in practice.*

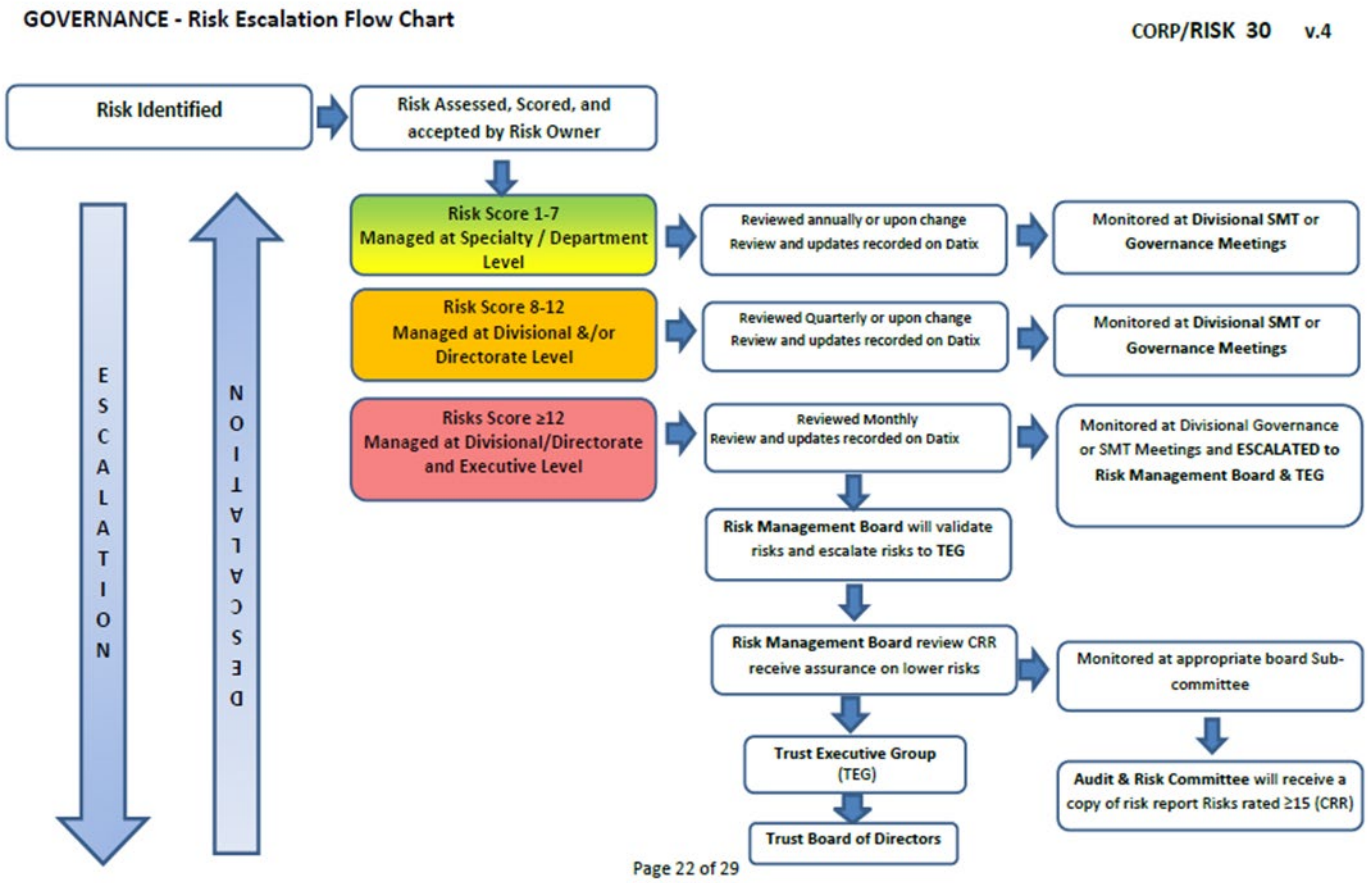
3. *The process for managing Directorate/Care Group-level risks is not understood by staff and is not followed in practice.*

4. *The process for managing Corporate-level risks is not understood by staff and is not followed in practice.*

The work plan for the committee will incorporate actions to ensure the risks identified by the internal auditors are addressed.

The newly appointed Risk Systems Manager will be in post in December 2022. This key role will support the Risk Management Board work plan and establish an operational risk group to improve the risk management governance process. This operational group with provide a moderation forum for divisional and corporate areas to agree consistency in risk scoring and wording so that assurance can be provided to the Risk Management Board.

The risk management governance structure is in line with the internal audit suggested process, and outlined below as per the Trust's Risk Identification, Assessment, and Management Policy[1], revised in June 2022.



The Risk Management Board will meet monthly on the third Monday of each month, with the next meeting being held on 21 November 2022.

Appendix 2 gives a visual representation of the reporting structure for the Risk Management Board and the Medical Advisory Committee, in the wider context of all the internal and external meetings where there is Medical Director involvement.

[1] https://dbhweb.wpenginepowered.com/wp-content/uploads/2022/10/Risk-Policy-v5-FINAL.pdf

Appendix 3 shows the timeline for risk management activities to the end of March 2023. This is in line with the internal audit recommendations and actions, being monitored by 360 Assurance.

The work plan from the Risk Management Board, associated actions and objectives of the newly appointed Risk Systems Manager will feed into a refreshed action plan for 2023/34.

8. SUMMARY AND CONCLUSION

The Board of Directors is asked to note the content of this report and be assured by the ongoing clinical areas of work within the EMDD portfolio.

APPENDIX 1

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Quarter 1

Learning from Deaths Report

April to June 2022

Addette Spenceley -Learning from Deaths Nurse

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

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

	**Deaths in Quarter 4 (Adult inpatients)** Doncaster = 359 Bassetlaw = 97 **Total Inpatient deaths =456**
	**Deaths in Quarter 1 (A&E)** Doncaster = 40 Bassetlaw = 9 **Total A&E deaths = 49** **TOTAL DEATHS = 505**
	**Deaths Screened by MEO** Doncaster =318 Bassetlaw = 71 **Total MEO scrutiny = (77%)**
	**Deaths scrutinised by ME** Doncaster = 386 Bassetlaw = 105 **Total ME team Scrutiny (97)%**
	Total deaths screened/scrutinised by the ME Team = 505 (100%)
	**Structured Judgement Reviews (SJR)** A task and finish group will be commissioned to develop an effective process for completion and return of SJRs
	**Hospital Standardised Mortality Ratio (HSMR) 12 month rolling** All this quarter's data is awaited from HED as of March 2022 HMSR is 103.33
	**Top 5 cause of death recorded on MCCD this quarter** 1.Pneumonia 106 2.Metastatic cancer 43 3.Cardiac related 43 4.Multi-organ failure 34 5.Sepsis 33
	**Top 5 "main condition treated" as coded from the notes:** 1. Lobar Pneumonia, unspecified 57 2. Sepsis, unspecified 37 3. Emergency use of U07.1 33 4. Congestive heart failure 22 5. Pneumonia, unspecified 18
	**Percentage of MCCDs issued within 3 working days of death when no coronial involvement** Bassetlaw 86 (81%) Doncaster 312 (78%) .

Contents

1. Executive Summary and Achievements

This is Quarter 1 (2022/23) Learning from Deaths report in accordance with the National Guidance on Learning from Deaths (March 2017). This quarter has seen a significant decrease in numbers from 568 in Q4 to 505 in Q1. This number of deaths is consistent with pre covid times 18/19 (440) and 19/20 (448) suggesting that Covid 19 is no longer having an impact on our crude mortality.

The Medical Examiner (ME) Team have scrutinised 100% (505) deaths this quarter. This is a great achievement. This is an excellent position to be in at this time of the year.

As reported last quarter, the medical examiner team has been recognised by the regional medical examiner's office as performing extremely well in achieving almost 100 % scrutiny since January 2021. As a result they have been asked to explore ways of scrutinising non- acute deaths. Effective working is continuing to prove extremely challenging due the difficulties in accessing primary care IT systems.

The Chief ME and Lead MEO have been piloting with 1 GP practice to roll out the non-acute scrutiny during the non-statutory phase and this is working very well. All MCCD's are sent directly to the Registrar from the Medical Examiner office.

Subsequently, the independence of the ME team is a key element of the service. The ME team staff regularly recognise areas of good practice, areas of concern and learning, these are distributed via Trust governance processes to action. The ME team has no other role within this area other than to "identify and pass on".

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

The Trust has recognised the need for a lead nurse to take forward and drive the national learning from deaths agenda. This post will provide an invaluable link between identifying concerns or compliments, learning from deaths and changing practice to enable quality care for all.

Findings from review of care episodes will be translated into meaningful learning and will be fed back through the correct processes. The Learning from Deaths (LFD) lead nurse is now in post and has assisted in the production of this quarterly report.

2.Introduction

“Death is inevitable and a natural event for all of us, and not all deaths will represent a medical failing or problem in the way the person has been supported during their life” (CQC: Learning, Candour and Accountability”, 2016)

Many deaths that occur in the NHS are either expected or anticipated. When Doctors identify that a patient may be in their final stages of illness, or that the death is imminent, it is important for an open and transparent relationship to be formed between the doctor, patient and family. Listening to concerns, expectations and fears at this stage are so important. Good communication and relationships when a death is expected or is imminent are likely to lead to good communication and compassionate care of family members after death.

An organisation with an existing open culture will find the implementation of a Learning from deaths agenda less challenging than those tending to have a more closed, inward looking fearful culture.

A quarterly report on Learning from Deaths has been produced since April 2017 as dictated by the March 2017 National Guidance on Learning from Deaths. The report is received by the Quality and Effectiveness Committee. The report has evolved over time, as other processes and ways of working have been introduced. The most significant change since December 2019 has been the introduction of the Medical Examiner (ME) System, the appointment of a Learning from Deaths Lead Nurse and of course since March 2020 the covid pandemic.

The trust recognised a need for a lead nurse to move forward and drive the Learning from Deaths Agenda. The Learning from Deaths Nurse (LFD) has been in post since May 2022. The aim of the LFD is to ensure that issues, themes and importantly good practice are translated into meaningful learning through the clinical governance processes at speciality level. The vision for this post is for ‘learning for the future, rather than apportioning blame to the past’.

The LFD Nurse that has successfully been appointed is Addette Spenceley. Addette is a nurse who has worked in the trust since 1999. She has a background of nursing in Acute Medicine, the Emergency Department and Frailty. Addette is also a learning Disability Ambassador and a recently qualified Professional Nurse Advocate. She is also the manager for the bereavement team.

As reported last quarter the changes to the legislation indicated by the Coronavirus Act 2020 saw huge changes in processes, which was published on 25th March 2020. The Coronavirus Act expired at midnight 24th March 2022. The following should be noted:

3 provisions within the act are continuing:

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

From the 25th March 2022:

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

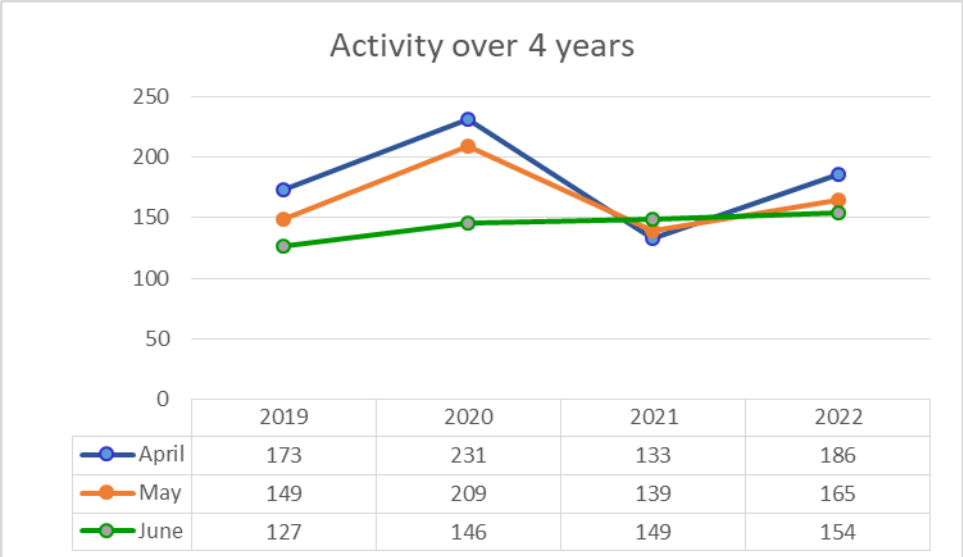
There is a legal obligation to report certain categories of death to the coroner before they can be registered. HMC will need to be involved if the medical practitioner did not attend the deceased in the 28 days before death, or the deceased was not seen after death by the medical practitioner.

After 24 March 2022, the MCCD can still be completed by the medical practitioner if they can state the cause of death to the best of their knowledge and belief. If the coroner is to be notified a MCCD can be completed by the medical practitioner beforehand to avoid delays that can cause further distress to the bereaved. If the coroner decides not to investigate, this reduces inconvenience to the doctor and the family. The coroner can complete Form 100A. Formally known as an 'APASS'.

3. Overview of Activity

In quarter 1 there has been a total of 505 trust deaths compared to 568 deaths in quarter 4. The table below demonstrates that numbers are slowly returning to pre covid numbers.

a) Activity (4 years data)

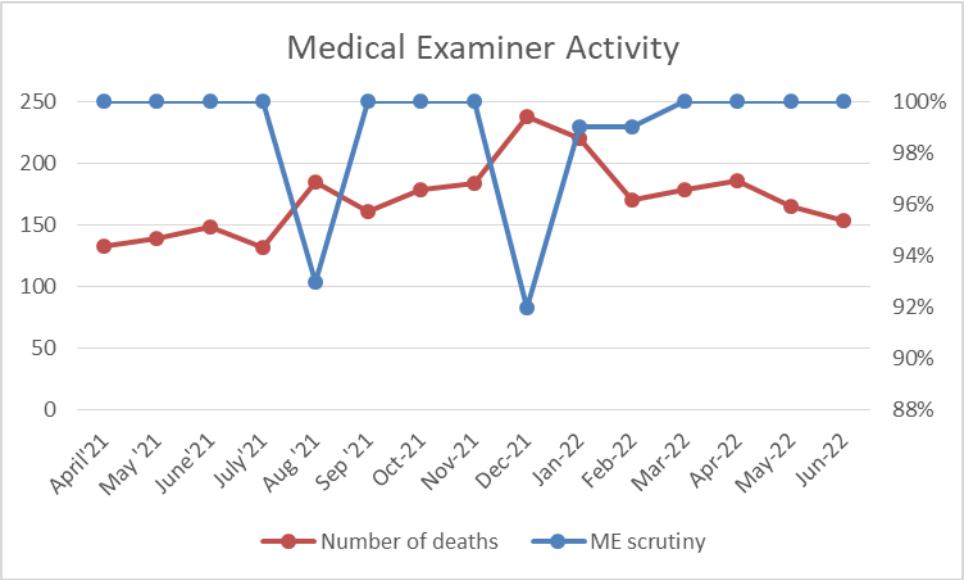


	2019	2020	2021	2022
April	173	231	133	186
May	149	209	139	165
June	127	146	149	154

4. Medical Examiner Team

The Medical Examiner (ME) team consists of 8 part time Medical Examiners, this now includes 3 GP's and 4 WTE Medical Examiner Officers. 3 VCF's for the ME team have been approved for the Medical Examiner office to recruit, in preparation for the statutory change in April 2023 to scrutinise all non-acute deaths.

The service began in December 2019 and has continued to work extremely hard to maintain circa 100% scrutiny of all adult hospital deaths since February 2021. The graph below illustrates the activity since April 2021.



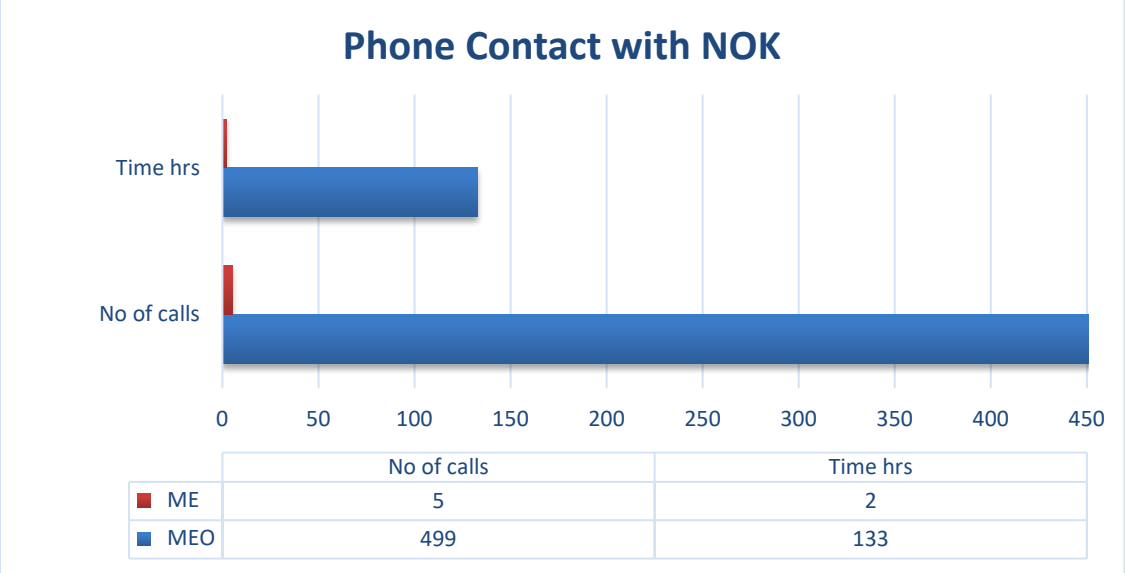
The introduction of medical examiner team is part of the Department of Health and Social Care's death certification reforms programme for England and Wales and will ultimately be a statutory requirement for all Trusts. Although it was hoped this would be a statutory requirement by April 2021, the covid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

This independent system is designed to:

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

Whenever the ME team conclude that a death is potentially avoidable or that any care provided has resulted in significant harm then the patient safety team is immediately notified by the completion of a Datix incident and the case will be scoped in line with the governance process for a potential serious incident. There have been 5 (1%) cases this quarter where a significant concern about the quality of care provided has potentially contributed to death as identified by the medical examiner or staff.

As stated above, one of the most significant aspects of this independent scrutiny is speaking to bereaved people and providing them with an opportunity to raise any concerns they may have with the treatment their loved one received during their hospital stay. In the vast majority of cases, the feedback is highly complementary. This quarter the ME team have spoken to 499 families (99%) 1% had no Next of Kin. 64 of these (13%) have raised concerns with 39 (8%) of these being offered the PALS contact number. Circa 135 hours has been spent speaking to bereaved people.



The types of concerns raised fall into the following categories:

- Poor Communication and insensitive communication.
- Previous admissions and attendance in ED before admission.
- Lack of compassionate visiting arrangements.
- Concerns over medical reviews over bank holiday weekend.
- Unhappy with overnight transfers and NOK not being made aware until they phone the next day.
- Discharged patient to early.

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

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

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

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

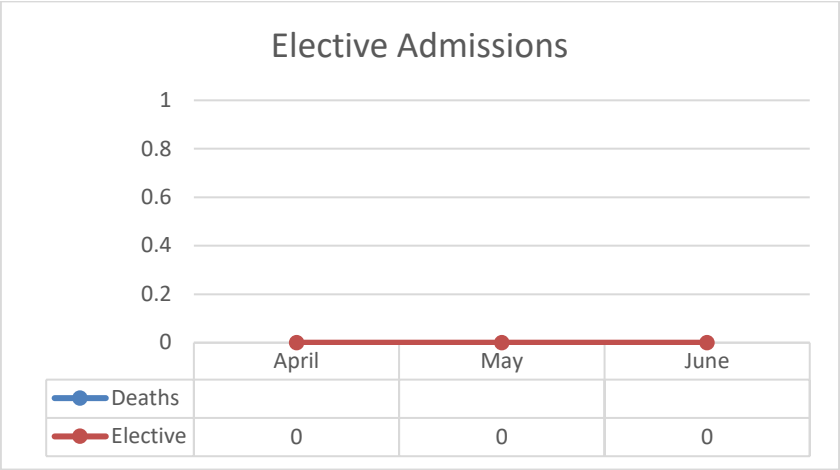
This quarter, 16 SJRs have been requested. 1 has been returned.

The Regional Mortality team are facilitating an SJR training session and a date is yet to be confirmed. Now that the LFD Nurse is in post, once training has taken place, plans are set for her to disseminate further training and refresher updates within the trust. An internal process has been agreed with clinical coding to enable consultants that are requested to do SJRs to be able to obtain clinical notes in a timely manner. This should allow a more timely completion and return.

6. Elective Admissions

There were 0 elective admissions resulting in death this quarter. If death occurs when a patient is admitted electively, it is reviewed by the medical examiner team.

Over time it has become apparent that the vast majority of "elective" deaths are not what we class as a "true" elective admissions. Most are very ill patients with significant co morbidities who attend hospital for pain relief or symptom management. It is essential that these cases are looked at with some rigor to reassure the Trust, should any issues with HMSR rates for elective deaths become apparent.



7. Learning Disability deaths

The Trust experienced 1 death of an adult patient with a learning disability this quarter, and 3 recorded in the previous quarter. A death of 1 patient with a documented diagnosis of autism also occurred.

Both patients were at DRI. All have been referred to the Learning Disabilities Mortality Review Programme (LeDeR). These 2 cases were concluded to have received good care by the ME team. 1 of these cases is still awaiting a SJR to be returned. Of the completed SJR returned, it was established that the patient received good care.

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

The LFD nurse and the Learning Disabilities nurse have established a working relationship and will be reviewing any SJR's alongside the doctor, in order to have a multidisciplinary approach to ensuring any gaps in care are identified and acted on, or any examples of good practice are championed.

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

A death can only be registered when a MCCD has been issued.

The timely issuing of a MCCD is crucial to ensure that bereaved families and carers can register the death and progress other essential activities following the death of their loved one. Where there is no Coroner involvement the death should be registered within 5 days.

An internal 3 working day target to have the MCCD completed and issued is in place. This quarter we have met that target 78% of the time at DRI and 81% at BDGH.

This exhibits a decrease from last month and ways to improve this are being implemented. Numbers of deaths have returned to pre covid times and staffing levels have also increased, however the ending of the Coronavirus act, sickness and the need for self isolation has had an impact on the figures, also the patients that only are reviewed by a limited number of doctors pose a challenge due to the doctors workload and allocated shift patterns.

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

Plans are in place to target doctors handovers for each speciality to explain the expectation of timely completion of referrals and paperwork.

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

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

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

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

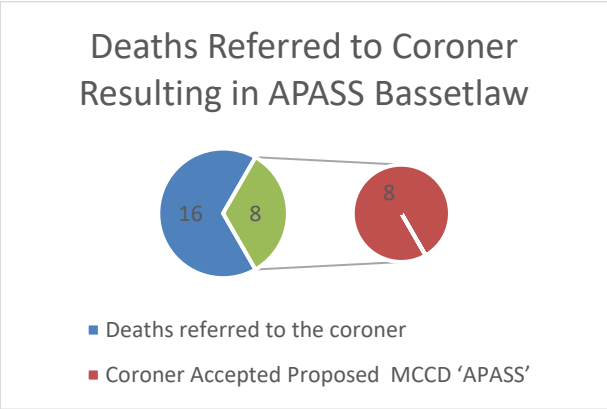
Referral to the Coroner does not necessarily mean the case will go to Inquest. In many cases the Coroners will review the referral and the ME Scrutiny and proposed cause of death as documented on the MCCD. Following communication and agreement with the family, if the proposed cause of death is accepted a form 100A is issued. This is commonly known as an 'APASS'

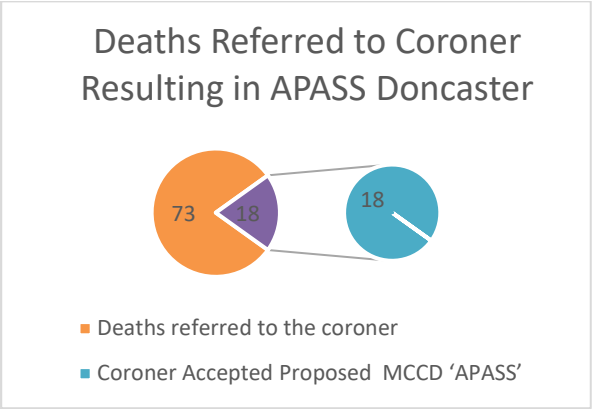
At Bassetlaw, the ME office is piloting an online HMC reporting portal. All referrals are submitted via the portal rather than email. The Notts HMC office get the referral directly to their system to prevent duplication. Cases that have been referred by the trust can then see their progress, for example when a PM result is available. This is being used at Mansfield Hospital and is reported to be working well.

An interim death certificate can be issued by the coroner, this could be due to the post-mortem result being inconclusive, an investigation is ongoing by the coroner or there is to be an inquest. The interim certificate replaces a certified copy of the death certificate until the inquest or investigation is concluded. This enables the death to be registered and therefore families can move forwards with their plans.

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

This quarter, Coroner's referrals have significantly decreased. We have set up a system whereby 1 bereavement officer rings the Coroner's officer on a set date to be informed of the outcomes. There has been some issues identified in receiving information from the HMC. All avenues are being explored to improve this process.





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

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

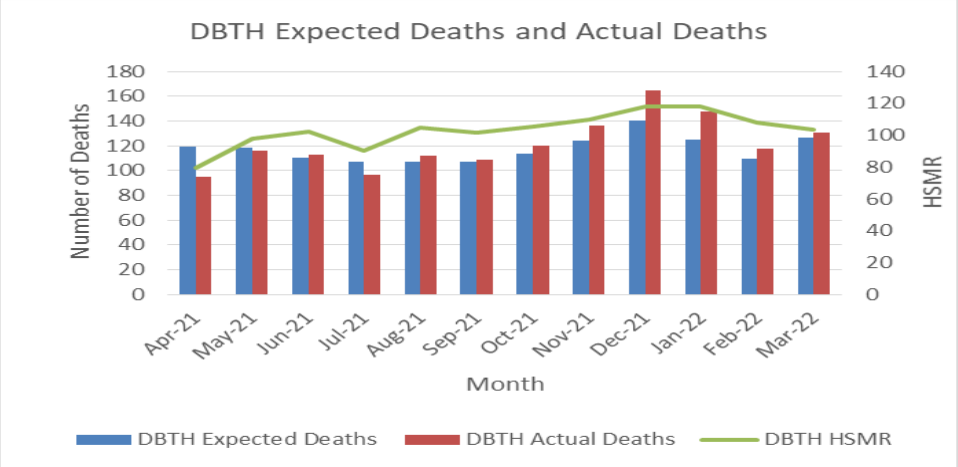
	From MCCD	Count
1	Pneumonia	106
2	Metastatic cancer	43
3	Cardiac related	43
4	Multi-organ failure	34
5	Sepsis	33

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

The top 5 main conditions treated were:

Diagnosis	Description	Number of patients who died (by 1st diagnosis on admission)
1) J181	J181:Lobar pneumonia, unspecified	57
2) A419	A419: Sepsis, unspecified	37
3) U071	U071: Emergency use of U07.1	33
4) I500	I500: Congestive heart failure	22
5) J189	J189: Pneumonia, unspecified	18

11. Expected deaths and actual deaths



As of March 2022, it is to be observed that DBTH expected deaths and actual deaths are marginally below the Hospital Standardised Mortality Ratio.

12. Learning

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

The learning from deaths nurse is the key component to ensuring effective communication of the learning identified.

It has been formulated that any compliments or concerns, that families discuss with either Medical examiner's office or bereavement team, are highlighted to the LFD nurse to be analysed and acted on accordingly.

The Datix team is assisting the LFD Nurse have formalised a process where relevant learning issues are filtered through to the LFD nurse to action where appropriate.

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

- Compassionate visiting should ALWAYS be considered by the senior nurse. This does include any patients that require extra support, such as patients living with dementia, learning disability or patients who respond more readily to a familiar person providing support with activities of daily living.
- Several complaints have been received this quarter by the lack of communication to families.
- Families have also reported that insensitivity of communication when breaking 'bad news'.
- Failure to implement End of Life when clinically indicated and appropriate.
- Families concerned about readmissions and querying whether their relative was medically optimised to be discharged in the first instance.

- Concerns from families over the lack of review over the bank holiday period

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

The visiting times are now less restrictive, with the withdrawal of relatives having to book time slots and allocate specific visitors in order to see their loved ones. Of course the issue of infection prevention and control remains ever present and the final allowance of visiting lies with the nurse in charge.

The lack of communication has been identified to the relevant areas for this to be addressed individually or departmentally.

The issue of breaking bad news is a sensitive subject and can involve several factors. There have been changes in some departments whereby private rooms have been created to ensure 'bad news' is broken in a private, quiet area.

There is internal work regarding end of Life services and at the time of writing this report this is being discussed and actioned.

Readmission to hospital sometimes cannot be predicted and this theme will be monitored.

The extended bank holiday did in itself bring staffing challenges and historically services are restrictive.

It is vital to share the positive learning from the involvement of speaking with families. All these message were passed onto the ward managers and was greatly received.

"*the care she received was exemplary and she could not praise your team enough. She wishes for her thanks to be shared with anyone who was involved in her care*."

One relative asked the ME team to pass on

"*their thanks to all of the ward staff. She said her father received fantastic care and family could not wish for better staff. They were extremely impressed. The Chaplain was also very compassionate and ensured families' wishes were met. They were extremely grateful to all"*

"One part of my role as Medical Examiner Officer involves speaking to the next of kin of deceased patients about the care received in hospital prior to death. I have spoken to the family who wanted me to pass on that all the staff were outstanding. He said he was very impressed with the care and could not thank you all enough. I would be extremely grateful if you could pass this on to your staff"

Positive learning is always shared by the ME team to the wards as mentioned in previous reports. This gives confidence to the staff and enables them to feel valued in their roles. Most importantly, sharing good practice is absolutely critical to improving leadership and quality.

13. Bereavement Team.

The bereavement team staff consist of 2 full time officers and 1 part time officer, this enables the service to be covered 6 days per week, with most days having 2 bereavement officers on duty. The advert was relaunched for a further part time officer at 22.5hrs. Shortlisting has been completed and the next stage is interview.

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

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

The LFD/bereavement manager has been attending the daily medical doctors handover at 0830hrs to support the bereavement officer in expressing the importance of timely completion of death related paperwork. This appears to be having a positive impact. The bereavement team have created a welcoming atmosphere for the visiting doctors and have continued to provide tea, coffee and biscuits for them.

Doctors illegible writing seems to be a consistent issue which provides difficulty in identifying the 'owning' doctor to complete paperwork and may prove a further challenge when familiar doctors change in the August rotation. Plans are in place for the bereavement team to attend the doctors induction, to introduce the bereavement team and familiarise the doctors to the process involved in completing relevant paperwork/referrals. Also targeted doctors handovers in other specialities will be happening.

Cremation continues to be the preferred method of funeral choice, interestingly, simple cremations are becoming a regular choice, this may be a reflection on the cost of living being experienced at this time.

This last quarter has seen datix reporting increase due to breaches of the national target guideline for completion of MCCD. This is due to the bereavement team having a more robust system in place to identify at a glance on the patient board within the office, the potential breaches and to flag these when they occur. The reasons identified for breach of target are:

- Determining the owning Drs team i.e., patients admitted under a speciality then transferred to DCC or medical patients sadly dying in ED having been reviewed by the medical team.
- Community deaths that have attended ED, been discharged and not seen in community by their GP before dying.
- Doctors annual leave

All of the above is being considered and being reviewed to identify ways of improving communication and escalation of issues. A process for patients who have died in ED and have had a medical doctors input has been discussed and a way forward has been formulated to make joined up working an easier process.

There have been several episodes of families attending the bereavement office in person to collect 'death certificates' has occurred, which induces further stress on the grieving families and anxiety for the bereavement office staff as historically they are in a non-person facing role; however deal with bereaved relatives over the phone. The bereavement team manager has addressed this issue by reiterating the correct procedure to inform relatives of, to all Matrons so they can cascade this to their teams. A piece has also been published in Buzz, the trusts online newsletter of the correct procedure.

14. Recommendations

Recommendations	Progress
To Ensure 100% MCCD's are available to the registrar within 3 days	Q1 79% across the Trust v Q4 91% in the previous quarter. Targeted approach to capture new DRs in August for explanation of process
Task and finish group to determine SJR process	To be completed once the LFD nurse has established in her role
Introduce the scrutiny of non-acute deaths	Continue to communicate with GP Surgeries. Delays in IT access has been escalated to the Trust's Clinical governance committee. Providers for IT systems have been received and costings awaited.
The Board, via the QEC, to receive this report for assurance of the ongoing work to improve mortality review and the learning across the organisation.	October 2022

15. Conclusion

Several areas of learning have been highlighted in the report and all of these have been raised with the clinical governance teams, individual practitioners or ward teams. Any potential serious incident/ avoidable death has been reported via Datix and alerted to the patient safety team. The Medical Examiner (ME) Team have scrutinised 100% (505) deaths this quarter. This quarter has seen a reduction of 63 deaths compared to Q4 and these numbers are now comparable to the same quarter in pre covid times. The LFD nurse's key aim will be to ensure that issues raised by the ME team are translated into meaningful learning through the correct clinical governance processes at specialty level.

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

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

This Q1 reports a very promising position. Work continues to explore ways of scrutinising non-acute deaths. Initial work has proved extremely challenging due the difficulties in accessing primary care IT systems. This has been recognised by the trust and a business case has been put forward to

assist with access to much needed IT systems to ensure the non-acute scrutiny can be started as soon as possible. The Lead MEO continues to drive the implementation of non acute death scrutiny

The appointment of the Learning from Deaths nurse is an exciting opportunity to enable meaningful learning to be cascaded throughout the trust, ensuring continuous quality improvement and recognition of the commitment of staff to strive to get it right first time, every time.

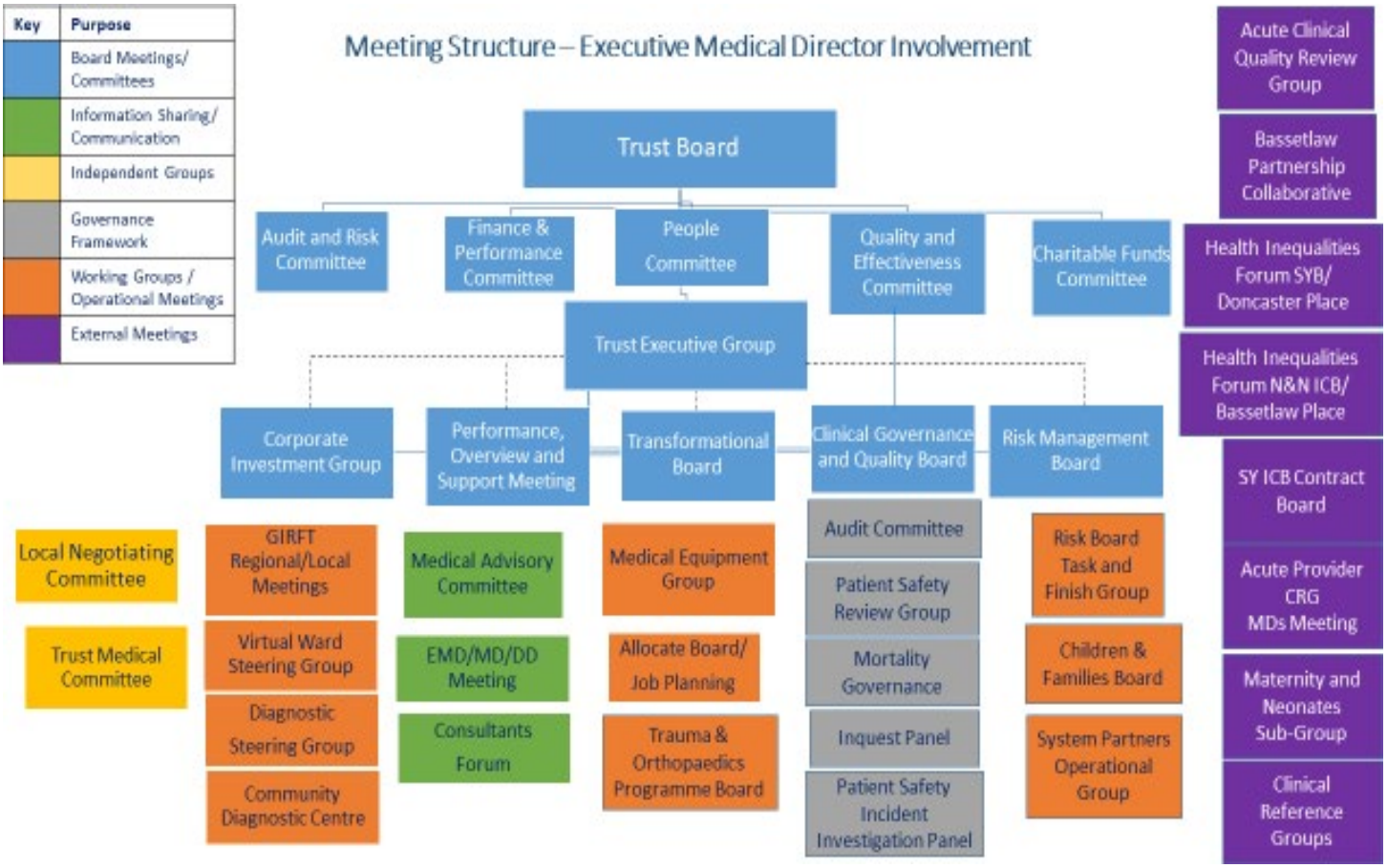
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust remain committed to investigating, learning from and taking action as a result of individual complaints where concerns have been made or where services can be improved.

Our vision is “to be the safest Trust in England, outstanding in all that we do”.

To achieve this the DBTH values must be followed which include always putting the patient first and committed to quality and continuously improving patient experience.

APPENDIX 2:

Reporting Structure for Risk Management Board and Medical Advisory Committee



APPENDIX 3:

Risk Management Time Line

Risk Management Time Line								
Action	**27/09/22**	**17/10/22**	**21/11/22**	**12/12/22**	**19/12/22**	**16/01/22**	**20/02/22**	**20/03/22**
Risk Policy Reviewed and Signed off by Board of Directors								
Risk Management governance process in place								
First meeting of Risk Board held								
Divisional Directors review and feedback on all risk scoring 20								
Divisional Directors to ensure risk owners in their areas are up to date and apportioned correctly								
Divisional Directors review and feedback on all risk scoring 15+								
Process embedded for new risks scoring 15+ to be escalated to Risk Board								
Risk Systems Manager in post								
Work plan from Risk Management Board established								
Risk Systems Manager to develop a Risk Operational Group that feeds into Risk Board								
Risk Systems Manager to develop a training plan for risk assessment, analysis and scoring								
Risk Systems Manager to develop a Datix training plan								
Training plans to be communicated and dates to be scheduled throughout 2023/24								

Appendix Level1

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

True North Strategic Aim 2 – Everybody knows their role in achieving our vision

Risk Owner: Trust Board – Director POD
Committee: People

People, Partners, Performance, Patients, Prevention

Date last reviewed: November 2022

Strategic Objective
Everybody knows their role in achieving our vision

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

Measures:
- At least 90% of colleagues have an appraisal linked to the Trust's objectives and values
- 5% improvement in colleagues reporting they are able to make suggestions to improve the work of their team/department.
- Delivery of a 5% improvement in the number of colleagues who have the opportunity to show initiative in their area and make improvements in their area of work.
- 90% of the Divisional and Directorate leaders will have undertaken QI training as part of leadership development programme.

- Yellow highlights are the updates since the version presented to People Committee on 8 November 2022

Risk PEO2 16 has been reviewed following the PC meeting and likelihood remained as 'likely' based on current position therefore no change to rating

Discussion at TEG meeting on 14 November linked to 360 Assurance feedback and recognition of some overlap in the themes of SA2 & SA3 resulting in some overlap in actions. To be considered when BAFs reviewed for 2023/24

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

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

Risks:
- Risk of disconnect between ward and Board leading to negative impact on staff morale and patient care
- Failure of people across the Trust to meet the need for rapid innovation and change
- Ongoing impact of restoration of services post Covid
- Capacity of teams to undertake appraisals in a timely manner
- Reliance on international recruitment whilst increase in education places come to fruition
- Levels of sickness absence impacting on staffing levels

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

Overall Risk Scores for Strategic Objective

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

In assessing rationale for the overall strategic risk current score, please articulate the individual strategic risks clearly, by considering the prompts below:
- *Is the target risk score realistic/when will it be achieved and is this date reflected in action completion dates?*
- *Are the controls in place effective – are they driving the risk score down? Are there any gaps in controls? Are any of the controls not having an impact – do they need removing from the BAF?*
- *Have actions to address gaps been identified and are these on track?*
- *Is there a need to seek additional assurance – either additional board scrutiny or independent assurance?*
- *Do the controls mitigate high level operational risks noted on the BAF?*

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

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

Comments:
- Considerations – capacity & capability of workforce including our leaders
-

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

Controls (mitigation to lead to evidence of making impact):	Last Review date	Next review date	Reviewed by	Gaps in Control
Monitoring progress of appraisal completion through central regular reporting within P&OD indicating compliance	Nov 2022	End Sept 2022	ZL	Appraisal Season launched 01 June 2022, ongoing monitoring of completion rates through appraisal season window, fortnightly reports and reviewed at Performance, Overview and Support meetings (POSM) with divisions. No gaps in control identified. Report presented at Nov PC meeting – 83% completion rate recorded for appraisal season Evaluation and review of 2022 season underway and improvements planned for 2023 (see action below)

Staff survey and focus groups – positive feedback on colleagues knowing Trust vision	Nov 2022	2022 staff survey results	JC/ZL	No gaps identified. Approach for 2022 staff survey action planning presented to People Committee, TEG and Board in July 2022 – supported. 2022 staff survey launched with 62% response rate with 2 weeks remaining, new provider secured. Actions taken by divisions in response to survey feedback being presented at POSM
Staff survey action plans to ensure appraisal conversations are meaningful as defined by the staff survey	Oct 2022	2022 staff survey results	JC	Paper on People Committee Agenda 5 July 2022. Appraisal season monitoring through fortnightly reporting and Performance, Overview and Support meetings with divisions. Appraisal season report presented at Nov PC meeting
Communication – Staff Brief, Listening Events, Facebook	Nov 2022	Jan 2023	AT/ZL	None – ongoing communication process. Addition of work on Board/Exec visibility. Monthly Board visits schedule began as planned in Sept 2022, Execs meeting being held monthly at Bassetlaw and now arranged for bi-monthly at Montagu
Numbers accessing Leadership Development Programme, including QI	Sept 2022	Mar 2023	JC	None identified – Prospectus of Leadership Programme Training & Development launched Mar 2022. Full review of leadership development offer to be undertaken following development of leadership behaviours framework

Assurances received (L1 – Operational L2-Board Oversight L3 External) **		**Last received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
L2, L3	Feedback from the appraisal season and national staff survey results	Jul 2022	People, Board	Full	Papers to People Committee 05 July, 6 Sept and 8 Nov 2022. Addition of Staff Engagement as standing agenda item at People Committee
L1,L2,L3	KPMG Job Planning Audit	Nov 2021	People, ARC, Board	No assurance opinion	Action plan actively monitored by ARC and People Committee. Timetable for completion of job plans being developed, led by Medical Director. Updates to be presented to People Committee – report to November meeting
L1	Staff Engagement paper and Appraisal Season report presented at September and November People Committee	Nov 2022	People		Committee assured

Corrective Actions required	**Action due date**	**Action status**	**Action owner**	**Forecast completion date**
Active monitoring on KPMG Job Planning audit to ensure all actions completed – see additional update above. Details on progress on actions in Pentana (360 Assurance system)	**Oct 2022 – deferred from May 2022**	**Amber -ongoing**	**TN**	**Autumn 2022**
Review of Appraisal Season to be undertaken after the season and on receipt of staff survey results (feedback on appraisals), including refresh of paperwork for 2023 season – 2 stage review	**Nov 2022 (initial review)** **March 2023 (review of survey results)**	**Initial review undertaken & report to Nov PC meeting** **Improvements identified and being developed for 2023 season**	**ZL**	**March 2023**
Development of new People Strategy from 2023	**Jan 2023**	**On track – agreed to align with national People Plan themes. PC agenda format changed from Sept 2022** **Themes and priorities being collated based on local feedback and national requirements**	**ZL**	**January 2023**
Design and implementation of new leadership behaviours framework for DBTH. Plan for engagement in Nov/Dec, development Jan/Feb. approval process & launch Mar/Apr	**Mar/Apr 2023**	**On track – plan in place for engagement in Nov/Dec which is underway**	**ZL**	**March/April 2023**
Approach to succession planning to be refreshed, following development of leadership behaviours framework	**May 2023**	**New action discussed at November PC**	**ZL**	**May 2023**

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

Appendix Level1

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

True North Strategic Aim 3 – Team DBTH feel valued and feedback from staff and learners in top 10% in UK

Risk Owner: Trust Board – Director POD
Committee: People

People, Partners, Performance, Patients, Prevention

Date last reviewed : November 2022

Strategic Objective
Team DBTH feel valued and feedback from staff and learners in top 10% in UK

Breakthrough Objective
Team DBTH feel valued and the Trust is within the top 25% for staff & learner feedback

Measures:

- Delivery of a 5% improvement in colleagues and learners recommending the Trust as a place to work and learn in the 2021/2022 staff survey results.
- Delivery of a 5% improvement in how valued colleagues feel by managers and the Trust in the 2021/ 2022 staff survey results
- Delivery of 5% improvement in health and wellbeing feedback in the 2021/2022 staff survey results
  Delivery of 5% improvement in WRES and WDES feedback in the 2021/2022 staff survey results

- Yellow highlights are the updates since the version presented to People Committee on 8 November 2022

Risk PEO2 16 has been reviewed following the meeting and likelihood remained as 'likely' based on current position therefore no change to rating

Discussion at TEG meeting on 14 November linked to 360 Assurance feedback and recognition of some overlap in the themes of SA2 & SA3 resulting in some overlap in actions. To be considered when BAFs reviewed for 2023/24

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

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

Risks:

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

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

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

Overall Risk Scores for Strategic Objective

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

In assessing rationale for the overall strategic risk current score, please articulate the individual strategic risks clearly by considering the prompts below:

- *Is the target risk score realistic/when will it be achieved and is this date reflected in action completion dates?*
- *Are the controls in place effective – are they driving the risk score down? Are there any gaps in controls? Are any of the controls not having an impact – do they need removing from the BAF?*
- *Have actions to address gaps been identified and are these on track?*
- *Is there a need to seek additional assurance – either additional board scrutiny or independent assurance?*
- *Do the controls mitigate high level operational risks noted on the BAF?*

Rationale for overall strategic risk current score:
Impact:

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

Comments:

- Requires good OD plan "fit for purpose"
- Staff survey impact
- Need good data
- Recruitment & retention – refresh of workforce plan
- Involvement in regional retention programme of work
-

Opportunities:

- Change in practices, new ways of working incl agile working
- Future new build
- Focus on wellbeing and EDI across the Trust

Controls (mitigation to lead to evidence of making impact):	Last Review date	Next review date	Reviewed by	Gaps in Control
Support introduction of Freedom to Speak Up Champions	Nov 2022	Nov 2022	PH/ZL	No gaps identified. Relaunch of Speaking Up in Autumn 2022, communication began September with different themes being highlighted weekly Engagement during this time will contribute to Speaking Up strategy

Appendix Level1

Staff survey action plans to ensure improvement		Nov 2022	2022 staff survey results	JC/ZL	Staff Survey Paper on People Committee Agenda 5 July. Updates and actions being taken provided at Performance, Overview and Support meetings with divisions. Approach for 2022 staff survey action planning presented to People Committee, TEG and Board in July 2022 – supported., 2022 staff survey launched with 62% response rate with 2 weeks remaining, new provider secured. Addition of Staff Engagement as standing agenda item for People Committee
Communication – Staff Brief, Listening Events, Facebook		Sept 2022	Oct 2022	AT/ZL	None – ongoing communication process. Addition of work on Board/Exec visibility. Monthly Board visits schedule began as planned in Sept 2022, Execs meeting being held monthly at Bassetlaw and being planned bi-monthly at Montagu. Action closed as plans in place
Development programme to include Everyone Counts/Civility		Aug 2022	Oct 2022	JC	No gaps currently identified
Strong partnership working with Partnership forum and JLNC		Jul 2022	Sep 2022	AJ/ZL	No gaps currently identified
Race Code Audit completed – advisory rather than opinion audit, a high risk identified (see new action below)		Oct 2022	Jan 2023	JC	Gaps in assurance addressed – see update against action below
Actions to improve sickness absence, linked to ongoing health and wellbeing programme of work		Nov 2022	Jan 2023	AJ	Actions and next steps identified in plan presented to People Committee – work in progress. Health & wellbeing proposal presented to Nov PC and supported. Proposal now being shaped for Charitable Funds Committee
Assurances received (L1 – Operational L2-Board Oversight L3 External) **		**Last received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
L1,L2	Standard POD and Education & Research reports for Board. Research Strategy presented to Board July 2022	Jul 2022	People, Board	Full	None
L1,L2	Staff networks (BAME, LGBTQ+, Long term conditions); Reciprocal Mentoring programme – feedback to learning partners	-	People, Board		People Committee work plan to be reviewed to ensure appropriate attention given to EDI including networks. Reciprocal Mentoring Programme – graduation in July 2022, TEG supported next cohort to launch planned Sept 2022. RMP now launching Jan 23
L3	KPMG Job Planning Audit	Jun 2022	People, ARC, Board	No assurance opinion	Action plan actively being monitored Timetable for completion of job plans being developed, led by Medical Director. Updates to be presented to People Committee – job planning report presented to Nov PC by Medical Director
1.3	Internal Audit – 360 Assurance Race Code advisory audit	Jul 2022	People, ARC		Audit report presented to People Committee in Sept 2022 – see update against action below
L1	Education report, Staff Engagement paper, Health and Wellbeing paper and Improvement Projects paper presented at September and November People Committee. Violence Prevention Standards report and EDI update presented at November People Committee	Nov 2022	People	No gaps identified, Committee assured	Committee assured and supportive of new Equality, Diversity and Inclusion action plan (linked to previous action from 360 Assurance audit) and Health & Wellbeing proposal

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

Appendix Level1

		Themes and priorities being collated based on local feedback and national requirements		

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

Control in relation to Payroll provider removed as been completed for a while and no longer impacting on risk rating

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	29 November 2022	**Agenda Reference:**	**D2**		
Report Title:	**People Update**				
Sponsor:	Zoe Lintin, Chief People Officer				
Author:	Zoe Lintin, Chief People Officer				
Appendices:	N/A				
Report Summary					
Purpose of report:	To provide Board with an update on developments in relation to activities to support staff engagement and experience together with an overview of the approach being taken to develop our new People Strategy.				
Summary of key issues/positive highlights:	There is a Board commitment and ambition to improve staff experience and engagement across DBTH, with a key indicator being our annual national staff survey results. This paper highlights some of the recent developments at DBTH and progress made against plans in relation to staff experience and supporting our people, including: - 2022 national staff survey - Appraisal season - Flexible working - Equality, diversity, and inclusion - Leadership Behaviours Framework The paper also outlines the engagement and approach being taken to shape our new People Strategy, which will also be informed by engagement in the workstreams outlined in this report as well as other ongoing pieces of work.				
Recommendation:	The Board is asked to note the actions being taken and to support the work programmes described.				
Action Require:	~~Approve~~	**Information**	**Discussion**	~~Assurance~~	~~Review~~
Link to True North Objectives:	TN SA1: *To provide outstanding care for our patients*	**TN SA2:** ***Everybody knows their role in achieving the vision***	**TN SA3:** ***Feedback from staff and learners is in the top 10% in the UK***	**TN SA4:** *The Trust is in recurrent surplus to invest in improving patient care*	

Implications	
Board assurance framework:	SA2, SA3
Corporate risk register:	PE01 19, PEO2 16, PEO3 3104
Regulation:	None

Legal:			None
Resources:			None
Assurance Route			
Previously considered by:			Some aspects considered by Informal Execs, People Committee and Trust Executive Group
Date:	November 2022	**Decision:**	Aspects shared and supported where required
Next Steps:			Update to Board in November 2022
Previously circulated reports to supplement this paper:			N/A

1. Introduction

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

This report provides an update in relation to the 2022 national staff survey, the approach being taken to create our new People Strategy, appraisal season, diversity, and inclusion and new workstreams on flexible working and developing a new leadership behaviours framework for DBTH.

2. 2022 National Staff survey

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

The 2022 national staff survey launched on 28 September and closes on 25 November 2022. There has been a comprehensive communications and engagement plan in place throughout the survey period and this has included: repeated all-user messages and targeted emails to leaders encouraging completion, a short video from the Chief People Officer, messages shared directly by the Chief Executive and Chief People Officer, a push notification to all 3,800 users of the Staff App and regular Facebook group posts.

In addition, we have spot prize incentives in place linked with our wider recognition programme and these are proving popular with colleagues. Leaders are also being encouraged to talk with their team members to encourage completion and attention was paid in the pre-survey period to promoting changes made since the last survey, to demonstrate to colleagues that completing the survey does make a difference.

At 21 November 2022, our response rate was an impressive 63% which shows a high level of engagement amongst our colleagues. This matched our final rate in the 2021 survey and our target for this year was to achieve at least this level of participation. At 11 November 2022, the highest response rate for acute and acute & community trusts using Quality Health as their provider was 60%, with an average of 37%. Therefore, we are in the leading group of acute trusts nationally.

3. People Strategy

Work has started on shaping our new People Strategy. It has been agreed that the new strategy will be based around the four pillars of the NHS People Plan: Looking after our people, belonging in the NHS, New ways of working and delivering care, Growing for the future. It will also take account of the NHS People Promise and the 'Future of HR and OD in the NHS' report published in November 2021, which sets out actions for organisations, systems, and national bodies.

The Chief People Officer has been seeking and taking on board feedback from colleagues, leaders, representatives and members of the People & OD and Education teams about our people priorities throughout her first six months at the Trust and is also working with system partners. All this engagement and input, together with the corporate objectives, will help to shape our People Strategy and new workstreams have already started as outlined in this paper.

4. Appraisal Season

This year, our appraisal season ran from 1 June to 30 September and a completion rate of 83.43% was achieved against a target of 90%. This was a significant improvement on the previous two years and provides

a good platform for 2023. The appraisal season covers all colleagues except medical colleagues who have a different system which in line with national requirements.

A review of the appraisal season is underway, and this will involve gathering feedback from appraisers and appraisees including focus groups. The paperwork will be refreshed and shortened for 2023, to provide a framework for the conversation, and the reporting and data recording processes will be reviewed. A further evaluation will be undertaken in the Spring to assess the staff survey responses in relation to quality of appraisals. In 2023 and future years the appraisal season will revert to starting in April and it will be maintained as a four-month period, from 1 April to 31 July.

5. Flexible Working

Our new Flexible Working workstream led by the Chief People Officer has now been launched, starting with an interactive on-line session and breakout group discussions with a range of colleagues from across the organisation. This was designed to start a conversation about our approach toward flexible working and included discussing the benefits, potential barriers, experiences and generating ideas for taking actions to build a flexible working culture at the Trust.

A working group is being developed as our next step, to start to prioritise and enact these ideas. This work forms part of our strategic approach to improving recruitment/retention and making DBTH an even better place to work and is also in recognition of the changing expectations in relation to ways of working.

6. Equality, Diversity, and Inclusion (EDI)

360 Assurance have undertaken an advisory audit to assess the governance in place in relation to our RACE Code action plan and the progress being made. A welcome action from the audit was to create one consolidated EDI action plan to cover all aspects of EDI and, as part of this work, to review the priorities and how impact will be measured.

The refreshed EDI action plan in its new format has been presented at and supported by People Committee and Trust Executive Group. The new plan provides greater clarity and clearer direction, with actions being modified to reflect SMART principles including timelines and a column added to provide assurance with evidence of work and outcomes against the actions.

7. Leadership Behaviours Framework

During November and December 2022, we are engaging with leaders and colleagues to seek input into the design and development of a new Leadership Behaviours Framework for DBTH. In addition to seeking engagement locally, this work will involve referring to national resources including the recent Messenger review on leadership in the NHS.

An initial on-line session facilitated by the Chief People Officer and Head of OD, EDI and Wellbeing is being held with the newly named Leadership Assembly on 22 November with a further session with this group being arranged for early December 2022. A session will be held with Board and Trust Executive Group colleagues on 12 December and a Governor briefing has been arranged for 10 January 2023. The Head of OD, EDI and Wellbeing is also liaising with colleagues across the organisation to join a range of team meetings to hold a shorter facilitated session and an ‘open’ session is being arranged.

8. Recommendations

The Board can be assured that actions are being taken to continue to improve our approach to staff experience and that progress is being made in different workstreams. The Board can also be assured that there is a high level of engagement in the annual national staff survey with agreed plans in place for local and corporate teams to respond to the results once published.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	29 November 2022		**Agenda Reference:**	D3	
Report Title:	**Guardian of Safe Working Quarterly Report**				
Sponsor:	Zoe Lintin, Chief People Officer and Dr Tim Noble, Executive Medical Director				
Author:	Dr Anna Pryce, Guardian of Safe Working				
Appendices:	None				
Executive Summary					
Purpose of report:	As a Teaching Hospital we are committed to continuously developing the skills, innovation and leadership of our people to provide high quality, efficient and effective care.				
Summary of key issues:	The Guardian of Safe Working is required to provide quarterly reports to the Board of Directors to provide assurance as to whether our trainees have access to a safe working environment and appropriate educational opportunities. This report draws attention to the higher levels of exception reporting between August and October 2022. Recurrent but sporadic understaffing in Medicine has resulted in incidents of Immediate Safety Concern occurring overnight with the most recent occurring in August 2022. However, Dr Pryce advises that no specific issues of concern regarding work schedules have been highlighted as a result of exception reporting. Rather, a widespread high workload amongst Junior Doctors is noted. This is anticipated to worsen as the winter months approach. The specialties with the highest numbers of exception reports are General Surgery, General Medicine and Accident and Emergency. However, the specialties with the highest proportion of rota gaps are Obstetrics and Gynaecology and Paediatrics. Access to educational opportunities continues to be problematic due to high clinical workloads, particularly in surgical specialties.				
Recommendation:	Members are asked to receive this report and to review the themes raised				
Action Require:	~~Approval~~	**Information**	~~Discussion~~	**Assurance**	~~Review~~

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

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

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

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

Author: Dr Anna Pryce, Guardian of Safe Working

Report date: November 2022

Executive summary

The overall number of exception reports during the last quarter is above average and there is a sustained monthly increase compared with earlier this year and with previous years. Recent specific areas of concern include a rise in reports from General Surgery as a result of high workload and leading to Trainees staying late in order to ensure patient care. The majority of reports regarding missed educational opportunities over the last quarter were also submitted by Trainees working in General Surgery (5/8).

Over the last 12 months, 3 reports raised issues of immediate safety concern and all occurred in Medicine during night-shifts due to understaffing. The specialties with the highest numbers of exception reports were General Surgery, General Medicine and Accident and Emergency. However, the specialties with the highest proportion of current rota gaps are Obstetrics and Gynaecology and Paediatrics.

Introduction

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

- Aggregated data on exception reports (including outcomes), broken down by categories such as specialty, department and grade
- Details of fines levied against departments with safety issues

• Data on rota gaps, staff vacancies and locum usage

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

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

Month	Complete	Unresolved	Total
November 2021	3		3
December 2021	10		10
January 2022	10		10
February 2022	6		6
March 2022	8		8
April 2022	4		4
May 2022	11		11 (2)*
June 2022	6		6 (3)*
July 2022	1		1
August 2022	8	2	10
September 2022	21	2	23
October 2022	8	10	18
Grand Total	**96**	**14**	**110**

Table 1. Number of exception reports by month, 1 November 2021 to 31 October 2022.

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

There has been a repeated pattern of seasonal variation in Exception Reporting (ER) with the highest number of monthly reports occurring during the winter months. This has been noted in previous years within this Trust as well as being noted nationally. Unusually, from August 2022 onwards the number of monthly reports has increased prior to the winter months.

There was 1 ER of immediate safety concern over the last quarter from General Medicine and due to understaffing overnight. Two out of five Junior Doctors were absent and this impacted upon patient care, the ability for Junior colleagues to take appropriate breaks and to access educational opportunities. This was due to unfilled rota gaps. There have been two other similar incidents over the past year. Difficulty with sourcing locum cover at short notice for night shifts has compounded this problem, although locum availability has improved over the course of the year. Unanticipated sickness absence in addition to rota gaps has led to understaffing.

Specialty	Nov 2021	Dec 2021	Jan 2022	Feb 2022	March 2022	April 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Grand Total
Gastro-enterology													
General medicine		7	5		1			1		2	4	5	25
General surgery	2				2	1	9 (0)	3 (0)		2	14	8	41 (29)
Cardiology													
Geriatric medicine													
Renal Medicine										3			3
Accident and emergency	1		3					2		3	3	5	17
Obstetrics and gynaecology		3	1	1	1				1		2		9
Otolaryngology				4	2								6
Trauma and Orthopaedics				1	1								2
Paediatrics			1		1	3	2						7
Grand Total	**3**	**10**	**10**	**6**	**8**	**4**	**11 (2)**	**6 (3)**	**1**	**10**	**23**	**18**	**110**

Table 2. Number of exception reports by specialty, 1 November 2021 to 31 October 2022.

Over the past 12 months, the majority of ERs have been submitted by Trainees working in General Surgery and in General Medicine. In the most recent 3 months, there has been a large increase in reports from Trainees working in General Surgery and also an increase in reports from Accident and Emergency.

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

Additional Hours Worked	42
Change in pattern of work	1
Service Support	0
Educational opportunities	8
Total	**51**

Table 3. Reason for submission of Exception Report, 1 August 2022 to 31 October 2022.

Over the past 3 months, the majority of ERs were submitted in relation to additional hours worked, reflecting the ongoing high workload of Junior Doctors. There continues to be a significant number of ERs due to Junior Doctors being unable to attend scheduled teaching sessions or other educational opportunities. This is in contrast to the very low number observed in previous years. The majority of these (5 out of 8) were from doctors working in General Surgery.

b) Work schedule reviews

No work schedule reviews were requested within the last quarter.

c) Locum bookings

Locum and bank usage.

The data below details bank and agency shifts covered by training grade doctors.

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	August	September	October
Internal Bank	**£567, 297**	**£503,540**	**£381,349**
Agency	**£784,184**	**£780,082**	**£855,189**
Total	**£1, 351, 481**	**£ 1, 283, 622**	**1, 236, 538**

Table 4. Cost of locum and bank usage, August 2022 to October 2022

The cost of 'locum' over has decreased in the most recent 2 months and has followed improvements in rota vacancies.

d) Vacancies

Rota vacancies have fluctuated over the course of the year, with the highest numbers of monthly vacancies occurring in August and September 2022 (41.6 and 40.0 WTE respectively). August usually has the lowest number of rota vacancies when compared with the other months. Of the current rota vacancies in October 2022, 7.8 WTE were in Paediatrics (24% posts were unfilled) and 7.2 WTE were in Obstetrics and Gynaecology (29% posts unfilled).

In previous years, monthly rota vacancies have varied between 19.2 WTE to 31.4 WTE (in 2021) and between 25.1 WTE to 34.2 WTE (in 2020) with the lowest number of vacancies occurring in August of those years. Overall, the monthly rota vacancies in 2022 exceed those of previous years, although the data indicates that attempts to fill rota gaps are now leading to a reduction in unfilled posts.

	VACANCIES (WTE)	Total posts	January	February	March	April	May	June	July	August	Sept	October
Medicine	Medicine (all sub-specialties)	**69**	5	7.8	6.8	6.2	6.4	6.4	6.4	7	6	5.4
	Emergency medicine	**25**	3.4	5.2	5.2	4.4	4.4	5.4	5.4	4	3	3
	Elderly Medicine	**16**	2	2	2	1	1	1	1	4	3.4	3.4
	Renal	**8**	0	0	0	0	0	0	0	1.2	1.2	1.2
Children & Family	Obstetrics & Gynaecology	**25**	6	8.8	9	9	9	9	9	7.2	7.2	7.2
	Paediatrics	**33**	5.5	6.9	8.1	8.1	8.1	8.1	8.1	7.8	7.8	7.8
	GU Medicine	**2**	0	0	0	0	0	0	0	0	0	0
Surgery & Cancer	ENT	**8**	0	1	1	1	1	1	1	0	0	0
	General Surgery	**20**	3	2.4	2.4	1.4	1.4	1.4	1.4	2	3	3
	Urology	**6**	0.4	0.4	0.4	0.4	0.4	0.4	0.4	2	2	2
	Trauma & Orthopaedics	**10**	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	1.2
	Vascular	**6**	2	1	1	1	1	1	1	1	1	1
Clinical Specialties	Anaesthetics	**14**	1.4	1.4	1.4	2	1.6	1.6	1.6	1.8	1.8	1.8
	ICT	**14**	0	0	0	0	0	0	0	1.4	1.4	1.4
	Total	**299**	**30.9**	**39.1**	**39.5**	**36.7**	**36.5**	**37.5**	**37.5**	**41.6**	**40.0**	**38.4**

Table 5. Trainee vacancies by specialty January 2022 to October 2022.

e) **Fines**

No fines have been levied within the last quarter.

Qualitative information

The number of exception reports has increased over the last quarter but continues to remain low compared with other local Trusts. At the Junior Doctor Forum (JDF) discussion with Junior Doctors across specialties aimed to ascertain whether this increase was as a result of improved awareness of Exception Reporting, whether it was due to new doctors being in post from August, or whether there were specialty-specific themes that could be identified. It was acknowledged that rota gaps and resultant understaffing continued to impact upon Junior Doctors' working conditions but that ER provided valuable support in identifying areas of difficulty and provided evidence to support business cases to expand the workforce.

Almost half of the ERs submitted over the last quarter were submitted from Surgery. Juniors reported often staying late in order to manage workload when they were unable to handover at the end of their shift. Although rota gaps are not comparatively high in Surgery (15% posts unfilled) it was reported that the workload was high, and this was the cause of Trainees staying late after their shift had finished and the reason for missed educational opportunities.

Eleven ERs were submitted from General Medicine. At the JDF Diabetes and Endocrine was highlighted by Trainees as problematic due to workload, despite good staffing levels, with junior colleagues having to frequently stay late to complete clinical work. However, this has not been observed from ERs being submitted by Trainees working in this specialty.

Exception reports submitted in relation to missed educational opportunities remain significant over the past 12 months when compared with previous years. There were 8 reports of this nature submitted between August 2022 and October 2022 with the majority of these occurring in General Surgery. Qualitative data from the JDF and ERs supports that high workload pressure and understaffing is the predominant cause of missed educational opportunities.

The poor morale of Junior Doctors and the difficulty accessing locum cover noted in the JDF in April 2022 were both deemed to be much improved at the recent November JDF.

Summary

Ongoing exception reports highlight the high workload of Junior Doctors and, more recently, especially those working in surgical specialties. This leads to individuals staying late to ensure safe patient care and missing educational opportunities. On occasion, due to unfilled rota gaps Junior Doctors working nights

in Medicine are working in conditions that are deemed to be unsafe for both patients and Junior Doctors. The specialties with the highest numbers of exception reports, however, are not those with the highest proportion of current rota vacancies.

A high proportion of ERs continue to be submitted due to acutely ill patients requiring unpredictable emergency care resulting in individual doctors staying late in order to ensure patient safety. Improved out of hours cover and handover arrangements could help alleviate this. Monthly exception report numbers typically show seasonal variation with higher numbers occurring over the winter months. However, monthly reports have increased this year prior to the winter months from August onwards and this is most likely a due to a combination of improved awareness of reporting, rota gaps, ongoing high workload and missed educational opportunities.

Engagement

The regional Guardian Forum now takes place online twice a year and the last meeting occurred on the 6th July 2022. The local quarterly Junior Doctors' Forum (JDF) took place via MS Teams on 3rd November 2022. A joint meeting with the Trainee Management Group has been implemented since December 2020. The JDF is open to all trainee Junior Doctors with the aim of improving engagement.

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

Recommendation

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

Appendix Level1

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

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

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

People, Partners, Performance, Patients, Prevention

Date last reviewed : November 2022

Strategic Objective
In recurrent surplus to invest in improving patient care

Breakthrough Objective
Every team achieves their financial plan for the year

Measures:

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

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

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

Overall Risk Scores for Strategic Objective

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

Risks:

- There is a challenge in 22/23, with the Trust reporting a c £10.1m deficit at the end of M7 which is c£1m off plan. Therefore the Trust is at risk of not delivering its yearend financial plan if this level of financial performance continues. This is primarily being driven by higher than planned pay costs due to high temporary staffing usage. This in turn is due to the impact of vacancies, higher than planned levels of COVID sickness, operational pressures (high bed occupancy and demand in urgent and emergency care) and impact of patient safety decisions (e.g. maternity services). The Trust also has a cost pressure because of the pay award of c£0.7m for the year.
- Part of the pay pressures are offset by non-pay underspends against elective recovery including the independent sector and a number of non-recurrent benefits against plan. The position reported includes all year-to-date Elective Recovery Funding given there is no clawback of funding in Q1 and Q2 despite the Trust not delivering electivity activity targets. An update on the rules for Q3 and Q4 ERF is not yet known. If the Trust's financial position was restated in line with the ERF rules and removing the impact of early year non-recurrent benefits, the Trust would be closer to c£11m off plan.
- Agency spend remains at historical levels and has been very high in the last three months and was at its highest level yet in month 7 at £2.3m, which is more than double pre-pandemic levels. The area of increase in agency since pre-pandemic continues to be nursing.
- Non-pay inflation is currently very high in the economy and is not funded at those levels within the funding allocations. For example we have seen increasing pressures on utilities and a range of contracts which will extend into the next financial year without further funding.
- COVID assumptions in the plan are based on low levels of COVID as seen in Summer 2021 and are consistent with the ask of the planning guidance. However COVID levels are higher than plan impacting on bed occupancy and sickness driving expensive agency usage.
- Income allocations have been significantly reduced from pandemic levels, including Commissioner's removal of previously provided non-recurrent funding. Therefore, focus on efficiency and productivity and cost reduction in 22/23 is paramount. The Trust continues to ask the ICB regarding funding allocations as we move into future years and has written and met with the ICB and PLACE regarding this over the last month.
- Cash risk - the deficit this financial year along with the significant capital programme will potentially cause cash flow issues in 22/23 impacting on the ability for the Trust to meet its financial obligations, without NHSE/I intervention. This is being closely monitored.
- Productivity reductions have been seen during COVID, where activity being delivered is significantly below pre-pandemic levels, whilst resource (especially clinical resource) has increased. Challenge in 22/23 is to deliver pre-pandemic levels of activity within pre-pandemic resources whilst providing safe and sustainable services.
- Trust's underlying deficit financial position has worsened during the pandemic. There is increasing focus nationally on underlying positions entering 22/23.
- Impact of major incident at W&C. The incident highlights significant risks concerning the funding route for and delivery of backlog maintenance costs. However, some additional capital funding has been provided in year of c£1.8m to support this. There however remains limited capital funding especially for significant builds given the Trust's estates risks. The Granger Report also identified a number of actions that are required in Health and Safety.
- Impact of inflationary pressures on capital projects within allocated funding – BEV, RAAC, ePR

In assessing rationale for the overall strategic risk current score, please articulate the individual strategic risks clearly taking into account the prompts below:

- *Is the target risk score realistic/when will it be achieved and is this date reflected in action completion dates?*
- *Are the controls in place effective – are they driving the risk score down? Are there any gaps in controls? Are any of the controls not having an impact – do they need removing from the BAF?*
- *Have actions to address gaps been identified and are these on track?*
- *Is there a need to seek additional assurance – either additional board scrutiny or independent assurance?*
- *Do the controls mitigate high level operational risks noted on the BAF?*

Rationale for overall strategic risk current score:

There is a challenge in 22/23, with the Trust reporting a c £10.1m deficit at the end of M7 which is c£1m off plan. As a result of the challenging financial position the Trust is in, the Finance team is currently producing and reviewing the year end forecast including risks and mitigations to support the achievement of the year end financial position. This will be discussed and agree with Divisions and Departments with a focus on grip and control of financial spend and use of resources. The ICB, supported by NHS E have also requested a Doncaster Place recovery financial plan. Once the forecast work is complete, this will then be presented to F&P and Board in the next finance update.

In the medium term:

- Currently the Trust is in a significant current (£10.1m) and underlying deficit position (c£35m) with there still being uncertainty regarding the future financial regime.
  This impacts on:
  - Trust's ability to invest in its services and infrastructure and maintain a sustainable site as its asset base ages further.
  - Delivery of safe and sustainable services for patients including any backlogs in activity due to COVID.
  - Ensuring the sustainability and safety of the Doncaster site.
  - Impacts on Trust reputation with potential regulatory action
  - Impacts on level of input and influence with regards to local commissioning.

Appendix Level1

CRR Risk cross reference	**F&P1 11**	**F&P12 1412**	**F&P20 1807**	ARC01 13				**Future risks:** • NHS financial landscape, regulatory intervention • Impact of reduced revenue funding allocations for 22/23 and beyond. • Change in financial regimes in relation to ICS and Place budgets • Return to control totals and trajectories in future years including agency caps. Increasing costs relating to old and poorly maintained buildings
Current CRR Risk Rating	**16**	**15**	**20**	**12**				
Risk Appetite Type	**Fin**	**Fin Reg**	**Qual Fin**	**Rep Reg**				
Risk Appetite Level	**Open**	**Open**	**Open**	**Open**				
Target Risk Rating	**8**	**10**	**8**	**4**				

Controls (mitigation to lead to evidence of making impact):	**Last Review date**	**Next review date**	**Reviewed by**	**Gaps in Control**
Key Financial Control Processes: Vacancy Control Panel, CIG, Grip and Control, Capital Monitoring Committee, Cash Committee. Reintroduction of financial escalation process with Divisions from June.	Nov 2022	Dec 2022	AC	Ongoing review of financial controls. No unexpected exceptions identified.
Budget Setting and Business Planning	Nov 22	Jan 22	AC/JS	No unexpected exceptions identified.
Internal & External Audit programme design & compliance outcomes	Sept 2022	Dec 2022	AC	Last Internal Audit provided significant assurance. External Audit on 21/22 provided an unqualified audit opinion. Further Internal audit to be completed in Q3.
Establishment of new Directorate: Recovery, Innovation and Transformation.	April 2022	Completed	JS	
Working with the ICS through CEO's and DoFs regarding funding arrangements. Reporting back through F&P and Board.	Oct 2022	Dec 2022	AC/JS	Ongoing monitoring as ICB develops and Place develops. No significant gaps in control, funding issues raised in letter to ICB and ongoing discussions with ICB.
Implementation of Granger Report Actions	Nov 2022	Dec 2022	AC/F&P	The report identified a number of gaps in control and actions, the majority of the actions has been implemented with the remaining in progress.

Assurances received (L1 – Operational L2-Board Oversight L3 External) **		**Last received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
L2, L3	Internal Audit Annual report including Head of Internal Audit Opinion	June 22	ARC, Board	Moderate Assurance	
L2,L3	Feedback from NHSI/E on statutory returns	Ongoing	F&P, Board	Full	None outstanding
L2	LCFS Annual Report	July 21	ARC	Full	None outstanding
L1,L2,L3	Internal Audit: General Ledger and Financial Reporting	March 22	ARC	Significant Assurance	Nothing significant noted in the Internal Audit
L2, L3	External Auditors Annual Report	June 22	ARC, F&P, Board	Unqualified Opinion	Nothing high risk identified in ISA 260, but some control recommendations to work on through the financial year with progress reported to ARC.

Corrective Actions required	**Action due date**	**Action status**	**Action owner**	**Forecast completion date**
1. Delivery of external and internal audit recommendations	June (IA) March (EA)	IA completed EA progressing	AC	Internal audit recommendations implemented on time. External audit actions progressing
2. Working with the ICS regarding funding allocations for Doncaster	March 23	Ongoing	AC	Ongoing – piece of work commissioned by ICB looking at cost and income movements, this is coming to a close now. Letter send to ICB and discussed with ICB and Place partners funding allocations. Will be picked up as part of planning for 23/24.
3. Delivery of reduced temporary staffing spend especially in Nursing	Ongoing	Ongoing	JS – supported by all Exec Directors	Nursing plan developed, trajectories required. Workstream to be set up for Medics. RIT leading on this project.
4. Development and delivery of CIP plan	Plan – April 22 Delivery March - 23	Good progress so far	All Exec Directors, JS lead for Efficiency and Effectiveness	Ongoing – positive progress on delivery in year so far.
5. Development and implementation of financial assurance processes in line with new Governance proposals (including escalation and monitoring processes).	June 22	Completed	AC	June 22 – implemented

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

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	29 November 2022	Agenda Reference:	**E2**
Report Title:	**Financial Performance – Month 7 (October 2022)**		
Sponsor:	Alex Crickmar, Acting Director of Finance		
Author:	Jenny Marsh, Acting Deputy Director of Finance Finance team		
Appendices:	Appendix A – NHS E forecast protocol		

Executive Summary	
Purpose of report:	To report the Month 7 financial position to the Trust Board including any risks to the delivery of the Trust's financial plan.
Summary of key issues	The Trust's deficit for month 7 (October 2022) was £0.9m, which was a £19k favourable variance to plan. The Trust's Year to Date (YTD) financial position was a deficit £10.1m as at the end of month 7 which is adverse to plan by £1.0m. It should be noted though that delivery of the financial plan was always predicated on improvements in run rate in the second half of the year including the impact of the CNST rebate, annual leave accrual and CIPs, however the Trust is behind plan by £1m at month 7. It is also worth noting that the in-month position has partly been achieved through one-off non-recurrent releases. Excluding these one-off items, the variance in month would have been £1.8m adverse to plan in month and £2.8m adverse to plan year to date. Therefore, the Trust is at risk of not delivering its year end financial plan if this level of financial performance continues. Within the position there are clearly some underlying factors that are a cause for concern, particularly around increasing pay spend. As a result of the challenging financial position the Trust is in, the Finance team is currently producing and reviewing the year end forecast including risks and mitigations to support the achievement of the year end financial position. The ICB, supported by NHS E have also requested a Doncaster Place recovery financial plan. Once the forecast work is complete, this will then be presented to F&P and Board. In conjunction with this NHS E have nationally released the change in forecast protocol which sets out what happens if a system or an organisation forecasts it will not meet its financial plan (appendix A). This includes for example conditions such as investments over £50k requiring ICB sign off, or anything over £100k requiring ICB and NHS E sign off. For clarity the Trust is not under this regime at this point and has not reported it will be off financial plan at year end. The table and narrative below set out the key issues driving the YTD position which are similar to last month end.

	YTD		
	Plan	Actual	Variance
Surplus/(deficit) (£m)	**-9.2**	**-10.1**	**-1.0**
Variance explained by			
Maternity pay pressure. Operational and safety pressures leading to higher than normal agency.			-2.1
Pay Emergency / operational pressures. Operational pressures due to vacancies, sickness and high bed occupancy rates.			-3.8
Excess Inflation - Contracts (Fresenius and Utilities)			-0.7
COVID costs in excess of plan - driven by higher sickness levels.			-0.5
Overachievement against plan on efficiency, due to VAT reclaim, W&C insurance payment and other new local schemes.			2.4
Underspend on elective recovery (Independent sector and other planned care)			2.7
Excluded device income not recovered due to blocks			-1.3
Non recurrent releases			1.8
Pressure from pay award			-0.4
Other small items			0.8
			-1.0

The YTD financial position continues to be largely driven by pay continuing to overspend, by £6.3m as at the end month 7, driven by high temporary staffing usage. This in turn is due to the impact of vacancies, higher than planned levels of COVID sickness (£0.5m), operational pressures (high bed occupancy and demand in urgent and emergency care) and the impact of patient safety decisions (e.g., £2.1m of maternity services premiums). In addition, the pay award for 22/23 is causing a £0.4m pressure to date (£0.7m for the year).

Temporary staffing premiums in maternity services were removed from the second week of October, however the pay position within Children and Families Division remained consistent with September, largely due to new staff being supernumery whilst in the training period.

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

These pressures are offset by continued non-pay underspends against elective recovery including independent sector delivery (£2.7m). Other non-pay underspends include a VAT reclaim in year of (£0.5m) as part of the annual VAT return, insulin pump rebate relating to previous years (£0.2m), £1m insurance proceeds relating to the W&C incident and other non-recurrent benefits including a gas rebate. A review of prior year balances on the balance sheet has resulted in a one-off benefit of (£1.8m) in the month 7 position.

The Trust is also seeing pressures on excluded devices and non-PbR drugs of £1.3m where spend is higher than plan, especially insulin pumps partly due to a change in NICE guidance which is under investigation. In the past these costs have been recovered through the contract, however given it is blocked this year, this pressure will sit with the Trust.

Therefore, in total the Trust has cost pressures of c£3m that are partly outside of its control (£0.7m inflation, £0.5m COVID costs, £0.4m pay award, £1.3m drugs/devices).

It should be noted that the position reported includes all year-to-date Elective Recovery Funding (c.£7.6m) given there is no clawback of funding in Q1, Q2 or month 7, despite the Trust not delivering electivity activity targets. Elective recovery Funding (ERF) rules for Q3 and Q4 are still awaited, meaning 75% of the remaining funding for month 8 to 12 is at risk (£4.2m).

To understand the Trust's underlying position against plan, the table below restates the year-to-date position adjusting for the one off non-recurrent items that are supporting it. This shows that the Trust would be closer to c.£11m off plan at this point, with the largest non-recurrent benefit due to the ERF clawback not being invoked.

	YTD		
	Plan	Actual	Variance
	£000	£000	£000
(Surplus)/Deficit Position for the purposes of system achievement	**9,165**	**10,121**	**956**
Non-recurrent items			
75% ERF income following national agreement to not clawback	0	5,674	5,674
Interim insurance payment relating to the W&C major incident	0	1,000	1,000
Prior year VAT reclaims	0	508	508
Balance sheet review	0	778	778
Rebates (relating to gas and insulin pumps)	0	409	409
One-off non-recurrent releases	0	1,816	1,816
Underlying (Surplus)/Deficit Position for the purposes of system achievement	**9,165**	**20,305**	**11,140**

Capital

Capital spend in month was £1.9m against the plan of £4.4m giving an in-month under-performance of £2.5m. YTD capital spend is £7.2m against the plan of £15m, giving a YTD underperformance of £7.7m. The key variances to plan are underspends in Estates of £4.3m and Medical Equipment of £0.3m. Whilst the capital variance YTD is significant, all Estates and IT business cases have been approved through CIG and expected to deliver by year end and the majority of MEG cases have now been approved with the remaining cases expected this month. Therefore, the Trust is currently forecasting to deliver its capital plan.

Cash

The cash balance at the end of October was £26.5m (September: £22.8m), meaning cash has increased by c £3.7m, due to the receipt of quarterly Health Education England (HEE) income (£6.4m), receipts from local Trusts, timing difference on last week October pay run being transacted on the 1st of November (£3.8m), partially offset by the Trust's deficit financial position. The underlying cash position therefore has decreased by c£4m in month. Cash is expected to fall throughout the rest of the year as a result of the impact of the planned I&E deficit and a backloaded capital plan. A cashflow forecast is being updated in line with the income and expenditure forecast position. However as noted last month there is a risk due to the cash position that the year end audit opinion may include an emphasis of matter section relating to going concern.

CIPs

In month the Trust has delivered £2.1m of savings versus the plan submitted to NHSE of £2.1m and is therefore on plan. YTD the Trust has delivered £11.2m of savings against a planned £8.8m, an over achievement of £2.4m. A separate paper to the Committee reports on this position in more detail.

Recommendation:	The Board is asked to note: • YTD at month 7 (October 2022) was £10.1m, which was adverse to plan by £1.0m. • The financial risks as outlined in the paper.

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

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

Implications

Board assurance framework:	This report relates to strategic aims 2 and 4 and the revised BAF risk F&P1.		
Corporate risk register:	See above		
Regulation:	No issues		
Legal:	No issues		
Resources:	No issues		
Assurance Route			
Previously considered by:	Finance and Performance Committee		
Date:		**Decision:**	N/A
Next Steps:			
Previously circulated reports to supplement this paper:			

FINANCIAL PERFORMANCE

Month 7 – October 2022

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

P7 October 2022

1. Income and Expenditure vs. Budget

Performance Indicator	Monthly Performance			YTD Performance		
	Actual £'000	Variance to budget £'000		Actual £'000	Variance to budget £'000	
Income	(43,030)	(741)	F	(298,610)	(2,940)	F
Pay	29,272	1,101	A	200,312	6,336	A
Non Pay	14,146	(381)	F	104,812	(2,358)	F
Financing Costs	532	(38)	F	3,846	(144)	F
(Profit)/Loss on Asset Disposals	0	0	A	(97)	(97)	F
(Surplus)/Deficit for the period	**920**	**(58)**	**F**	**10,263**	**798**	**A**
Adj. for donated assets and gains on disposal of assets	(3)	39	A	(143)	158	A
Adjusted (Surplus)/Deficit for the purposes of system achievement	**917**	**(19)**	**F**	**10,121**	**956**	**A**

Income: Over-achieved F | Under-achieved A

Key

F = Favourable **A** = Adverse

Expenditure: Underspent F | Overspent A

2. CIPs

Performance Indicator	Monthly Performance			YTD Performance			Annual Plan £'000
	Plan £'000	Actual £'000		Plan £'000	Actual £'000		
Local	0	857	F	0	4,037	F	0
Workforce (vacancy control)	402	402	F	3,570	3,570	F	5,500
ERF productivity	458	458	A	3,208	3,208	A	5,500
Temporary staffing	100	0	A	500	0	A	1,000
Procurement	63	7	A	438	98	A	750
Non-pay cost containment	750	0	A	750	0	A	2,000
Unidentified	333	333	A	333	333	A	4,500
Total CIP	**2,106**	**2,058**	A	**8,799**	**11,247**	F	**19,250**

3. Statement of Financial Position

	Opening balance £'000	Closing balance £'000	Movement £'000
Non Current Assets	**246,595**	**252,544**	**5,949**
Current Assets	62,494	60,034	**-2,460**
Current Liabilities	-77,772	-84,959	**-7,187**
Non Current liabilities	-13,286	-17,343	**-4,057**
Total Assets Employed	**218,031**	**210,276**	**-7,755**
Total Tax Payers Equity	**-218,031**	**-210,276**	**7,755**

4. Other

Performance Indicator	Monthly Performance		YTD Performance		Annual Plan £'000
	Plan £'000	Actual £'000	Plan £'000	Actual £'000	
Cash Balance		26,523		26,523	18,505
Capital Expenditure	4,370	1,871	14,953	7,212	34,190

5. Workforce

	Funded WTE	Substantive WTE	Bank WTE	Agency WTE	Total in Post WTE
Current Month	6,617.19	5,709.22	441.34	249.12	6,399.68
Previous Month	6,595.80	5,547.49	424.35	207.57	6,179.41
Movement	21.39	161.73	16.99	41.55	220.27

1. Month 7 Financial Position Highlights

Executive Summary Income and Expenditure – Month 7

	Month 7			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000
Income	**-42,289**	**-43,030**	**-741**	**-295,671**	**-298,610**	**-2,940**
Pay						
Substantive Pay	27,000	24,748	-2,253	186,119	168,897	-17,222
Bank	-63	1,764	1,827	130	13,428	13,297
Agency	190	2,309	2,119	1,552	13,550	11,997
Recharges and Reserves	1,043	452	-592	6,174	4,437	-1,737
Total pay	**28,171**	**29,272**	**1,101**	**193,976**	**200,312**	**6,336**
Non-Pay						
Drugs	935	975	41	6,364	6,650	286
Non-PbR Drugs	1,822	1,770	-52	12,742	13,329	587
Clinical Supplies & Services	2,795	3,511	716	20,552	22,470	1,918
Depreciation and Amortisation	1,257	1,143	-114	8,800	8,616	-184
Other Costs (including reserves)	6,273	5,335	-938	48,590	42,498	-6,093
Recharges	1,446	1,412	-34	10,122	11,250	1,128
Total Non-pay	**14,527**	**14,146**	**-381**	**107,170**	**104,812**	**-2,358**
Financing costs	**570**	**532**	**-38**	**3,990**	**3,749**	**-241**
(Surplus)/Deficit Position	**979**	**920**	**-58**	**9,465**	**10,263**	**798**
Less donated asset adjustment and gains on disposal of assets	**-43**	**-3**	**39**	**-300**	**-143**	**158**
(Surplus)/Deficit Position for the purposes of system achievement	**936**	**917**	**-19**	**9,165**	**10,121**	**956**

The Trust's deficit for month 7 (October 2022) was £0.9m, which was a £19k favourable variance to plan. The Trust's Year to Date (YTD) financial position was a deficit £10.1m as at the end of month 7 which is adverse to plan by £1.0m. It should be noted though that delivery of the financial plan was always predicated on improvements in run rate in the second half of the year including the impact of the CNST rebate, annual leave accrual and CIPs, however the Trust is behind plan by £1m at month 7.

It is also worth noting that the in-month position has partly been achieved through one-off non-recurrent releases. Excluding these one-off items, the variance in month would have been £1.8m adverse to plan in month and £2.8m adverse to plan year to date. Therefore, the Trust is now at risk of not delivering its year end financial plan based on this level of financial performance. Within the position there are clearly some underlying factors that are a cause for concern, particularly around increasing pay spend.

As a result of the challenging financial position the Trust is in, the Finance team is currently producing and reviewing the year end forecast including risks and mitigations to support the achievement of the year end financial position. The ICB, supported by NHS E have also requested a Doncaster Place recovery financial plan. Once the forecast work is complete, this will then be presented to F&P and Board.

In conjunction with this NHS E have nationally released the change in forecast protocol which sets out what happens if a system or an organisation forecasts it will not meet its financial plan (appendix A). This includes for example conditions such as investments over £50k requiring ICB sign off, or anything over £100k requiring ICB and NHS England sign off. For clarity the Trust is not under this regime at this point and has not reported it will be off financial plan at year end.

The table and narrative below set out the key issues driving the YTD position which are similar to last month end.

	YTD		
	Plan	Actual	Variance
Surplus/(deficit) (£m)	**-9.2**	**-10.1**	**-1.0**
Variance explained by			
Maternity pay pressure. Operational and safety pressures leading to higher than normal agency.			-2.1
Pay Emergency / operational pressures. Operational pressures due to vacancies, sickness and high bed occupancy rates.			-3.8
Excess Inflation - Contracts (Fresenius and Utilities)			-0.7
COVID costs in excess of plan - driven by higher sickness levels.			-0.5
Overachievement against plan on efficiency, due to VAT reclaim, W&C insurance payment and other new local schemes.			2.4
Underspend on elective recovery (Independent sector and other planned care)			2.7
Excluded device income not recovered due to blocks			-1.3
Non recurrent releases			1.8
Pressure from pay award			-0.4
Other small items			0.8
			-1.0

The YTD financial position is largely driven by pay continuing to be overspent by £6.3m which in turn is driven by high temporary staffing usage. This is primarily in:

- Maternity Services: Use of bank and agency staff at premium rates to cover vacancies and meet operational and safety pressures (£2.1m temporary staffing premiums). These have now been removed and in October the pay position within Children and Families Division remained consistent with September largely due to new staff being supernumery whilst in the training period.

- Medicine Division – where we have high pay expenditure due to vacancies, sickness and operational pressures including high bed occupancy rate, some of which is driven by an increase in length of stay which is under review.

- COVID Sickness – we have seen higher levels of COVID sickness than plan especially in Q1 when COVID levels were higher. This is causing a £0.5m pressure year to date.

- The pay award for 22/23 is causing a £0.4m pressure to date.

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

These pressures are offset by continued non-pay underspends against elective recovery including independent sector delivery (£2.7m). Other non-pay underspends include a VAT reclaim in year of (£0.5m) as part of the annual VAT return, insulin pump rebate relating to previous years (£0.2m), £1m insurance proceeds relating to the W&C incident and other non-recurrent benefits including a gas rebate and CIP deliver in excess of the target to date. A review of prior year balances on the balance sheet has resulted in a one-off benefit of (£1.8m) in the month 7 position.

The Trust is also seeing pressures on excluded devices and non-PbR drugs of £1.3m where spend is higher than plan, especially insulin pumps due to a change in NICE guidance. In the past these costs have been recovered through the contract, however given it is blocked this year, this pressure will sit with the Trust.

Therefore, in total the Trust has cost pressures of c£3m that are partly outside of its control (£0.7m inflation, £0.5m COVID costs, £0.4m pay award, £1.3m drugs/devices).

It should be noted that the position reported includes all year-to-date Elective Recovery Funding (c.£7.6m) given there is no clawback of funding in Q1, Q2 or month 7, despite the Trust not delivering electivity activity

targets. Elective recovery Funding (ERF) rules for Q3 and Q4 are still awaited, meaning 75% of the remaining funding for month 8 to 12 is at risk (£4.2m).

To understand the Trust's underlying position against plan, the table below restates the year-to-date position adjusting for the one off non-recurrent items that are supporting it. This shows that the Trust would be closer to c.£11m off plan at this point, with the largest non-recurrent benefit due to the ERF clawback not being invoked.

	YTD		
	Plan	Actual	Variance
	£000	£000	£000
(Surplus)/Deficit Position for the purposes of system achievement	**9,165**	**10,121**	**956**
Non-recurrent items			
75% ERF income following national agreement to not clawback	0	5,674	5,674
Interim insurance payment relating to the W&C major incident	0	1,000	1,000
Prior year VAT reclaims	0	508	508
Balance sheet review	0	778	778
Rebates (relating to gas and insulin pumps)	0	409	409
One-off non-recurrent releases	0	1,816	1,816
Underlying (Surplus)/Deficit Position for the purposes of system achievement	**9,165**	**20,305**	**11,140**

Further Detail

Income: The month 7 position is aligned to the contract values submitted in the final plan including growth assumptions, inflationary uplifts, ERF allocations, and the Pay Award uplift. The clinical income position is £1.9m favourable to plan, driven by non-recurrent funding for the Lung Health Checks project, Community Diagnostics Centre, winter pressure and recurrent funding for specialist Non PbR drugs and Devices; each offset against expenditure. ERF has been assumed to be fully received YTD from Commissioners, in line with ICB guidance that there will be no national clawback of ERF from systems for underperformance in Q1, Q2 and month 7. Further information with regards to Q3 and Q4 ERF is yet to be announced. Inter-system commissioners have yet to all confirm agreement on ERF funding and therefore a risk of £224k has been included at month 7.

Within the plan the Trust included a contract risk relating to growth assumptions outside of the SY ICB as discussions (mainly relating to Notts ICB) continue to be held at a regional level. The risk included in the position at month 7 is £0.95m.

Non-clinical income was £1.0m favourable to plan, with a number of key variances to note:

- £1.1m favourable variance on recharges which is offset with a corresponding increase in expenditure.
- £0.7m adverse variance on COVID testing income which is offset with a corresponding decrease in expenditure.
- Other smaller items make up the other £0.6m favourable variance.

Pay expenditure: £6.3m adverse to plan, with the variance mainly driven by Medical and Nursing spend in Medicine, Surgery and Children and Families Divisions. COVID related pay is £0.5m over budget mainly on backfill for COVID sickness. The pay award for 22/23 is causing a £0.4m pressure to date and is expected to cause a £0.7m pressures by year-end.

Agency spend in month has increased by £0.4m from month 6, mainly driven by increased Medical spend in Medicine, Surgery and Clinical Specialist Services Divisions. Temporary staffing spend (£2.3m in month) remains significantly higher than pre-pandemic levels (c £0.9m pre-pandemic) and above last year levels. The

table below sets out the agency spend by type for quarter 4 of 2021/22 and month 1 to month 7 of 2022/23, demonstrating the continued high levels of agency spend.

Total agency spend by category	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Administration and estates	42	55	33	63	70	55	108	49	47	33
HCA and other support staff	82	64	82	26	66	97	81	28	15	7
Medical and dental	760	722	886	805	881	943	895	1,015	979	1,220
Non Medical Non Clinical	43	37	78	64	68	56	40	186	112	154
Nursing & midwifery	380	418	755	702	616	626	801	923	765	878
Scientific, therapeutic and tech	31	25	40	28	22	17	26	-2	-32	16
Total	**1,338**	**1,321**	**1,874**	**1,688**	**1,724**	**1,793**	**1,950**	**2,199**	**1,886**	**2,309**

Non-Pay Expenditure: £2.4m favourable to plan, largely due to an underspend against elective recovery including independent sector spend (£2.7m), VAT reclaim in year of (£0.5m) as part of the annual VAT return, finalisation of the year end positions on apprentice levy and Parkhill contract (£0.2m) and a rebate on insulin pumps relating to previous years (£0.2m). These are offset with excess inflation costs of £0.7m (including continued pressures on utilities and the Fresenius contract) and other costs that are offset with income (£0.4m).

Capital

Capital spend in month was £1.9m against the plan of £4.4m giving an in-month under-performance of £2.5m. YTD capital spend is £7.2m against the plan of £15m, giving a YTD underperformance of £7.7m. The key variances to plan are underspends in Estates of £4.3m and Medical Equipment of £0.3m. Whilst the capital variance YTD is significant, all Estates and IT business cases have been approved through CIG and expected to deliver by year end and the majority of MEG cases have now been approved with the remaining cases expected this month. Therefore, the Trust is currently forecasting to deliver its capital plan.

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CIPs

In month the Trust has delivered £2.1m of savings versus the plan submitted to NHSE of £2.1m and is therefore on plan. YTD the Trust has delivered £11.2m of savings against a planned £8.8m, an over achievement of £2.4m. A separate paper to the Committee reports on this position in more detail.

2. Recommendations

The Board is asked to note:

- The Trust's deficit YTD at month 7 (October 2022) was £10.1m, which was adverse to plan by £1.0m.
- The financial risks as outlined in the paper.

Classification: Official-Sensitive: Commercial

Publication reference: PR2054

Protocol for changes to in-year revenue financial forecast

7 November 2022, Version 1

Part 1: Protocol for changes to in-year revenue financial forecast

1. Scope

1.1. The achievement of financial balance, while maintaining the quality of healthcare provision, is a legal requirement for all systems. The organisations within each system have a duty to co-operate in the delivery of system objectives. Further, when a system overspends against its allocation for the year, spending must be restricted elsewhere to make sure that overall the NHS remains within its spending limits.

1.2. This protocol should be the last resort when all options have been explored and implemented for the achievement of a breakeven position at a system level or plan at an individual provider level. Monitoring of providers will be undertaken at a system level, recognising that there is discretion within a system for one provider to underspend to compensate for another overspending. This protocol focuses on deterioration to financial positions; potential improvements should be discussed with systems/NHS England regional teams in advance of any changes.

1.3. In exceptional circumstances it may be necessary for a system or an individual organisation to revise its forecast to reflect an overspend. In this event, the system or organisation must demonstrate that all possible steps have been taken to minimise the extent of any overspend.

This should be set out in the form of a recovery plan that describes the mitigating actions being implemented to reduce spending and improve financial control. The recovery plan should aim to bring the organisation/system back to financial balance as quickly as possible, which may take up to 12 months or potentially longer in more extreme cases.

1.4. The protocol set out in the first part of this paper must be followed by:

- any **provider** considering a deterioration in forecast but which the system can absorb, in which case the operation of the protocol will be overseen by the system; or
- any **system** forecasting for a deficit, in which case the operation of the protocol will be overseen by the region.

1.5. The introduction of this protocol by NHS England should not be taken as permission to overspend – this constitutes a breach of statutory duty which will be taken very seriously. The second part of this paper sets out the additional

conditions that will or may be applied to any organisation that forecasts a deterioration to plan or any system that forecasts an overspend.

2. Overview

2.1. Revisions to forecast outturns can be made at month end at any point in the year but only in line with the protocol, and specifically paragraphs 2.2 (timing) and 2.3 (multiple changes) below. The system and regional teams should be fully involved and kept informed of the process in advance of any change.

2.2. Changes would not be expected in the early months of the year given that this follows closely after the planning process. Changes in the final quarter will be looked on as a sign of very poor financial control likely to attract further scrutiny.

2.3. The protocol process must be started again for any further changes. A subsequent deterioration in financial position may also be viewed as lack of financial control, depending on the circumstances.

2.4. As a pre-condition to invoking the protocol, the system must evidence that all the actions detailed in the operational planning round letter dated 20 May 2022 from Julian Kelly have been completed:

- Evidence the key lines of enquiry produced for plans.
- Established processes to monitor agency and bank usage controls.
- Established processes to monitor consultancy spend and non-clinical agency controls.
- Completion of the workforce analysis bridging from pre-pandemic workforce showing where additional staff have been deployed.
- Compliance with the HFMA check list review requirements: https://www.hfma.org.uk/docs/default-source/publications/briefings/improving-nhs-financial-sustainability-are-you-getting-the-basics-right.pdf?sfvrsn=b46877e7_2.

3. Conditions for an NHS Provider

3.1. Where an NHS provider wishes to report a **forecast deterioration against plan** which the system overall can absorb, the system will oversee the provider in meeting the following conditions:

- Complete a variance analysis to be presented to the system leaders across a range of disciplines explaining why the overspend will occur including the underlying causes.
- Detailed review of any uncommitted expenditure.

- Prepare a recovery plan showing the steps that have been and will be taken in order to reduce expenditure and hence minimise the extent of the overspend to include detail of the difficult choices that have been made in arriving at this position.
- Include in the above any shortcomings identified from the HFMA review and how they are being addressed.
- Provide evidence of sign-off by the whole of the executive team of the above.
- Submit to a suitably independent review with for example a neighbouring provider to confirm all possible mitigating steps are being taken, reflecting that an overspend by one provider will need to be compensated for by other providers.
- Provide evidence of non-executive scrutiny of the above, and sign off by the board of the proposed change of forecast.

3.2. The system will submit a summary of the above to the NHS England regional team to evidence that the protocol has been followed.

4. Conditions for an ICB/System

4.1. Where an ICB and/or system wishes to report a forecast deficit position, the NHS England regional team will oversee the system in meeting all of the conditions set out above, for the ICB itself if relevant, for each individual provider that has or is expected to report a deterioration from plan if relevant, and at local discretion the other providers in the system.

4.2. In addition to setting out the steps that each individual organisation will take to address its financial problems, the recovery plan must also set out all of the actions that the system as a whole will deliver, including any compensating actions that other organisations in the system will take. This may include other providers improving their position to compensate. The system recovery plan may be subject to further external scrutiny.

5. Process for changes

5.1. As soon as a system becomes aware of issues that may require this protocol to be followed, the regional team should be contacted and a timeframe for this process agreed. The timeframe must allow for completion of all of the actions set out above, and fit with the monthly reporting timetable.

5.2. Immediately prior to the change of financial position being submitted through the monthly reporting process, each relevant organisation must submit to the system a board assurance statement (BAS) signed by the chair, chief executive, chief financial officer, and a non-executive director such as the finance committee chair

to confirm adherence to this protocol and their commitment to the delivery of the recovery plan.

5.3. Where the system is to report a change of financial position, a report must be submitted to the NHS England regional team setting out how the conditions set out above have been complied with.

5.4. Where a Trust reports a deteriorating forecast and as a result the Trust requires cash support through the Interim Revenue Support process, the current monthly process for accessing revenue support will continue to be available for necessary and essential expenditure to protect continuity of patient services. Providers will have to demonstrate their revenue cash requirements to NHS England and should contact the NHS England Group Accounting and Systems team at england.providerrevenuesupport@nhs.net to discuss their requirements and submit revenue support requests where this is required.

Part 2 – Consequences for deterioration in forecast

6. Overview

6.1. Part 2 of this paper sets out the conditions that will (or may at the discretion of the region or system as appropriate) be applied to:

- any **provider** reporting a forecast deterioration to plan which the system is forecasting to absorb, to be applied by the system; or
- any **system** reporting a forecast deficit (regardless of the plan), in which case the operation of the protocol will be overseen by the region.

7. Provider conditions

7.1. Implement a double-lock sign-off process for any revenue investments above £50,000 with sign-off required by the provider and the ICB; further details of the operation of this mechanism will be issued separately, and may need to be tailored to fit with local governance arrangements.

7.2. Complete a workforce review to describe changes in headcount which covers as a minimum:

- Movement in substantive/bank/agency WTEs and cost from Q4 2019/20 by workforce type and service
- Sets out key controls over workforce currently in place and any to be introduced
- Sets out key risks to workforce (eg, sickness rates, vacancy hot-spots) and actions to mitigate these
- Process for the sign-off of bank staff, and extent of embedding the same controls as agency staff
- Self-certified monitoring of agency usage by Providers' Boards, and compliance with usage and rate limits.

7.3. Additional financial and other reporting requirements may be imposed on the provider by the system, including progress with efficiency plans and recovery actions.

7.4. The completed HFMA checklist internal audit report to be shared with NHS England regional team for review and follow up.

8. ICB/System conditions

8.1. Implement the above conditions for all providers in the system that have or are intending to change their forecast to show an overspend.

8.2. Implement a triple-lock sign-off process for any revenue investments above £100,000 with sign-off required by the organisation, system and NHS England regional team; further details of the operation of this mechanism will be issued separately, and may need to be tailored to fit with local governance arrangements.

8.3. NHS England Regional Director of Finance or nominated deputy will be invited to attend the system finance committee or equivalent.

8.4. Additional financial and other reporting requirements may be imposed on the system, including progress with efficiency plans and recovery actions.

8.5. The system should make sure that all efforts are being made to reduce pay costs, including not employing differential pay practices that exacerbate pay pressures. Further restrictions on recruitment, agency, consultancy and bank usage may be imposed at the discretion of the regional team.

8.6. A formal review of capital allocations will be completed by the NHS England national team, including digital to determine whether any capital funding restrictions should be applied.

8.7. In line with the business rules for commissioners, any historic cumulative overspend previously frozen may be reinstated, and further overspends will likely require payback in future. The SOF rating for the organisation or system is likely to be reviewed as a result of the deterioration to the financial position.

Appendix Level1

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

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

Risk Owner: Trust Board – Medical Director/Chief Nurse
Committee: QEC

People, Partners, Performance, Patients, Prevention

Date last reviewed : November 2022

Strategic Objective
To provide outstanding care and improve patient experience

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

Measures:

- *Covid risk SA1* ID 2472 incorporated into SA1*
- *Updated existing Board Assurance Framework for IPC as new guidance due in May 2022 still not produced by NHSE*
- *Review and utilisation of PSIRF (patient safety incident framework) and the focus on embedded learning*
- *NICE – delivery of statutory audits of clinical effectiveness*
- *Evidence of "closing the loop", through sharing of learning from incidents and follow up from QI processes*
- *Focus on key safety risks – IPC Outbreaks - waits, falls, milestones set through business planning for each division aligned to the division's breakthrough objectives*
- *Clinical effectiveness, processes to include the following of NICE guidance*
- *IQPR measures*
- *Feedback from patients via compliments and complaints, to include learning and engagement with stakeholders*
- *Patient survey outputs and effectiveness of action plans*
- ~~*Urgent and Emergency care programme in place , includes, relocation of AMU back to AMU , and the opening of EAU*~~
- ~~*Increase in trolley capacity in emergency department to support ambulance handovers*~~
- *Patient Safety Incident Response Framework (PSIRF) compliance*

Opportunities:

- Change in practices, new ways of working, regional Integrated Care Boards established for South Yorkshire and Nottingham & Nottinghamshire.
- Advent of more digital care –digital transformation including electronic patient record and virtual ward
- Greater opportunity for collaboration at place / system level
- Implementation of national patient safety strategies that improve patient care
- Restructure to focus on patient experience
- Quality improvement processes focused on Falls in the 10 high risk areas

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

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

Risks:

- *Risk of patient harm if we do not listen to feedback and fail to learn*
- *Risk of not using available quality assurance data to best effect in order to identify areas to improve or manage patient care.*
- *Risk to safety and poor patient experience as a result of failure to improve the estate and infrastructure.*
- *Risk of non-delivery of national performance standards that support timely, high quality care*
- *Risk to safety and poor patient experience if we do not improve emergency flow in our capacity constrained environment*
- *Current gaps in registered workforce whilst new registrants and international nurse's complete preceptorship with increased reliance on agency staff.*
- *Risks to patient both in terms of flow and communication as a result of the pathways relating to Infection, Prevention and Control measures due to uncertain covid pandemic pattern*

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

CRR Risk cross reference	Q&E9 1517	F&P 6 7	F&P 8 16	Q&E F&P 2472	QEC-PSIRF 3112		
Risk area	Medicine supply	Regulatory Stds	workforce	COVID	PSIRF		
Current CRR Risk Rating	15	16	16	15	12		
Risk Appetite Type	Qual	Reg	Qual Peop	Qual Peop Finance	Qual		
Risk Appetite Level	Open	Minimal	Open	Open	Open		
Target Risk Rating	12	9	8	10	3		

Overall Risk Scores for Strategic Objective

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

In assessing rationale for the overall strategic risk current score, please articulate the individual strategic risks clearly, by considering the prompts below:

- *Is the target risk score realistic/when will it be achieved and is this date reflected in action completion dates?*
- *Are the controls in place effective – are they driving the risk score down? Are there any gaps in controls? Are any of the controls not having an impact – do they need removing from the BAF?*
- *Have actions to address gaps been identified and are these on track?*
- *Is there a need to seek additional assurance – either additional board scrutiny or independent assurance?*
- *Do the controls mitigate high level operational risks noted on the BAF?*

Rationale for overall strategic risk current score:
Impact:

- Impact on performance
- Impact on Trust reputation
- Impact on safety of patients
- Impact on patient experience
- Potential delays to treatment
- Possible Regulatory action

Future risks:

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

Comments:

- Need to ensure Trust Values are effective
- Need to develop quality/patient safety strategy
- Need to sustain improvements in QI initiatives
- Need to widen the focus on patient and user feedback

Controls (mitigation to lead to evidence of making impact):	Last Review date	Next review date	Reviewed by	Gaps in Control
Accountability Framework & Quality framework process Risk Stratification, Validation and Clinical Prioritisation of Patient Pathways.	September 2022	December 2022	Med Director (TN) & COO	Action plans in place, reviews on going Processes embedded within admitted pathways and diagnostics. Current PAS system unable to provide full view of follow-up patients on non-active pathways. Further work to support the processes for non-

KPMG work complete and business as usual continues through the Outstanding Outpatients forum in terms of ongoing developments, improvements and digital transformation.					admitted pathways underway within Digital Transformation and operationally, including the development of a patient pathway management system
~~Awaiting completion of external patient safety and governance review prior to implementation~~ External peer review of patient safety and governance complete and report received - now aligned to the PSIRF project plan.		~~May 2022~~ November 2022	~~November 2022~~ March 2023	Med Director (TN)	~~Awaiting outcome of recommendations to understand gaps In control, not currently mitigated~~ Business Case includes details of the required workforce structure to deliver PSIRF. Project Plan developed with milestones to deliver the recommendations, needs a dedicated implementation team
Urgent and Emergency Care Improvement Programme – ongoing		~~April 2022~~ November 2022	~~November 2022~~ April 2023	Med Director (TN) & COO	Actions & plans in place monitored through Urgent and Emergency Care Programme Board
Action plans to respond to CQC patient surveys		~~April 2022~~ November 2022	~~November 2022~~ March 2023	Chief Nurse & Med Director (TN)	Action plans in place in response to CQC recommendations, monitored through PEEC via regular reporting. ~~Due to departure of current post holder time frame delayed. Recruitment process taking place currently~~
Patient Experience, Patient and Public Involvement and Accessible Standards in place which form part of the patient experience pathway		~~June 2022~~ November 2022	~~November 2022~~ March 2023	Chief Nurse	Work plan and strategy to be enhanced to improve patient experience, will be driven by new Chief Nurse when in post January 2023.
Assurances received (L1 – Operational L2-Board Oversight L3 External) **		**Last received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
L3	Internal Audit reviews on quality outcomes, falls documentation compliance 20/21, ~~DToC 2019/20,~~ Complaint process 2020/21. Action plans completed against internal audit and reviewed at QEC in June.	June21	ARC, Board	Full	None
L1,L2	SNCT undertaken to ensure safe staffing completed in June2022, report outcome will be expected at board in September 2022.	Jan 22	QEC, Board	Full	Awaiting completion of SNCT data collection which is taking place in May 2022. Audit completed , data analysis taking place and will be presented at September 2022 Board
L2,L3	Okenden feedback received from the LMNS, action plans developed to achieve 7 key actions	Dec 21	Board	Full	Action plan in place
L1,L2,L3	BAF completion on specific areas, evaluated by CQC, IPC BAF reviewed at Board of Directors December 2020. BAF reassessed 14th July 2021, to be reassessed with latest guidance. Updated BAF shared with Board on the 25th January 2022	Jan 22	Board	Full	
L2	Nurse Staffing Assurance Framework shared at Board on the 25th of January 2022	Jan 22	Board	Full	
L3	National Getting It Right First Time (GIRFT) reviews across specialties on a rolling programme of work.	September 2022	Board	Full	~~Medical Director undertaking a full review of all recommendations and actions and links to Specialty level and Divisional Strategic plans.~~ Medical Director supporting implementation of recommendations

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

Appendix Level1

The PSIRF is a contractual requirement under the NHS Standard Contract. Workforce structure to be resourced to ensure compliance. Dedicated PSIRF implementation team required to ensure each phase and transition timescales are achieved.				

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

Areas in yellow highlight indicate change from last version

Appendix Level1

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

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

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

People, Partners, Performance, Patients, Prevention

Date last reviewed : November 2022

Strategic Objective
In recurrent surplus to invest in improving patient care

Breakthrough Objective
Every team achieves their financial plan for the year

Measures:

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

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

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

Overall Risk Scores for Strategic Objective

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

Risks:

- There is a challenge in 22/23, with the Trust reporting a c £10.1m deficit at the end of M7 which is c£1m off plan. Therefore the Trust is at risk of not delivering its yearend financial plan if this level of financial performance continues. This is primarily being driven by higher than planned pay costs due to high temporary staffing usage. This in turn is due to the impact of vacancies, higher than planned levels of COVID sickness, operational pressures (high bed occupancy and demand in urgent and emergency care) and impact of patient safety decisions (e.g. maternity services). The Trust also has a cost pressure because of the pay award of c£0.7m for the year.
- Part of the pay pressures are offset by non-pay underspends against elective recovery including the independent sector and a number of non-recurrent benefits against plan. The position reported includes all year-to-date Elective Recovery Funding given there is no clawback of funding in Q1 and Q2 despite the Trust not delivering electivity activity targets. An update on the rules for Q3 and Q4 ERF is not yet known. If the Trust's financial position was restated in line with the ERF rules and removing the impact of early year non-recurrent benefits, the Trust would be closer to c£11m off plan.
- Agency spend remains at historical levels and has been very high in the last three months and was at its highest level yet in month 7 at £2.3m, which is more than double pre-pandemic levels. The area of increase in agency since pre-pandemic continues to be nursing.
- Non-pay inflation is currently very high in the economy and is not funded at those levels within the funding allocations. For example we have seen increasing pressures on utilities and a range of contracts which will extend into the next financial year without further funding.
- COVID assumptions in the plan are based on low levels of COVID as seen in Summer 2021 and are consistent with the ask of the planning guidance. However COVID levels are higher than plan impacting on bed occupancy and sickness driving expensive agency usage.
- Income allocations have been significantly reduced from pandemic levels, including Commissioner's removal of previously provided non-recurrent funding. Therefore, focus on efficiency and productivity and cost reduction in 22/23 is paramount. The Trust continues to ask the ICB regarding funding allocations as we move into future years and has written and met with the ICB and PLACE regarding this over the last month.
- Cash risk - the deficit this financial year along with the significant capital programme will potentially cause cash flow issues in 22/23 impacting on the ability for the Trust to meet its financial obligations, without NHSE/I intervention. This is being closely monitored.
- Productivity reductions have been seen during COVID, where activity being delivered is significantly below pre-pandemic levels, whilst resource (especially clinical resource) has increased. Challenge in 22/23 is to deliver pre-pandemic levels of activity within pre-pandemic resources whilst providing safe and sustainable services.
- Trust's underlying deficit financial position has worsened during the pandemic. There is increasing focus nationally on underlying positions entering 22/23.
- Impact of major incident at W&C. The incident highlights significant risks concerning the funding route for and delivery of backlog maintenance costs. However, some additional capital funding has been provided in year of c£1.8m to support this. There however remains limited capital funding especially for significant builds given the Trust's estates risks. The Granger Report also identified a number of actions that are required in Health and Safety.
- Impact of inflationary pressures on capital projects within allocated funding – BEV, RAAC, ePR

In assessing rationale for the overall strategic risk current score, please articulate the individual strategic risks clearly taking into account the prompts below:

- *Is the target risk score realistic/when will it be achieved and is this date reflected in action completion dates?*
- *Are the controls in place effective – are they driving the risk score down? Are there any gaps in controls? Are any of the controls not having an impact – do they need removing from the BAF?*
- *Have actions to address gaps been identified and are these on track?*
- *Is there a need to seek additional assurance – either additional board scrutiny or independent assurance?*
- *Do the controls mitigate high level operational risks noted on the BAF?*

Rationale for overall strategic risk current score:

There is a challenge in 22/23, with the Trust reporting a c £10.1m deficit at the end of M7 which is c£1m off plan. As a result of the challenging financial position the Trust is in, the Finance team is currently producing and reviewing the year end forecast including risks and mitigations to support the achievement of the year end financial position. This will be discussed and agree with Divisions and Departments with a focus on grip and control of financial spend and use of resources. The ICB, supported by NHS E have also requested a Doncaster Place recovery financial plan. Once the forecast work is complete, this will then be presented to F&P and Board in the next finance update.

In the medium term:

- Currently the Trust is in a significant current (£10.1m) and underlying deficit position (c£35m) with there still being uncertainty regarding the future financial regime.
  This impacts on:
  - Trust's ability to invest in its services and infrastructure and maintain a sustainable site as its asset base ages further.
  - Delivery of safe and sustainable services for patients including any backlogs in activity due to COVID.
  - Ensuring the sustainability and safety of the Doncaster site.
  - Impacts on Trust reputation with potential regulatory action
  - Impacts on level of input and influence with regards to local commissioning.

Appendix Level1

CRR Risk cross reference	**F&P1 11**	**F&P12 1412**	**F&P20 1807**	ARC01 13				**Future risks:** • NHS financial landscape, regulatory intervention • Impact of reduced revenue funding allocations for 22/23 and beyond. • Change in financial regimes in relation to ICS and Place budgets • Return to control totals and trajectories in future years including agency caps. Increasing costs relating to old and poorly maintained buildings
Current CRR Risk Rating	**16**	**15**	**20**	**12**				
Risk Appetite Type	**Fin**	**Fin Reg**	**Qual Fin**	**Rep Reg**				
Risk Appetite Level	**Open**	**Open**	**Open**	**Open**				
Target Risk Rating	**8**	**10**	**8**	**4**				

Controls (mitigation to lead to evidence of making impact):	**Last Review date**	**Next review date**	**Reviewed by**	**Gaps in Control**
Key Financial Control Processes: Vacancy Control Panel, CIG, Grip and Control, Capital Monitoring Committee, Cash Committee. Reintroduction of financial escalation process with Divisions from June.	Nov 2022	Dec 2022	AC	Ongoing review of financial controls. No unexpected exceptions identified.
Budget Setting and Business Planning	Nov 22	Jan 22	AC/JS	No unexpected exceptions identified.
Internal & External Audit programme design & compliance outcomes	Sept 2022	Dec 2022	AC	Last Internal Audit provided significant assurance. External Audit on 21/22 provided an unqualified audit opinion. Further Internal audit to be completed in Q3.
Establishment of new Directorate: Recovery, Innovation and Transformation.	April 2022	Completed	JS	
Working with the ICS through CEO's and DoFs regarding funding arrangements. Reporting back through F&P and Board.	Oct 2022	Dec 2022	AC/JS	Ongoing monitoring as ICB develops and Place develops. No significant gaps in control, funding issues raised in letter to ICB and ongoing discussions with ICB.
Implementation of Granger Report Actions	Nov 2022	Dec 2022	AC/F&P	The report identified a number of gaps in control and actions, the majority of the actions has been implemented with the remaining in progress.

Assurances received (L1 – Operational L2-Board Oversight L3 External) **		**Last received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
L2, L3	Internal Audit Annual report including Head of Internal Audit Opinion	June 22	ARC, Board	Moderate Assurance	
L2,L3	Feedback from NHSI/E on statutory returns	Ongoing	F&P, Board	Full	None outstanding
L2	LCFS Annual Report	July 21	ARC	Full	None outstanding
L1,L2,L3	Internal Audit: General Ledger and Financial Reporting	March 22	ARC	Significant Assurance	Nothing significant noted in the Internal Audit
L2, L3	External Auditors Annual Report	June 22	ARC, F&P, Board	Unqualified Opinion	Nothing high risk identified in ISA 260, but some control recommendations to work on through the financial year with progress reported to ARC.

Corrective Actions required	**Action due date**	**Action status**	**Action owner**	**Forecast completion date**
1. Delivery of external and internal audit recommendations	June (IA) March (EA)	IA completed EA progressing	AC	Internal audit recommendations implemented on time. External audit actions progressing
2. Working with the ICS regarding funding allocations for Doncaster	March 23	Ongoing	AC	Ongoing – piece of work commissioned by ICB looking at cost and income movements, this is coming to a close now. Letter send to ICB and discussed with ICB and Place partners funding allocations. Will be picked up as part of planning for 23/24.
3. Delivery of reduced temporary staffing spend especially in Nursing	Ongoing	Ongoing	JS – supported by all Exec Directors	Nursing plan developed, trajectories required. Workstream to be set up for Medics. RIT leading on this project.
4. Development and delivery of CIP plan	Plan – April 22 Delivery March - 23	Good progress so far	All Exec Directors, JS lead for Efficiency and Effectiveness	Ongoing – positive progress on delivery in year so far.
5. Development and implementation of financial assurance processes in line with new Governance proposals (including escalation and monitoring processes).	June 22	Completed	AC	June 22 – implemented

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

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	29 November 2022	**Agenda Reference:**	**E4**
Report Title:	**Operational Performance Update to include Ambulance Handovers** **INTEGRATED QUALITY & PERFORMANCE REPORT (IQPR) / Performance Exception Report (October 2022)**		
Sponsor:	George Briggs, Interim Chief Operating Officer		
Author:	Laura Fawcett-Hall, Head of Performance		
Appendices:	Winter Plan		
Purpose of report:	The overall integrated performance report aims to: • Deliver an executive summary – summarising the operational context, performance headlines and the forward plan. • Share the full performance metrics through the IQPR at a glance charts. • Provide the full Performance Exception report for the headline metrics.		
Summary of key issues:	**<u>Operational Context – Headlines of Data Trend Analysis</u>** • ED attendance levels remain higher than previous 4 years with the majority of the increase in the minors pathway • In common with all Trusts, emergency demand and staffing pressures have impacted on elective delivery, however, the Trust maintained a programme of elective work through October 2022. • Sickness levels has impacted performance during October 2022. • The performance report for October 2022 is presented in this operational context. **<u>Headlines from Integrated Performance Report (October 2022)</u>** *Emergency* • **4 Hour Access** – in October 2022 the Trust delivered 68.1% achievement against national target of 95%, which was is a decrease from the September 2022 position of 69.38%. Performance for the month benchmarks "in the pack" across Northeast and Yorkshire. A wide-ranging action plan is in place. • **12 Hour Waits –** The Trust are reporting 229 12-hour trolley breaches in October 2022 which is a decrease from the September 2022 position of 242. The Trust continues to have significant exit block with increased boarding times experienced as a result. • The Trust are reporting 6.56% 12 hour waits from time of arrival, an increase on previous months. • **Ambulance Delays -** There are continued challenges across both sites. NHSE have commissioned a QI project for DBTHT and YAS to work together to identify areas for improvement at pace. An exception report is provided monthly as the Trust remains an outlier. Work is ongoing to create additional capacity with a key focus on reducing LoS and increasing daily discharges. In addition, structural		

work commenced 11/10/22 to increase ESA capacity to receive ambulances and this is due for completion on 21/11/22.

- **Emergency Care Bundle –** The new standards are now live and being reported.
- **Length of Stay** Focused work to reduce LoS has started for both elective and non-elective admissions. SAFER Red 2 Green team to continue with focus on supporting areas with lower compliance and 100 day challenge action plan being progressed with partners focusing on discharge pathways.

Elective

- **Activity** - Overall, the Trust was not on plan for October 2022 and had lower activity levels compared to 19/20. In October 2022 Daycase delivered 83.9% of plan (down 0.9% from previous month), elective delivered 80.9% of plan (2.3% down from previous month, first outpatients delivered 93.5% of plan and follow ups were at 75% of plan.
- **52 Week Breaches** – in October 2022 the Trust reported 1384 breaches due to Covid 19 delays, a decrease from last month of 35. The 3 specialities with the most 52 week breaches are Trauma and Orthopaedics, Gynaecology and ENT.
- **104 week waits** – At the end of October 2022, there was 1 patient waiting over 104 weeks. The patient had an incorrect clock stop during covid. The patient has since been reviewed and discharged, there was no reported clinical harm.
- **Referral To Treatment (RTT)** - in October 2022 the Trust delivered 65.1% performance within 18 weeks, below the 92% standard. This position is an increase from September 2022 (64.7%) and is still being affected by a lack of bed capacity and staffing issues. The Trust took part in the Super September activity and validation exercises.
- **The total waiting list** increased again during October 2022 to 51,066. The previous position in August was 50,601 and September was 50,983.
- **Diagnostics** – in October 2022 the Trust achieved 59.8% against a target of 99%. This is an increase of performance from last month by 6.7% (September 2022, 53.1%). Diagnostic performance has started to improve after a updated capacity and action plan has been agreed alongside a recovery plan agreed with the ICB NHSE

Cancer

- **Faster Diagnosis Standard –** In August 2022 the Trust achieved the FSD standard with 75.2% against the performance target of 75%.
- **31 Day Standard** – in September 2022 2 out of 3 nationally reported measures were achieved.
- **62 Day Standard –** in September 2022 0 out of 2 nationally reported measures were achieved.
- **Open Pathways over 104 Days –** in September 2022 the number of open pathways was 20, an increase from 6 in August 2022 and 11 in July 2022.
- Cancer performance still performs well compared to peers

Next Steps on Performance & The Operational Plan

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

	• Agree and embed enhanced rates payment approach across clinical teams to further reduce waiting times • Modular ward now in use, utilisation being monitored weekly. • Retain focus on diagnostic modalities – trajectory now agreed and being tracked. • Maintain grip and focus on all long-waiting patients; IP challenges in ENT and ophthalmology due to sub-specialisation/orthopaedics due to demand and backlog • RTT recovery plan currently in development. • Continue to increase productivity • In line with NHSE guidance regarding the ongoing validation of all patients (every 12 weeks), the Trust are assessing digital tools to be able to support this work. • A summary version of the final DBTH NHS FT winter plan is attached for information **Industrial Action Planning** • Planning for the potential industrial action has commenced, despite DBTH not identified in the RCN proposal a working party of the COO DDP&OD and EPRR team has met and the national questionnaire has been completed. • The Trust will take part in the national scenario planning over November and December to ensure we are linked in with potential industrial action across the ICB and we are in a sensible position for other industrial action`s that may be agreed **From an emergency perspective, the key next steps are:** • Reduce Ambulance handover delays - ESA model implementation completed on the Doncaster site. Soft launch at Bassetlaw took place on 21 October. • Reduce Ambulance handover delays - NHSE commissioned DBTH/YAS QI project to identify improvement at pace – workshop planned 2 December • Reduce LOS - Partnership working to develop Transfer of Care Hubs and a discharge to assess model of care. • Reduce LOS - National Patient Pathways under development within Nerve Centre to support with reporting and understanding demand for community services. Overall, the Trust continues to experience significant operational challenges and will continue to focus on safety, sustainability and supporting its teams, people and patients
	The Board is asked to note and comment as appropriate on the attached.

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

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

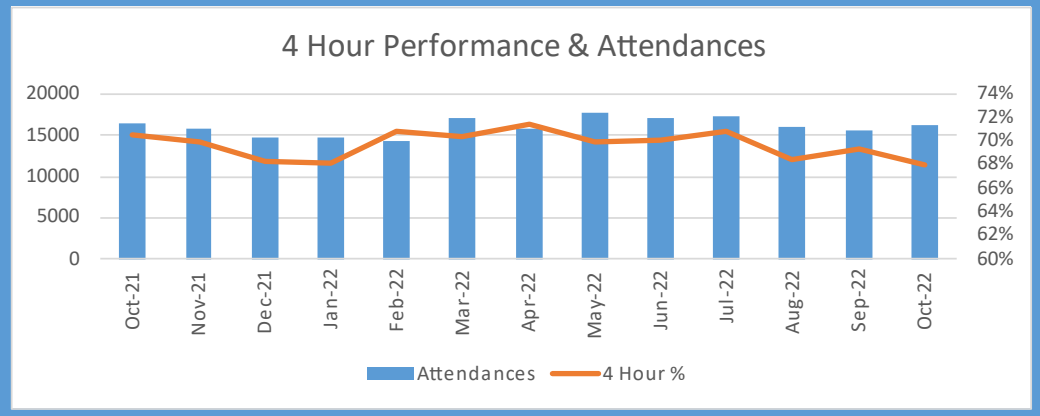
Implications	
Board assurance framework:	Changes made to SA1 and COVID 19 addition to SA1 to reflect risk and related to winter planning & also planning mitigation
Corporate risk register:	Report regards Risks ID 6 and 2349 on the Risk Register - F&P 6 and F&P 8. • Failure to achieve compliance with performance and delivery aspects of the SOF, CQC and other regulatory standards • Failure to specifically achieve RTT 92% standard Report outlines actions plan to make progress, no change to risks on CRR
Regulation:	Report links to national quality and access standards. Performance against the standards contributes to the CQC regulatory framework.
Legal:	Report outlines performance against standards, published annually by NHS England, some of which are outlined in the NHS Constitution.
Resources:	Impact on resources of delivering activity taken account of in Trust plans

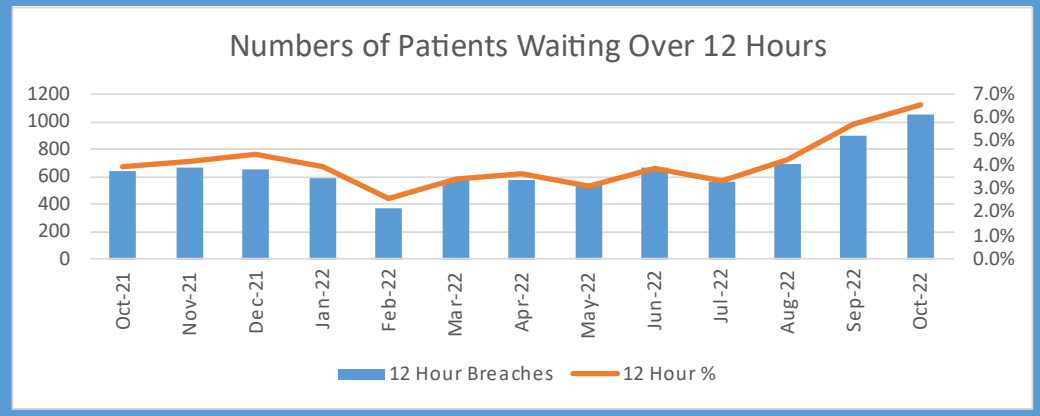
Assurance Route			
Previously considered by:			
Date:		**Decision:**	
Next Steps:	Agreement of 2022/23 performance trajectories to be monitored via new IQPR & related documentation		
Previously circulated reports to supplement this paper:			

Trust Integrated Exception Performance Report – October 2022

1. Urgent and Emergency Care – 4 hour standard and new standards
2. Urgent and Emergency Care – Ambulance Standards
3. Urgent and Emergency Care – Length of Stay
4. Urgent and Emergency Care – Length of Stay (Discharge)
5. Elective – Activity
6. Elective – Waiting List and Long Waiters
7. Elective – Outpatients
8. Diagnostic Waits
9. Cancer – Referral to Diagnosis
10. Cancer – Treatment
11. Health Inequalities
12. Performance – The Forward View

1. Urgent and Emergency Care: 4 hour performance and 12-hour standards





Key issues:

- 4 hour performance 68.1% for Trust. Main breach reasons continue to be doctor and bed waits
- Attendance levels remain higher than any of previous four years, with an increase across majors pathways in October
- Reduced streaming to FCMS due to acuity of walk in patients and inconsistent service provision on Bassetlaw site
- Ambulance peaks in activity at high impact times
- Medical skill mix and vacancy
- Significant exit block impacting on flow with increased boarding times experienced as a result
- 12 hours from arrival 6.56%

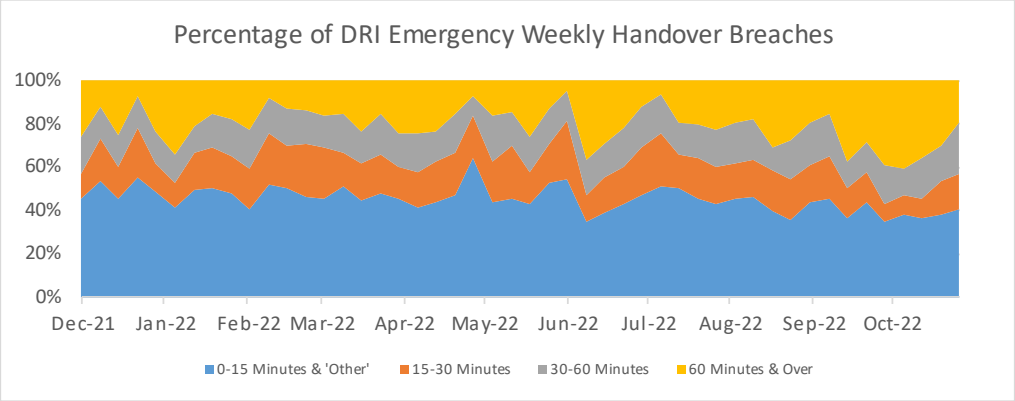
Key actions:

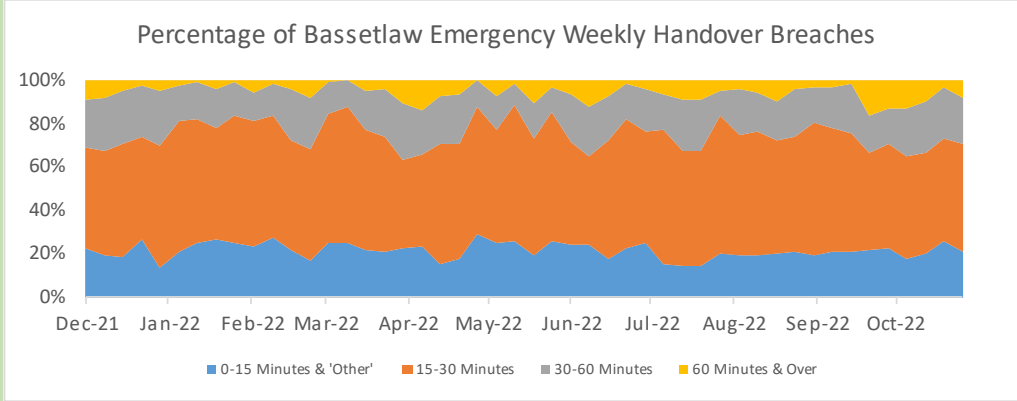
- ESA model implementation completed on the Doncaster site. Soft launch at Bassetlaw took place on 21 October.
- Re-establishment of EAU model completed 3rd Oct to help increase ED flexibility and majors flow
- Preferred options reviewed for 'Larger front Door'- increased UTC capacity aligned with national specification being worked into business case for delivery next financial year
- Continue to embed SDEC criteria led referral model for ESA and YAS patients with focused pathway work being undertaken for surgical SDEC
- ED streamer continues to be embedded with a notable increase in patients streamed away seen in October
- Overnight observations with clinical teams to identify issues with overnight performance ongoing

October 2022 Performance

Hospital	4 Hour % Achieved	Attendances	Breaches	%Streamed From FDASS
Bassetlaw	77.27%	5126	1165	9.07%
Doncaster	58.70%	9736	4021	20.84%
Montagu	99.93%	1361	1	0.00%
Trust	68.03%	16223	5187	15.37%

2. Urgent and Emergency Care: Ambulance waits





Key issues:

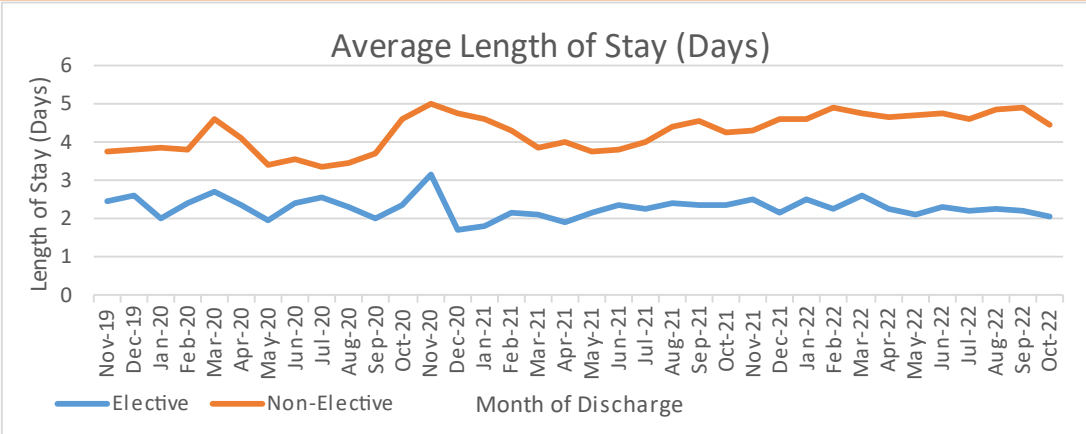
- Ambulance handover performance position continues to be challenging in October
- Increased levels of ambulances continue in the Doncaster & Bassetlaw area.
- Increasing challenges to flow of ambulances coming into and the receiving of handovers.
- Issues related to flow out of ED & wider trust continue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

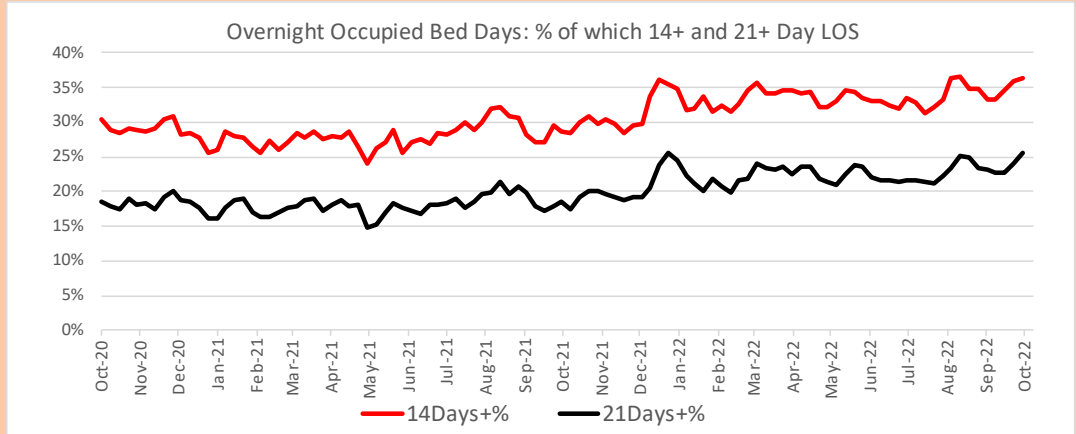
Key actions:

- DBTH to attend YAS meetings to launch and educate regards direct SDEC pathways
- FCMS working on direct admission pathways due to number of ambulance arrivals that are referred from ED to FCMS
- Larger I.T work commencing regards direct access of EPRF information directly in to symphony to improve operational management of patients before they arrive
- Qi observational work completed on Bassetlaw site with EMAS colleagues – considered as part of ED Time Out Event
- Structural work commenced to increase ESA capacity to receive ambulances – completion date 21 November
- EAU re-instated 3 October
- NHSE commissioned DBTH/YAS QI project to identify improvement at pace – workshop planned 2 December

Month	Hospital	Total Arrivals	%<15 Minutes	% 15-30 Minutes	% >30 Minutes	Longest Wait
Oct-22	Bassetlaw Hospital	768	21.88%	47.40%	30.34%	03:35
Oct-22	Doncaster Royal Infirmary	1838	40.26%	11.10%	48.64%	06:09
Oct-22	Trust	2606	34.84%	21.80%	43.25%	06:09

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





Key issues:

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

Key actions:

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

4. Urgent and Emergency Care: Length of Stay (Same Day Emergency Care - SDEC)

Discharges by Time of Day (Excluding Day case)

Discharge Time	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Before Noon	13.1%	14.9%	15.4%	14.1%	13.5%	12.0%	14.1%	13.2%	12.9%	12.1%	12.4%	12.2%	13.8%
Before 4PM	45.8%	48.2%	47.7%	47.0%	46.5%	42.9%	46.8%	46.9%	46.4%	45.5%	43.3%	44.0%	45.3%
After 4PM	53.8%	51.3%	51.7%	52.7%	53.1%	56.8%	53.1%	52.8%	53.2%	54.0%	56.3%	55.6%	54.0%

Key issues:

- Not currently co-located with other SDEC areas (surgery/gynae) or ED – deters direct referrals
- Current staffing shortfalls - both ACP and medical for medical SDEC (ACU)
- Increase in overall attendances and reduced space in ED – opportunity identified for streaming to Surgical SDEC
- Issues for DBTH relate to flow into ED and into wider Trust
- Referral criteria pathways focused which reduces opportunities

Key actions:

- Work ongoing developing plans for SDEC co-location with support from Strategy team
- SDEC Pathways with surgical team being reviewed to access additional opportunity
- Direct referral pathways in place for YAS and EMAS to SDEC – work continues to embed
- Working with ICS SDEC Transformation group to make further improvements
- Re-implementing Early Senior Assessment model to improve streaming to SDEC from arriving ambulances – increase seen in October as a result
- Single point of access now in place via Consultant Connect – work to be undertaken to increase call pick up

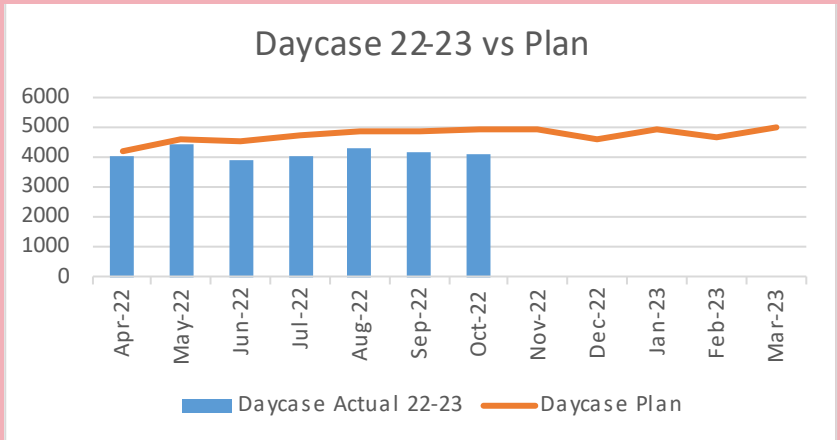
% of all Non-Elective Admissions to an SDEC Ward

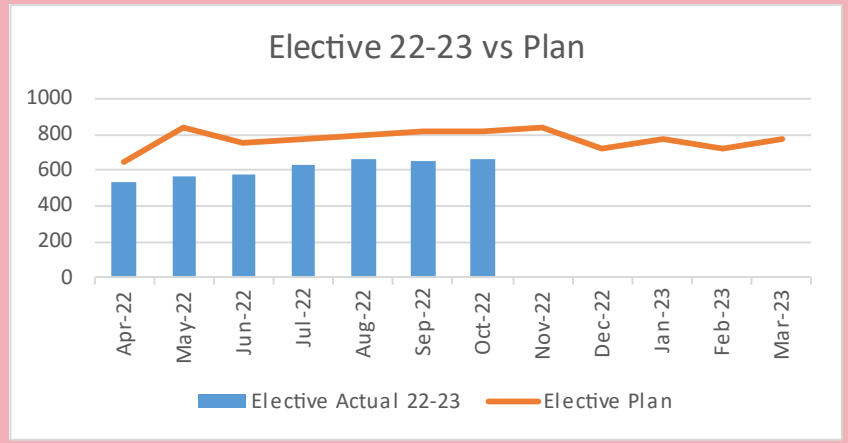
Ward	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
ACUTE MEDICINE DECISIONS UNIT			3.2%	5.2%	4.5%	4.0%	3.2%	4.2%	3.5%	3.4%	2.9%	3.2%	0.1%
AMBULATORY CARE UNIT - DONCASTER	8.1%	8.4%	7.5%	8.9%	8.8%	10.1%	9.2%	10.1%	11.0%	10.0%	10.1%	10.6%	10.6%
EMERGENCY SURGICAL AMBULATORY CARE	4.3%	4.7%	5.2%	6.3%	5.0%	5.0%	5.2%	5.2%	6.0%	5.9%	5.8%	5.6%	4.3%
GYNAECOLOGY SAME DAY EMERGENCY CARE	0.4%	0.4%	0.4%	0.3%	0.2%	0.1%	0.0%	0.5%	1.3%	1.6%	2.3%	1.7%	1.2%
TRAUMA AMBULATORY CARE UNIT												0.0%	
Grand Total	12.9%	13.5%	16.3%	20.8%	18.6%	19.2%	17.6%	19.9%	21.9%	21.0%	21.1%	21.1%	16.2%

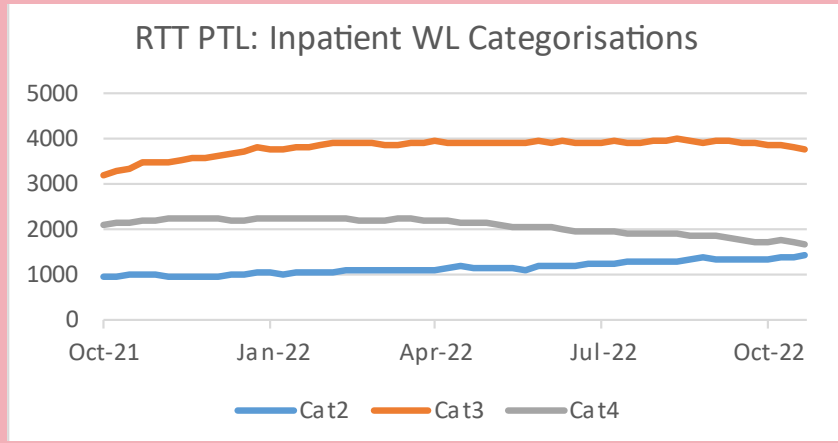
Number of Non-Elective Admissions to an SDEC Ward

Ward	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
ACUTE MEDICINE DECISIONS UNIT			142	219	178	174	133	190	158	155	128	146	5
AMBULATORY CARE UNIT - DONCASTER	377	372	330	375	347	442	389	459	493	453	445	484	509
EMERGENCY SURGICAL AMBULATORY CARE	202	206	231	264	198	219	219	239	269	268	258	256	208
GYNAECOLOGY SAME DAY EMERGENCY CARE	19	18	18	13	7	4	1	23	59	72	101	76	58
TRAUMA AMBULATORY CARE UNIT												1	
Grand Total	598	596	721	871	730	839	742	911	979	948	932	963	780

5. Elective: Daycase and Inpatient Elective







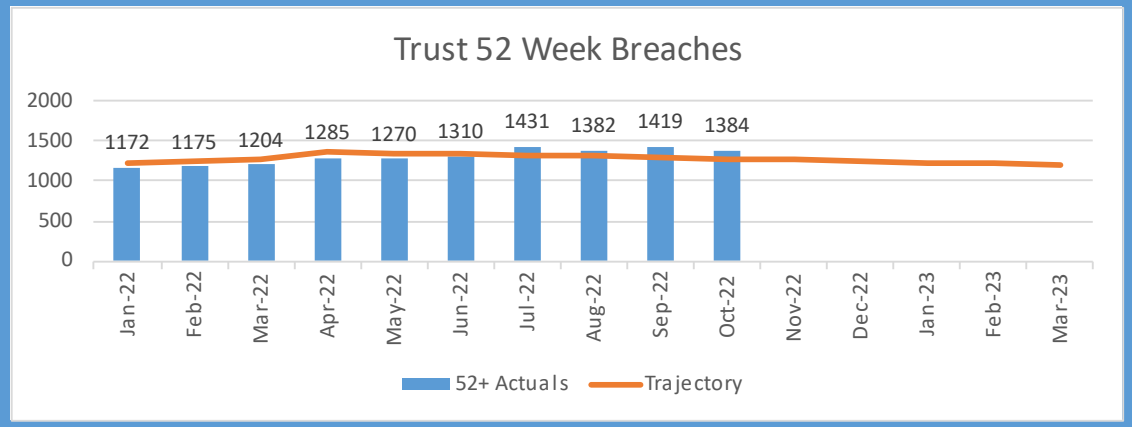
Key issues:

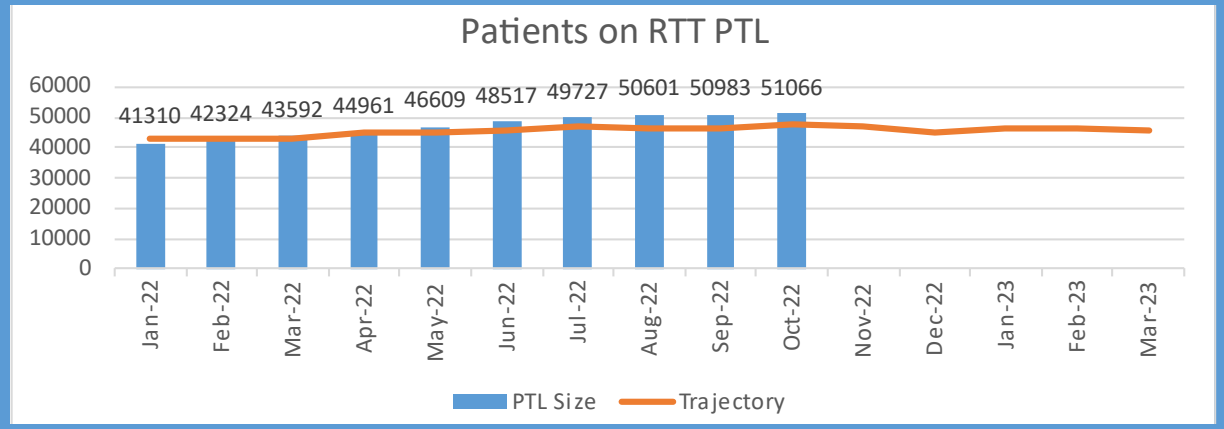
- Day case - Trust delivered 83.9% of plan (0.9 percentage points down from previous month) and 89.5% of 19/20 activity (down 4.9 percentage points)
- Elective - Trust delivered 80.9% of plan (down 2.3 percentage points on previous month) and 80.8% of 19/20 activity (+1.0 percentage points)
- All patients are listed on the basis of clinical prioritisation and longest waiting times
- Daily clinical review continues to prioritise patients according to available capacity
- Loss of available capacity due to lack of emergency surgical beds, prolonged spike in increased trauma demand, lack of non-elective flow and significant staffing gaps in elective pathway.
- Modular theatre and ward opened at the end of Octover 2022 for a soft launch, numbers and utilisation being monitored weekly through POSM.

Key actions:

- Continue to list all patients, prioritising urgent, Cat 2's and the longest waiting Cat 3's & 4's
- Maintain drive to reduce long waiters with focus on 78 weeks
- Beds at Parkhill used tactically to support DRI bed base (ongoing)
- Outsourcing continues and is providing increasing levels of service as we further develop working relationships and build on existing processes and working practices
- Maximising surgical activity at Doncaster, Bassetlaw and Mexborough to maintain elective programme where theatre resource allows.
- Conversion of inpatients to day case wherever possible
- Maximising use of theatre lists/sharing lists to ensure best use of theatre, surgeon, anaesthetic resources (ongoing)

6. Elective: Patient Tracking List and Long-Waiters





Key issues:

- At the end of October 2022 there are **1384** Incomplete Pathways to be reported as 52+ weeks which is a reduction from 1419 in September
- The total number of Incomplete pathways has increased in October to 51066 from 50983 in September.
- There was one pathway over 104 week waits at the end of October. Patient reviewed no clinical harm, discharged treated.
- The Trust Level month end 18 week performance for October 2022 is 65.1%, which is an improvement from September 2022 which was 64.7%, and still lower than 'normal' due to the continued impact of Covid-19.

Key actions:

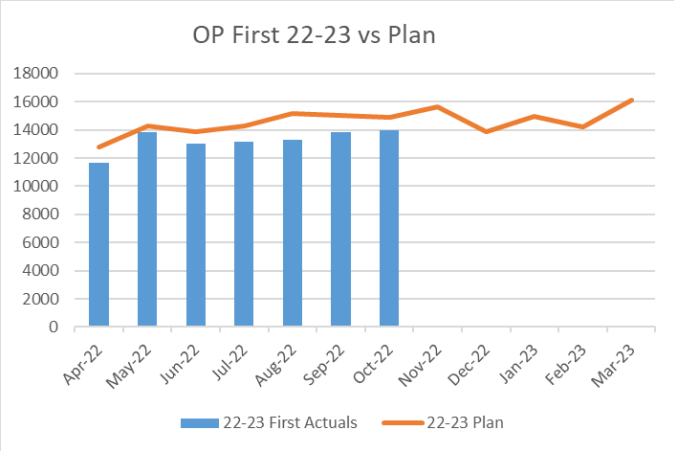
- Weekly PTL meetings maintained to ensure consistent approach across Trust to managing long waiters, both for outpatient and inpatient activity
- RTT Audits across all clinical service areas to identify opportunities for improvement/training
- RTT training for clinicians reinstated
- Maintained focus on 104 week waiters and all 78 ww patient pathways man-marked and tracked
- Access policy currently being reviewed and updated, target date for completion December 2022.
- Starting procurement process for a digital patient pathway tracker.
- Currently developing a business case for resource to support increased validation

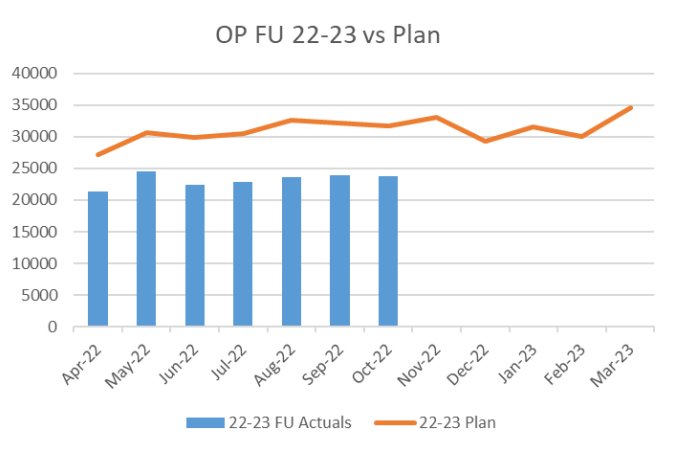
CCG	Values	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
NHS Bassetlaw CCG	Total Waiters	9269	8936	8848	9014	9334	9601	9922	10234	10507	10597	10757	11074
	% Under 18 Weeks	70.1%	66.6%	66.2%	66.3%	67.0%	67.3%	69.8%	68.1%	66.0%	65.5%	64.4%	64.8%
NHS Doncaster CCG	Total Waiters	26526	26083	25967	26589	27380	28196	29327	30620	31420	32060	32350	34483
	% Under 18 Weeks	70.9%	67.9%	67.0%	67.1%	68.3%	67.7%	70.7%	69.4%	67.2%	66.9%	65.5%	65.3%
Trust	Total Waiters	42372	41503	41310	42324	43592	44961	46609	48517	49727	50601	50983	51066
	% Under 18 Weeks	70.5%	67.4%	66.8%	67.3%	68.3%	68.1%	70.7%	69.1%	66.7%	66.2%	64.7%	65.1%

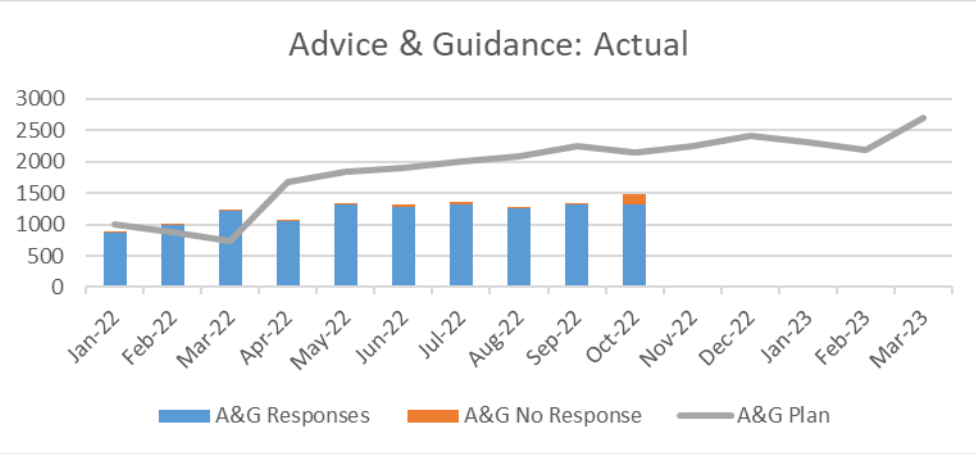
Reported 52+ Weeks: Top 6 Specialties

Specialty	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
TRAUMA & ORTHOPAEDICS	561	564	555	540	532	616	670	740	794	809	850	847
GYNAECOLOGY	20	29	38	45	77	103	127	139	153	167	161	161
ENT	107	108	119	112	96	91	103	112	114	127	128	133
UROLOGY	67	92	91	92	103	88	76	88	125	95	111	85
OPHTHALMOLOGY	239	275	279	287	321	317	224	150	154	110	85	70
X05 OTHER - SURGICAL SERVICES	13	19	19	34	29	30	21	21	18	19	28	26

7. Elective: Outpatients





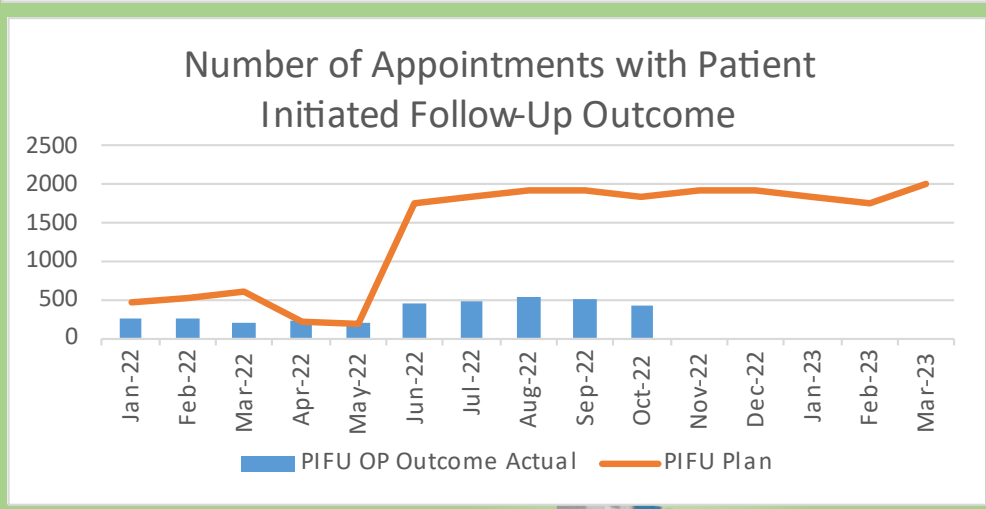


Key issues:

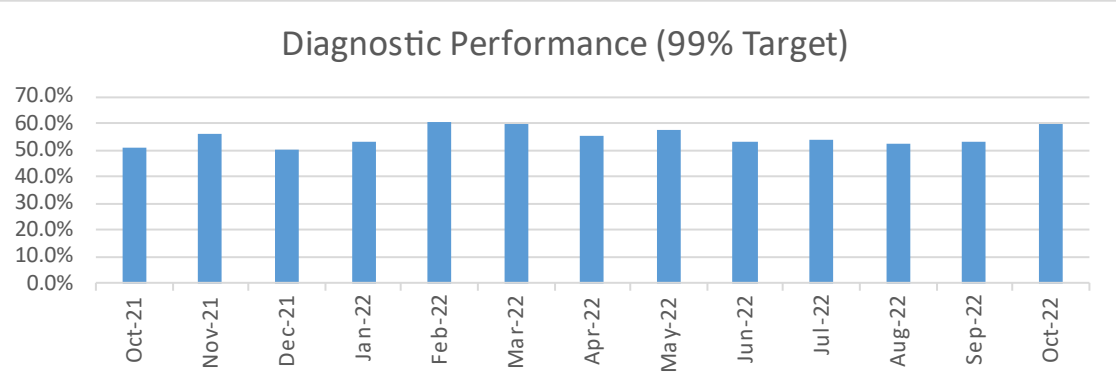
- First outpatient appointments the Trust delivered 93.5% of plan and 83.6% of 19/20 activity in October. A 1.4 percentage point increase on September's activity vs plan
- Follow-up outpatient appointments the Trust delivered 75.0% of plan and 83.6% of 19/20 activity in October. A 0.8 percentage points increase on September's activity vs plan
- PIFU plans progressing with an increased number of pathways being considered, NHSE in attendance at the Trust to support this work. Considering open appointments as part of the plan.
- Challenges securing backfill / additional sessions due to ongoing issues with additional session payment rates.

Key actions:

- Ongoing conversations with Trust staff regarding additional payment rates.
- Review of booking rules for all OP clinics as part of capacity and demand planning.
- Continue current trend with A&G (16 per 100 OPFA by March 23)
- Embed PIFU (5% of all OP attends by March 23) across specialties
- Outstanding Outpatients focussing on 22/23 targets but also continues to develop support systems/processes
- Continued focus on validating limited number of patient pathways
- Consultant RTT training to ensure sound understanding of RTT rules and guidelines



8. Diagnostic waits



	Waiters <6W	Waiters >=6W	Total	Performance
Trust	10453	7027	17480	59.80%
NHS Doncaster	6951	4662	11613	59.86%
NHS Bassetlaw	2652	1783	4435	59.80%

Exam Type	<6W	>=6W	Total	Performance	Longest Waits
MRI	1849	526	2375	77.85%	42
CT	2302	383	2685	85.74%	31
Non-Obstetric Ultrasound	3613	3814	7427	48.65%	43
Barium Enema	0	0	0		0
DEXA	334	755	1089	30.67%	23
Audiology	399	1169	1568	25.45%	81
Echo	497	196	693	71.72%	10
Nerve Conduction	145	33	178	81.46%	26
Sleep Study	23	4	27	85.19%	3
Urodynamic	43	26	69	62.32%	74
Colonoscopy	351	42	393	89.31%	38
Flexible Sigmoidoscopy	126	27	153	82.35%	32
Cystoscopy	373	23	396	94.19%	85
Gastroscopy	398	29	427	93.21%	35
Total	**10453**	**7027**	**17480**	**59.80%**	**85**

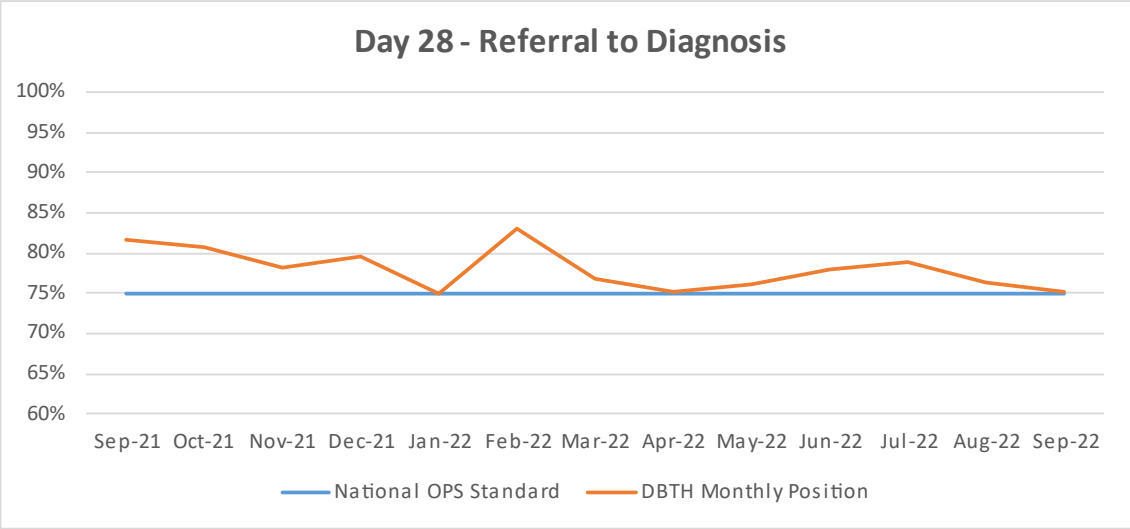
Key issues:

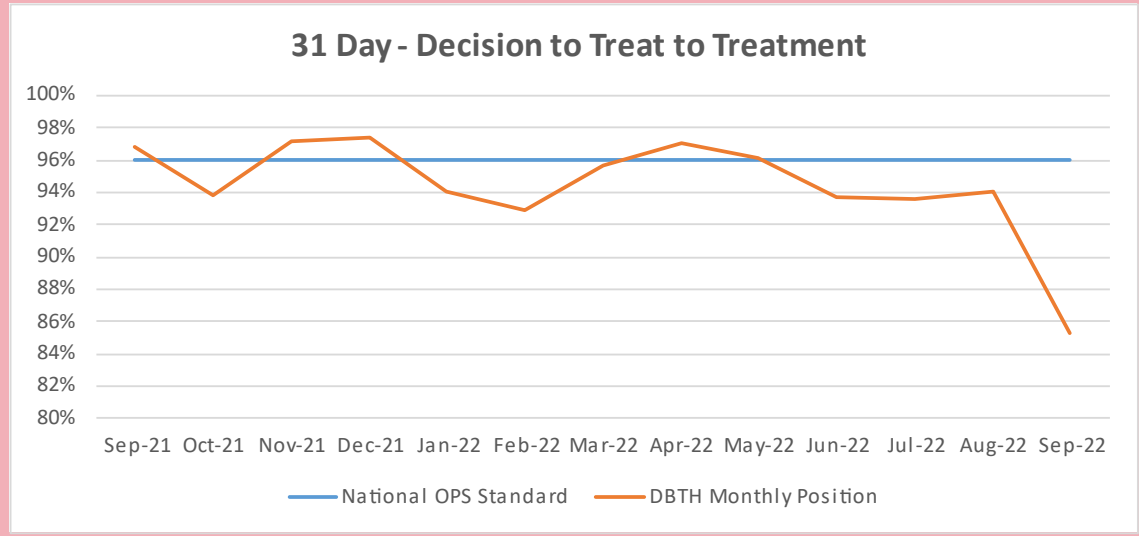
- Performance against the 6-week target improved from 53.1% in September to 59.8% in October.
- CT Performance increased to 85.7%, a fourth consecutive month of improvement.
- Non-Obstetric Ultrasound performance improved to 48.7%, the third consecutive month of improvement, although this modality still accounts for more than half of the long waits across all modalities.
- Demand for CT and MRI continues to grow and exceed capacity requiring the commissioning of additional capacity to achieve performance targets.
- Audiology and DEXA remain well below target with performance between 25-31%

Key actions:

- Audiology has undertaken an in-depth analysis of capacity and demand and is developing a plan to meet demand and achieve waiting time targets.
- Additional NOUS activity is being undertaken by recently appointed radiologists supplemented by use of an insourcing provider.
- Additional NOUS capacity will be established from November as part of the Community Diagnostics Centre development.
- CT and MRI initiatives will commence in December to address waiting list backlogs.
- A business case is being developed for additional static CT and MRI scanners in the next phase of the Community Diagnostics Centre plans

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





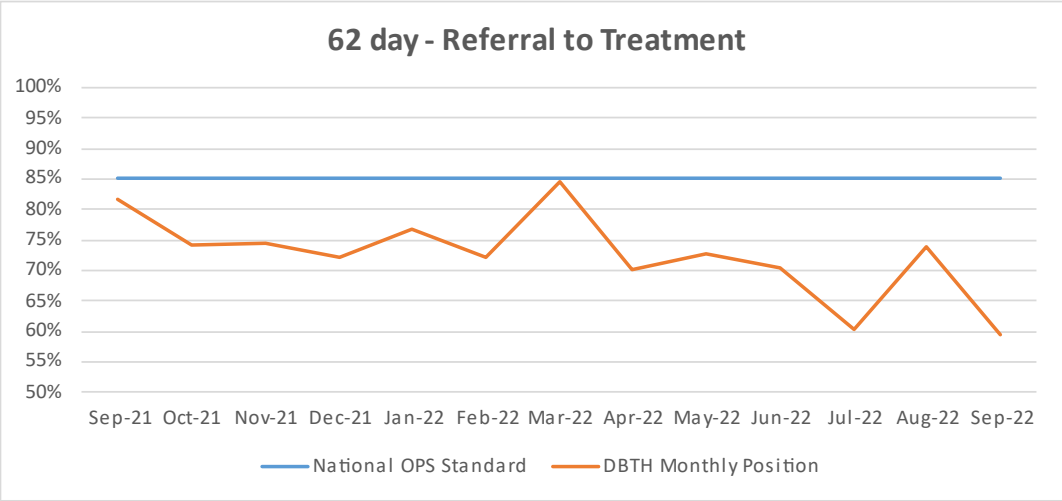
Key issues:

- Trust FDS standard compliant August 76.3% – but variability in tumour groups reflects pathway capacity linked to access and diagnostic capacity including staffing resource month on month
- Management of individual diagnostic waits within the Day 28 time line impacting on individual tumour groups achieving Best Practice Time Pathway milestone events
- Reporting and review of diagnostic results attribute to significant percentage of administrative breaches within individual tumour groups
- Key staffing pressure in Histopathology from late Q1 impacting on turnaround times for reporting and impacting on all Cancer Waiting Times Standards

Key actions:

- Continue to review position on a 3 monthly rolling model till year end to establish key themes and pinch points regarding medical and clinical resources. Monthly reports now available and being shared with senior clinicians. Focus on avoidable and unavoidable breaches
- Establishing a quarterly improvement trajectory for each individual tumour groups for the FDS standard, based on 2021/22 compliance utilising activity, breach reasons, performance against to standard and overlay BPTP guidance.
- Histopathology pathways and transfer models linked across the wider ICS are now being reviewed. At Trust level we are seeing a worsening position.

10. Cancer - Treatment



Sep-22	31 Day Classic	31 Day Sub Surgery	31 Day Sub Drugs	62 Day Classic 50/50	62 Day Screening	62 Day Consultant Upgrades
Operational Standard	*96%*	*94%*	*98%*	*85%*	*90%*	*85% (locally agreed)*
Trust	85.3%	94.1%	100.0%	59.6%	88.0%	80.2%

Key issues:

- Increasing complexity of pathways based on clinical findings, medical reasons and staging/Genomic testing resulting in delayed first treatment for 62 day pathways
- Capacity issues and patient fitness linked to local first treatment delays.
- Target Lung Health Checks workload feeding into other tumour groups based on incidental imaging findings.
- Compliance linked to Day 38 IPT impacting on Tertiary Care compliance, some of these issues can be linked to Day 28 compliance for certain tumour groups
- Increase in total number of 104 day treatment breaches in Q2.
- Increased us of PET scans across all tumour groups impacting on 62 day pathways
- Containing pressure on Oncology staffing and access within the ICB

Key actions:

- Establishing a quarterly improvement trajectory for each individual tumour groups for the 62 day standard, based on 2021/22 compliance utilising activity, breach reasons, performance against to standard. Potential to improve on Day 38 IPT transfers delays
- Reduce the number of 104 day referral to treatment breaches on classic 62 day pathway
- Patient Navigator posts established in in 6 services although funded from external funding - Business case required to ensure substantive funding in place for 2023/24.
- Implementing checklists for patients that are referred to out of areas tertiary treatment centres.
- ICB solution is currently being reviewed due to continued issues

11. Health Inequalities

Key actions:

Awareness
- Initial comm's via Buzz
- Intranet area development

Areas under development to include Health inequalities

- SET training development (to be included in next SET update)
- QI training
- QPIA development
- Monday.com inclusion
- Audit of current project areas
- Assessment tool

Initial meetings with
- Facilities
- P and OD
- PMO
- Education and research

- Public health consultant is now in post and undertaking discovery work.

Ethnic Category	Doncaster Population %	Bassetlaw Population %	Doncaster and Bassetlaw Combined %	Waiting List Ethnicity Breakdown: Nov-22
Asian/Asian British	2.5%	1.1%	**2.1%**	1.4%
Black/African/Caribbean/Black	0.8%	0.5%	**0.7%**	0.7%
Mixed/multiple ethnic groups	1.1%	1.1%	**1.1%**	0.8%
Other ethnic group	0.4%	0.6%	**0.4%**	0.9%
White *	95.3%	96.7%	**95.7%**	83.3%
Not stated /Not known / NULL	0.0%	0.0%	**0.0%**	12.9%

Index of Multiple Deprivation (IMD) Decile (where 1 is most deprived 10%)	Doncaster Population %	Bassetlaw Population %	Doncaster and Bassetlaw Combined %	Waiting List IMD Breakdown: Nov-22
1	25.3%	8.3%	**20.5%**	19.7%
2	16.0%	13.2%	**15.2%**	15.5%
3	11.9%	12.6%	**12.1%**	12.8%
4	9.2%	8.5%	**9.0%**	9.4%
5	6.8%	9.2%	**7.5%**	7.4%
6	10.0%	13.4%	**11.0%**	10.7%
7	7.4%	12.3%	**8.8%**	9.1%
8	6.8%	14.0%	**8.8%**	8.3%
9	5.1%	8.4%	**6.0%**	6.0%
10	1.5%	0.0%	**1.1%**	1.1%
Unknown	0.0%	0.0%	**0.0%**	0.0%

*Based on 15/11/2022 Data

Key issues:

- A significant Cultural change is needed to ensure a Health inequalities Len's is used throughout DBTH (Through education, Communication and integration of policies).

- The current Health Inequalities landscape within DBTH is not fully understood and work is needed to audit current good practice, share learning and identify areas of improvement.

- Data is not focussed of Health Inequalities as a priority, leading to inadequate datasets to allow informed identification of areas of concern or areas requiring target support.

12. Performance – The Forward Look – October 2022

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

Urgent and Emergency Care

- Reduce Ambulance handover delays - ESA model implementation completed on the Doncaster site. Soft launch at Bassetlaw took place on 21 October.
- Reduce Ambulance handover delays - NHSE commissioned DBTH/YAS QI project to identify improvement at pace – workshop planned 2 December
- Reduce LOS - Partnership working to develop Transfer of Care Hubs and a discharge to assess model of care.
- Reduce LOS - National Patient Pathways under development within Nerve Centre to support with reporting and understanding demand for community services.

Elective

- Agree and embed enhanced rates payment approach across clinical teams to further reduce waiting times
- Monitor usage of modular ward.
- Maintain grip and focus on all long-waiting patients; IP challenges in ENT and ophthalmology due to sub-specialisation/orthopaedics due to demand and backlog
- RTT recovery plan in development.
- In line with NHSE guidance on validation of all patients every 12 weeks, we are assessing digital tools to be able to support this work

Cancer

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

Winter Plan 22/23		Approved Plan		Month 8	Year End
Division	Scheme	Amount	WTE	Spend To Date	Forecast
Division of Medicine	Ward 22 – General Ward (16 beds)	914,899	32.25	**138,634**	901,049
Division of Medicine	Mex – Rehab Beds (10 TOC beds)	309,548	13.60	**40,026**	349,574
Division of Medicine	Open Discharge Lounge on Sunday @ BDGH	6,380	0.27	**0**	5,316
Division of Medicine	Registered Nurse - Discharge Lounge @ DRI	29,461	1.42	**0**	24,551
Division of Medicine	HCA - Discharge Lounge @ DRI	20,675	1.42	**0**	17,229
Division of Medicine	Hospital @ BDGH Late Shift (Mon, Tue, Fri)	16,805	0.66	**2,801**	16,805
Division of Medicine	Hospital @ DRI nights	55,642	2.83	**9,274**	55,642
Division of Medicine	DRI ED - extra streaming nurse to support potential additional activity	72,059	2.83	**0**	60,049
Division of Medicine	Bass ED - extra streaming nurse to support potential additional activity	72,059	2.83	**0**	60,049
Division of Medicine	In reach into ED 4 hours per day from Medics - DRI	6,273	0.10	**0**	6,273
Division of Medicine	Pharmacy to support Discharge lounge/ED/EAU	20,747	1.00	**0**	17,289
Division of Medicine	Bassetlaw ACP to support ward rounds (Sat/Sun)	17,249	0.43	**0**	14,374
Division of Medicine	Consultant Shift at DRI Weekends/BH	30,108	0.40	**5,018**	30,108
Division of Medicine	Discharge transport from ED DRI Nights/evenings	37,262	-	**6,210**	37,262
Division of Medicine	Site Matron	40,439	1.00	**10,414**	39,299
Division of Medicine	Deputy Director of Nursing Operations	57,544	1.00	**15,135**	56,238
Surgery and Cancer Division	Band 5 nurse support to ENT ambulatory pathway in ESAC	27,476	2.11	**0**	27,476
Surgery and Cancer Division	Extra twilight shift CSW - 4pm – 12midnight – 7 days a week	29,555	1.77	**0**	29,555
Surgery and Cancer Division	Extra twilight registrar cover - 4pm – 12midnight – 7 days a week	59,629	1.77	**0**	59,629
Clinical Specialist Services Division	Operate 2nd CT scanner at weekends at the DRI	67,290	4.00	**0**	67,290
Clinical Specialist Services Division	Establish 4th theatre radiographer at the DRI to increase emergency/trauma theatre	25,820	1.00	**0**	25,820
Clinical Specialist Services Division	Increase pharmacy provision for the discharge lounge	49,518	2.00	**0**	49,518
Clinical Specialist Services Division	Increase radiographer establishment temporarily by 2 radiographers for 4 months to increase reporting radiographer capacity for hot reporting of x-ray images from the Emergency Department.	51,640	2.00	**0**	51,640
Clinical Specialist Services Division	Extend MRI scanner hours at the Doncaster Royal Infirmary from 8pm to 10pm daily for 4 months and establish temporarily an MRI porter post to minimise delays in inpatients being scanned	19,293	1.37	**0**	19,293
Clinical Specialist Services Division	Increase physiotherapy and occupational therapy capacity at DRI Monday to Sunday to improve flow	76,032	4.00	**0**	63,360
Clinical Specialist Services Division	Increase physiotherapy capacity at BH Monday to Friday and weekends to improve flow	21,475	1.00	**0**	17,896
		2,134,875	**83.06**	**227,512**	**2,102,583**

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	29 November 2022		**Agenda Reference:**	**E5**	
Report Title:	**Recovery, Innovation & Transformation Update**				
Sponsor:	Jon Sargeant, Director of Recovery, Innovation & Transformation (RIT)				
Author:	Jon Sargeant, Director of Recovery, Innovation & Transformation (RIT)				
Appendices:	None				
Executive Summary					
Purpose of report:	To provide an update on the changes in the Recovery, Innovation and Transformation Directorate.				
Summary of key issues:	This report lays out the current status of work within the directorate including: 1. Service Line Review / Strategy 2. Performance Overview Support 3. Mexborough Elective Orthopaedic Centre (MEOC) 4. Single Site Trauma (SST) 5. CIP Performance 6. 2023/24 Business Planning.				
Recommendation:	Members are asked to receive this report.				
Action Require:	~~Approval~~	**Information**	~~Discussion~~	~~Assurance~~	~~Review~~
Link to True North Objectives:	**TN SA1:** *To provide outstanding care for our patients*	**TN SA2:** *Everybody knows their role in achieving our vision*	**TN SA3:** *Team DBTH feels valued and feedback from staff and learners is in the top 10% in the UK*	**TN SA4:** *The Trust is in recurrent surplus to invest in improving patient care*	

Implications			
Board assurance framework:			
Corporate risk register:			
Regulation:	None		
Legal:	None		
Resources:	None		
Assurance Route			
Previously considered by:	These papers have previously been considered by TEG as F&P.		
Date:	N/A	**Decision:**	N/A
Next Steps:	N/A		

Previously circulated reports to supplement this paper:	N/A

Table of Contents

1. INTRODUCTION

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

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

2. MEETINGS (TRANSFORMATION & POSM)

The first meeting of the Transformation Board took place on Monday 8th August and a subsequent meeting took place on Monday 17th October. Diagnostics, Outpatients, UEC and Data Warehouse were taken for approval. The Winter plan and the development of an overall elective recovery plan were discussed and a new approach was taken for the October meeting with SRO's speaking directly to the dashboards on Monday.com for their relevant projects. The following projects were discussed:

1. Workforce
2. Urgent and Emergency Care
3. Quality
4. Elective Recovery (Outstanding outpatients and Outstanding theatres)
5. Data Assurance
6. Diagnostics
7. Digital Transformation
8. Strategy and Improvement
9. Quality Improvement (Qi)
10. Infrastructure Capital Projects.

The POSM sessions continue to be an effective forum for identification and resolution of issues. There are however further improvements required to make them as beneficial as possible for the organisation including further definition of control environments from respective executives and more rapid resolution and progression of actions. A standard agenda provides the division with an opportunity to raise emergent issues or items which required further briefing. Each quadrant of the performance assurance framework is then discussed with the respective executive lead. A number of meetings were stood down due to OPEL Level 4 being declared, however more recently it has been agreed to have a shortened agenda and meeting (45mins rather than 1.5 hours) to assist divisions during these busy periods and escalate/resolve any issues that can assist them in the delivery of services.

3. SERVICE LINE REVIEW / STRATEGY UPDATE

The service strategy workshops have been completed for all specialties. Final iterations have been completed for Maternity, Gynaecology and Paediatrics within the Children's and Families division. These have been issued to the specialties for last alterations to be returned by 25th November. The Children's and Families Division will subsequently update its priorities in early December.

All other divisional management teams have reviewed the strategy document and updated the section 4 divisional priorities. These are being incorporated into the final document which will be completed once

Children's and Families return their priorities. The final document will be complete w/c 12th December 2022.

Following on from the initial session held in the summer with the executive to determine the development of a trust site strategy a working group has been established to lead the site strategy development, involving representatives from the CMO, COO and Strategy directorates, facilitated by Consilium Partners. The group have determined to build on the clinical services strategies to develop the strategic framework for the clinical role and development of each of our hospital sites. The aim is to inform our decisions and priorities for change to our current service provision. We will use the end product to inform and influence the wider acute strategy and collaboration with the ICS's and other providers across South Yorkshire and Nottinghamshire. The site strategy will play a key role in ensuring the long-term sustainability of the Trust and its services. The 3 phases have been agreed and adjusted slightly since last month to include services that are in a 'hub and spoke' delivery model with partner organisations.

Work has begun to complete phase 1, detailed below, with the plan to complete by w/c 12th December.

Site Strategy Timeline

W/C	14/11	21/11	28/11	5/12	12/12	19/12	26/12	2/1	9/1	16/1	23/1	30/1	6/2
Phase 1	1st draft		2/12 agree with spec		16/12 TEG paper							ICS paper	
Phase 2									Work shop this week				
Phase 3													TEG Paper
TEG					12/12				9/1				

Service Strategy Timeline

- Final Priorities returned from Children's and Families w/c 5th December
- Complete Final version of Service Strategy Document w/c 12th December.

4. MONTAGU ELECTIVE ORTHOPAEDIC CENTRE (MEOC) PROJECT

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

- To reduce elective orthopaedic waiting lists
- Improve productivity and efficiency
- Increase quality and effectiveness of surgical interventions.

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

Update on progress since last Board Report

1. Three meetings were held between the CEOs and executive colleagues in July, August and September 2022 to agree the vision and way forward for the MEOC project. It was decided that the overall vision is to implement an Orthopaedic Centre of Excellence at Mexborough Montagu Hospital delivering a wide range of elective orthopaedic surgery at high volume, quality and outcomes. This will be attractive to staff and patients and support the ICS in reducing waiting lists. It was further agreed that the £15m TIF funding would act as a 'proof of concept' and that the three organisations would work together to maximise the impact on high volume low complexity elective orthopaedic care within the limitations of the capital budget.

2. CEOs requested that Trauma and Orthopaedics Leads from each provider meet and discuss the way forward. Richard Parker chaired this meeting on 18/10/22 which agreed a series of three meetings with wider clinical stakeholders to agree the clinical, operational and staffing models for the MEOC 'proof of concept'. GIRFT leads in orthopaedics and anaesthetics contributed to the meetings. Barnsley and Doncaster & Bassetlaw clinicians expressed enthusiasm for the proposed solution. Rotherham clinicians remain uncomfortable with the level of risk associated with 'cold site' surgery. Rotherham leadership remain committed to the project and will work with their clinicians. A final meeting to support an agreed line in the business case is taking place on 24/11/22.

3. The MEOC 'proof of concept' will deliver inpatient (hip and knee arthroplasty) and day case (hand, foot shoulder and ankle) high volume, low complexity orthopaedic surgery with activity split between the partner organisations as follows:

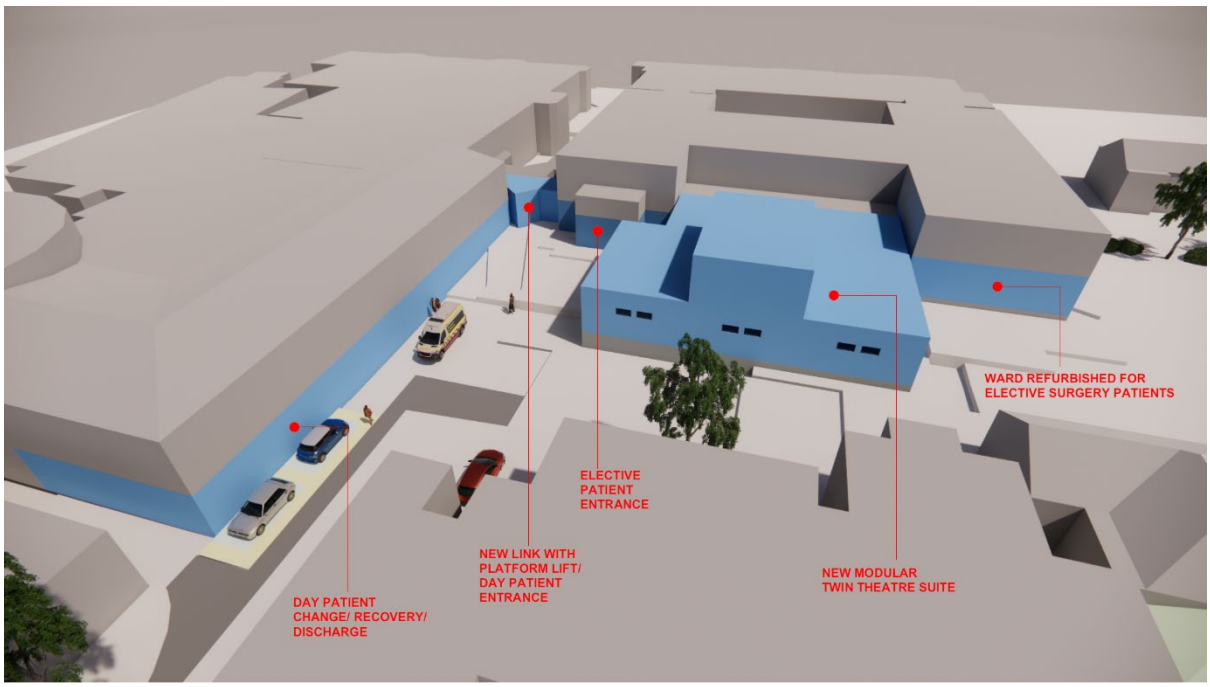
    a. 25% Barnsley

    b. 25% Rotherham; and

    c. 50% Doncaster & Bassetlaw.

4. The Project Team met with the South West Ambulatory Orthopaedic Centre which implemented a 'cold site' lower limb arthroplasty service at the beginning of the year. This is achieving an average length of stay of 0.5 days with 60% of patients discharged on day 0. The MEOC target is 2.75 days, in line with current GIRFT guidance. Data from this project has been procured and a visit is being arranged in the new year for clinician to clinician discussions. The potential benefits and risks associated with a higher throughput approach will be debated during the construction phase of the project.

5. The Project Design Team has completed the initial design work and identified a solution which delivers 2 new modular theatres collocated with 12 refurbished beds situated on the ground floor of the Rehabilitation Unit. Day case admission and discharge will take place in unutilised capacity in the adjacent Rockingham Day Surgery Centre. The capital cost is £14.79m and includes acceptable levels of contingency together with a risk share arrangement with the proposed modular supplier to remove downside impact of hyperinflation. Planning permission progress has been hampered by lack of capacity in the Doncaster Metropolitan Borough Council's planning team but based on initial discussions and professional advice there do not appear to be any major planning restrictions. The MEOC footprint forms part of the wider Development Control Plan (DCP) for Mexborough Montagu Hospital which confirms the solution is consistent with existing and developing estates plans (e.g., Community Diagnostic Centre and Hydrotherapy Pool).



6. A short form business case is in preparation and will be submitted for local and then national approval in December 22 and January 23. The revenue and value for money aspects are being worked on currently. It is anticipated that approval to place an order with contractors will be given in February 23 and current timelines indicate the new facility will be operational in October/November 23. It is anticipated that development of the broader 'Centre of Excellence' strategy will commence in Spring 23.

5. SUSTAINABLE TRAUMA (FORMERLY SINGLE SITE TRAUMA)

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

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

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

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

Update on progress since last Board Report

1. Six shortlisted options have been developed for the potential future configuration of trauma services:

   - ***Option 0:*** Pre-covid deployment (March 2020) (Option 0 is the business as usual (BAU) option against which alternatives are tested in the economic appraisal.)
   - ***Option 1:*** Current deployment (September 2022)
   - ***Option 2:*** Trauma at DRI and Elective at Bassetlaw
   - ***Option 3:*** Elective at DRI and Trauma at Bassetlaw
   - ***Option 4:*** Higher Risk Lower Complexity Elective at DRI & Bassetlaw
   - ***Option 5:*** All higher risk and complex elective IP at DRI
   - ***Options 4 & 5:*** Focus IP trauma and complex elective at DRI with lower complexity/risk, ambulatory and day case and minor operations at Bassetlaw and with outpatients at both sites. The difference between options 4 & 5 relates to the ability to do more higher risk but low complexity work at Bassetlaw through release of HVLC capacity as a result of the proposed Montagu Elective Orthopaedic Centre.

   28 stakeholders across trauma and orthopaedics, anaesthetics, nursing and broader Clinical Specialist Services were approached to score the options. To date 13 have replied. The scores by investment objective and option show that options 4 & 5 consistently score better than the other options:

Option	Option 0	Option 1	Option 2	Option 3	Option 4	Option 5
Sustainable Trauma	32	35	34	19	40.5	42
Efficient Trauma	31	36	32	22	39	40
Effective Trauma	34	35	33	19	39	42
Patient outcomes	35	35	33	19	41	43
Right Sized	33	30	28	17	41	38
Optimises sites	38	31	28	21	45.5	40
Supports elective & trauma	36	35	26	25	42	40
Supports public consulation	39	33	23	21	39	40
Total	**278**	**270**	**237**	**163**	**327**	**325**

Option 4 presupposes that MEOC will move HVLC activity out of Bassetlaw District General Hospital to Montagu Hospital. This frees up space for higher risk work to be undertaken at Bassetlaw. There is concern among the anaesthetists that critical care and out of hours medical cover at Bassetlaw are fragile and could not support more complex orthopaedic surgery in the longer term. This is not the trust's strategic position but is a tactical problem which needs to be resolved.

Stakeholders were asked to comment on the benefits, risks, strengths, opportunities, weaknesses and threats associated with each option. The key messages that can be drawn from this information in relation to Option 4 are as follows:

i. Sharing workload between sites makes better use of theatres, beds and staffing and is preferred over a crude split of trauma and elective care.

ii. Cohorting complex patients requiring complex surgery is preferred over a trauma and elective split due to perceived recruitment and retention benefits, management of equipment and inventory and cost containment.

iii. Sharing workload across sites mitigates the concern that patients and public will not support perceived 'downsizing' of their local service.

iv. Providing access to beds and theatres at all sites go some way to limiting handover and transfer of patients, leading to improved length of stay and improved patient experience.

v. There is a clear appetite for the MEOC proposition which provides more capacity and allows for strict ring fencing of HVLC work during Winter Pressures.

vi. There is concern that complex elective work at DRI will suffer due to medical outliers but this is true at both acute sites under all options and is mitigated through point 5 above.

vii. There is concern that the fragility of medical cover at both Bassetlaw and MEOC needs to be resolved to allow Option 4 to be successful.

The next step is to feedback the results of the appraisal to stakeholders and then undertake financial and value for money assessment of the options to determine the preferred option.

2. Work has progressed with regard to the development of 'measures' for trauma split into two groups. Those that are required to support the calculation of resources for the business case and those which will be employed to support ongoing operational performance. There is some overlap between the two.

   38 measures have been developed and reviewed by operational, surgical and nursing colleagues. The measures have all been agreed as relevant and valuable for future monitoring. However, there are too many to act as an attention directing dashboard for the service, so the measures have been grouped and summarised into the most important, the aim being for the remainder to be available for drill down to understand the cause of any deviation from plan.

   The measure groupings are as follows:

   - **Daily status** – lead indicators based on output from the trauma board to support forward planning
   - **Delivery** – time-based measures which determine whether patients are flowing through the service as planned and without undue delay
   - **Quality** – standards-based measures which capture deviations from plan such as readmissions, expected date of discharge, red to green, potential harm events, best practice tariff and complaints/complements
   - **Use of resources** – throughput-based measures which assess the utilisation and volumes being delivered by key functions along the care pathway, e.g., beds, theatres, outpatients and minor operations
   - **Morale** – survey-based measures which seek to understand the experience and satisfaction of both staff and patients

   The Project Team has developed a guide for the use and governance processes for the measures to support monitoring of trauma performance into the future. This is aligned to existing trust processes.

3. Further work has been undertaken with regard to the data required for the business case. Data to support pathway analysis is complicated due to the need to link together Symphony (A&E), CAMIS (patient administration) and Bluspier (theatre data) causing delays in developing corroborating and underpinning evidence.

The primary aim of the data analysis is to provide insight into the historical performance of trauma services, identify areas for improvement and forecast future activity and capacity requirements for business as usual (Option 0) and the preferred option.

Analysis of historic theatre and bed-based activity is largely complete with a review on 03/11/2022 identifying refinements required. The forecast analysis for beds is drafted with equivalent information on theatres and outpatients underway. Forecasts look forward 5 years. Completion of the data analysis was targeted for 11/11/2022 but higher priority work related to the Vanguard theatres at Bassetlaw reallocated resources. This work will now be completed during the week commencing 21/11/2022.

Conversations are underway with Bluspier to identify changes to data recording and reporting on the Trauma Board to better manage pathways and reduce delays to care through better insight and ability to manage patient priority against targets.

Forecast future capacity will be mapped to the deployment of services identified by the preferred option and used to determine any capital investment required at each location.

4. The business case is due to be submitted to CIG on 19th December 2022.

6. CIP PERFORMANCE

F&P approved the target of £19.25m, all programmes will be monitored through the PMO as in previous years and will go through the robust governance process previously shared. The overall target has been broken down into the following schemes.

CIP element	Target
Vacancy control	5,500,000
ERF productivity	5,500,000
Temporary staffing	1,000,000
Non-pay containment and procurement savings	750,000
Non-pay cost containment and other non-recurrent savings	2,000,000
Unidentified	4,500,000
Total	19,250,000

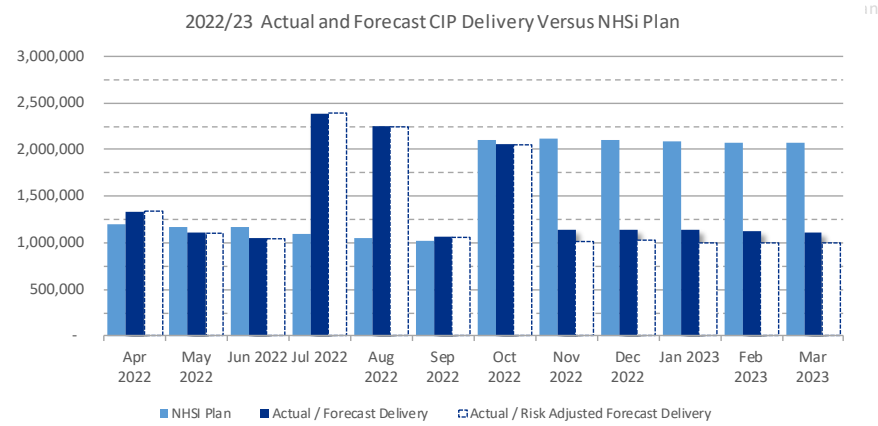
CIP Current Signed Off Schemes

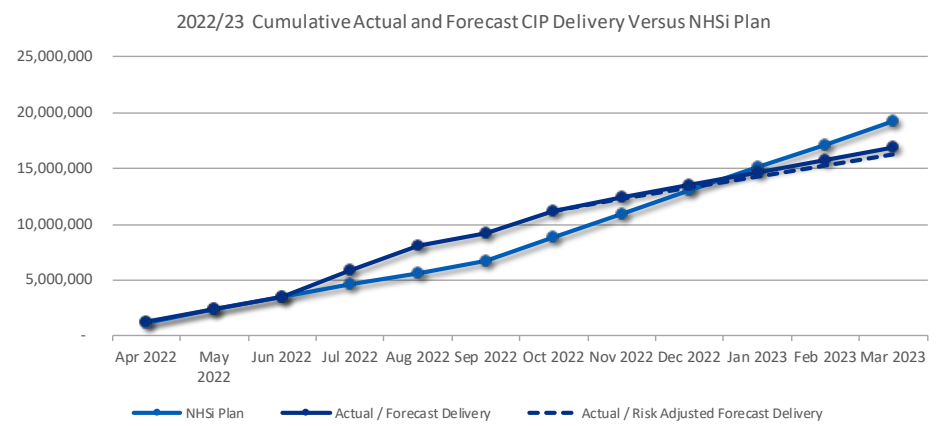
The forecast to date for schemes signed off is £16.9m, work is underway to identify, quantify and validate additional opportunities.

CIP element	Target	Forecast	Variance
Vacancy control	5,500,000	5,500,000	0
ERF productivity	5,500,000	3,781,248	-1,718,752
Temporary staffing	1,000,000	81,390	-918,610
Non-pay containment and procurement savings	750,000	220,043	-529,957
Non-pay cost containment and other non-recurrent savings	2,000,000	2,000,000	0
Unidentified / LOCAL Schemees	4,500,000	5,317,868	817,868
Total	**19,250,000**	**16,900,550**	**-2,349,450**

CIP Current Delivery

The graph and table below show the actual delivery of CIP versus plan YTD for 22/23 and the overall delivery against the total target of £19.25m. The Trust has delivered £2.06m of savings in M7 versus the plan submitted to NHSI of £2.11m, an under-delivery of £0.05m.





	April	May	June	July	August	September	October	November	December	January	February	March	Total
NHSI Plan	1,192,102	1,166,820	1,169,715	1,093,771	1,055,316	1,015,778	2,105,777	2,112,235	2,105,782	2,081,355	2,078,121	2,073,231	**19,250,000**
Actual / Forecast Delivery	1,334,904	1,107,896	1,048,791	2,386,988	2,245,589	1,065,204	2,057,912	1,137,156	1,142,703	1,134,888	1,131,651	1,106,868	**16,900,550**
Delivery/Forecast v NHSI Plan	+142,802	-58,924	-120,924	+1,293,217	+1,190,274	+49,426	-47,865	-975,079	-963,079	-946,467	-946,470	-966,363	**-2,349,450**
Cumulative NHSi Plan	1,192,102	2,358,921	3,528,636	4,622,407	5,677,722	6,693,500	8,799,277	10,911,512	13,017,294	15,098,649	17,176,770	19,250,000	
Cumulative Actuals and Forecast	1,334,904	2,442,800	3,491,591	5,878,579	8,124,168	9,189,372	11,247,284	12,384,440	13,527,143	14,662,031	15,793,682	16,900,550	
Cumulative Delivery/Forecast v NHSI Plan	+142,802	+83,878	-37,045	+1,256,172	+2,446,446	+2,495,872	+2,448,007	+1,472,928	+509,849	-436,618	-1,383,088	-2,349,450	

In month Performance

In October 2022 the Trust has delivered savings of £2.06m versus the NHSI plan of £2.11m. The following table details the key variances between forecast and actual delivery:

	Month 7				
CIP element	In Month Delivery Plan	In Month NHSi Plan	In Month Actuals	In Month Variance to Delivery Plan	In Month Variance to NHSi Plan
Vacancy Control	401,611	401,611	401,611	0	0
ERF Productivity	114,583	458,333	458,333	343,750	0
Temporary Staffing	20,347	100,000	0	-20,347	-100,000
Procurement Savings	62,500	62,500	7,282	-55,218	-55,218
Unidentified	0	750,000		0	-750,000
Non Pay (Reserves Release)	333,333	333,333	333,333	0	0
C&F - Local	9,624	0	38,118	28,494	38,118
CSS - Local	68,685	0	36,586	-32,099	36,586
S&C - Local	20,489	0	20,489	0	20,489
Medicine - Local	700,711	0	697,193	-3,518	697,193
E&F - Local	13,685	0	13,685	0	13,685
Other Corporate - Local	51,283	0	51,282	-1	51,282
Total	**1,796,851**	**2,105,777**	**2,057,912**	**261,061**	**-47,865**

Material areas of under-delivery (>£25k)

Temporary Staffing - £100k under-delivery to NHSi Plan

Workforce premium savings were to commence in month 3, however due to a number of factors including high level of vacancies and sickness actual spend has increased. The FBP team are working with divisions to help support management of temporary staffing in line with Trust internal processes.

Procurement Savings - £55k under-delivery to NHSi Plan

Savings continue to be behind plan, review meetings have been set up with the Head of Procurement to review current schemes within the plan, forecast savings are deteriorating month on month and this has been escalated to the Director of Finance as SRO.

Material areas of over-delivery (>£50k)

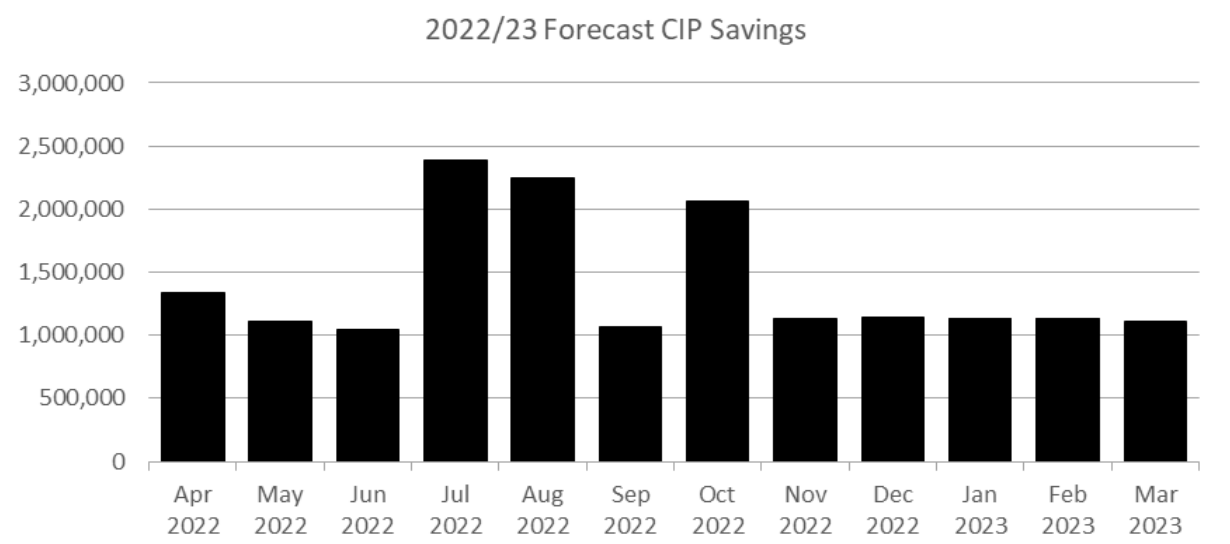
Medicine Release of over accruals 22/23 £490k

The Medicine FBP has reviewed all accruals / SLAs for the current year and identified excess accruals of £840k (full year) the Director of Finance has approved the release of these accruals in month. A Review of Medicine accruals / SLAs for 21/22 is currently being validated with potential for release in month 8. Other divisions / corporate department reviews have also commenced.

Progress on CIP planning

Planning RAG definitions:

"New Idea"	White	At idea stage with no further documentation.
"In development"	Red	Project Charter, Roles and Indicative Finances completed
	Amber	Milestones, detailed finances and baseline performance completed
	Green	Detailed plan, KPIs, Risks, Issues and QPIA completed
In delivery	Black	All sign offs received including QPIA



Workstream	Black	Green	Amber	Red	White	Total
Local	5,273,376	-	-	14,486	-	**5,287,862**
Workforce Plan / Vacancy Control	5,500,007	-	-	-	-	**5,500,007**
ERF	3,781,248	-	-	-	-	**3,781,248**
Agency	81,390	-	-	-	-	**81,390**
NonPay	2,000,000	-	-	-	-	**2,000,000**
Procurement	220,043	-	-	-	-	**220,043**
RPA	-	-	-	-	30,000	**30,000**
Total	**16,856,064**	**-**	**-**	**14,486**	**30,000**	**16,900,550**

Current priorities are:

- Identifying schemes and opportunities for the 2022/23 programme.

  Additional schemes for development have been fed back from Divisions and are currently with the finance teams for financial assessment. Divisions or corporate departments with a continuing lack of identified opportunities will be escalated through the Performance, Overview and Support Meetings and picked up in separate escalation meeting through the financial assurance process.

- Further develop and progress the additional workstreams identified through the KPMG review, the new dedicated workstreams are:
  - Agency Management and Grip & Control (SRO: Jon Sargeant)
  - VAT (SRO: Alex Crickmar)
  - Major Contracts (SRO: Alex Crickmar).

7. 2023/24 BUSINESS PLANNING

This paper outlines the trust's approach to business planning and proposed timeline for 2023/24.

Context and role of business planning

Business planning is a key function for every organisation: the process of coming up with a sensible, coherent, and comprehensive plan for the short and medium term. This allows the Trust to understand expected levels of performance and decide how resources are allocated to deliver the best care to our patients and experience to our staff.

The NHS has been through a difficult period with sustained pressures through urgent and emergency care alongside challenges recovering elective and diagnostic activity to historic levels and meeting current demand. This has seriously impacted on PTL sizes and delivery of core targets. Other challenges also remain around staffing with consequential impacts on the care we provide to our patients.

Through the 2023/24 business planning process the Trust is aiming to chart our plan to return to and exceed the levels of performance seen prior to COVID (appreciating this may be a multi-year journey) whilst ensuring we embrace the latest transformations and lessons learned during this period. This will allow us to continue working towards our Trust "True north" objectives.

Current intelligence on national expectations

The Trust has not yet received planning guidance for the coming 2023/24 financial year and based on our awareness of national discussions are expecting to receive this in December at the earliest but more probably January.

Although formal planning guidance is not yet available a number of the expectations are already clear from previous guidance as well as the recent "Our plan for patients" https://www.gov.uk/government/publications/our-plan-for-patients/our-plan-for-patients. These set out that Trust must deliver the following:

- ***Long waiters*** - eliminating waits of over 18 months by April 2023, over 15 months by March 2024, and over a year by March 2025
- ***Elective recovery*** - As a minimum deliver 104% of our 2019/20 activity
- ***Diagnostics*** – Continue to expand diagnostics capacity through CDC and internal capacity to deliver 120% of 19/20 activity
- ***Staff*** – Continue to build on the areas highlighted in 22/23 planning guidance to support staff well-being and offer clear career paths and development
- ***Finance*** – Achieve national targets around deficit position and capital spending limits
- ***Efficiency*** – Return to and exceed historic productivity levels and identify efficiencies to ensure Trust financial sustainability
- ***Sustainability*** – Meet national expectations around sustainability and the "green plan"
- ***Inequalities*** – Plan and deliver reductions in health inequality with partners

It is likely that the coming year will have significant financial constraints based on indicative feedback from national teams. We will therefore need to ensure we target investments based on need and impact as well as delivering efficiencies to give the Trust the ability to invest further.

Key business planning processes

Business planning is based on triangulating a series of parallel processes to produce the overall outputs. The table below details these processes and the organisational leads:

Process	Led by	Corporate Support
Activity / Capacity planning	Operations / Performance team	IBPs / Information team
Demand forecasting and performance modelling / RTT recovery	Operations / Performance team	IBPs / Information team
Workforce planning	POD	FBP/SPBP
Training and education	E&R	SPBP
Budget setting	DOF	FBP
Cost pressure	DOF	FBP
Projects / development	**RIT** Digital – CIO; Infrastructure – Head of capital infrastructure; Efficiency – PMO; Change – PMO/S&I/Qi	PMO
Capital	RIT	As above
Divisional narrative plans	RIT	PMO
Corporate narrative plans	RIT	N/A

Further detailed guidance and templates have been developed for the majority of areas with final versions to be ratified before the end of November. These include setting out how the Trust will use national tools and programmes to develop high quality plans including Model Health System, the GIRFT programme and ICB led initiatives.

Timetable

The table below details the key dates in the 2023/24 business planning process:

Task	Forecast completion date
Communications and letter to divisions with pre-populated templates	30th November
Workshops and supporting activities	22nd November – 6th January
Draft plans from divisions and departments	6th January
Review meetings	6th January – 27th January
Presentation of draft plan and planning guidance at TEG / F&P	February
Final divisional plans	17th February
Presentation of final plan at TEG / F&P	March
Final plan submitted to ICB	TBC
Plans circulated to organisation and uploaded to intranet	April

Recommendation

It is recommended that the Trust board approve and note the process and timetable set out in this paper.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	29 November 2022	**Agenda Reference:**	**F1**
Report Title:	**Community Diagnostic Centre Imaging Suite Business Case**		
Sponsor:	Jon Sargeant, Executive Director of Recovery, Innovation and Transformation		
Author:	Shahida Khalele, CDC Project Manager and Clare Ainsley, Strategic Programmes Manager		
Appendices:	Appendix A - VFM		

Report Summary	
Purpose of report:	In early July 2022 a year 2 business case was supported by the National CDC Panel to expand the development at Montagu to include non-obstetric ultrasound and endoscopy. The case was supported by the National CDC panel on the condition that a business case for permanent static CT and MRI was expedited from year 3 (23/24) into year 2 (22/23). This is the expedited business case for static CT and MRI. This business case builds on the Year 2 Montagu Community Diagnostic Centre (CDC) development, expanding the CDC by investing in a new build within the estate to include additional imaging in the form of Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) and Ultrasound facilities to build towards the Integrated Care Board (ICB) vision of a Large CDC in Montagu. The CT and MRI new build put forward in this case will over time replace the independent sector staffed mobile CT and MRI. The plan is to manage a transition from the staffed IS mobiles to the NHS staffed permanent static CT and MRI during 2023/24.
Summary of key issues/positive highlights:	Community Diagnostic Hubs (CDHs) were initially identified as a key recommendation in the Sir Mike Richard's review, Diagnostics: Recovery and Renewal published in October 2020. They were proposed as a new service model to contribute to the required expansion of diagnostic services to meet future demand and to enable the separation of planned and unplanned diagnostics. The report by Sir Mike Richards also included a suite of associated recommendations including the need to expand the diagnostic workforce, estate, equipment, and the use of technology to facilitate delivery. A National Diagnostic Transformation Programme Board was established to oversee the implementation of recommendations and a multiyear National Community Diagnostic Centre (CDC) Programme is now in place to manage the delivery of CDCs (formally CDHs). Simultaneously the National Cancer Programme has increased its focus on enabling faster diagnosis and is due to shortly publish a new Faster Diagnosis Framework.

	One of the key objectives is the delivery of the best practice timed pathway milestones to meet the new 28 days Faster Diagnosis Framework (FDF). It is envisaged that CDC will contribute to this. To implement the recommendations locally, Phase 1 of a CDC development at Montagu hospital has commenced with staffed mobile CT and MRI scanning funded by the National CDC Programme already commenced, which also continued into 22/23 with continuation funding. This paper provides details of phase 2b of this development. Phase 2b development will include: • Static CT and MRI scanners, including purchase of Cardiac MRI software and associated pathway workforce at the Montagu CDC site. • The plan is then to move the Ultrasound facility from the rotunda into this newbuilding which would then free up space for the expansion of Physiological measurements into the rotunda clinic rooms. • A plan for Retford Hospital X-ray Upgrade to support training initially then to be developed and used as a general X ray spoke in future phases Allowing a standardisation and redesign of clinical pathways across SY&B to reduce unnecessary steps, tests and duplication, reducing health inequalities and a better experience for patients by providing single point of access to a range of safe, quality diagnostics Capital costs of £905k in 2022/23 and £13,704k in 2023/24 and recurrent revenue of £2,269k (pre-inflation) from year six (2028/29), the revenue requirement is higher in earlier years due to the need of agency support until the training programme is fully established. There is currently an ongoing debate regarding procurement for the CDC programme and our finance team are currently working through the situation with auditors and finance colleagues across the system and programme to decide on the approach for financial spend in years. This may lead to a change in cost profiling across years, however the financial ask for the full business case remains the same. F&P have sight of the full business case on the usual DBTH proforma to enable sufficient scrutiny. In addition, the national case submission will be presented to Board of Directors on 29th November 2022 If agreed by F&P and Board the template case will be submitted to Doncaster Place for approval and via the South Yorkshire & Bassetlaw Integrated Care System and then onto the National CDC Team for approval in December.				
Recommendation:	It is recommended that the Finance and Performance Committee/Board of Directors reviews this business case and supports the proposal going forward for ICS and National CDC Team funding approval to implement Phase 2b CDC in 2022/23.				
Action Require:	**Approval**	~~Information~~	~~Discussion~~	~~Assurance~~	~~Review~~

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

Implications	
Board assurance framework:	N/A
Corporate risk register:	This development positively contributes to mitigating performance risks
Regulation:	
Legal:	
Resources:	Detailed within business case for workforce, IT, estate and infrastructure

Assurance Route			
Previously considered by:	CDC Working Group, CDC Steering Group & Finance & Performance Committee		
Date:	24.11.2022	**Decision:**	
Next Steps:	Following approval by Board and F&P the case will submitted to the SY&B ICS by and then onto the National CDC Team for approval. (National CDC case template submitted to Board of Directors on 29th November 2022)		
Previously circulated reports to supplement this paper:			

DONCASTER & BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

MONTAGU COMMUNITY DIAGNOSTIC CENTRE
Imaging Suite Build MMH

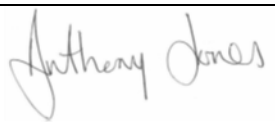
FULL BUSINESS CASE 2022

MONTAGU COMMUNITY DIAGNOSTIC CENTRE
Imaging Suite Build MMH
Business Case

SRO:	**Jon Sargeant, Director Recovery Innovation & Transformation**
Project Manager:	**Shahida Khalele, CDC Project Manager, Strategy and Improvement** **Clare Ainsley, Strategic Programmes Manager, Strategy and Improvement**
Organisation:	**Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust**
Division/Corporate Department	**CLINICAL SPECIALITIES DIVISION**

Approvals

	Name	Signature	Date
Approved by *Divisional or Corporate Director* that the business case has been through the appropriate committee structures and is supported by the division	Andrew Pott Divisional Director Jas Sawhney Clinical Director - Radiology	 Andrew Potts  Jas Sawhney	18.11.2022
Approved by *Senior Management Accountant* that a quality assurance process has been undertaken to ensure sign offs are complete and that all parts of the business case template have been completed and that all financial issues are accurately recorded within the business case.	Claire Stewart Head of Financial Planning, Commissioned Income & Costing	 Claire Stewart	17.11.2022
Internal finance department process which will require sign off	Kirsty Edmonson – Jones SRO Director of Innovation & Infrastructure Alex Crickmar Acting DOF Richard Somerset Head of procurement	 Kirsty Edmondson-Jones  Richard Somerset	17.11.2022 18.11.2022

Approved by *Deputy Director of People & OD* that all relevant HR issues are accurately recorded within the business case	Anthony Jones, Deputy Director of P&OD	 Anthony Jones	21.11.2022
Approved by *Head of ICT* - that all IM&T implications are accurately recorded in the business case	Ken Anderson, Chief Information Officer		18.11.2022
Approved by *Head of Estates and Facilities* that all Estates & Facilities issues are accurately recorded in the business case	Andy White Head of Capital Infrastructure	 Andy White BSc, MRICS	18.11.2022

Version History

Version	Owners Name	Summary of change	Date
Draft V1	Shahida Khalele	Initial draft	Sept 2022
V2	Shahida Khalele	RC/CA comments added	Oct 2022
V3	Shahida Khalele	Procurement route finalised	Oct 2022
V4	Shahida Khalele	Estates plans included AW	Oct 2022
V5	Shahida Khalele	Additions to capital requirements – DO AW	Nov 2022
V6	Shahida Khalele	Amendments to case following review KEJ CW AP	Nov 2022
V7	Shahida Khalele	Final amendments to case CA SK	Nov 2022
V8	Shahida Khalele	Final case JS CA	Nov 2022

Business case approval timeline

EXCECUTIVE TEAM	Deadline	Governance - Meeting date
Business case draft checked Clare Ainsley Richard Canetti	19th October 2022	
Finalise finances Claire Stewart	14 Oct - 3rd November 2022	
Finalise Estates Procurement P22 to P23 route Andy White	14th Oct - 3rd November 2022	
Check/updated detail Shahida Khalele	4th November 2022	

Sign Off **Alex Crickmar**	7th - 10th November 2022	
SRO Approval **Jon Sargeant**	7th -10th November 2022	
Front page sign off **Andrew Potts/Jochen Siedel** **Anthony Jones** **Ken Anderson** **Claire Stewart** **Andy White**	10th -14th November	
Recommendations and Amendments BC **Shahida Khalele**	14th -17th November 2022	
F&P	Papers submission 18th November 2022	**24th November 2022**
BOARD OF DIRECTORS	Papers submission 21st November 2022	**29th November 2022**
DONCASTER PLACE & ICB	December 2022 TBC	
NATIONAL TEAM	December 2022 TBC	

CONTENTS & GLOSSARY OF TERMS

Glossary of Terms

A&E	Accident and Emergency
BCCG	Bassetlaw Clinical Commissioning Group
BCS	Bowel Cancer Screening Consortium (Rotherham, Barnsley, Sheffield, Doncaster)
BH	Bassetlaw Hospital

BOS	Barrett's Oesophagus Study
CDC	Community Diagnostic Centres
MMH	Mexborough Montagu Hospital
DBTH	Doncaster and Bassetlaw Teach Hospitals
CCG	Clinical Commissioning Group
CDH	Community Diagnostic Hubs
CQC	Care Quality Commission
DCCG	Doncaster Clinical Commissioning Group
DRI	Doncaster Royal Infirmary
FBC	Full Business Case
FDS	Faster Diagnosis Standard
FPC	Finance and Performance Committee
HEE	Health Education England
ICS	Integrated Care System
IPC	Infection Prevention Control
JAG	Joint Advisory Committee
KPI	Key Performance Indicator
MMH	Mexborough Montagu Hospital
NHSEI	National Health and Service England/ Improvement
OBC	Outline Business Case
PCN	Primary Care Network
PID	Project Initiation Document
PIR	Post Implementation Review
SRO	Senior Responsible Owner
SYB ICS	South Yorkshire and Bassetlaw Integrated Care System

EXECUTIVE SUMMARY

Community Diagnostic Hubs (CDHs) were initially identified as a key recommendation in the Sir Mike Richard's review, Diagnostics: Recovery and Renewal published in October 20201. They were proposed as a new service model to contribute to the required expansion of diagnostic services to meet future demand and to enable the separation of planned and unplanned diagnostics.
A National Diagnostic Transformation Programme Board was established to oversee the implementation of the Sir Mike Richard's Review. A multiyear National Community Diagnostic Centre (CDC) Programme is now in place to manage the delivery of CDCs (formally CDHs).

Simultaneously the National Cancer Programme has increased its focus on enabling faster diagnosis and is due to shortly publish a new Faster Diagnosis Framework. One of the key objectives is the delivery of the best practice timed pathway milestones to meet the new 28 days Faster Diagnosis Standard (FDS). It is envisaged that CDC development will contribute to this.
Funding has been identified, with £23.28M capital allocated for potential use by NEY in 2021/22.

Nationally £105M revenue has also been identified, with a further £96M growth allocation, although it is not yet understood if the latter is in baselines and/or additional. In addition, £250K was also confirmed for programme infrastructure.

The South Yorkshire & Bassetlaw Integrated Care System (SYB ICS) has developed CDC plans in conjunction with local partners. The Montagu CDC is a significant part of this ICS development and is being implemented with a phased approach. Work has already commenced on Phase one with the implementation of staffed mobile scanning units and phase two builds on this development.

This business case describes proposals for phase 2 of the development of a Community Diagnostic Centre at Montagu Hospital. It seeks to gain approval and funding from NHS England for the procurement and implementation of the plans. If approved by Board this will be submitted to the Integrated Care System and region for consideration as part of the national programme.

CDC Phase 1 -Approved
The DBTH bid for Phase 1 proposal submitted mid July 2021 for capital investment of £232,000 and Revenue £827,000 with proposed activity of 1002 MRI and 1602 CT over 6 months. Funds have been approved, received and activity started at the beginning of January 2022 and was complete by end of March 2022.
The Phase 1 Montagu CDC Business Case secured in year operational revenue costs associated with the capital. Discussions are underway nationally and locally in relation to onward revenue implications, and continuation of these services for year 2 to 5 CDC plans.

CDC Phase 2 – Approved
Continuation Funding – Funding was approved for 12 months continuation of the CT and MRI service following submission of D1.April 2022-March 2023. Continuation of the above activity progresses through the next 12 months.

Phase 2 – Year 2

Phase 2 included the development of one fully functional endoscopy suite and Ultrasound facilities in addition to the continuation of the mobile imaging secured in phase 1 and training facilities and multifunctional clinic space.

It was a recommendation by the National team upon approval of the Phase2/Year2 BC for DBTH NHS FT to expedite the Business Case to implement permanent Static CT and MRI scanners and the expansion of physiological measurements within this financial year. (Phase 2b)

The way in which this development aligns with the recommendations of Sir Mike Richards's diagnostic review is outlined in the table below:

Modality	Aims	Delivery
CT & MRI	Capacity to be expanded over the next five years to meet increasing demand and changes due to national guidance.	Staffed mobile scanners will be replaced by a Static CT scanner and a Cardiac MRI scanner in a new building (Imaging Suite) with provision to move U/S out of the rotunda into the Imaging Suite on the MMH site.
Physiological Measurements	Capacity to be expanded over the next five years to meet increasing demand and changes due to national guidance.	Purchase of ECG and Echocardiography equipment providing additional capacity for the expansion of Physiological Measurements within the CDC.

Phase 2b business case preparation meetings have been taking place since July 2022 with key service leads and stakeholders including those in primary care.
It is planned to include the continuation of the staffed mobiles, which is to be funded through the D1 continuation process for both CT and MRI will continue at a similar activity level.

The costs in this case are for increasing the activity once the build is complete to 5 days per week and then 7 days per week the following year in a move to develop the in house capacity throughout the lifetime of the project in order to move to a longer-term sustainable model.

DBTH is an active partner in the Doncaster and Bassetlaw place and the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS). The Montagu CDC proposals fits strategically with excellent geographical access for Doncaster and Bassetlaw and neighbouring Barnsley and Rotherham. The development is situated close to areas of high deprivation and is therefore likely to support improved access and addressing local health inequalities.

The separation of planned and unplanned diagnostics is advocated by the Sir Mike Richard's recommendations to improve efficiency, increasing diagnostic capacity at Montagu Hospital supports this by increasing capacity for planned work at a covid light site.

The following CDC benefits and cross cutting aims set by the national Programme have been met in the business case for the ICs and National Team approval process.

CDC Benefits Case Primary & Cross cutting aims checklist			
Benefits Case Primary Aims		**Cross Cutting Aims**	
To improve population health outcomes	Yes	To improve staff satisfaction	Yes
To increase diagnostic capacity by investing in new facilities and equipment and training new staff	Yes	To make every contact count	Yes
To improve productivity & efficiency	Yes	To utilise CDCs as test sites for cutting edge research	Yes
To contribute to reducing health inequalities	Yes	To contribute to NHS net zero emissions	Yes
To deliver a better more personalised diagnostic experience	Yes	To act as anchor institutions	Yes
Support integration of care across primary, secondary & community care	Yes		

The South Yorkshire ICS Imaging network are fully supportive of this business case to secure permanent, NHS owned assets.

The SY Imaging Network is a local partnership of providers and other healthcare organisations delivering a joint programme of development and improvement across the ICS. With the expectations outlined in the recent Sir Mike Richards' review, and recognising actual trends over the past decade, it is expected that demand for Imaging will continue to grow in future years. To meet this growth the Imaging Network will need to ensure increased capacity is planned for - central to this will be increasing the capital assets available and increasing local training programmes to ensure the new equipment can be sustainably staffed.

The SY Imaging Network supports the CDC developments, recognising the sites provide an excellent opportunity to increase capacity for our patients. Initial baseline forecasting suggests the SYB network will need at least 3 additional MRI and 4 additional CT machines. In the longer term the network recommends permanent, NHS-owned assets, as the most appropriate way to increase capacity, with regards to both financial sustainability for the system and patient and staff experience and is committed to working collaboratively to develop sustainable plans in future.
Considering the patient requirements across SYB and the recommendations for fixed assets the Imaging Network supports the proposal outlined within the case for Doncaster place.

The need to increase diagnostic activity is a clear requirement of the recent planning guidance and securing the CT and MRI scanning provision could be a key component of this for DBTH.

Various options for the case were generated by the project teams and following this a set criterion scoring exercise was undertaken, involving relevant key stakeholders (listed below)

- Associate Director of Operations-DBTH
- Head of Capital Infrastructure-DBTH
- Head of Radiology – Clinical Specialities Division- DBTH
- Management Accountant & DoF Divisional Accountant- Finance & Healthcare Contracting Directorate- DBTH
- Procurement Head of Procurement – Finance & Healthcare Contracting Directorate-DBTH
- HR Services DRI People Business Partner- P&OD DBTH

The option recommended, includes all modalities listed in the table below:

Costs

Capital costs of £905k in 2022/23 and £13,704k in 2023/24 (see breakdown below).

Capital costs	**£m**
Building work	12.3
Medical Equipment	2.2
IT equipment / Other	0.1
Total capital costs (2022/23)	**14.6**

The table below provides a summary position of the I&E impact of this case for the first 10 years, from year six (2028/29) the revenue costs become recurrent at a cost of £2,269k, the below costs have been adjusted to include inflation.

	Year 0 2022/23	Year 1 2023/24	Year 2 2024/25	Year 3 2025/26	Year 4 2026/27	Year 5 2027/28	Year 6 2028/29	Year 7 2029/30	Year 8 2030/31	Year 9 2031/32
INCOME & EXPENDITURE										
Revenue Costs - Pay	0	-400	-1,816	-1,893	-1,519	-1,129	-1,067	-1,089	-1,112	-1,136
Revenue Costs - Non Pay	0	0	-461	-829	-842	-855	-868	-882	-895	-909
Depreciation / Impairment	0	-8,063	-296	-296	-296	-296	-296	-296	-296	-296
NHSEI/NHSD Revenue Funding	16	533	2,809	3,256	2,895	2,518	2,468	2,505	2,541	2,579
Net Operating Surplus / (Deficit)	16	-7,930	235	238	237	238	237	238	237	238
PDC Charges	-16	-133	-236	-237	-237	-238	-238	-238	-238	-238
Net Surplus / (Deficit)	0	-8,063	0	0	0	0	0	0	0	0
Add back Impairment		8,063								
Adjusted Net Surplus / Deficit	0	0	0	0	0	0	0	0	0	0

The business case is looking to secure £14.6m capital, £905k of this will utilise the SYB CDC Capital Allocation for 2022/23. The additional £13.7m capital be sourced from National CDC funds.

The capital costs include a contingency of £1.7m. This represents a total capital contingency of 11.6% to cover inflation, optimism bias and general contingency items.

CDC Phase 2b Development Timeline

Detailed design development (at risk)	Nov-Dec 22 (P+HS/CAD21
HLIP development, mini comp	Nov-Dec 22
Appointment of PSCP (novation of design team)	Jan 23
Business Case submission internally – (Note cost plan only and not GMP and no planning at this stage)	Nov 22
External approval	Dec 22 – March 23
Planning Jan-March 23	Jan-March 23
Market test packages	Jan-March 23
GMP	March 23
Validation/Stage 4 contract	April-May 23
Start on site	June 23
Completion of CDC CT/MRI Imaging Unit and Electrical Infrastructure – (assuming 7 months construction / stage 4 period)	Dec 23/Jan 24
Contractors float period	Jan 24
Commissioning including RPA	Feb-March 24
Operational	April 24

Timeline for each modality "going live" is as follows:

CT	April 2024
MRI	April 2024
Retford x-ray	July 2023
Physiological Measurements Diagnostics including Echocardiography and Spirometry	starting Q2/3 2023 and expanding beyond 2024

Recommendation

It is recommended that the members of F&P review and approve the case for onward submission to the ICS and national team

1 INTRODUCTION

Vision statement for Community Diagnostic Centres

Community Diagnostic Centres (CDCs) will deliver additional, digitally connected, diagnostic capacity in England, providing all patients with a coordinated set of diagnostic tests in the community, in as few visits as possible, enabling an accurate and fast diagnosis on a range of a clinical pathways.

All CDCs must contribute to the following primary aims:

Primary Aims	Cross Cutting Aims
To improve population health outcomes	To improve staff satisfaction
To increase diagnostic capacity by investing in new facilities and equipment and training new staff	To make every contact count
To improve productivity & efficiency	To utilise CDCs as test sites for cutting edge research
To contribute to reducing health inequalities	To contribute to NHS net zero emissions
To deliver a better more personalised diagnostic experience	To act as anchor institutions
Support integration of care across primary, secondary & community care	

Through the National CDC Programme there is an opportunity for us to consider how best to develop our community diagnostics in a way that meets our population needs and future diagnostic growth. There is a need to balance a pragmatic approach in year 1 with longer term planning for years 2-5 and the timescales for planning are challenging.

This business case builds on the Year 2 Montagu Community Diagnostic Centre (CDC) development, expanding the CDC by investing in a new build within the estate to include additional imaging in the form of Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) and Ultrasound facilities to build towards the Integrated Care Board (ICS) vision of a Large CDC in Montagu.

The Montagu CDC commenced in 2021/22 when funding for independent sector staffed CT and MRI mobiles was supported by the National CDC Team.

In early July 2022 a year 2 business case was supported by the National CDC Panel to expand the development at Montagu to include non-obstetric ultrasound and endoscopy. This case was supported by the National CDC panel on the condition that a business case for permanent static CT and MRI was expedited from year 3 (23/24) into year 2 (22/23). This is the expedited business case for static CT and MRI.

The CT and MRI new build put forward in this case will over time replace the independent sector staffed mobile CT and MRI. The plan is to manage a transition from the staffed IS mobiles to the NHS staffed permanent static CT and MRI during 2023/24.

2. STRATEGIC CASE

CONTEXT

The NHS must radically overhaul the way that MRI, CT and other diagnostic services are delivered, according to a major review commissioned by NHS England.

The Sir Mike Richard's Diagnostic Review published in October 2020 clearly set out the national case for change, increasing demand across all diagnostic modalities, insufficient capacity resulting in inability to meet diagnostic waiting times and an inability to support the delivery of the commitments in the NHS Long Term Plan. Significant workforce challenges across diagnostic modalities and most recently the impact of Covid 19 has further driven the need for change and demonstrated the importance of diagnostics.

Over the next five years the plan would see CDCs launched across the country, the imaging workforce expanded by 4,000 radiographers, a doubling of CT scanning capacity and a comprehensive equipment renewal programme.

The review identifies how the need for radical change has been further amplified by the Covid pandemic. New services will need to be implemented over time, requiring significant investment in facilities, equipment and workforce alongside replacing outdated testing machines. The CDCs will be part of a drive to separate services for patients with suspected Covid-19, and should include as a minimum CT, MRI, Ultrasound, and X-ray services

Recommendations include:

- Tests for emergency and elective diagnostics should be separate, to reduce hold-ups for Patients
- CT scanning capacity should be doubled over the next five years to meet increasing demand and to match other developed countries
- Tests for heart and lung diseases need to be enhanced given the link to coronavirus
- More staff need to be trained to undertake screening colonoscopies
- The imaging workforce needs to be expanded as soon as possible with 2,000 additional Radiologists and 4,000 radiographers as well as other support staff

In line with this national direction of travel is case also aligns with the needs of the NHS Long Term Plan with regards to the diagnostics required across the country. The NHS Long term plan sets out how the NHS will move to a new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting.

South Yorkshire & ICS Strategy

The challenges identified nationally are mirrored regionally and in South Yorkshire and Bassetlaw. The 6 weeks diagnostics waiting time standard is recovering albeit progress is slow and there are areas of challenge across the region including non-obstetric ultrasound and endoscopy.

Community Diagnostic Centres are well placed to support the delivery of the National Cancer Rapid Diagnostics Programme and the capacity created by the development of CDCs will contribute to the delivery of the Faster Diagnosis Standard (FDS) and the recovery of cancer services.

Given that there are areas of challenge and improving access to diagnostics is key to recovering elective activity and cancer pathways there is a strong local strategic case for change for the development of a Community Diagnostic Centre at Montagu Hospital.

Diagnostic demand is increasing with late presenters, bowel screening age extension, Faster Diagnosis 28-day Standards. Backlogs are becoming a challenge for some modalities and there are ongoing constraints due to Covid-19 and recovery from the pandemic.

Mexborough has a population of working age adults similar to the national average but has a higher percentage of residents from older age groups and the community continues to be predominantly White British.

Poverty and deprivation are significant challenges in Mexborough. Mexborough has a significantly different index of multiple deprivation (43.6) to England (21.7) and Doncaster (30.3). The trend continues as Mexborough has significantly higher levels of income deprivation (23.2%) compared to England (12.9%) and Doncaster (16.6%). Unemployment and long-term unemployment figures are higher than national rates amongst working-age adults. The impact of poverty is felt across the life course with significantly high numbers of children and older people living in poverty.

Households also struggle to heat their homes, thus, increasing the prevalence of fuel poverty. 32.1% of children are currently living in poverty in Mexborough and this is likely to be a significant contributing factor of poor child development and lower educational levels. It is vital to consider how poverty can be mitigated through actions that support the community and improve the health of its residents.

People in Mexborough have a lower life expectancy and live more years in poor health than the average person. There are also high levels of feeling low, self-harm and depression.

The proportion of people who report their health as bad or very bad or who have a long-term limiting illness is significantly higher than figures reported for Doncaster and England.

A large percentage of residents live with conditions related to smoking, which increases the risk of chronic obstructive pulmonary disease (COPD), lung cancer and emphysema.

There are significantly higher rates of emergency hospital admissions which suggests residents are struggling to self-manage their health conditions. There is a significantly higher proportion of older people living alone in the area than in England or Doncaster.

Alignment with DBTH Strategy

Partnership working for the benefit of the populations we serve clearly aligns with the current DBTH Strategic Direction 2017-2022 and developing future strategy. This case supports the identified strategic vision, which is shown below and Trust strategic objectives:

Trust Values

The Trust's vision is "To be the safest trust in England, outstanding in all that we do".
Our values: "We Care"

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

"As an Acute Teaching Hospital trust, and a leading partner in health and social care across South Yorkshire and Bassetlaw, we will work with our patients, partners and the public to maintain and improve the delivery of high-quality integrated care."

Strategic Objectives

Patients	***We will work with patients to continue to develop accessible, high quality and responsive services*** The proposal will increase diagnostic capacity to allow timely care for an increased number of patients in an appropriate environment.
People	***As a Teaching Hospital we are committed to continuously developing the skills, innovation, and leadership of our staff to provide high quality efficient and effective care*** This investment will enable DBTH and SY&B ICS to ensure the right pathways are in place with the right facilities, encouraging recruitment and retention of staff by improving their working environments.
Performance	***We will ensure our services are high performing developing and enhancing faster diagnostics at Montagu Hospital CDC, meeting Faster Diagnostic Standards, and leading to improved performance against other standards such as the 2 weeks wait target*** This case sets out the infrastructure and facilities required for expansion to meet increase in demand. Development of the CDC facility is required to ensure a match between demand and capacity so that care is in line with national standards, and the recovery and renewal report.
Partners	***We will increase community partnership working to benefit people and communities*** Model of care developed as part of the South Yorkshire & Bassetlaw ICS and with local commissioners.
Prevention	***We will support the development of enhanced community-based services, prevention, and self-care.***

	The proposal reduces clinical risk and increases diagnostic capacity and providing faster access and diagnosis.

The Trust's current strategy has been developed, with focus maintained on the delivery of high quality, patient centred services in the most appropriate setting with excellent clinical outcomes. This phase of the CDC development will enable DBTH to work towards the ambitions set out and evaluate the project to inform future phases of the development subject to further capital investment and funding required.

We have engaged with staff, external partners, patients, and other stakeholders to ensure that our revised strategic direction continues to fit with the changing needs of the wider health community we serve, while working in tandem with national and SY&B ICS directives.

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH)

DBTH is one of Yorkshire's leading acute trusts, serving a population of more than 420,000 across South Yorkshire, North Nottinghamshire and the surrounding areas.

Hosting three main hospital sites and a number of additional services, the Trust is one of only six Teaching Hospitals in the region. It was awarded teaching hospital status in 2017. A modern and forward-facing Trust employing over 6,500 members of staff, the hospital provides a full range of local hospital services across the following sites:

Doncaster Royal Infirmary (DRI)

DRI is a large acute hospital with over 500 beds, a 24-hour Emergency Department (ED), and trauma unit status. In addition to a full range of hospital care, it also provides some specialist services including vascular surgery. It has inpatient, day case and outpatient facilities.

Bassetlaw Hospital in Worksop (BH)

BH is an acute hospital with over 170 beds, a 24-hour ED and a full range of hospital services including a breast care unit and renal dialysis. It has inpatient, day case and outpatient facilities. The hospital is situated in the residential area of Kilton, about half a mile from Worksop Town Centre and it is close to A1, M1 and M18 motorways.

Montagu Hospital in Mexborough (MMH)

Montagu is a small non-acute hospital with over 50 inpatient beds for people who need further rehabilitation before they can be discharged. There is a nurse-led Urgent Treatment Centre, open 9am-9pm. It also has a day surgery unit, renal dialysis, a chronic pain management unit and a wide range of outpatient clinics. Montagu is the site of the Trust's Rehabilitation Centre, Clinical Stimulation Centre and the base for the Abdominal Aortic Aneurysm screening programme.

The Trust also provides outpatient and other health services at Retford Hospital, including clinical therapies and medical imaging.
The Trust provides a full range of acute clinical services. It also provides some community services (including family planning and audiology) and some specialist tertiary services including vascular surgery.

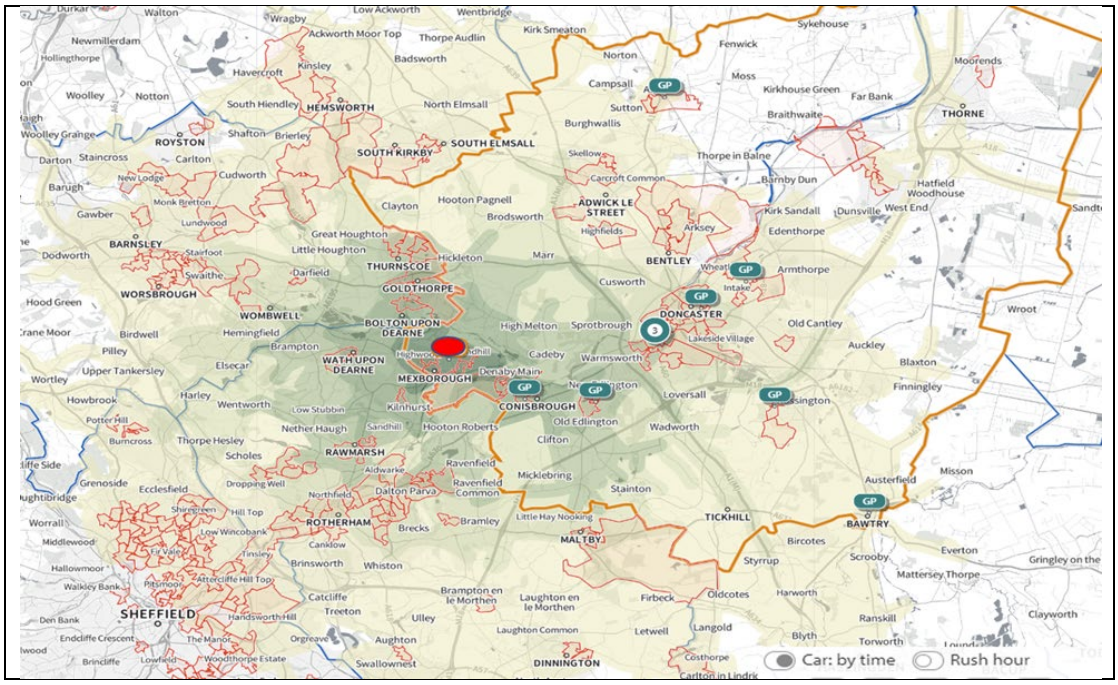
Estate has been assigned within an area of the Montagu Hospital, Mexborough for the purpose of the CDC

Choice of geographic location

Montagu Hospital is located in the Dearne Valley in South Yorkshire that is a relatively disadvantaged area from which patients have historically had to travel to one of the main hospital sites in Doncaster, Barnsley or Rotherham to access many diagnostic tests.

The development of a Community Diagnostic Centre at Montagu Hospital will help address health inequalities by-

- Improving access to diagnostic services for patients from relatively disadvantaged localities in the western and central part of Doncaster and the adjoining areas in Barnsley and Rotherham.
- Reduce the need for travel with fewer visits to get a faster diagnosis, the associated cost and inconvenience that can represent a barrier to access which can further exacerbate health inequalities.
- LSOAs that are in that are in the most 10% most deprived areas in the UK (highlighted red on the map)



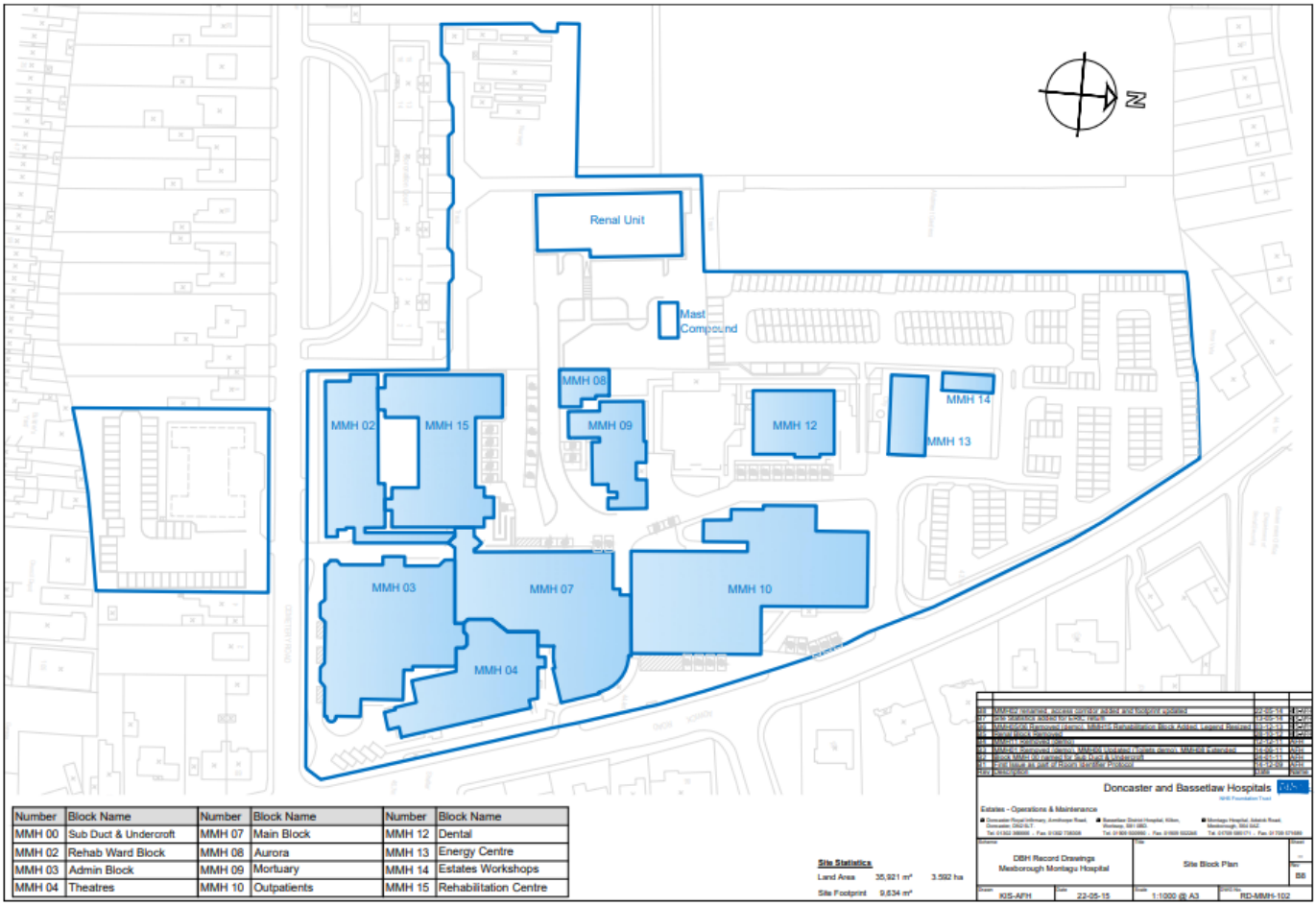
MMH is highlighted on the map with a red dot. This map shows the opportune location of MMH in relation to the SY&B ICS with easy access from Rotherham, Barnsley as well as Doncaster residents. It shows the 10 Practices with the slowest recovery of LGI/UGI 2WW referrals (the 3 is a cluster of 3 practices) within Doncaster CCG.

The travel by car to Montagu, there is good car access to the site, including onsite car parking. Discussions are underway to see if additional parking or an overflow could also be available in the area to enhance the current parking facilities.

Work is underway to understand public transport option for the wider ICS population and current Doncaster residents are able to access via train and bus from Doncaster stations. There is a free shuttle bus service which runs between MMH and DRI. This free service runs directly between the two sites and takes approximately 30 minutes. The shuttle operates from Monday to Friday inclusive except Bank Holidays.

Site ownership

The Business Case is concerned with capital changes at the MMH site and the land in the ownership of DBTH at MMH is as indicated below. There are no land transactions required for this scheme.



Number	Block Name	Number	Block Name	Number	Block Name
MMH 00	Sub Duct & Undercroft	MMH 07	Main Block	MMH 12	Dental
MMH 02	Rehab Ward Block	MMH 08	Aurora	MMH 13	Energy Centre
MMH 03	Admin Block	MMH 09	Mortuary	MMH 14	Estates Workshops
MMH 04	Theatres	MMH 10	Outpatients	MMH 15	Rehabilitation Centre

3. CASE FOR CHANGE

Community Diagnostic Centres (CDCs) offer checks, scans and tests, in community and other health care settings, scaling up since July 2021. Nationally CDCs collectively delivered over 880,000 diagnostic tests in 2021/22, which represents a full year effect of 1.7m.

£2.3bn capital funding is being invested in the roll out of CDCs and digital diagnostics, with targeted funding for imaging and endoscopy in acute trusts, plus lung and breast screening.

The funding for diagnostics transformation is projected to deliver 17 million more diagnostic tests over the next three years and will increase our annual capacity by 9 million tests by March 2025 - a 38% increase in the number of scans the NHS can deliver every year.

The expansion of CDCs will mean that the NHS is projected to have 37.9% more MRI capacity, 44.7% more CT capacity, 26.8% ultrasound, 23.1% echocardiography and 18.7% endoscopy capacity by March 2025 compared to pre-pandemic levels.

This funding is modelled to provide an additional 200 MRIs, just under 300 CTs and around 160 endoscopy rooms which will be added through the CDC programme.
Systems have been able to access dedicated revenue funding to support the set up and running of CDCs since 2021/22 and will continue to do so in 2022/23, 2023/24 and 2024/25.

SYB System Approach & Support for the Montagu Hospital CDC

As a system the South Yorkshire and Bassetlaw Integrated Care System is working in collaboration with each of the five places to develop plans for Community Diagnostic Centres.

The aim is to develop a network of Community Diagnostic Centres that is aligned to the developing Networks for Imaging, Pathology and Endoscopy to increase diagnostic capacity across the system in a way that meets future diagnostic demand, is locally sensitive to support the resolution of diagnostic challenges to aid recovery and improves equity of access to diagnostics, to contribute to improved health outcomes and reducing health inequalities.

Montagu Hospital is-

- Separate to emergency diagnostic facilities, located away from an acute site where diagnostic tests can be done on a site that already provides outpatients, day case, a minor injuries unit and inpatient rehabilitation unit, with the ability to provide a separate entrance to a CDC facility.
- Configurable to meet specifications of the required diagnostic services as per the CDC requirements
- Able to provide sufficient capacity to manage infection and ensure a covid-19 minimum environment
- Located in a relatively disadvantaged area in west Doncaster and the adjoining areas in Barnsley and Rotherham, and as such will increase access to diagnostics for a number of disadvantaged communities.
- Is serviced by public transport and there are also well-established transport links between Doncaster Royal Infirmary and Montagu Hospital that could be further built upon with potential to expand pending feedback from patient engagement activities.
- Has sufficient parking facilities for patients, carers, and staff
- Able to facilitate the activities needed by a CDC e.g. transport for histopathology
- Can be further enabled with network connectivity building on the existing IT infrastructure
- Has the potential to be accessible for extended hours
- There is potential to contribute to CDC cross cutting themes, including supporting DBTH as an anchor institute
- Ideally situated to support the equality agenda by planning for the facilities to accommodate reasonable adjustments
- Configured to meet health and safety and accessibility guidance

It is possible to initiate development to maximise elective recovery and enable transformation of diagnostics services, separating planned and unplanned diagnostics, with the ability to expand subject to the provision of revenue funding to support expansion.

The development of a Community Diagnostic Centre at Montagu Hospital is part of this system wide approach and is fully supported by the SYB Integrated Care System, all partner organisations, and the ICS Accountable Officer, and included Gastro Hosted Network, Provider Alliance and Cancer Alliance and Commissioners.

Doncaster Population

Doncaster's population has grown to 312,785 in 2022. . Over the next 10 years the number of people aged over 65 in Doncaster will be more than people aged under 18.

The health of people in Doncaster is generally worse than the England average. This has recently been highlighted in SY&B ICS news especially post pandemic. Whilst there have been improvements in health including increasing healthy life expectancy and reduced rates of teenage pregnancy too many people still experience poor health with too many people dying prematurely (i.e. before the age of 75) from preventable conditions. Doncaster was ranked 124 out of 150 for premature deaths overall in 2021.

This is reflected by lower life expectancy for both men and women than the England average by 2 years for men and 1.6 years for women.

There are also stark differences within Doncaster as life expectancy varies depending on where people live: 10.7 years lower for men and 7.1 years lower for women.
Health, however, is created by more than health services. The places people live, their education, housing, work, exposure to crime and their environments all contribute to creating health and wellbeing. Doncaster is one of the 20% most deprived districts/unitary authorities in England and about 24% (13,300) of children live in low-income families and this has a significant impact on health.

Risk factors and disease in Doncaster

Behaviours	
In general, Doncaster has less healthy lifestyles than the rest of the country. This is true for children as well as adults:	**22.7% of people over 16 are smokers**
	74.4% of adults are overweight or obese
	33.6% are physically inactive
	Doncaster is ranked 120/152 areas for Alcohol-Related Hospital Admissions
Diseases	
Diseases such as cancer, cardiovascular disease, liver disease and respiratory diseases account for between 80-90% of all preventable deaths, although local work to increase awareness of cancer symptoms, early identification and treatment over the past 2 years have resulted in some improvement	**2.2% of people are living with a diagnosis of cancer**
	3.8% of people are living with a diagnosis of Coronary Heart Disease
	2.6 of people are living with a diagnosis of COPD
	7.7% of adults are living with a diagnosis of diabetes
Older people	
There are increasing numbers of older people in the Borough, many live alone and require help and support to maintain their independence. The more the population grows and ages the more people will develop dementia.	

Source: Doncaster Place Plan refresh 2019-22

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A large percentage of residents live with conditions related to smoking, which increases the risk of chronic obstructive pulmonary disease (COPD), lung cancer and emphysema.

There are significantly higher rates of emergency hospital admissions which suggests residents are struggling to self-manage their health conditions. There is a significantly higher proportion of older people living alone in the area than in England or Doncaster.

Doncaster Place Plan

Key leaders from across health and social care in Doncaster have come together to articulate a shared vision and to develop a plan for the whole of Doncaster. The Place Plan describes the joint focus over the next five years to 2021, building upon the existing body of work and plans already in place.

Care and support will be tailored to community strengths to help Doncaster residents maximise their independence, health, and wellbeing. Doncaster residents will have access to excellent community and hospital-based services when needed. The Plan has been developed across the three areas below:

Prevention and Early Help: This is focused on developing community assets and resilience, bringing together our response to the wider determinants of health and social care. It recognises the prevention step needed before all others, but also extends to early help and intervention to support children and families.

Integrated Intermediate Health and Social Care: Support independence in people's own homes, test and push forward integration commissioning and provision, and avoid hospital admissions.
Enablement and Recovery Services: This is focused on shifting services out of hospital and into the community where appropriate care is delivered closer to home through redesigned services. The CDC aligns with this plan in bringing diagnostic services closer to the community of Mexborough.

Doncaster Place Commissioning Plans

In addition to the priorities identified in the place plan, one of the main priorities identified by the CCG in Doncaster is Cancer prevention and diagnosis, also Community Care and Primary Care were identified as some of the main areas requiring support.

DBTH is a leading experienced acute provider in South Yorkshire and Bassetlaw with great accessible sites for the South Yorkshire region.

Montagu Hospital is a non-acute site with excellent accessibility across the SYB ICS for future development opportunities to be addressed. The region is also seeing demand increases and backlog recovery required from COVID19

Spending objectives

GENERIC DRIVERS FOR INTERVENTION AND SPEND	SMART OBJECTIVES	STRATEGIC FIT
EFFECTIVENESS	To improve the quality of services by delivering better patient/corporate outcomes/safety/experience	To meet new policies and operational targets
EFFICIENCY	To improve the delivery of patient/corporate services through better use of inputs and outputs	Supply side capacity and capability
ECONOMICAL	To reduce the costs of patient/corporate services	Optimisation of cost and benefits Affordability Achievability
COMPLIANCE AND CONFORMANCE	To meet legal, regulatory or organisational requirements	Accepted best-practice
REPLACEMENT	To re-procure services or equipment to avert service failure and provide business continuity	Business continuity and resilience – long term benefits and risks

In the context of the above and the Trust Strategic Objectives, the investment objectives for this project are detailed below, alongside the deliverables and targeted outcomes. It is important to note that the agreement of the following benefits has been via the steering group and wider stakeholder involvement.

Investment objectives	Key deliverables	Targeted outcomes
Tests for emergency and elective diagnostics will be separate	Increase capacity of diagnostics Review pathways and reduce any waste	Reducing waits for patients
Imaging workforce expansion	Interim measures - Locum - Existing staff - Manned units Long term sustainable measures - Expansion of roles - Invest in our own staff - Recruitment drives - Progression pathways Reduce sickness/absence	Reduce costs of temporary locum staff and invest in training our own staff and recruitment drives to encourage people to work at DBTH NHS FT – local events and university open days Lean working
Shorter hospital stays through tests undertaken on day of request	Free up beds – cost implications Staff Site activity Acute/ emergency procedures	Reduce the impact on Acute sites and hospital admissions, sites closer to residents of Mexborough
Better linkages with primary care	Networking with Primary care – prevention and Health inequalities SY&B ICS evaluation and working together – best practice	Avoidance of acute hospital use – enable recovery from COVID 19 with establishment of Diagnostic services throughout the Doncaster area
Areas of deprivation considered when establishing the location for CDC	Everyone counts – inclusivity Reach out to deprived areas Raise awareness	Reduction of Health Inequalities Preventative Care
To improve quality of services and better patient care	Patient feedback /involvement Spend on services and training of staff to deliver outstanding care	Improved access to services within the region better alliances within ICS
Meet the demand of Diagnostics	Capacity and Demand – analytics Business review Targets	Locally meet the demands for Diagnostic procedures in the area improving Health and helping residents to live longer
Rapid diagnostic Services and Faster Diagnosis Standards	Align with these standards and	Meet the standards
Trust Strategy	Investment for sustainable future of the Trust and the wider NHS	Alignment with the trust strategy for being outstanding in all that we do

Business needs

Work already undertaken by the division and Four Eyes Consultants has highlighted that there is known to be a significant shortfall and gap in the number of appointment slots required to meet the various level of demands and priorities for Radiology and associated interventions e.g., biopsies. As outlined previously, there is also insufficient workforce currently to meet the business needs. Further modelling work with Consultants IST which has now been completed informs us for future plans and investment required to meet the business needs.

A CDC at Montagu Hospital will support a broad range of clinical pathways, as advocated in the CDC Guidance including cancer pathways, musculoskeletal pathways, and potentially cardiovascular and respiratory pathways

In South Yorkshire and Bassetlaw (SYB), our hospitals have been working together for a number of years to improve clinical standards and care outcomes for patients, and also make their organisations great places to work.

Existing arrangements

The department undertook a large project in 2021 to review the demand and capacity it currently has in place for the DM01 modality areas using the NHS E/I tool. This has been rolled into business as usual and is refreshed at least twice a year. This is also feeding into the wider ICB project again looking at the regional demand and capacity available to these modality areas. This piece of work once completed will allow a more informed decision of what the regional response to imaging is.

In addition to demand capacity the department constantly reviews referral rates for both acute and elective referrals at a speciality level which is in the process of being developed into a dashboard.

The department also used the model hospital data to review and bench mark the service against others both locally and nationally although there are limitations to the information.

There has been some room utilisation undertaken in MRI which has highlighted where efficiency can be improved in order to reduce waste within the service. Within the MRI service there has been a review of scanning protocols to bring the scan time in line with Sheffield Teaching Hospitals again driving efficiency by speeding up through put.

Medical Imaging is delivered across 6 sites at DBTH providing a 24/7 service on Bassetlaw and Doncaster sites, it has a total head count of 267 staff.

In 2019/20 it undertook 444,422 examinations, of which 71,539 were CT scans across 2 scanners.

GIRFT highlighted that as a Trust- Medical Imaging undertake a higher proportion of examinations per 100 admissions (with exception of MRI) and higher percentage of A&E and outpatient referrals to Medical Imaging. This was again reported in the A&E GIRFT feedback 2021 -higher percentage of imaging per G&A bed when compared to the national referring trends (data from 2017/18).

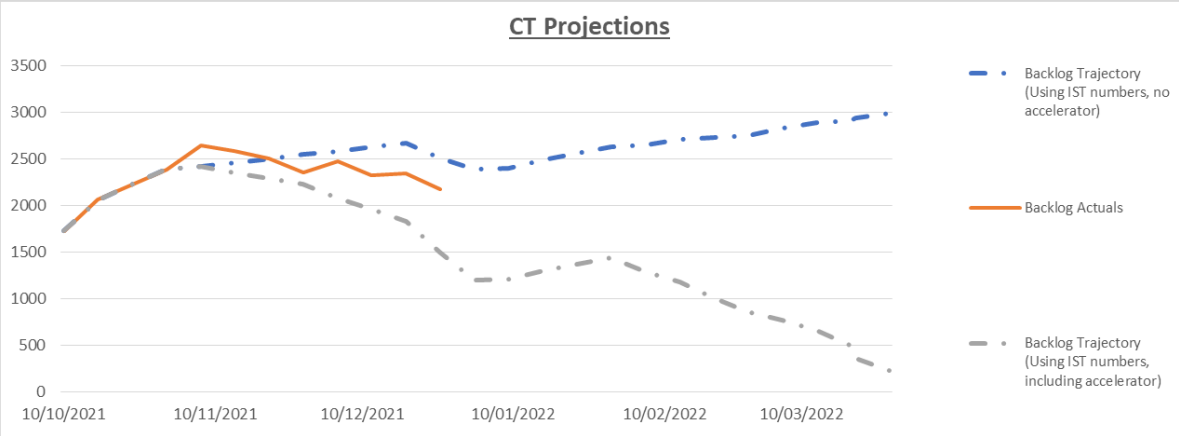
There has been use of a Mobile CT scanner (3 days a month) finished March 2020.

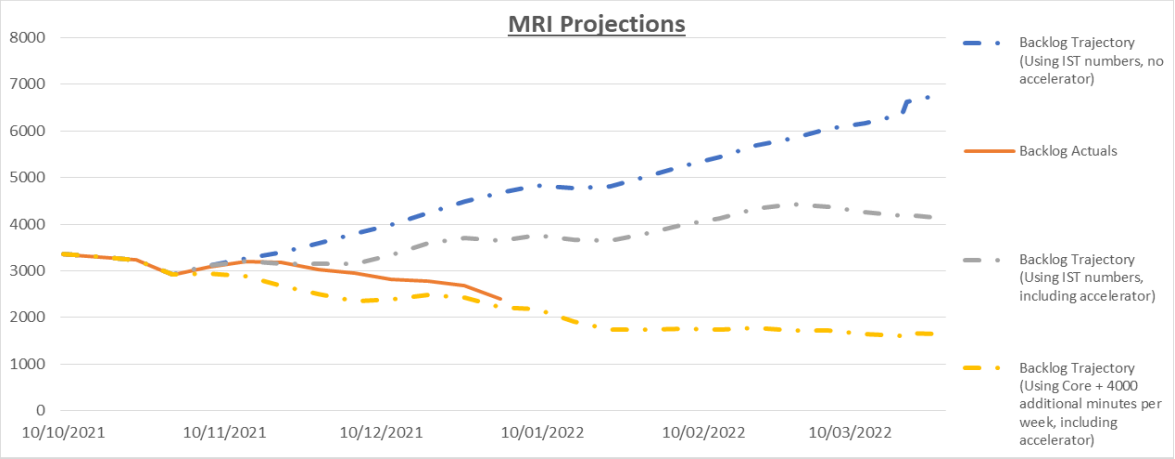
A second scanner was provided at DRI site and staffed (Monday to Friday 9 am to 5 pm) from March 2020, funded 1.8 WTE.

CT - An NHSE/I pod was on site from July 2021 to September 2021 further funding was allocated in October 2021 for manned CT unit to be used and clear backlogs November – December 2021.

Phase 2 of the CDC allowed continuation of the CT and MRI scanners on the MMH site with funding approved for 12 months March 2022 – April 2023. This activity when completed will have completed 3204 CT and 2004 MRI Scans with the service operating 2 days per week.

DBTH – Trajectories Diagnostic Scanning CT & MRI





The department accepts referrals from inpatient and outpatient and currently there is extensive access for primary care. The department is currently in the process of implementing the BMUS guidelines with support from both CCGs as a way of gate keeping inappropriate examination referrals directly into the medical imaging department. This commenced in December 2021 with the removal of direct access for primary care to shoulder ultrasounds with an appropriate MSK CATS pathway put in place for primary care and the patient to follow.

Potential Scope and Services

As detailed previously the approved CDC Phase 2 plans for Montagu Hospital CDC have continued the use of mobile CT and MRI, It was a recommendation by the National team upon approval of the Phase2/Year2 BC for DBTH NHS FT to expedite the Business Case to implement permanent Static CT and MRI scanners and the expansion of physiological measurements within this financial year. This case also includes Retford Hospital Xray Equipment upgrade and additional activity as spoke and training facilities

Radiology - Increasing diagnostic capacity and the effect on the ICS

Retford X-ray

The general x-ray service at Retford has not been provided for a number of years due to the equipment quality and limited staff resources. By having one radiographer and the degree apprentices based there it will enable high quality training at a steady pace.

This benefits of a bid for Upgrade of Retford X-ray equipment via the CDC funding are

- Training for the degree apprentices, students and new recruits
- Additional long term capacity to increase training using the CDC equipment, allowing the system to increase staffing numbers
- For the local community of Retford as it improves accessibility to general x-ray for them and expands the CDC by creating a spoke to the service.
- Separates xray provision from the Acute site at Bassetlaw and Doncaster hospitals
- Support of the system-wide strategic approach to capacity and demand management for the Imaging Network
- The future spoke to the CDC can offer a different type of working environment, creating an alternative to acute work, which improves the health and well-being of staff and may improve recruitment and retention

The Xray facility at Retford would be open from 8.30am-5pm, 5 days per week initially however there is scope to expand this as the spoke develops in future phases.

CT & MRI

Work completed by the ICS in the CT/MR capacity paper identified the need for seven additional scanners (4 CT and 3 MRI) across the SYB region in the next five years. Placing an additional CT and MRI scanner at Montagu CDC will support this need and contribute to closing this anticipated capacity gap

The benefits of an increased bid for CT and MRI equipment via the CDC funding are:

- Offsetting future revenue cost pressures of mobile and outsourced solutions, static permanent CT and MRI will be better value for money for the NHS
- Additional long-term capacity to increase training using the CDC equipment, allowing the system to increase staffing numbers
- Reduced impact of cancellation and delays to outpatient CT and MRI appointments. Currently most outpatient diagnostics is delivered on acute sites and lists must be balanced between the demands of inpatient, emergency, and outpatient diagnostics. Increased static CT and MRI capacity would enable us to separate planned and unplanned diagnostics and mitigate the risks associated with balancing these.
- Most of the CT and MRI outpatient activity can safely be delivered away from acute sites

- Support of the system-wide strategic approach to capacity and demand management for the Imaging Network
- The Montagu CDC can offer a different type of working environment, creating an alternative to acute work, which improves the health and well-being of staff and may improve recruitment and retention

The introduction of a training facility at the CDC will offer an opportunity for all organisations across the SYB network to develop staff to support imaging across the region and future developments of a reporting academy for both radiographers and radiology registrars.
The overall ambition would be to have the CT and MRI service running Monday – Sunday 8 am until 8 pm through this facility to provide scanning on each modality for 11.5 hours each day.

Within the first year of opening the imaging growth would move from the current 2 days a week scanning to 5 days a week imaging, a move from 23 hours to 57.5 hours a week.
In year two that would increase to scanning 80.5 hours a week (Monday to Sunday 8 am until 8pm).

	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
						BUILD COMPLETE													onwards
CT	2days/mobile CT						5days/per week -static CT											7days/per week	
	241	241	241	241	241	241	602	602	602	602	602	602	602	602	602	602	602	602	843
						BUILD COMPLETE													
MRI	2 days/mobile MRI						5days/per week-Static MRI											7days/per week	
	161	161	161	161	161	161	402	402	402	402	402	402	402	402	402	402	402	402	563
XRAY	5 days/general xray																		
	600	600	600	600	600	600	600	600	600	600	600	600	600	600	600	600	600	600	600

CT	yr1	57.5 hours of scanning a week or 172 patients	MRI	yr1	57.5 hours of scanning a week or 115 patients	Xray	yr 1	July 23-March 24
		X42 WEEKS /12MONTHS			x42weeks/12months			
	yr2	80.5 hours of scanning a week 241 patients		yr2	80.5 hours of scanning a week 161 patients		yr 2	Apr 24-Mar 25
		X42 WEEKS /12MONTHS			x42weeks/12months			

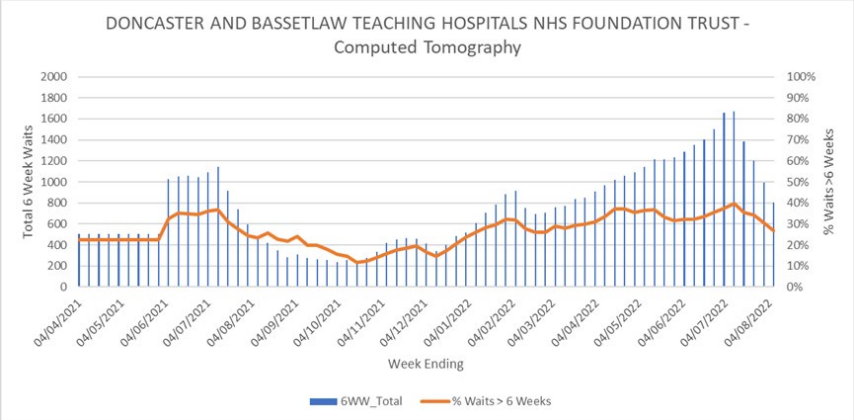
CT activity increase

We currently scan for 23 hours each week on the Montagu CDC site, approximately 69 patients a week depending on complexity, number of body parts to be imaged and the need for contrast.

This would increase to 57.5 hours of scanning a week or 172 patients, once the fixed asset is in place.

As we increase the opening hours in the second year this would increase further to 80.5 hours of scanning a week 241 patients, again these numbers are dependent on patient scan complexity.

The graph below shows the current 6 week wait for Elective CT at DBTH



South Yorkshire ICS Capacity & Demand Review 2022
Waiting lists – 6 week wait DBTH

Contrast studies will be undertaken at the Montagu CDC in line with the "Community Diagnostic Centres Imaging Contrast Reactions, Resus and Medical Emergency Support Checklist" document with a written departmental protocol to support practice, linked into the current CDC protocol for management of the unwell patient in an outpatient setting. Staff at Montagu already received anaphylaxis training and training needs will be assessed in conjunction with the Resuscitation Team at DBTH NHS FT to ensure staff are appropriately trained for the CDC. This will be undertaken prior to launch to facilitate immediate bookings of contrast studies at launch date in July 2023.

The below tables display future capacity gaps in both elective and emergency in-hours CT modelling, without future investment DBTH will be 88 per week short of CT capacity

<u>System wide elective capacity to 2026</u>

SY ICS Elective
Capacity Status (hours per week)

Site	2022	2023	2024	2025	2026
Barn Elec	-0	-3	-6	-9	-13
Barn Colon	+6	+6	+6	+6	+6
Barn Card	+1	+1	+1	+0	+0
DABL Elec	-7	-14	-21	-29	-38
Roth Elec	-8	-12	-17	-21	-26
Roth Card	-1	-2	-2	-2	-3
Shef Chd Elec	+9	+8	+7	+6	+6
Shef Tch Elec	-27	-37	-48	-59	-72
Shef Tch CTC	+0	-0	-1	-1	-2
Shef Tch Card	-1	-1	-2	-3	-3
Total capacity status	-28	-54	-82	-112	-144

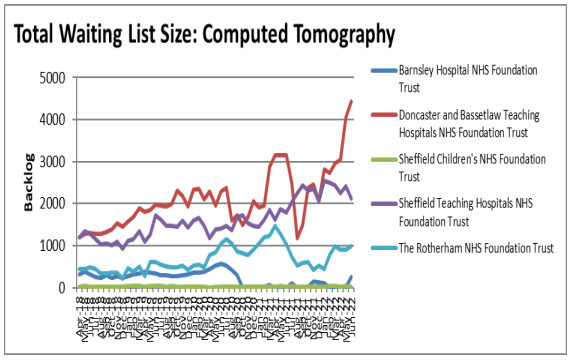
*DABL should read DBTH

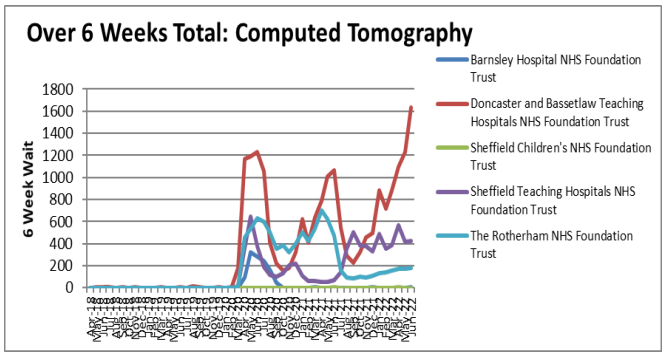
<u>System wide emergency capacity to 2026</u>

SY ICS EM In Hours
Capacity Status (hours per week)

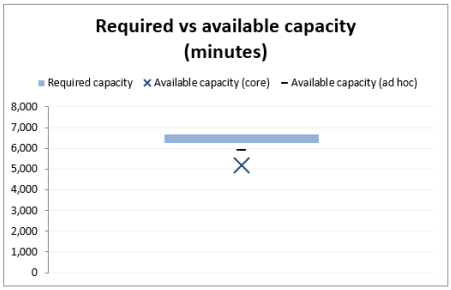
Site	2022	2023	2024	2025	2026
Barn EM IH	+9	+5	+2	-2	-6
Dcst EM IH	-23	-29	-36	-43	-50
Bstl EM IH	+2	+0	-2	-4	-6
Roth EM IH	+13	+9	+5	+0	-5
Shef Chd EM IH	-2	-2	-3	-4	-5
Shef NGH EM IH	+5	-3	-13	-23	-33
Shef RHH EM IH	-15	-20	-25	-30	-36
Total capacity status	**-10**	**-39**	**-71**	**-106**	**-142**

The below graphs identify the continued demand on CT services at DBTH, with backlogs continuing to remain high despite continued high levels of activity – this is indicative of current CT capacity being at saturation point.





Through detailed capacity and demand work, complete with support from NHS E IST, it was identified that to meet the current demand for Elective CT, DBTH are **18 hours** per week short of available capacity. In addition to this, DBTH have a waiting list sixe of circa 52,000 minutes, with a sustainable waiting list size calculated at circa 12,000 minutes.

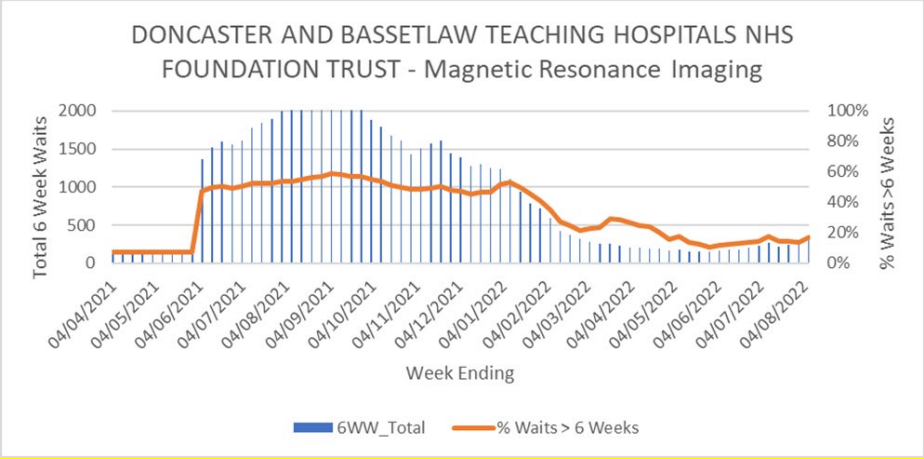


MRI activity increase

We currently scan for 23 hours each week on the Montagu CDC site, approximately 46 patients a week depending on complexity, number of body parts to be imaged and the need for contrast.

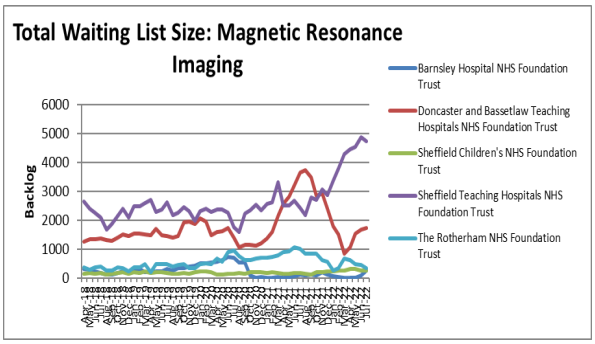
This would increase to 57.5 hours of scanning a week or 115 patients, once the fixed asset is in place

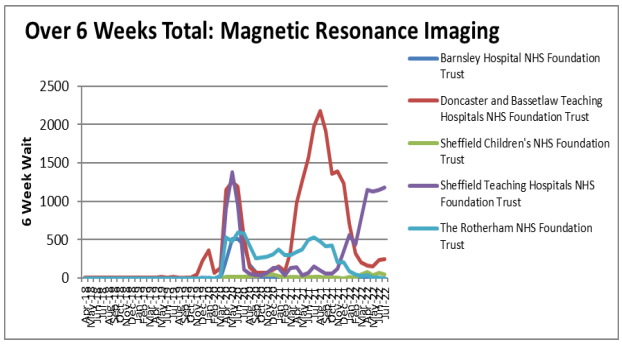
As we increase the opening hours in the second year this would increase further to 80.5 hours of scanning a week 161 patients,again these numbers are dependent on patient scan complexity.



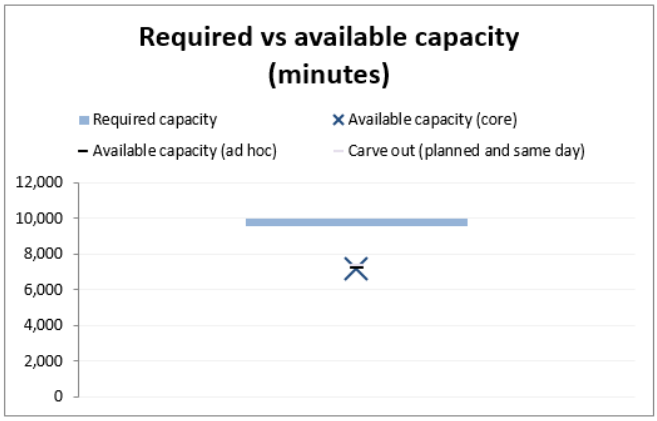
South Yorkshire ICS Capacity & Demand Review 2022
Waiting lists – 6-week wait DBTH

The additional activity will be increased to provide capacity both locally and regionally, to support the delivery of cancer pathways and surges in in patient work during peak periods e.g., winter pressures and covid demands.





Following completion of DBTH C&D modelling, supported by the IST, it was identified that DBTH are currently short of **39.8 hours** of elective MR scanning time per week. Total Capacity needed to meet 65th Percentile of demand and clear backlog in 1 year = **3,155 mins** or **52.6 hours per week.** This equates to **40.7% more** capacity based on current core capacity.



MRI - Cardiac Imaging & Echo-Cardiography

Currently DBTH doesn't offer cardiac MRI and the only centre that does in South Yorkshire is the Northern General Hospital, Sheffield. This means that patients outside the Sheffield area have limited and if required have to have long inpatient stays, sometimes expensive and inconvenient commutes. The delays can lead to missed/delayed diagnosis and treatments and poor outcomes for our patients. The current situation is leading to health inequalities in the region in patients with cardiovascular disease.

Cardiac MRI is the gold standard test to assess LV function and is the best test for tissue characterisation of the myocardium and cardiac masses. It is used to diagnose a wide range of heart conditions including coronary heart disease, valve disease, and cardiac tumours and is essential to look for the aetiology of a cardiomyopathy. It can guide revascularisation and the need for device therapy.

There is strong evidence and current guidelines suggest that cardiac MRI is the best test for diagnosing conditions where other tests have been ambiguous such as myocardial infarction with non-obstructive coronary arteries. It is also frequently needed in patients presenting with ventricular arrhythmias including cardiac arrest. This helps inform the cause of the arrhythmia and the need for defibrillator implantation.

Locally this forms part of the ventricular arrhythmia pathway where patients are transferred to the Northern General Hospital Sheffield for their cardiac MR. They are returned to their local DGH pending a decision regarding treatment and device therapy. This process may take weeks. Patients can wait around 14 days for an inpatient cardiac MRI which carries a degree of risk, has caused distress for the patients and caused a problem with patient flow. This is on top of the cost of the bed days.

If cardiac MRI could be offered locally then it would solve these issues and lead to better patient care and reduce some of the health inequalities in the region.

Currently at DBTH ETT is often used in the diagnosis of IHD in patients with new onset chest pain. ETT is an excellent test in certain situations but due to some issues with the test there is a move away from this in current guidelines.
Guidelines suggest moving towards cardiac CT or functional imaging with stress echocardiography, MPS or cardiac MRI. DBTH does not offer stress echocardiography and there is a large demand on the CT and MPS service that is struggling to cope resulting in unacceptable long waiting times.

Cardiac MRI can help relieve the burden on these other services and evidence suggests with better diagnostic and prognostic accuracy. CMR could be a one stop shop to assess structure, function, ischaemia and viability.

The use of cardiac MRI is increasing in 2019/20, 236 cardiac MRIs were requested in 2021/22, 410 scans were requested and its use is likely to grow in the future.
Studies suggested that in 2018, by head of population, 1,776 cardiac MRI scans performed per million people, with significant variation nationally. For example, 4,256 per million in London vs. 396 per million in Wales. It is thought that now the average there will be around 2000 scans performed per million.

Currently the Northern General scans approximately 2000 scans per year but only a fraction of these scans are stress perfusion scans to look for ischaemia. The maximum capacity they have for this test currently is 4 per week and this is not enough for the region.

We have previously been informed by the STH that we cannot request stress perfusion cardiac MRIs on patients from other District Hospitals due to capacity which means only patients in the Sheffield area have access to this important and very useful test in South Yorkshire. This is inequitable on our patient population.

The waiting time for a cardiac MRI to be performed as an outpatient at NGH is often over 3 months which is unacceptable in some cases. In cases of MINOCA or where there is diagnostic uncertainty because we do not offer an inpatient cardiac MRI service the patients are discharged with an outpatient cardiac MRI scan. Unfortunately the diagnostic yield for conditions such as myocarditis which is often in the differential falls significantly after 14 days which again means we end up providing suboptimal care to some patients.

DBTH offering a cardiac MRI service we would improve patient care, relieve stress on other services, and be able to reduce waiting times in the region by offering the service to other regions that have limited access such as Rotherham, Barnsley and Sheffield. Streamline pathways such as the VA pathway and make DBTH a more attractive proposition for implanting complex devices. Offering an inpatient service is likely to significantly reduce patient bed days. The service would also generate revenue for the Trust.

There is scope to enable provision of this service at the Montagu CDC. The Trust already employs a consultant cardiologist that is EACVI level 3 accredited who can run a service and provide training in the centre. As well as access to the scanner to assist and run an efficient service they would ideally need 1 or 2 cardiac MRI trained radiographers and an additional CMR trained radiologist or cardiologist and a radiologist to report extra cardiac findings. There may be interest from Cardiologists in the region that are CMR trained such as in Chesterfield and Barnsley that may be interested in supporting this service and collaborating on a 2nd regional cardiac MRI centre. An Adequate software package to analyse the images would also be required.

ECG
The demand for ECG is expected be increased until formal pathways are embedded for the CDC. This will help to support the single patient journey and facilitate the best patient experience.
Following discussions with clinical networks it is expected that there will be an increase in activity, with volumes unknown at this time.

Impacted areas, requirements, and issues

Impacted areas	External Requirements	Patient-related issues	Internal Requirements
Workforce	Agency staff /NHSP – temporary basis – long term plan to be developed.	N/A	Development of future workforce Training & Development

	Potential for overseas recruitment and local SY&B ICS recruitment drives. Outsourced reporting of imaging		
Estates & Facilities -	Contracted work – architects – plans building	N/A	Capital Project and Programme Management provided from existing DBTH infrastructure
Information Management & Technology (IM&T) -	Contracted work – engineers – hardware/software Equipment Out of Hours IT support	Privacy Impact Assessment	Information security
External stakeholders	Steering groups Working groups Planning & Implementation meetings	N/A	Sharing information – timelines/milestones Effective communication & engagement of modalities
Reputation of the organisation	Positive impact – communication Negative impact- Perceptions of stakeholders and public - engagement events local population involvement Gastro Hosted Network/CCG Support and ICS collaboration	Local engagement events – local newspaper	Communications & Engagement - BUZZ HIVE – Internal updates Promotion – launches/press releases

Workforce (WTEs and costs)

Health Education England continues to take action to ensure that the NHS has the cancer workforce it needs.

This includes investing £52 million in 2021/22 in the cancer and diagnostics workforce, through delivering additional medical places and providing grants to train clinical endoscopists, reporting radiographers, clinical nurse specialists and chemotherapy nurses, as well as developing an advanced clinical practitioner role in oncology and extending cancer support worker training.

In 2016 – 2021, the annual growth rate of the overall cancer workforce in priority specialisms has remained between 3-4%.

The Trust's Workforce Plan 2019-2021 demonstrates how the Trust is addressing its current workforce gaps and how in the longer term the workforce will need to adapt and change in line with the Trust's strategic direction. The Workforce Strategy priorities are:

- Retain the workforce, making DBTH the employer of choice.

- Develop existing talent into new and existing roles.
- Attract new workers, from current and future generations of working adults, into priority health, care and support careers.
- Introduce a robust approach to workforce planning.

To assess whether the Strategy is making a difference, the Trust will monitor progress against its key performance indicators for:

- Vacancy rates (target of 5%)
- Bank and agency spend
- Turnover (target 10%) and retention rates (target 90%)
- Sickness rates (target 3.5%) and staff engagement (target 4.00)

All aspects of workforce planning have been actively considered with the clinical teams and the ICS Workforce Hub to develop a phased workforce plan for the Imaging Suite at Montagu. This has included consideration of supply, the potential to upskill the existing workforce, develop new ways of working, introduce new roles, and secure the right leadership arrangements.

CDC Workforce model

The workforce model for the additional modalities has been developed in conjunction with the Imaging Network, the ICS and the Health Care Scientist Lead for SYB considering all aspects of workforce planning, supply, potential opportunities for new roles, upskilling, new ways of working and leadership.

There is a strong commitment to ensure development staff at all levels of practice from Assistant Practitioner to Advanced Practitioner to support all aspects of the service and to mirror the SYB ICS workforce model for effective future service delivery.

Opportunities are being pursued to create a Band 3 apprenticeship level which would support staff from entry level Band 2 through to registered professional, establishing a clear career pathway for the population of Doncaster, Mexborough and the SYB region within the NHS.

The workforce model for Year 1 allowed extended hours for the booking and admin staff and the use of staffed mobile vans for CT and MRI including evening and weekend provision to allow access to healthcare for all.
In Year 2 this continued however future discussions have been linked into the development of a sustainable workforce to support the delivery of other key services across SYB with extension to support CT, MRI and cardiorespiratory physiological studies. These services will initially run for 37.5 hours a week extending over the remaining three years to provide a comprehensive 7-day service, in line with the development of the medical and non-medical workforce.

The Montagu CDC provides an opportunity to train staff via apprenticeships in a non-acute setting. This will be explored for both Allied Health Professionals (AHP) and Healthcare Scientist (HCS) roles in line with regional workforce development programmes, offering access from entry level 2 through to Advanced Practice at level 7.

Initial delivery of the physiological services would be via a generic workforce with consideration given to developing the existing teams. This would be supported by access to HCS Level 3 apprenticeships and creating a future pathway through to registration. The full development of the physiological services will be implemented within Phase 3 allowing time to link in with partners and Clinical Networks to fully realise the benefits of the centralised service. Links have been established with the ICS, HEE and the SY ICS Echocardiography Group to identify future requirements for echo provision and to secure access to HEE funding.

DBTH NHS FT has successfully secured the radiologist workforce to undertake reporting of the scans and the outsourcing will cease in future phases of the CDC.

The introduction of a training academy at the CDC would offer an opportunity for all organisations across the SYB network to develop staff to support imaging across the region.

In 2021 the radiology department at DBTH NHS FT recruited two degree apprentices (both internal candidates working previously as radiographic department assistants). A further recruitment of 3 WTE degree apprentices in 2022 has grown this number to 5. Four of these individuals will qualify in 2023 with the final individual qualifying in 2024.

A further development to recruit radiographers through international channels has received executive support. These overseas staff members will take time to recruit and then train into NHS radiographers, the department is planning on 5 months for each individual having reviewed the Yeovil model.
This hybrid solution of recruiting radiographers through three different channels (graduate, international recruitment and degree apprentices) will solve the ongoing staffing challenges enabling staff to feed through into more specialist areas. International recruitment is not included in this business case.

The phases of the CDC project will require an influx of radiographers with an understanding in CT, MRI and US which will take time to train. In order to release staff members into these specialist areas then there is a requirement to increase the general radiographer training opportunities. The universities struggle to increase undergraduate numbers and are limited by training places and so the Radiology department has looked at how it can grow its own.

The model which has a high level of interest and a high potential of success is that of the degree apprenticeship. This feeds existing staff members from a lower grade who want to progress into this arena, as well as pulling new staff to the organisation from the local community. The degree apprentice naturally attracts new staff members who want to remain with the organisation, a major benefit to the project.

By recruiting 5 WTE degree apprentices in March 2023 and then 6 the following year in March 2024 this will enable an influx of general radiographers in 2026 and 2027, freeing up already in post radiographers to work in specialist areas.

The radiographer staff numbers required to run the MRI and CT fixed asset scanners is 10.8 WTE. There is a requirement of 11 WTE general radiographers required to enable staff to flow into these specialist areas.

Modality		Opening times	Hours opened per week	Number of radiographers required to operate scanner
CT	Radiographer	8 am until 8 pm	84	5.4 WTE
	RDA	8 am until 8 pm	84	2.7 WTE
MRI	Radiographer	8 am until 8 pm	84	5.4 WTE
	RDA	8 am until 8 pm	84	2.7 WTE

(RDA) Radiology Department Assistant

This large influx of degree apprentices on the medical imaging department over the next two years will be trained and form part of a service at a remote site, Retford. The service has not been provided there for a number of years due to the equipment quality and limited staff resources. By having one radiographer and the degree apprentices based there it will enable high quality training at a steady pace. This benefits the degree apprentices and the local community of Retford as it improves accessibility to general x-ray for them and expands the CDC by creating a spoke to the service.

The service users for this equipment will be GP referrals, outpatients and any follow up appointments enabling the degree apprentices to have a broad spectrum of patients during their first year of training.

	2023	2024	2025	2026	2027
2021 Cohort		Qualification of 4 WTE degree apprentices			
2022 Cohort			Qualification of 1 WTE		
2023 Cohort				Qualification of 5 WTE	
2024 Cohort					Qualification of 6 WTE

Although the admin team would be supervised day to day by the CDC service lead they would fall under the line management of the medical imaging team leaders and service manager (who is part of the radiology senior management team)

The MI CDC Service Lead would come into the radiology senior management team.

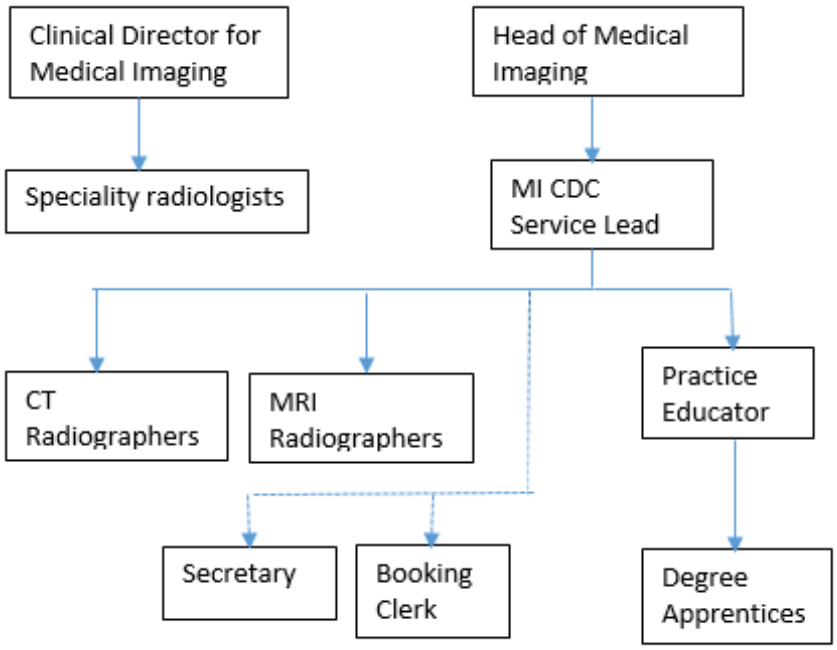
The speciality radiologists would be line managed by the clinical director for medical imaging, job planning and appraisals would be undertaken by this individual. They would attend the radiology consultant meetings, REALM and radiology governance.

The CT and MRI radiographers would all rotate through the different scanners we have across DBTH to ensure staff and service resilience.

The practice educator will be responsible for the aiding the training of the degree apprentices which will predominantly take place on the Retford site in the first year of this degree course. This will enable the apprentices to gain sound and in depth knowledge of x-ray and a sound understanding of the human body. The training will run alongside their time at university and the practice educator will facilitate the students time within the working environment.

The practice facilitator will also support the learning needs of CT and MRI radiographers which will follow a well-established model which is currently in place at DBTH. New starters within these modality areas already have radiographic experience and transition and learning is undertaken by the individual and supported by the modality teams. If the individual wants to complete a post graduate qualification within the modality area this is also supported as it is recognised that this in depth learning enhances the team.

CDC-Imaging Suite Management structure



Staff groups	AFC Band
Service lead	AfC Band 8a
Practice Educator	AFC Band 6
Diagnostic Radiographers with specialist knowledge in CT or MRI	AfC Band 6
Diagnostic radiographers	AfC Band 5
Radiographic department assistants	AfC Band 3
Secretary	AfC Band 3
Admin staff	AfC Band 2

Staff will be transferred from the acute hospital site. There is a requirement to fill the general radiographer pool in order to release the staff into specialist areas such as US, CT and MRI. These specialist areas will be filled by way of promotion within the team as will the service lead.

Reporting Radiologist

As part of the CDC project phase 2a, additional funding was secured for 3 SAS level doctors, all to be based at MMH to support reporting, ultrasound, and contrast injections. These Doctors are now in post. The radiologist workforce may be subject to further expansion as the Montagu CDC

Job plan for an SAS level doctor

10 PAs a week consisting of the following

1 SPA	
2 US sessions	Each session 4 hours / 1 PA
1 MDT	
6 sessions	2 duty (poor levels of reporting activity due to continuous interruptions via telephone) 4 dedicated reporting sessions concentrating on CT reporting

Radiology Staffing Costs

Workforce	WTE	Banding	Start Date	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Practice Educator	1.21	6	Apr-23	4,504	4,504	4,504	4,504	4,504	4,504	4,504	4,504	4,504
Radiographers	5	5	Apr-23	15,166	15,166	15,166	15,166	15,166	15,166	15,166	15,166	15,166
Radiographers	5	5	Apr-24	0	0	0	0	0	0	0	0	0
Radiographers	1	5	Apr-25	0	0	0	0	0	0	0	0	0
Radiology Dept Assistant	5.4	3	Nov-23	0	0	0	0	0	0	0	12,883	12,883
Receptionist & Booking Clerk	5.4	2	Nov-23	0	0	0	0	0	0	0	11,800	11,800
Service Lead	1	8a	Apr-24									
Secretary	2.7	3	Nov-23								6,441	6,441
Agency backfill	10.8	7 Agency	Apr-24									
Estates - J Hutchinson confirmed	1	6										
Total				**19,670**	**19,670**	**19,670**	**19,670**	**19,670**	**19,670**	**19,670**	**50,794**	**50,794**

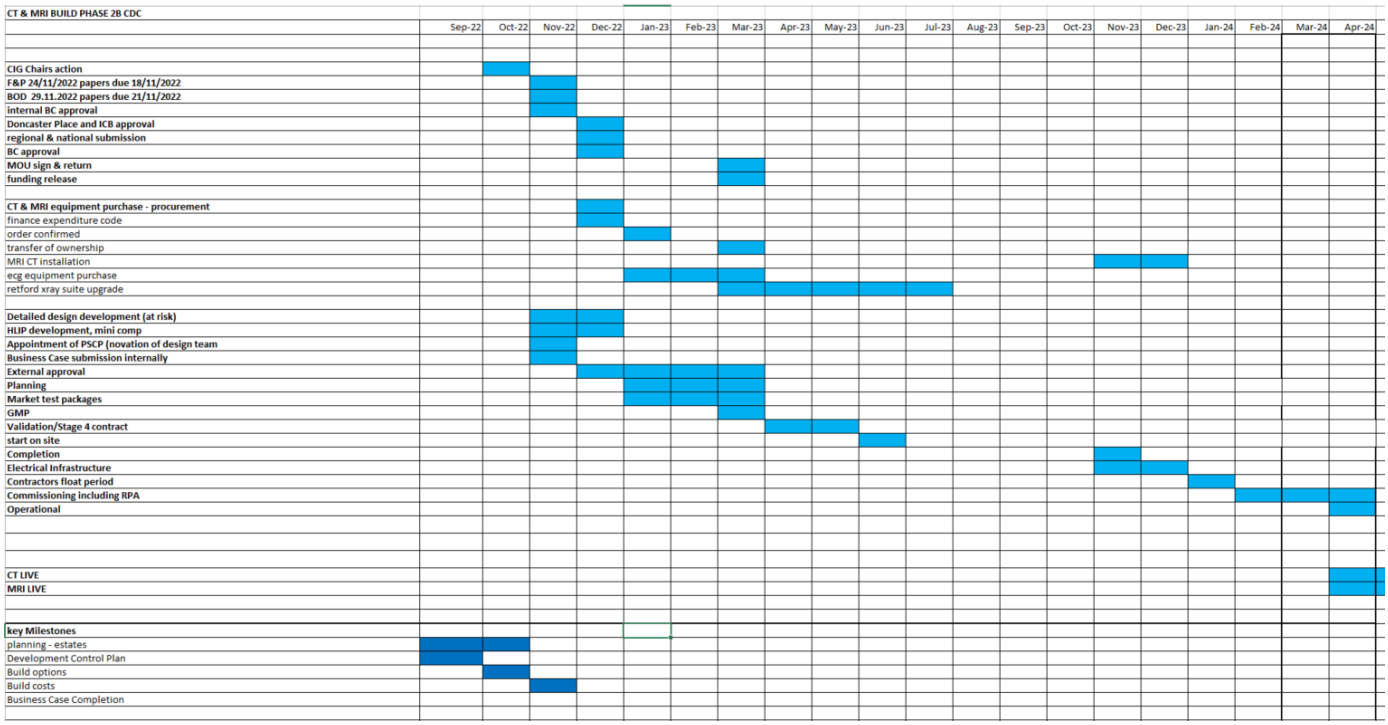
Estates & Facilities

The initial high-level design and cost plans have been developed for this business case up to Stage 2 (Concept Design) of the RIBA Work Plan. The further work stages will be carried out by the Trust approved Multi-Disciplinary Design Team except for the Cost Planning service which is carried out through the Trust appointed Cost Planner (QS) through a separate commission.
The Trust cost advisor will be retained to produce contract documentation and check value for money.

Scheme Delivery

Detailed design development (at risk)	Nov-Dec 22 (P+HS/CAD21
HLIP development, mini comp	Nov-Dec 22
Appointment of PSCP (novation of design team)	Jan 23
Business Case submission internally – (Note cost plan only and not GMP and no planning at this stage)	Nov 22
External approval	Dec 22 – March 23
GMP	March 23
Validation/Stage 4 contract	April-May 23
Start on site	June 23
Completion – (assuming 7 months construction / stage 4 period)	December/Jan 23
Completion of CDC CT/MRI Imaging Unit and Electrical Infrastructure – (assuming 7 months construction / stage 4 period)	Nov 22 – Dec 23
Contractors float period	Jan 24
Commissioning including RPA	Feb-March 24
Operational	April 24

CT	April 2024
MRI	April 2024
RETFORD XRAY	JULY 2023
Physiological Measurements Diagnostics including Echocardiography and Spirometry	starting Q2/3 2023 and expanding beyond 2024



Fire Compliance

DBTH's Fire Advisor has been consulted on the project and provided input into the design to Stage 2, including identification of suitable fire zones, provision of fire doors, locations and access to fire escapes.

The works will be in full compliance with all requisite guidance and legislation and the Trust Fire Safety Advisor will be fully integrated into the detailed design, construction and hand over stages including agreement with South Yorkshire Fire & Rescue and building control approval.

Infection Control

DBTH's Infection and Prevention Control and Joint Advisory Group (JAG) leads have been consulted on the project to the degree required to Stage 2 but will be intrinsically involved in the design, commissioning and hand over of the project.
The teams will provide advice on the design, including use of suitable finishes, control of contamination and provision of the required ventilation rates.

Resilience

Throughout the design stage the issues surrounding providing resilience to the proposed developments has been considered and items contained within HTM00-07 taken into consideration, including:

- Engineering Services
- Security
- Fire

Engineering Services

The Design will consider all requisite HTM and HBN guidance and where certain standards are not able to be complied with due to the constraints of the existing build and systems, a derogation schedule will be developed and agreed.

The new developments will be directly linked to the existing engineering services which are currently provided resilience via a newly installed standby generator.

All works will be designed in tandem with the Trust Estates and Facilities teams and standard component and incumbent suppliers where appropriate

Security
Security will be fully considered throughout the design and allowance made appropriately in conjunction with the Trust Local Security Management Specialist. Measures will consider the provision of secure access control to all areas as appropriate.

Construction Design and Delivery
The Project Team to Stage 2 included:

- Project Management - DBTH Estates and Facilities Capital Planning Unit
- Architect – P+HS Architects
- M&E Consultant – CAD 21
- Civil & Structural Consultant – AJP
- Quantity Surveyor – WT Partnership

However, further to the successful appointment of the Trust's new framework Multi-Disciplinary Design Team, the Project Team from Stage 3 will be as follows:

- Project Management - DBTH Estates and Facilities Capital Planning Unit
- Architect – AECOM
- M&E Consultant – AECOM
- Civil & Structural Consultant – AECOM
- Quantity Surveyor – WT Partnership

Construction will be procured through the new Trust contractor framework which has just been awarded following a rigorous ITT exercise based on 60/40 price/quality to the following companies for this size of project:

- Sewell
- Tilbury Douglas Construction Ltd
- Wilmott Dixon

Contract to be chosen appropriate to the size and complexity of the project which will be either the relevant JCT or NEC contracts.

Contribution to carbon reduction plan -net zero, Greener NHS

The overarching design approach to the new CT/MRI building at Mexborough Montagu Hospital will be in line with the guidance principles set out by the NHS England Guidance Document "Delivering a Net Zero National Health Service". This will ensure the CT & MRI building will have reduced energy and reduce carbon.
The building will be designed with enhanced levels of insulation and high efficiency heating, ventilation and air conditioning plant. There is the potential for the use of electrically driven high efficiency air sourced heat pumps that would provide the heating and hot water to the new CT & MRI building. It would not be the intent to connect the building into the existing gas fired heating network.

The scheme will also have high efficiency LED lighting within every space. A review of on-site renewable technologies will be carried out a detailed design stage consider technologies such as Photovoltaic panels to generate on site electricity that would feed back into the building.

Information Management & Technology (IM&T)
Montagu Hospital is an existing health care facility owned by the Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust and as such has existing IT infrastructure. As an established NHS FT there is an understanding of the need for data to be recorded and shared for clinical, operational and assurance purposes. Costs have been included to cover the additional IT and telephone ports required in the build.

IMT resources will be required in the planning, installation and set-up for the identified IT requirements discussed and costed with the CIO for the department within the timescales set out and once funding has been agreed.

In the development of the CDC at Montagu Hospital existing digital and IT services will be used. IT will be required to receive and process referrals, book patients, and help prepare them for tests, enable coordinated testing, enable reporting and completion of tests. The importance of interoperability to enable seamless integration and connectivity between IT systems is understood. Preliminary work is underway to understand potential data and information flows that would support CDC development.

Digital Considerations for CDC Implementation

In this business case provision is made within the project for Information Technology (IT) infrastructure including Wi-Fi and telephony to support full connectivity with the main hospital to facilitate electronic booking processes and digital diagnostic equipment in line with NHS standards.

There is currently no imaging sharing system within the South Yorkshire and Bassetlaw SYB) Integrated Care System (ICS); this remains in the procurement stage, however mutual aid arrangements across SYB have embedded temporary solutions within trusts as an interim arrangement. Agfa Xero is available to view historical imaging across the ICS. It is envisaged that, images will be returned to source of referral for reporting, except for CT, MRI, and Ultrasound, allowing time for the development of the image sharing system and shared reporting systems to be identified.

Online booking systems are being developed which will be offered for the CDC alongside traditional methods of booking via phone to support all patient groups. Patients will be able to contact the CDC directly for any queries relating to appointments of results. The online booking system will support 24/7 booking

access for patients to make an appointment and will be available on all Trust internet sites within SYB to allow patients to access the CDC. Patients will receive a text reminder for appointments.

Appointments made via the traditional telephone route will trigger an appointment letter for the patient with full instructions regarding their attendance at the CDC.

To support delivery of the CDC home working solutions for reporting were already well embedded within Radiology for all reporters and all other modality reporting for Consultant Radiologists.

Existing trust IT helpdesk and support functions are in place to support the CDC.

The development of CDC performance dashboard will incorporate national reporting requirements.

In accordance with the trusts ICT strategy and the wider SYB ICS digital strategy work will continue to ensure future streamlining of systems through joint digital processes to make the most effective use of the CDC.

A network approach is being undertaken across the South Yorkshire ICS to develop an IT infrastructure and system which allows one system to book patients, review notes and follow patient pathway.
A streamlined IT infrastructure is required which works across the ICS. The ICS require a shared portal to ensure all patient capacity and demand as well as results can be shared across Trusts.
Safe booking of patients and the ability to book interpreters online is a useful resource.

Site connectivity and infrastructure-

- PCs, laptops, hardware
- Network Links
- Helpdesk and Support arrangements
- VPN and local mobile connectivity solutions

Appointment, booking and scheduling-

- Systems to be used across patient flow
- Avoid digital exclusion and support patient choice
- Use of optimisation software

Patient management-

- EPR Patient information system
- NHS Number use for all clinical data transfers. Link patients for record sharing, integration, referrals and prescribing
- Primary/Community care system access

Clinical systems-

- Integration between all digital systems to allow patient end to end flow
- Laboratory Systems LIMS
- Single system for Radiology image sharing
- Use of NHS Standards (DICOM, HL7, National clinical imaging procedure code set)

Digital Equipment-

- Use of Digital diagnostic equipment

Results and testing-

- Test results systems
- Requests and GP
- Order/Comms
- Integration into patient record

Reporting Systems-

- Requests and Referrals – electronically
- Connection to NHS e-referral system (ERS)
- Booking system
- Advice
- Discharge letters
- Comply with security and access control

Mobile & Home working-

- Solutions for key users – Reporting

Digital Maturity-

- Data flows aid IT capabilities
- Digital models
- Benchmarking

Medical Equipment

All of the medical imaging equipment that is purchased as part of this project will need to be commissioned for the larger modalities this will have to be built on site and then checked through the radiation advisors.

Each of the modalities will require maintenance contracts in place with the original equipment manufacturer. New items of equipment are also often covered under a limited warranty which means that there is no maintenance costs for the first year.

All of the equipment within the funding bid will require initial checks and commissioning through the RPA's and room checks will also be required to ensure the integrity of environment from a radiation perspective.

This project development includes the build of a new environment of which work on design has already started. There has been input from a radiation perspective as to the design and there will need to be a matron sign off from a quality and patient experience.
These assets will then become part of the departments' asset list and future capital replacement scheme.

Internal Stakeholders

The following internal stakeholders have been and continue to be involved in the development of the MMH CDC plans:

DBTH clinical staff from Clinical Speciality Services division and modality representation from: Endoscopy, Radiology, Pathology, Histopathology, Cardiorespiratory. Management colleagues from infrastructure areas: IT, Information, Finance, Estates, People & Organisational Development, Communication & Engagement, Strategy and Improvement and admin and booking.

External Stakeholders

External Stakeholders involved in the MMH CDC plans include representatives from:

- CCG (Barnsley and Doncaster)
- HEE
- NHSEI
- Health Inequalities links
- ICS
- Gastro Hosted Network
- PCNs
- GPs
- CDC Steering Group
- SY&B ICSCDC group
- Barnsley FT
- Rotherham FT

There is a requirement to host 4 CDCs across the SY&B regions therefore these plans have been development with full stakeholder engagement across the SY&B ICS and have also been scrutinised by North of England NHSEI colleagues.

CDCs are a new concept and providers of services will be scrutinised to learn lessons for future developments. DBTH will increase its reputation in the area as one of the main acute providers, providing safe and quality care to our existing standards.

Communications & Engagement

SYB ICS Public engagement

The tight deadlines for year 1 submissions made it difficult to do any 'new' engagement with the public so to ensure some insight helped shape Year 2 submissions, and to sense check the year 1 submissions, new engagement was commissioned by SYB ICS.

A survey open to all, and focus groups with seldom heard communities, looked to engage local service users around their experience of diagnostics and how community diagnostic hubs might affect their care journeys.

An online survey ran from the 13th of September 2021 to the 20th October 2021. A link to the survey was advertised by the ICS through a range of NHS communications channels with local service users. 56 responses were received.

There were five focus groups, undertaken by South Yorkshire's Community Foundation, using the same questions as those in the survey. These were undertaken in a range of locations across South Yorkshire and enabled the engagement to access harder-to-reach groups, to consider their input alongside that provided by local service users more generally (7 members of seldom heard communities who couldn't attend the focus groups also completed the same survey).
The main positive aspects of the experience were:

- the short waiting times involved both in getting an appointment and whilst at the hospital
- the care and competence shown by NHS staff,
- the quality of the diagnostic equipment involved
- the test helped to move them along their diagnostic journey.

The main negative aspects of the experience were:

- waiting times for appointments and the delay in getting the results after a test was completed
- the difficulties in travelling to and from the diagnostic sites
- the quality of the information provided to the patient

It was most important to local service users that:

- the different parts of the diagnostic process were completed as quickly as possible
- there was clarity for the patient around when things would happen
- they were kept fully informed throughout the process with the potential to use technology to enable faster communication
- services were somewhere accessible to them, and that they received a high standard of compassionate and competent care from NHS staff.

Participants were most keen to see imaging, screening, and health checks available at the hubs. There was a general enthusiasm for as many services as possible to be undertaken within the community, although some still preferred to visit a hospital due to familiarity or concerns over what might happen if a procedure went wrong. There was also a mixture of views over whether the knock-on consequences of hubs on NHS services would be positive or negative.

Equality

Groups held with residents belonging to ethnic minorities also raised some differences. On the most practical level, there were challenges posed by language barriers, particularly when dealing with complex medical information, and the impact this had upon their ability to access care.

Different cultural considerations were also suggested, such as that centres within the community might result in some residents being put off by the desire not to be seen accessing some types of tests and that the gender of the doctor was important in some cases.

There was also a mixture of views around the impact centres could have on local service provision, from a belief that they might enable specialisation around conditions more commonly found within some communities to a concern that it would result in the 'ghettoization' of healthcare.

Next Steps have been established to:

- Ensure engagement report is considered in and incorporated in decision making on future CDC bids
- Ensure operational suggestions about areas patient experience could be improved in diagnostics are fed into services
- Sign off engagement report so that it can be posted on the ICS website and participants can have fed back to them how their input has contributed.

DBTH Public and Staff Engagement

The trust has been keen to engage both staff and Patients in the development of the CDC at MMH. This has had a very positive response from both public and staff. There have been several articles published in the DBTH Newsletter BUZZ, in the local press/Facebook to highlight the developments of the CDC, and how the investment is being utilised in the health of the local community.

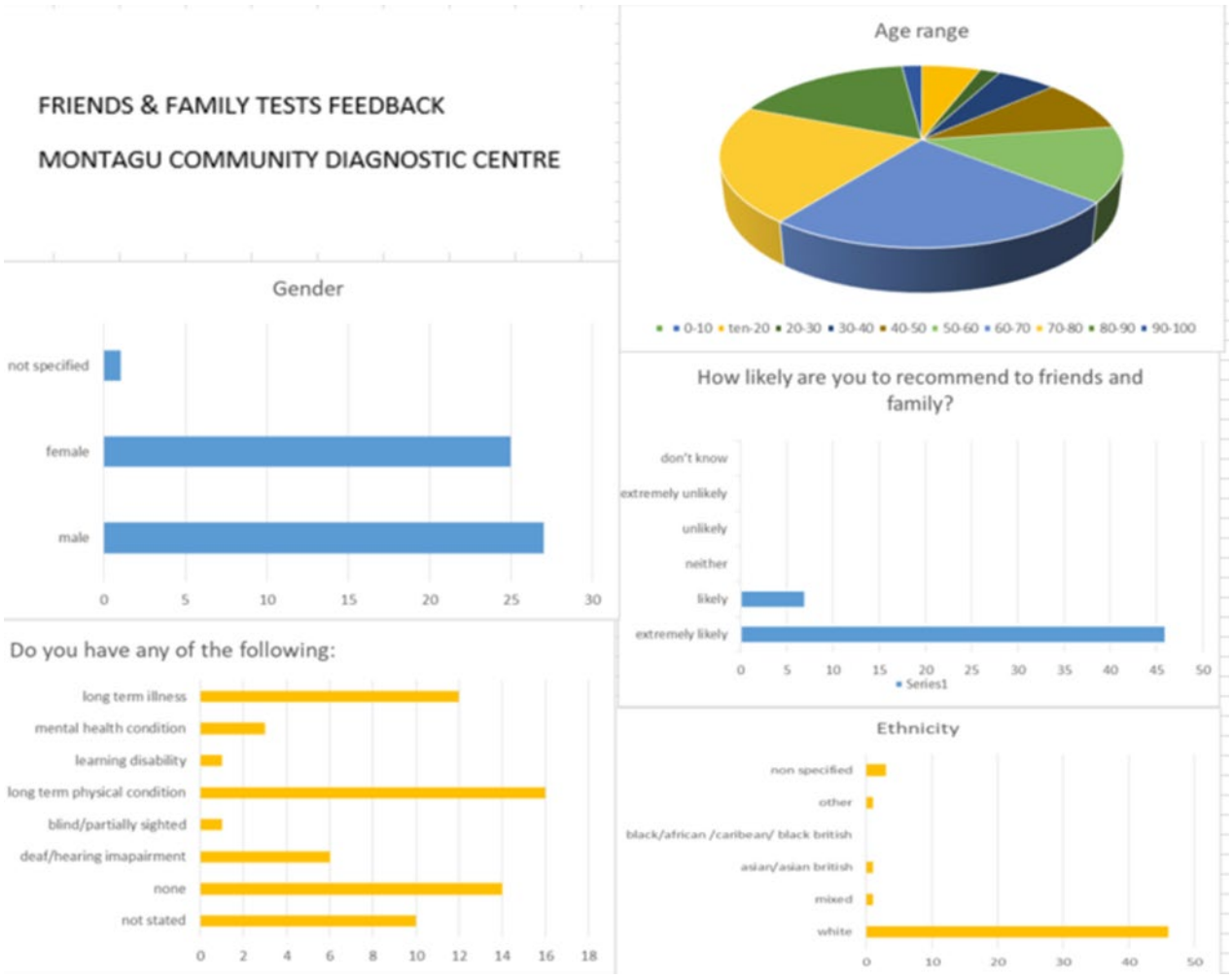
Existing staff currently based at the hospital site are aware of the CDC potential in later phases. They see this development as much needed as they are fully area of the difference between demand and core capacity. Any development of the CDC to fixed assets will require discussion with both the CT and MRI teams as there will be a requirement for those staff members to go and work within this new facility. Trust posts on social media such as Facebook have seen a very positive response from both staff and public who have used the services already in Phase 1 of the Project and have shared their experiences all of which have been positive.

The Friends and Family test surveys are being requested at MMH for the MRI/CT Phase 1 elements and will be evaluated to inform future service improvements. Public representatives' expressions of interest are being collected to form part of the future design. A naming competition will also take place within the local community to showcase the value of Community Diagnostic Centres to the community and allow local engagement with the project.

As a Trust, we gather the results of our FFT and analyse them rapidly to see if any action is required. The responses to the FFT question will be used to create an overall score that will be published on our website, as well as shared with colleagues and partners. The comments, however, are retained by the service, to pass on to staff and managers in order to share positivity or make changes in response.

This test can be carried out online or in the form of a feedback sheet which is filled out after the patient's appointment.

The friends and family test for Phase 1 showed results as shown below:



Service user comments

Main Benefits

This project enables the following CDC benefits

CDC Benefit	Beneficiary	Success Indicator/Measurement
To improve population health outcomes	Population Health	The population of the Dearne in South Yorkshire experience some of the poorest health outcomes, with 45% of people living with one or more long term conditions. There is a high under 75 mortality rates from cardiovascular disease and at age 55 80% of people with cardiovascular disease will have co morbidities including arthritis, depression, diabetes, and chronic kidney disease. Patients from the Dearne and nearby areas are more likely to smoke, have mental health problems, be admitted to hospital for an ambulatory care sensitive or urgent care sensitive conditions and fail to attend an outpatient appointment. There is also a higher proportion of residents that are carers and overall, there are low rates of self-care. There is a significant health burden amongst the Dearne population and low health expectations. It is understood that there are 230.1 deaths from causes considered preventable per 100,000 population in the Dearne compared to 182.8 in the UK overall. It has also been identified through insight work that resident have concerns around finances, care in later life and may be suspicious of conventional health services, all with the potential to act as barriers to access. The development of a community diagnostic Centre in Mexborough improving rapid access to a range of diagnostic modalities at Montagu Hospital will facilitate faster diagnosis for multiple care pathways and contribute to enabling earlier stage diagnoses for cancer pathways with consequent improvement in health outcomes and survival rates, as well as earlier diagnosis for other pathways such as MSK that will accelerate the onward journey for patients into their treatment
To increase diagnostic capacity		Nationally, it is expected that the annual demand change for CT will be an increase of c6.8% and MRI c5.6%. Increases in demand of this sort are already being experienced across the SYB Imaging Network and are likely to continue for the foreseeable future. A capacity planning exercise for Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust undertaken in March 2021 demonstrated that the Trust had 86% of the CT capacity and 94% of the MRI capacity necessary to meet 2019/20 demand levels. The capacity deficits equated to shortfalls of 3801 CT scans and 1177 MRI scans. Assuming demand grows this year in line with the national assumptions above, the capacity shortfalls may be expected to increase to 5676 CT scans and 2265 MRI scans in 2021/22.

		The CDC has delivered additional capacity of around 3200 CT scans and 2000 MRI scans per year. This increase has offset 56% of the CT scanner deficit and 88% of the MRI scanner capacity deficit projected for 2021/22 based upon demand reflecting the 2019/20 level uplifted by the national growth assumption. Also, Ultrasound Non Obstetric will be carried out in the CDC and Endoscopic procedures.
To improve productivity and efficiency of diagnostic activity		Delivering additional diagnostic capacity for a range of modalities on an elective only site (with an MIU and a small volume of inpatient rehabilitation). It will provide a reliable, resilient and efficient service platform, separating out planned diagnostics and supporting streamlined patient pathways - including appointment coordination and referral guidelines– which will require patients to make as few visits as possible to hospital before receiving a definitive diagnosis and contribute to improved productivity. The proposal has a focus on reducing clinical variation by developing shared pathways across the system, supporting the system to facilitate and enable the services to do more by working together, broadening, and strengthening our partnerships to increase capacity.
To contribute to reducing health inequalities		The proposed Community Diagnostic Centre at Montagu Hospital would contribute to improved population health by enabling earlier stage diagnoses to be made with consequent improvement in outcomes. The location of the Centre in Mexborough would help address health inequalities by improving access to diagnostic services for patients from relatively disadvantaged localities in the western part of the borough of Doncaster and the adjoining areas in Barnsley and Rotherham. At present patients from these localities travel to main hospital sites to access many diagnostic modalities and the associated cost and inconvenience represent barriers to access which exacerbate health inequalities. The potential for the Imaging Suite with Cardiac Scanning further supports equitable access for a diagnostic modality where demand is outstripping supply in SYB and we understand that there are challenges in access for some socio-economically disadvantaged populations.
To deliver a better, more personalised, diagnostic experience for patients		The development of a community diagnostic Centre at Montagu Hospital will deliver a better, more personalised, diagnostic experience by increasing capacity to contribute to reduced waiting times, supporting the delivery of straight to test pathways, facilitating coordinated same day testing to reduce the number of visits where possible and embedding the rapid diagnostic principles including navigation for patients to support attendance this should collectively support the delivery of a more personalised diagnostic experience for patients.
Support integration of care across primary, secondary and community care		The development has the opportunity to support integration of care across primary, secondary and community by initially improving local access to a range of diagnostic modalities for primary care clinicians, in a way that minimises travel for their local population and enables relationships to develop between referrers and local services. Going forward there is an opportunity to explore developments that could further support integration across primary and secondary care, with the potential to increase the capacity for cardio-respiratory investigations, including GP direct access investigations on the site.

Cross Cutting Aims
A. To improve staff satisfaction The location of a community diagnostic centre at Montagu Hospital will provide diagnostic services staff with an additional workplace choice with an opportunity to work on an elective only site. The community diagnostic centre will provide an excellent working environment with good facilities, innovative patient services, an important role in workforce development and training, and an ability to accommodate preferences for flexible working. For those staff wishing to maintain an involvement in acute diagnostic services opportunities will be provided to rotate onto one of the acute sites.
B. To make every contact count and deliver health promotion where it is meaningful and impactful to do so. The delivery model for the Community Diagnostic Centre at Montagu Hospital will incorporate opportunities to provide health promotion. As the scope of the CDC expands from CT and MRI scans to a broad range of diagnostic services, co-located with rapid diagnostic services for suspected cancer, there will be abundant opportunities to provide patients with information and support to make lifestyle changes, notably including smoking cessation.
C. To utilise CDCs as test sites for cutting edge research, new innovations and evaluations. The phased development of a CDC as described would enable consideration of how best to use digital and technological innovation to manage and improve patient care and contribute to one of the cross-cutting themes of a CDC being test sites for quality improvement and innovation.
D. To contribute to NHS Net Zero ambitions By providing more local diagnostics services for patient's resident in the Dearne Valley the community diagnostics centre at Montagu Hospital will contribute to reduced journey times and, for local residents, will provide options not currently available to travel on foot or by cycle. Where applicable carbon reduction will be factored in and where required will be equivalent to BREEAM 'Excellent'
E. To act as anchor institutions, consciously supporting positive social, economic and environmental impacts locally. Doncaster and Bassetlaw NHS Foundation Trust has made a formal commitment to fulfilling its role as an anchor institution making a strategic social and economic contribution to local communities. The Trust has undertaken a stocktake of its anchor institution activities and is reviewing opportunities to expand activity. It has established an executive led governance structure to oversee progress.

The development of a community diagnostic centre at Montagu Hospital will positively support the local area socially, economically, and environmentally by

- Where possible purchasing locally for social benefit
- In future phases refurbing and fully utilising the building space
- Widening access to quality work for local people
- Ensuring development in a way that reduces its environmental impact and carbon footprint
- Enabling us to work more closely with others to learn from each other, as part of the SYB approach to develop a network of community diagnostic centres and thus model civic responsibility

Benefits Realisation

This CDC project will enable the following benefits:

Strategic Fit	Aligns with the Trust Strategic Direction 2017-2022 to be the safest hospital in England and forthcoming new Strategy and supporting Clinical and Estates Strategies to develop services helping to reduce health inequalities, provided in the best environment. This development will be monitored through the Trust governance and regular updates will be provided to the Quality Effectiveness Committee and Trust Executive Group as well as via local and regional commissioners.
Clinical Quality and Patient Safety	Increases diagnostic facilities and support and all clinical practices will undergo the same rigour and monitoring with effective DBTH Clinical Governance practices. Adhering to all national and local policies for diagnostic care.
Patient Outcomes	Reduces harm and increases opportunities for improved clinical outcome through increased diagnostic facilities – patient opinions on care will be sought via the Friends and Families testing and a dedicated Communication and Engagement Plan is being produced to actively involve communities and community services in positive patient outcomes.
Patient Experience	Will reduce complaints in relation more being an elective site, enhanced facilities for better flow - increase compliments and improve patient experience in an improved environment, monitored as above.
Clinical Staff and Resources	Have a positive effect on health and wellbeing of the workforce and create a better environment for education and staff training. Improve working environment and positively impact on recruitment and retention.

Added benefits	
Reduction in waiting lists	Reduced waiting lists monitored via service waiting list coordinators and performance teams
Contribution to fulfilling FDS	Contribution to fulfilling FDS target success, monitored via infoflex and Cancer Alliance
Rapid Diagnostic Service improvements implemented and delivered	Rapid Diagnosis Service improvements implemented and delivered monitored via infoflex and Cancer Alliance
Increased facilities and resources to help with COVID19 recovery	Increased facilities and resources to help with COVID19 recovery, additional diagnostic facilities available on a COVID light site and giving quicker diagnosis to patients who may need to use acute care or can continue to be cared for by community providers. Patients seen in a timely manner and recovery accelerated
Increased morale in staff with more resources to help with impacts	Increased morale in staff with quality facilities for patients and excellent opportunities to be part of research and QI initiatives, with additional training facilities

Benefits Delivery

The delivery of benefits will be managed through the Transformation Board. A copy of the benefits realisation plan can be seen below:

Project Objective	Benefit	Enablers	Outcome	Baseline Measure	Owner
To provide more resilience and increase the productivity	Improve the patient pathway increasing the speed of clinical assessment & Diagnosis	Patient Information Improved patient pathway Trusts KPI targets	Reduced length of time from arrival to start of treatment KPI targets	PLACE (patient surveys) Trust Risk register	Steering Group

	Provide additional capacity to the trust through a Static service with increase in activity from phase 1 of the CDC and diminish use of Mobile scanners.	Internal adjacencies Stakeholder engagement Workforce expansion	Reconfiguration will provide Increased speed of assessment and diagnosis	Implementation of a key adjacency	Steering group
To ensure the increased capacity expectations are achieved in line with the change in service model (FDF) and national guidance standards (Cancer Standards)	Ensure the service model of care delivered is in line with National and Trust economy KPI's	Compliance with best practice standards.	Trust performance KPI's met.	PLACE (patient surveys)	Trust Board Transformation Board
	Patient care is enhanced and clinical risk reduced	Model of care and design enhances efficiencies and reduces times for treatment	Trust performance KPI's met. Improved patient experience	Current performance reports	Trust Board CDC Steering group
	The new build environment enhances clinical practice with improved patient outcomes	Robust design Stakeholder engagement Key internal adjacencies align with strategic guidance.	Provides improved departmental adjacencies which align with strategic guidance KPI figures reflect benchmarking relating to patient referral, diagnosis and treatment times	Current Data Quarterly performance reports PLACE surveys Trust risk register	Trust Board CDC steering group
To facilitate the modernisation and change in working practices to support the model	The design solution minimises the disruption to existing services	Robust design solutions Engagement with stakeholders Efficient programme management	Post project evaluation indicates project completed on time with minimal disruption	Programme Plan	Estates and Facilities PSCP
To provide a solution that aligns with the Trusts change in service model.	The design solution provides additional capacity	Robust design solution	Post project evaluation KPI's met.	Current performance reports	Estates and Facilities PSCP

The development will be delivered on time with minimal disruption to existing service	Maintain the existing service throughout the whole build programme	Robust design solution Efficient programme management	Post project evaluation indicates project completed on time with minimal disruption	Programme Plan	Estates and Facilities PSCP

The key opportunity is presented by the new design for facilities, which will ensure sufficient capacity to meet demand, efficiencies in service delivery, compliance to standards and minimised disruption to overall Trust operations.

Main Risks

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

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

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

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

As part of the planning and implementation of the project a PLACE assessment will be completed for the CDC Development. This will allow patients, public and staff to ensure that the development meet their expectations for quality of care and location of services.

Risks and issues for the specific project will be managed through the governance structures detailed in the management case in line with the Trust policies and procedures identified above.

The key risks in terms of construction currently, can be identified as resource provision and inflationary increase on the cost of materials due to Covid.

At present the country is seeing significant increase in the occurrence of absence of staff due to isolation following positive covid testing etc. Also, the cost of certain materials (concrete, copper, steel) have increase exponentially due to demand and availability over the last year.

The effect of the material increase has been allowed for in the cost plan, but the availability of staff is less predictable. However, it is hoped that the peak for Covid is now reducing, and the appointment of a Tier 1 contractor will have sufficient resource and supply chain for the size of company to mitigate this issue.

			(C)onsequence				
			Insignificant	Minor	Moderate	Major	Catastrophic
			1	*2*	*3*	*4*	*5*
(L)ikelihood	Rare	*1*	1	2	3	4	5
	Low/Unlikely	*2*	2	4	6	8	10
	Possible	*3*	3	6	9	12	15
	High/Likely	*4*	4	8	12	16	20
	Almost certain	*5*	5	10	15	20	25

Risks	Rating			Mitigation plan
	L	C	Score (L x C)	
FINANCE & FUNDING				
Cost escalation	3	3	9	Fixed price/change control/stage payments
Capital and Revenue funding not being available	3	5	15	ICS fully aware and part of development
Capital timeline delays	2	4	8	Estates reviewed area and developed plans
Funding ceases whilst awaiting approval for MRI/CT	3	4	16	ICS discussions – risk raised Continuation funding
Uncertainty of future financial arrangements	3	4	12	Risk identified nationally, SYB to continue to link into national dialog to enable risk to be mitigated
Funding gap – services if funding not approved	3	3	9	Risk raised – ICS
TIMELINE				
Timely release of funding	3	4	12	Business Cases submitted on time
Mobilisation not starting to timescales required	3	4	12	Early planning and mobilisation meetings
Funding gap between phases caused by delay in national approval process	3	4	12	ICS – risk raised with ICS – High priority
Sustainability of services	2	8	16	Evaluate post implementation – highlight risk
ESTATES & FACILITIES				

Construction timescales	3	4	12	Monitoring timeline – risk raised
estates proceeding at risk to enable modalities to start in financial year	4	4	16	Monitor risk
EQUIPMENT CONTRACT				
Purchase of equipment in financial year	2	5	10	Procurement routes explored to enable purchase in FY
IT				
IT infrastructure not being designed/funded and in place by start date	3	4	12	Monitoring progress
IT infrastructure and one system for ICS working required in time/resource available	3	4	12	Joint ICS programme
WORKFORCE				
standardised workforce model agreement across ICS	3	3	9	Monitoring progress
Training links with adequate support and time to train staff	2	3	6	SY&B ICS approach to staff training
STAKEHOLDERS				
All relevant partners not signing up to schemes	3	4	12	Partners involved throughout design process

Quality impact assessment

The quality and performance impact assessment indicates that positive impacts to improve the service are anticipated, rather than any adverse or negative impacts. Appendix VI.

The proposal for Phase 2 of the Community Diagnostic Centre is to increase long term MRI, CT, Non obstetric Ultrasound and Endoscopy Capacity and expand on Phlebotomy, Pathology and Cardio-respiratory services at Montague Hospital, Mexborough which is located away from the pressures on acute facilities, including high demand on space and parking.

Patients will benefit from an improved experience which aims to reduce waiting times, improve access and reduced travel for some patient cohorts.

The overarching objectives that support the proposal and subsequent phases of the development include:

- Shortened interval from presentation to diagnosis
- Reduce the number of ED/GP visits before an admission/cancer diagnosis
- Reducing waiting times for CT/MRI including waiting for results
- Diagnose or rule out cancer at an earlier stage, and thus improve outcomes
- Enable Cardiac MRI scans and diagnostics for cardiac patients
- Reduce health inequalities where possible

Equality impact assessment

The equality impact assessment undertaken for this project has an equality rating of outcome 1 i.e. no adverse impacts on the key groups. With this rating there is no requirement to undertake further detailed assessment. See Appendix V. for completed assessment template.

Constraints

The Phase 2 scheme proposed is deliverable within the 2023/24 financial year subject to timely national approval of the SY&B ICS plans taking place and resources are released by the SY&B ICS expected January 2023.

The constraints and dependencies to this project are:

- **Workforce -** Recruitment and retention within this project will align with the Trust's overall workforce plan.

- **Physical –** The new CDC development is to be constructed as a new building of MMH with access constraints for construction materials and machinery. Alongside this there are existing services contained within the site which provide for other adjacent departments that are required to be maintained.

  Timeliness: the hospital will see continued pressure with increased demand. From an operational perspective, the new facilities must be ready as soon as practicably possible.

- **Trust Capital Programme:** Trust wide schemes for redevelopment of the Trust sites are all interdependent. This is one of a potential number of site-wide reconfiguration schemes however, this is planned and managed within the Estates Department. Appendix VII. Estates: Construction/delivery risk register

Dependencies

This proposal is dependent upon the approval of the business case and NHSEI National CDC Team approval, which DBTH will be submitting December 2022, following an agreed process including the Trusts Executive, Finance and Performance Committee and Board of Directors approval.

There are no other known dependencies outside the scope of the investment proposal upon which successfully delivery is dependent. This business case adheres to the SFI's and procurement rules.

4. ECONOMIC CASE: OPTIONS ANALYSIS

The critical success factors for the investment proposal are the attributes essential for successful delivery, against which the options will be appraised, together with the agreed spending objectives.

Critical Success Factors

Key CSF	Critical Success Factor
Strategic fit and meets business needs	Clinical Standards: The option will allow for compliance with clinical standards leading to improved clinical outcomes and patient /carer experience. Supports integration of care across primary, community and secondary care and the wider diagnostics transformation programme
	Constitutional Standards: The option will allow for improved Elective performance and flow, meeting mandated standards. Contributes to improved Faster Diagnosis Standards and Cancer Two week wait performance.
	Travel & transport: The option allows faster diagnosis in fewer visits as possible.
	Health & Wellbeing : The option provides facilities to meet the health & wellbeing of the teams working in the area
	Sustainability : The option provides flexibility in use of space and allows for innovation service change.
	Health Equalities: The option addresses health inequalities across the population served
Potential value for money	Health Economy: The option provides VFM - The option will not worsen the long term financial stability of DBTH
	Health Economy: The option optimises social value and positively enables Net Zero and Carbon reduction
	Optimises public value (social, economic and environmental), in terms of the potential costs, benefits and risks.
	Estates/Infrastructure: The option enables future use of vacated space for service delivery
Supplier capacity and capability	Estates/Infrastructure: The option matches ability of suppliers to deliver
Potential affordability	Health Economy: The option will be achievable if funded by the National Community Diagnostic Funds and supported by ICB Place Commissioners and the regional teams.
Potential achievability	Workforce: Workforce availability to provide the service in line with national guidance (Royal Colleges, CQC and JAG)

Investment Objectives

- To deliver an estate which enables the best possible experience for adults requiring diagnostics and staff working within those environments, with clinical quality, patient flow and outcomes performance improvement
- To create an adaptable, flexible and digitally enabled estate, scaled for future demand growth, shifts in care setting, improved patient flow and best use of workforce skills
- To create a physical environment that meets statutory and regulatory requirements within the curtail of the scheme, and takes account of relevant national policies and guidance including Net Zero Carbon and Pandemic Proofing
- Create an environment that fosters partnership working and integration, allowing improved access and addressing Health Inequalities
- To create an estates solution which reduces the overall cost of delivering acute care services for financial sustainability and ongoing value for money in operation
- To develop the Montagu CDC in a way which maximises the positive economic and social benefits for the area , and fulfils the Trust's role as an 'anchor' organisation
- Provide sustainability in adults diagnostic services across the South Yorkshire ICS, releasing capacity on acute sites and enabling faster diagnosis and therefore more appropriate and timely interventions in care
- Reduction in Emergency Care use by creating timely diagnosis
- To create an environment that supports quality improvement, research, innovations and service evaluations.
- Meets the agreed spending objectives, related business needs and service requirements, and provides holistic fit and synergy with other strategies, programmes and projects
- Enables future training of staff and create additional roles for the ICB system
- Reduced Infection Prevention Control risks – ability to social distance and isolate when required
- Improved recruitment and retention rates (including reduced sickness)

Main options

The financial appraisal for each option is shown in the relevant section below.

OPTION 1	Business as usual (the baseline from which improvement will be measured) Continue as is with no additional CDC provision
OPTION 2:	The "do minimum" (a realistic option that meets core requirements} Do Minimum – continue with Mobile scanners
OPTION 3:	Additional options which meet the requirements of a CDC and have additional benefits of VFM and health population outcomes.

	Mexborough Montagu Hospital (MMH) –Purchase MRI and CT Scanners and MMC Build on MMH site
OPTION 4:	Additional options which meet the requirements of a CDC and have additional benefits of VFM and health population outcomes. Mexborough Montagu Hospital (MMH) – Purchase MRI and CT Scanners and MMC Build on MMH site including space for 2 Ultrasound rooms.
OPTION 5:	Additional options which meet the requirements of a CDC and have additional benefits of VFM and health population outcomes. Mexborough Montagu Hospital (MMH) – Purchase MRI and CT Scanners and MMC Build on MMH site including space for 2 Ultrasound rooms and reporting facilities using Traditional Build methods.
Option 6	Additional options which meet the requirements of a CDC and have additional benefits of VFM and health population outcomes. Mexborough Montagu Hospital (MMH) – Purchase MRI and CT Scanners and MMC Build on MMH site including space for 2 Ultrasound rooms and reporting facilities using Traditional Build methods. Build a second floor to include cardiorespiratory services. This option was considered not viable with the restrictions on the financial budget at the time.

Details for the options are given in the tables below:

OPTION 1	Business as Usual Do minimum to change from current state
COSTS	No costs
TIMESCALES	n/a
ADVANTAGES	No added costs No loss of car parking spaces
DISADVANTAGES	No continuing benefits to patients of a CDC located away from acute care No continuation of improved outcomes with faster diagnosis and faster treatment No Permanent solution reduction in waiting lists and no additional capacity for the system No added Improvement in Faster Diagnostic Framework (FDF) achievement

OPTION 2	Continue with Mobile vans MRI and CT
COSTS	
TIMESCALES	Continuation from previous contract
ADVANTAGES	Improvement in RDS or FDS achievement for with requirements of a CT and MRI Reduce backlogs over time
DISADVANTAGES	Doesn't mitigate true problem for clinical specialities backlogs with limiting to CT and MRI 2 days per week Cost of project and funding availability Missed opportunity for NHS owned assets for long term sustainability Missed opportunity with regards for training facilities and workforce developments

OPTION 3	MMC build MRI and CT
COSTS	£ TBC
TIMESCALES	Design 12 weeks 7months
ADVANTAGES	Construction shorter- done off site (saving on site costs) Offsite manufacturer- monitored in terms of quality Potentially bigger building- built in modules Limitations to specification
DISADVANTAGES	Principle contractors- not part of a package. Level of radiation within walls potentially higher- RPA to be involved Vibration of MRI scanners Removing equipment in and out of build- needs robust detail 35 years lifecycle Modular structure restricts layout Re-allocation of car parking spaces Installation of new Electrical Infrastructure

OPTION 4	MMC Build to include CT and MRI and space for 2 ultrasound rooms
COSTS	£ TBC
TIMESCALES	Design 12 weeks to 7 months Can be done to the same timescales as option 2 and 3
ADVANTAGES	Ultrasound will be installed onsite straight away Efficiency in reception teams, safety – sufficient number of staff teams in one building Resus access Efficiency from radiologist on site as all modalities are together – reporting efficiency 7 day access to unit
DISADVANTAGES	Principle contractors- not part of a package. Level of radiation within walls potentially higher- RPA to be involved Vibration of MRI scanners Removing equipment in and out of build- needs robust detail 35 years lifecycle Modular structure restricts layout Re-allocation of car parking spaces Installation of new Electrical Infrastructure

OPTION 5	Traditional build to include MRI and CT and space for 2 ultrasound rooms
COSTS	£TBC
TIMESCALES	Design 12 weeks to 7 months Can be done to the same timescales as option 2 and 3
ADVANTAGES	The layout of the building can be made to exact specifications Ultrasound will be installed straight away Efficiency in reception teams, safety and resus, more professionals in one place with having opportunity to have all Imaging modalities in one place Efficiency from radiologist as all together Opportunity with regards for training facilities and workforce developments Continuing benefits to patients of a CDC located away from acute care Continuation of improved outcomes with faster diagnosis and faster treatment Permanent solution reduction in waiting lists and additional capacity for the system Improvement in Faster Diagnostic Framework (FDF) achievement
DISADVANTAGES	Re-allocation of car parking spaces Installation of new Electrical Infrastructure

OPTION 6	Potential for another floor for cardiorespiratory
COSTS	Escalation of cost due to 2nd floor
TIMESCALES	Increased timescale
ADVANTAGES	Additional capacity Cardio Respiratory
DISADVANTAGES	Cost implications – restricted budget
	Taken out due to being over the financial budget

Costs:

It was noted for the scoring that the costs were not supplied due to being and subject to change once further information was acquire from architects and MMC providers. Due to time restrictions not all quotations for works were able to be supplied when the scoring took place. These have now been updated and added to the financial summary in Section 6 Finance Case.

Options Review
A scoring exercise took place between 23rd September 2022 and 5th October 2022 with key stakeholders, to score the options above based on defined Critical Success Factors and Investment Objectives.

Key stakeholders identified for scoring option:

- Associate Director of Operations-DBTH
- Head of Capital Infrastructure-DBTH
- Head of Radiology – Clinical Specialities Division- DBTH
- Management Accountant & DoF Divisional Accountant- Finance & Healthcare Contracting Directorate- DBTH
- Procurement Head of Procurement – Finance & Healthcare Contracting Directorate-DBTH
- HR Services DRI People Business Partner- P&OD DBTH

The scoring exercise identified that Option 5 was the preferred option. This option gives additional capacity for CT and MRI including space for 2 Ultrasound rooms and reporting facilities all in one unit and helps with patient and service management.

Option 5 - Montagu Hospital is an existing health care facility owned by the Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust. As per the CDC guidance the primary considerations for estates have been considered and this site is a good strategic fit, which also meets the business needs and has the capability to accommodate the extra capacity fairly seamlessly due to the following reasons:

MMH is:

- Separate to emergency diagnostic facilities, located away from an acute site where diagnostic tests can be done safely. On a site that already provides outpatients, day case, a minor injuries unit and inpatient rehabilitation unit, with the ability to provide a separate entrance to a CDC facility.
- Configurable to meet specifications of the required diagnostic services as per the CDC requirements
- Able to provide sufficient capacity to manage infection and ensure a covid-19 minimum environment

- Location is in a relatively disadvantaged area in west Doncaster and the adjoining areas in Barnsley and Rotherham, and as such will increase access to diagnostics for a number of disadvantaged communities.
- Serviced by public transport and there are also well-established transport links between
- Doncaster Royal Infirmary and Montagu Hospital that could be further built upon with potential to expand pending feedback from patient engagement activities such as patient satisfaction feedback through friends and family tests.
- Has sufficient parking facilities for patients, carers and staff
- Able to facilitate the imaging activities needed by a CDC
- Can be further enabled with network connectivity building on the existing IT infrastructure
- Has the potential to be accessible for extended hours as a self-contained Imaging Suite.
- Has potential to contribute to CDC cross cutting themes, including supporting DBTH as an Anchor institute
- Enabled to support the equalities and health inequalities agenda by planning for the facilities to accommodate reasonable adjustments
- Enabled to meet health and safety and accessibility guidance
- Practically possible to initiate development to maximise elective recovery and enable transformation of diagnostics services, separating planned and un-planned diagnostics, with a sustainable future proof model with static CT and MRI scanners
- Keeping all Imaging modalities together in one space to improve efficiency of the service and ensure safety for patients and procedures.

This phase of the expansion of the Montagu CDC due condition to expedite the Business Case for static CT and MRI and its tight timescales of mobilisation, was deemed to be the best viable option which meets the main aim and objectives and CDC investment and is well situated geographically and in an area of high deprivation and need.

The traditional build option enables a purpose build modern and spacious building which provides a pleasant environment for both patients and staff and enables all Imaging facilities to be side by side with the added advantage of radiologist being available for any intervention, advice and reporting, thus improving patient outcomes.

In the longer term the CT and MRI are permanent, NHS-owned assets, this is deemed as the most appropriate way to increase capacity, with regards to both long term financial sustainability for the system and patient and staff experience.

5. COMMERCIAL CASE

Cost and Funding

The finances have been worked up in line with the requirements of the case. The Trust is seeking capital investment via PDC of £905k in 2022/23 and £13,704k for the build and associated equipment of the facility (and recurrent revenue of £2,269k (pre-inflation) from year six (2028/29), the revenue requirement is higher in earlier years due to the need of agency support until the training programme is fully established.

Procurement

All DBTH NHS FT procurement is carried out in line with the Trust policy and guidance for the procurement of goods, services and works which can be shared on request and commensurate with Standing Financial Instructions etc. The Trust also has an 'Estates Capital Procedure and Quality Policy' and the works will be also managed through this, giving further assurance to the project.

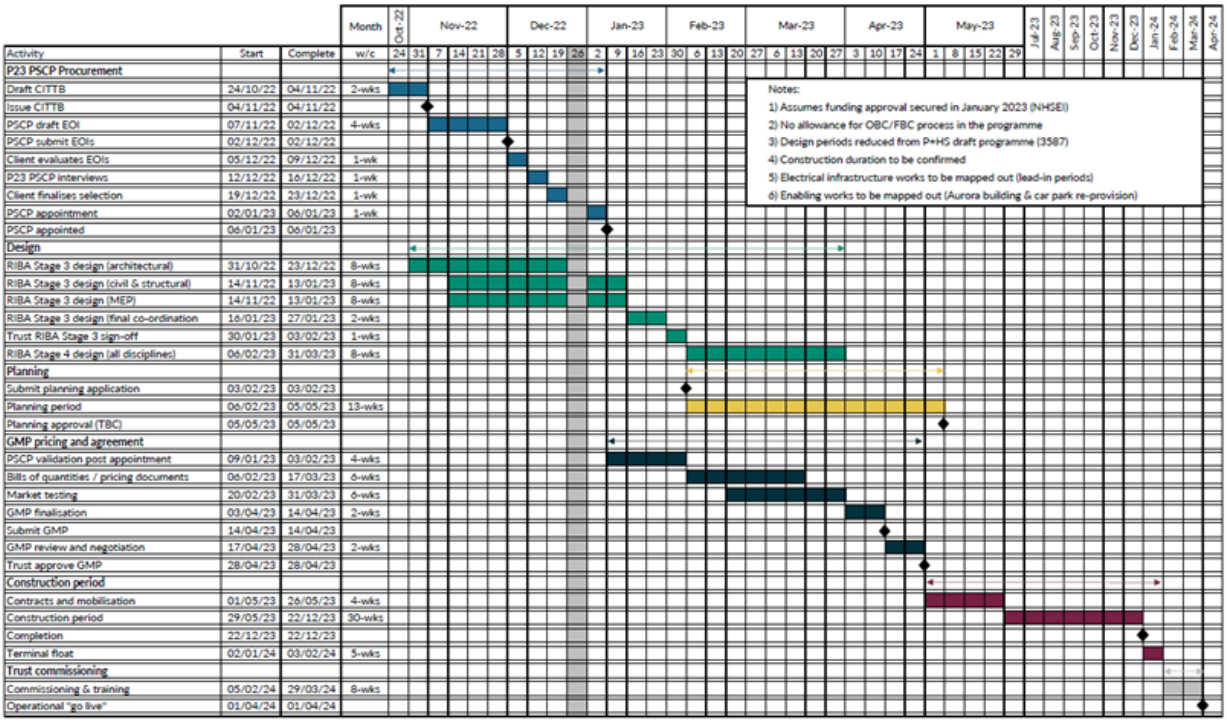
The Trust will own all equipment procured through the contract and be responsible for the operation, maintenance and replacement in the future.

The initial high-level design and cost plans have been developed for this business case up to Stage 2 (Concept Design) of the RIBA Work Plan. These will continue to be delivered at risk in order that the programme can be maintained which was a pre-requisite of the approval of Phase 2, and consequently, the Trust would seek to recover these costs whether the business case was approved or otherwise. Due to the level of design works carried out by the current design team, the Trust would be looking to potentially novate the design team into which ever framework was chosen for the delivery of the overall facility.

It would be noted that the Trust have recently successfully undertaken an exercise to appoint its own framework contractors which were chosen on the basis of 60/40, Finance/Quality. However, the limit of this framework is £5m which may be exceeded by this particular phase.

The project team will therefore be looking to enter either into a mini competition in association with the 8no contractors on the North East Framework for P23 or other similar options though an alternative approved framework. A draft programme for the implementation of the P23 framework with ITT etc is suggested below.

Pre-Construction Programme



Activity	Start	Complete	w/c
P23 PSCP Procurement			
Draft CITTB	24/10/22	04/11/22	2-wks
Issue CITTB	04/11/22	04/11/22	
PSCP draft EOI	07/11/22	02/12/22	4-wks
PSCP submit EOIs	02/12/22	02/12/22	
Client evaluates EOIs	05/12/22	09/12/22	1-wk
P23 PSCP interviews	12/12/22	16/12/22	1-wk
Client finalises selection	19/12/22	23/12/22	1-wk
PSCP appointment	02/01/23	06/01/23	1-wk
PSCP appointed	06/01/23	06/01/23	
Design			
RIBA Stage 3 design (architectural)	31/10/22	23/12/22	8-wks
RIBA Stage 3 design (civil & structural)	14/11/22	13/01/23	8-wks
RIBA Stage 3 design (MEP)	14/11/22	13/01/23	8-wks
RIBA Stage 3 design (final co-ordination	16/01/23	27/01/23	2-wks
Trust RIBA Stage 3 sign-off	30/01/23	03/02/23	1-wks
RIBA Stage 4 design (all disciplines)	06/02/23	31/03/23	8-wks
Planning			
Submit planning application	03/02/23	03/02/23	
Planning period	06/02/23	05/05/23	13-wks
Planning approval (TBC)	05/05/23	05/05/23	
GMP pricing and agreement			
PSCP validation post appointment	09/01/23	03/02/23	4-wks
Bills of quantities / pricing documents	06/02/23	17/03/23	6-wks
Market testing	20/02/23	31/03/23	6-wks
GMP finalisation	03/04/23	14/04/23	2-wks
Submit GMP	14/04/23	14/04/23	
GMP review and negotiation	17/04/23	28/04/23	2-wks
Trust approve GMP	28/04/23	28/04/23	
Construction period			
Contracts and mobilisation	01/05/23	26/05/23	4-wks
Construction period	29/05/23	22/12/23	30-wks
Completion	22/12/23	22/12/23	
Terminal float	02/01/24	03/02/24	5-wks
Trust commissioning			
Commissioning & training	05/02/24	29/03/24	8-wks
Operational "go live"	01/04/24	01/04/24	

Notes:
1) Assumes funding approval secured in January 2023 (NHSE))
2) No allowance for OBC/FBC process in the programme
3) Design periods reduced from P+HS draft programme (3587)
4) Construction duration to be confirmed
5) Electrical infrastructure works to be mapped out (lead-in periods)
6) Enabling works to be mapped out (Aurora building & car park re-provision)

Please note the following:

1. The programme is extremely tight and doesn't have any slack for delays in decision making
2. The electrical infrastructure works needs co-ordinating with the programme as the order for the substation will need to be placed at risk of planning and GMP approval (currently 30-week lead-in period)
3. The enabling works for the Aurora Building provisions and demolition and car park re-provision needs to be factored in, but again this would need to be undertaken at risk of GMP and planning.
4. The design periods have been trimmed from previous draft programme iterations to make the overall programme work – this will need to be revied with the rest of the design team.
5. The programme aligns with the P23 timeline. A small slippage could be accommodated (reduce PSCP validation period post award from 4 to 2 weeks), although this still would need to be expedited speedily.

The project is a new build and lends itself to MMC options as well as traditional build options, although both have been assessed in terms of value for money and delivery capability and recommendations within this Business Case lean towards a traditional build solution.

Where standardisation is possible it will be used and any repeatable elements implemented.

Where applicable carbon reduction will be factored in and where required will be equivalent to BREEAM 'Excellent'

During the works, all existing services will be protected and maintained to ensure continuous operations of adjacent buildings. There may be localised shut downs however, which will be closely planned and co-ordinated.

6. FINANCIAL CASE

As stated above, the requirement of this business case is a further development of the approved phase 2a case which aims to put in place a permanent static building for both MRI and CT which was originally approved on the use of mobile vans. The detail below outlines the financial assumptions and values attributable to the design, build and ongoing running costs of the static building only and does not include the continued costs associated with the current mobile arrangement and ongoing requirement until the opening of the facility outlined in this case which have already been approved in phase 2a.

The overall financial assumption for this case is that both capital and revenue funding will be provided to cover the delivery requirements of the case and so it is expected that the case will have no overall impact on the Trust's finances.

The overall costs associated with the proposed build facility which show capital costs of £905k in 2022/23 and £13,704k in 2023/24 and recurrent revenue of £2,269k (pre-inflation) from year six (2028/29), the revenue requirement is higher in earlier years due to the need of agency support until the training programme is fully established.

Capital costs	**£m**
Building work	12.3
Medical Equipment	2.2
IT equipment / Other	0.1
Total capital costs (2022/23 & 2023/24)	**14.6**

Capital costs for the build have been developed with external cost advisors to the Trust supporting on the design requirements of the build, it is important to note that the costs currently are estimates as GMP costs are not available at this stage, but the inclusion of contingency and optimism bias has been included to mitigate any financial risk. Equipment requirements have been developed by Trust colleagues and quotations have been provided with the support of procurement and IT colleagues to provide a complete capital cost.

The table below provides a summary position of the I&E impact of this case for the first 10 years, from year six (2028/29) the revenue costs become recurrent at a cost of £2,269k, the below costs have been adjusted to include inflation.

The table below provides a summary position of the I&E impact of this case for the first 10 years, from year six (2028/29) the revenue costs become recurrent at a cost of £2,269k, the below costs have been adjusted to include inflation.

	Year 0 2022/23	Year 1 2023/24	Year 2 2024/25	Year 3 2025/26	Year 4 2026/27	Year 5 2027/28	Year 6 2028/29	Year 7 2029/30	Year 8 2030/31	Year 9 2031/32
INCOME & EXPENDITURE										
Revenue Costs - Pay	0	-400	-1,816	-1,893	-1,519	-1,129	-1,067	-1,089	-1,112	-1,136
Revenue Costs - Non Pay	0	0	-461	-829	-842	-855	-868	-882	-895	-909
Depreciation / Impairment	0	-8,063	-296	-296	-296	-296	-296	-296	-296	-296
NHSEI/NHSD Revenue Funding	16	533	2,809	3,256	2,895	2,518	2,468	2,505	2,541	2,579
Net Operating Surplus / (Deficit)	16	-7,930	235	238	237	238	237	238	237	238
PDC Charges	-16	-133	-236	-237	-237	-238	-238	-238	-238	-238
Net Surplus / (Deficit)	0	-8,063	0	0	0	0	0	0	0	0
Add back Impairment		8,063								
Adjusted Net Surplus / Deficit	0	0	0	0	0	0	0	0	0	0

The sections below highlight the key costs and assumptions included in the above financial summary:

1. Pay – The staffing requirements for the clinical model have been provided by the division which have been costed based on 22/23 Agenda for Change rates, support staff for the division and corporate areas have been considered and included where required.

2. Non-Pay – This includes costs associated with clinical consumables, recurrent IT costs for licences and also the increased lifecycle costs associated with expanding the Montagu site, which has been adjusted to reflect the current increase in utility prices as well as the increased usage based on the requirements to run both MRI and CT 7 days a week.

3. Inflation – All costs and funding have had the inflationary assumptions applied as per the Long-Term Plan

4. VAT – The inclusion of VAT has been incorporated into both the capital and revenue costs as appropriate.

5. Impairment – The financial assessment includes an impairment adjustment of £8,063k following completion of the build, this is based on independent valuer assessment which has been completed. This adjustment equates to nearly 70% of the build value, which is due to significantly higher construction costs being seen as a result of labour shortages from Covid-19, Brexit and the current economic turmoil.

6. Depreciation – The calculation included is based on a 60-year life of the building, with the build cost adjusted for the above impairment valuation and also a residual value after 60 years of £1.5m as provided by the independent valuers.

7. Public Dividend Capital (PDC) – This is produced through the Long-Term Financial Model (LTFM).

7. MANAGEMENT CASE

The Estates & Facilities Directorate's Capital Planning Unit (CPU), will manage and deliver the construction element of the scheme and manage the input of the client-side stakeholders in terms of the requisite input in the detailed design, including clinical representatives, IPC, Estates & Facilities, and Fire Safety etc.

A Project Manager from the CPU will be dedicated to being the primary contact for the build through from detailed design through to commissioning and hand over, including the first-year defects liability period.

CDC planning has been coordinated across the ICS, with developments supported to meet local population needs and tackle diagnostic challenges. Approval has been sought through appropriate governance arrangements, including Trust and CCG governance in each place, the developing SY Provider Collaborative and ICB shadow governance arrangements.

The delivery of the scheme will be overseen by a working group comprising clinical, estates, project management, and operational, representatives.

The works will be project managed and overseen by the Trusts Capital Projects Team and carried out by one of the new Trust framework contractors in association with the IT department and contractors.

The ongoing management will be via the Clinical Specialties Division.

SYB Commissioners are in support of the Phase 2 Montagu CDC proposals being put forward for year 2.

There is an understanding that the CDC developments to date each provide an opportunity to develop community diagnostics in a way that addresses identified areas of challenge for different diagnostic modalities in different places in SYB and that the system will have an opportunity to learn from these approaches to inform its longer-term plan. However, it continues to be within a challenging environment that we progress this work, with uncertainty around the funding growth that can be anticipated in future years and the priorities that this will need to support, in addition to the transition from CCGs to an ICB that most recently has been delayed until July 2022.

It is within this environment that commissioners support the proposals being put forward and will continue to be in active dialog with providers in each place and as a system to ensure a range of options are in place to support planning and delivery beyond year 2 in a flexible way that minimises risk for all parties and maximises the potential benefits from CDCs.

Project management

This is one of the key Strategic Projects for DBTH to enhance services for patients, reduce waiting times and gain better access to diagnostic services in a community setting. It is being managed internally with Director of Recovery, Innovation and Transformation as Senior Responsible Owner (SRO) and as a dedicated project manager.

The Capital Planning Unit (Part of the RIT Directorate) have managed the design, cost planning and programming for the facility and will oversee and manage the procurement and delivery, commissioning and post contract period of the build.

Governance

DBTH have established a Transformation Board and CDC Steering group and CDC working groups with lines of governance to Trust Executive Group, SY&B ICS CDC Project Board and Cancer Alliance. Membership of the groups consists of all relevant stakeholders across the SYB ICS.

TRANSFORMATION BOARD MEMBERSHIP	STEERING GROUP MEMBERSHIP
Title & Organisation	**Title & Organisation**
Chair- SRO Director of Recovery Innovation & Transformation	Chair- Strategic programmed Manager S&I DBTH
Director of Restoration, Innovation & Transformation	Deputy Chair- Senior Project Manager , Cancer Transformation DBTH
Deputy Chair- Chief Nurse	Medical Director, Operational Stability & Optimisation DBTH
Director of Finance & Estates	RDS Clinical Lead
Executive Medical Director	GP Cancer Lead DCCG
Director of People & Organisational Development	Deputy Director of Nursing, Cancer & Chemotherapy DBTH
Chief Operating Officer	Speciality lead Nurse GI
Communications Lead	Transformation Programme Lead SYB ICS
Chief Information Officer	General Manager D&P Clinical Specialities DBTH
Director of Estates & Head of Capital Infrastructure	Head of Financial Planning, Commissioned Income & Costing, DBTH
Divisional Director CSS and Surgery & Cancer	Cancer Services Manager DBTH
ICS Representative	Senior Communications & Engagement Manager DBTH
ICB Representative NHS South Yorkshire	Head Of Re-design & Transformation BCCG
GP Federation Lead	Divisional Director D&P Clinical Specialities
Deputy Director of Nursing, Cancer & Chemotherapy DBTH	Joint Ageing Well Lead- Commissioner DCCG
Provider Alliance Lead	Project Manager (CDC) S&I DBTH
	Head of Radiology DBTH
	Head of Biomedical Science - Histopathology
	Divisional Director of Operations Surgery & Cancer DBTH
	Head of Capital Infrastructure

IT & DATA Membership	Key responsibilities
IT Business Partner	Optimise IT Solutions and data flows for the CDC Develop IT Solutions Agree implementation plan for developments
Data Analyst DCCG	
Cancer Manager- DBTH	
Information Analyst	
Clinical Team- Matron	
Inflo-flex System Manager	

Clinical Coding	Develop and ensure information management requirements Review information governance arrangements
IT & Data Focus	
IT Development and Solutions	
Management Information Flows	
Reporting Requirements	
Information Governance – Data Transfer	

Clinical Pathway Model and Operation -Membership	Key Responsibilities
Deputy Director of Cancer & Chemotherapy	Enhance patient care Clinical & Operational Protocols Develop a clinical model SOPs and Pathways Workforce Model Clinical and service quality Education and Training Evaluation
Head of Radiology	
Endoscopy Lead nurse	
Senior Project Manager Cancer	
GM Surgery & Cancer Services	
General manager D&P	
	Pathway Focus
Cardiology MS Consultant	MDT Development Clinical Documentation Clinical guidance
Endoscopy lead nurse	
Head Of Radiology	
Principal Clinical Physiologist	
Business Manager	

Communications & Engagement Membership	Key Responsibility
Communication & Engagement Team DBTH	Oversee Comms and Engagement plan and activities Develop proactive briefings and coordinate communications Develop approach to patient and public engagement Ensure joined up and consistent approach aligned to regional and national communications plans
Project Manager	
Healthwatch Doncaster	
Director of Digital DCCG	
Endoscopy Lead nurse	
External Comms – GP/Primary Care	

Project assurance

SY&B ICS and local CCG independent scrutiny is in place and overarching programme management via Strategic Programmes Manager at DBTH.
Completed workbook and highlight report of Risks and Issues taken to CDC Steering group monthly.

Change management

These proposals include funding arrangements for a dedicated Project Manager who will act as a change management agent and Lead Nurse position who will lead this service improvement and change.

Benefits realisation plans

In the context of the above and the Trust Strategic Objectives outlined in section 2.1.5, the investment objectives for this project are detailed below, alongside the service benefits. It is important to note that the agreement of the following benefits has been via the Transformation Board/Steering group and wider stakeholder involvement.

Risk management plans

The Risk Register will be incorporated within the DBTH Strategic Project workbook and will be updated and tracked by CDC Project Manager and Lead Nurse and reported to CDC Steering group and CDC meetings with areas of escalation going to Trust Executive Group/Board of Directors dependent on level of issue.

All projects are subject to risk and uncertainty. Successful project management should ensure that major foreseeable risks are identified, their effects considered, and actions taken to remove, or mitigate the risks concerned.

Risks will be categorised and managed in line with the Trusts Risk Identification, Assessment and Management Policy.

Contract management arrangements and plans

As noted previously, DBTH NHS FT procurement is carried out in line with the Trust policy and guidance for the procurement of goods, services and works which can be shared on request and commensurate with Standing Financial Instructions etc. The Trust also has an 'Estates Capital Procedure and Quality Policy' and the works will be also managed through this, giving further assurance to the project.

The Trust will own all equipment procured through the contract and be responsible for the operation, maintenance and replacement in the future.

The initial high-level design and cost plans have been developed for this business case up to Stage 2 (Concept Design) of the RIBA Work Plan. These will continue to be delivered at risk in order that the programme can be maintained which was a pre-requisite of the approval of Phase 2, and consequently, the Trust would seek to recover these costs whether the business case was approved or otherwise. Due to the level of design works carried out by the current

design team, the Trust would be looking to potentially novate the design team into which ever framework was chosen for the delivery of the overall facility.

It would be noted that the Trust have recently successfully undertaken an exercise to appoint its own framework contractors which were chosen on the basis of 60/40, Finance/Quality. However, the limit of this framework is £5m which may be exceeded by this particular phase.

The project team will therefore be looking to enter either into a mini competition in association with the 8no contractors on the North East Framework for P23 or other similar options though an alternative approved framework. A draft programme for the implementation of the P23 framework with ITT has been tabled earlier in the document.

All risks will be dealt with openly from the outset and the Trust. The preferred bidder will actively contribute to the identification, mitigation and apportioning risk to the relevant party. This process will continue throughout the project. Please note however that proceeding on cost plan only does come with associated risk in terms of cost certainty as final tendered costs will not have been sought or an understanding of ground conditions etc. An allowance will be made for this within the cost plan, but hyper-inflation also may affect the final contract values.

Through the selected framework, the Principle Contractor will:

- Take single point responsibility for managing the design and construction process through to completion
- Pull together a team from its supply chain partners to successfully deliver the scheme.
- Commit to providing construction solutions that will provide best value.
- Provide the benefits of having experience of long-term partnering arrangements through the new contractor framework agreement

8. POST EVALUATION ARRANGEMENTS AND PLANS

Post Implementation Review

Project Review will take place 6 months after mobilisation and continuous performance management of CDC by PM and Nurse Lead for first year of mobilisation and then onward operational management structure will be put in place.

The end stage of the project will result in the completion, handover, and commissioning of the new facilities. The Transformation board is responsible for providing assurance that the project has been delivered in terms of product and quality in line with the Business Case.

A Post Project Evaluation will take place 6 months after mobilisation of the new CDC. PIR template is attached in Appendix 8, this will ensure that lessons can be learnt from this project for future developments.
Areas covered within the review are:

- Provide a brief description of the project including:

What was the purpose of the project?
What was the need for the project?
In what way did the project support the Strategic Direction of the Trust?

- Assessment of Costs

- Assessment of Deliverables
- Assessment of Benefits
- Assessment of Risks
- Assessment of duties
- Skills Transfer
- Assessment of Project Management Arrangements
- Assessment of Economic/Commercial Impact
- Conclusion and Recommendations

Objectives and targets will be reviewed on a continuous basis via the care group management team and care group accountability monthly meetings.

9. CONCLUSION AND RECOMMENDATION

In conclusion, to meet increased activity and demand DBTH needs to expand in line with Sir Mike Richards Recovery and Renewal programme. The separation of planned and unplanned diagnostics and recommendations to improve efficiency; increasing diagnostic capacity at Montagu Hospital supports this by increasing capacity for planned work at a covid light site.

Benefits of a large Community Diagnostic Centre at MMH:

- Patients have access to diagnostic tests at this modern facility away from a busy hospital. This is part of the new recommended way forward for the NHS and has become more important as a result of the global pandemic.
- This helps us to prioritise the capacity that we have available at our other hospitals for emergency patients or those who are already in the hospital. This is not only good for our patients, but also the way we care for people across Doncaster Bassetlaw and Mexborough by enabling them to have imaging scans away from the acute hospital.
- This centre is a major step forward in addressing the rising demand for diagnostic services across the region and collaborative working across the ICS.
- These facilities will also support potential ICS changes in future care pathways
- The CDC will tackle health inequalities and drive population health outcomes,
- Provide quicker and more convenient access to testing, whilst improving patient experiences of the diagnostic process.

The aim that the development of integrated, symptom-based pathways will be agreed upon between primary and secondary care, implementing learning from changes made as a result of COVID-19.

The MMH CDC will enhance high quality care for our patients, as well as enabling DBTH to be equipped for the future as a leading provider of health care services in the region.

The Community diagnostic centre will offer countless operational benefits, creating a sustainable, efficient, and digitally enabled diagnostics service fortified to withstand the evolving pressures the NHS faces.
It is essential that as a Trust and a Teaching Hospital and anchor institution, we embrace the learnings of the pandemic, and the opportunity for change, to ensure its legacy is one of transformation.

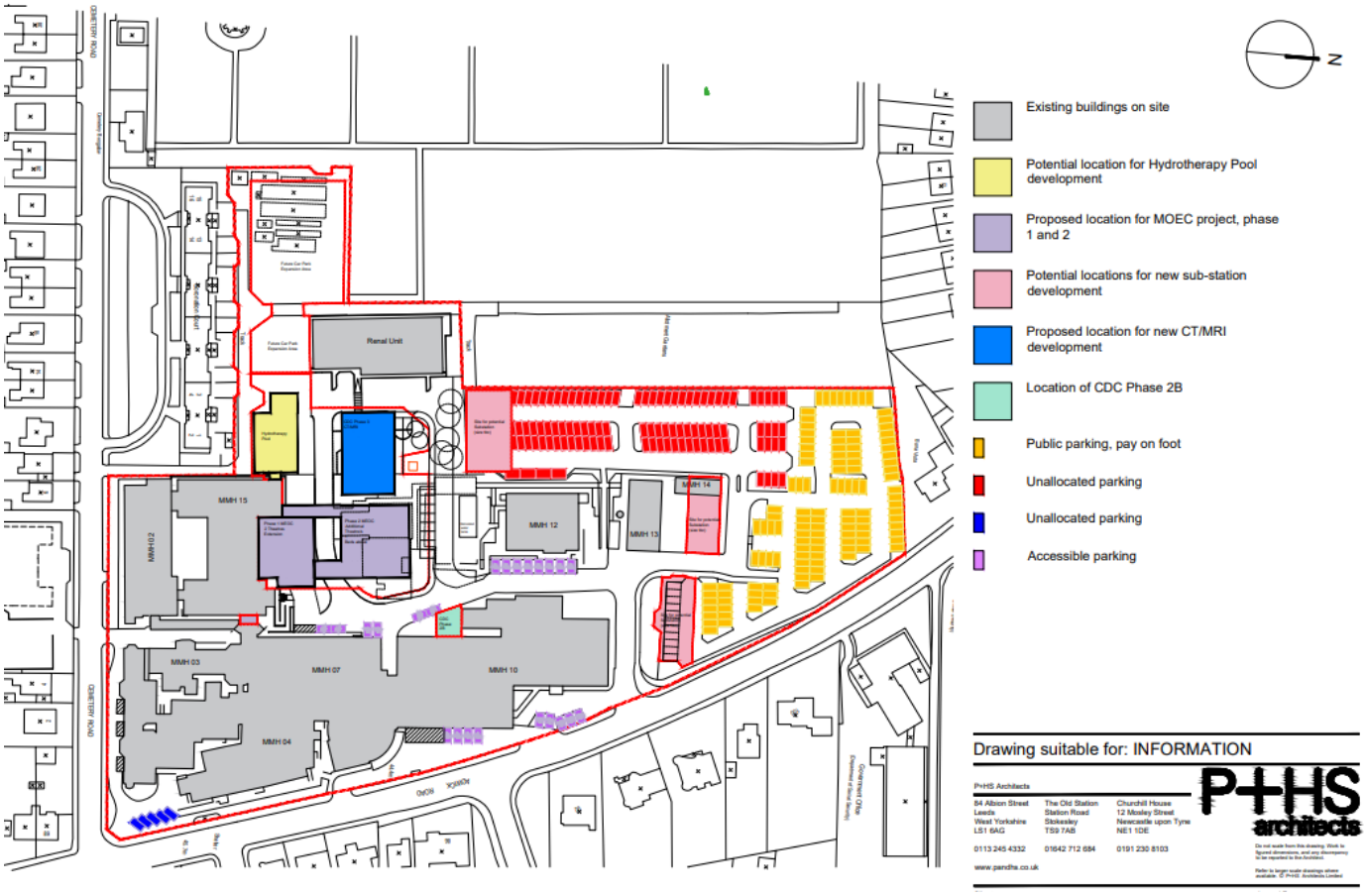
The preferred option is Option 5 after scoring exercise.

This option will be achievable with National NHSEI CDC Team funding approval and will be undertaken mitigating clinical risk, giving optimum estate and facilities to manage the increased activity.

9. CONTINGENCY PLAN (NOT APPLICABLE)

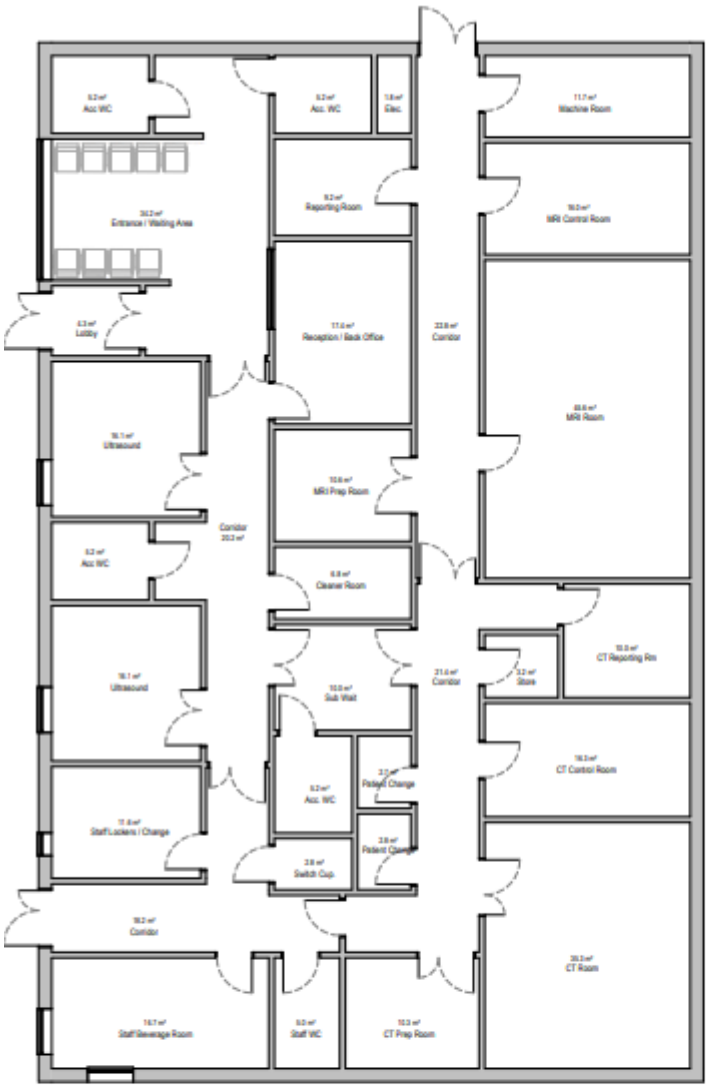
Appendix 1.

SITE DEVELOPMENT CONTROL PLAN MMH



Appendix 2.

FLOOR PLAN – IMAGING SUITE



GROUND FLOOR PLAN

1 : 100

0 1 2 3 4 5 10m

Scale 1:100

AREA SCHEDULE - GIA	
Name	Area
GIA	450.74 m²

ROOM SCHEDULE - LEVEL 00	
Room Name	Area
Staff Beverage Room	16.7 m²
Corridor	18.2 m²
Staff WC	5 m²
Staff Lockers / Change	11.6 m²
Ultrasound	16.1 m²
Acc WC	5.2 m²
Ultrasound	16.1 m²
Sub Wait	10 m²
Cleaner Room	6.8 m²
MRI Prep Room	10.6 m²
CT Room	35.3 m²
CT Control Room	16.3 m²
MRI Room	45.6 m²
Machine Room	11.7 m²
Reception / Back Office	17.4 m²
Acc. WC	5.2 m²
Acc WC	5.2 m²
Switch Cup.	2.8 m²
Acc. WC	5.2 m²
Patient Change	2.7 m²
Patient Change	2.8 m²
Store	3.2 m²
Corridor	21.4 m²
CT Reporting Rm	10 m²
CT Prep Room	10.3 m²
Corridor	22.8 m²
Entrance / Waiting Area	34.2 m²
Corridor	20.2 m²
Reporting Room	9.2 m²
Lobby	4.3 m²
Elec.	1.8 m²
MRI Control Room	16 m²

Area of Plant Room or Plant enclosure excluded from GIA.
Room areas subject to further review with clinical team.

P+HS architects

Doncaster and Bassetlaw Hospitals

3588 CDC Phase 3 CT/MRI

3588 - PHS - XX - 00 - DR - A - 010

Proposed Ground Floor Plan

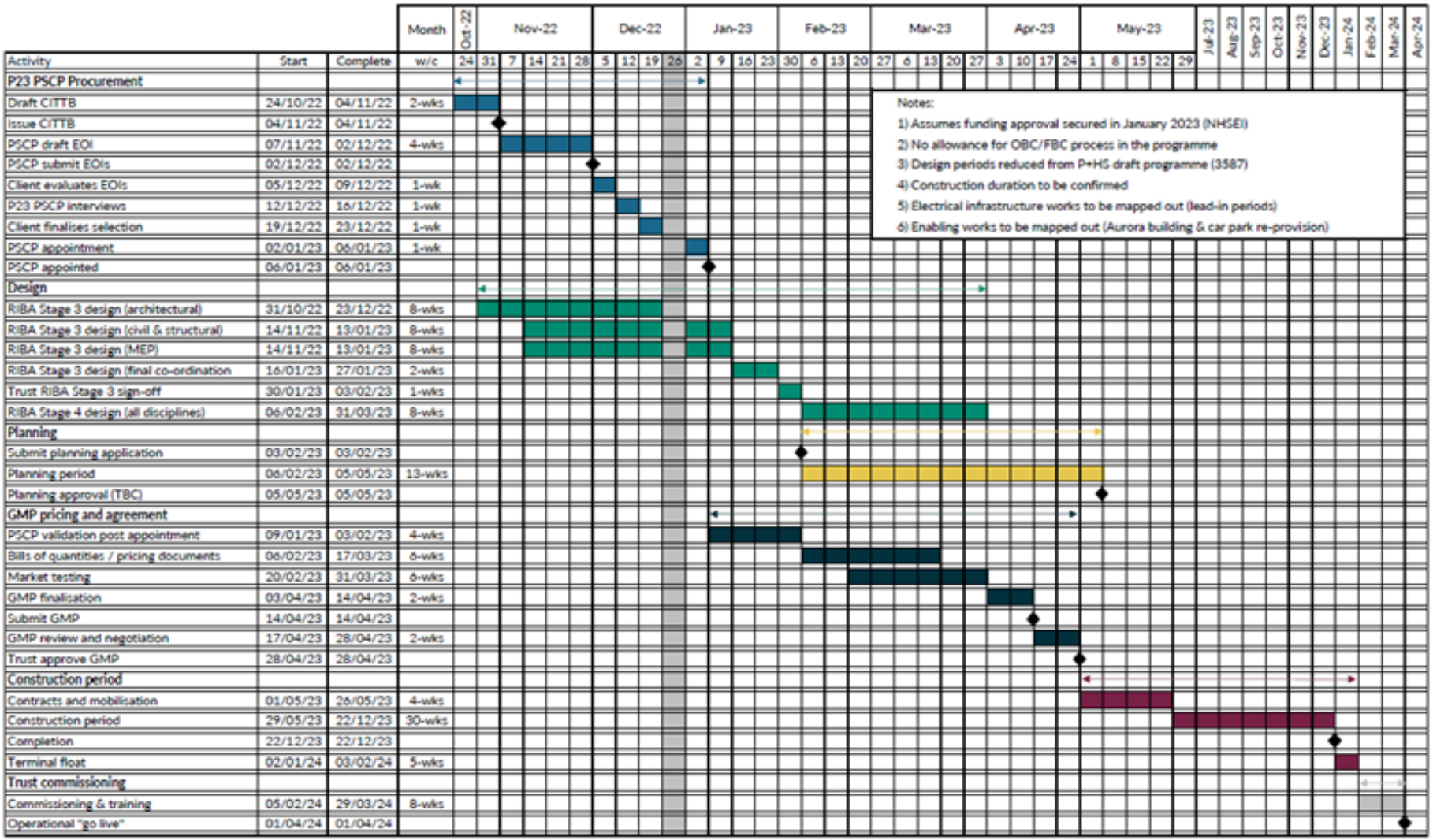
S2 INFORMATION P01

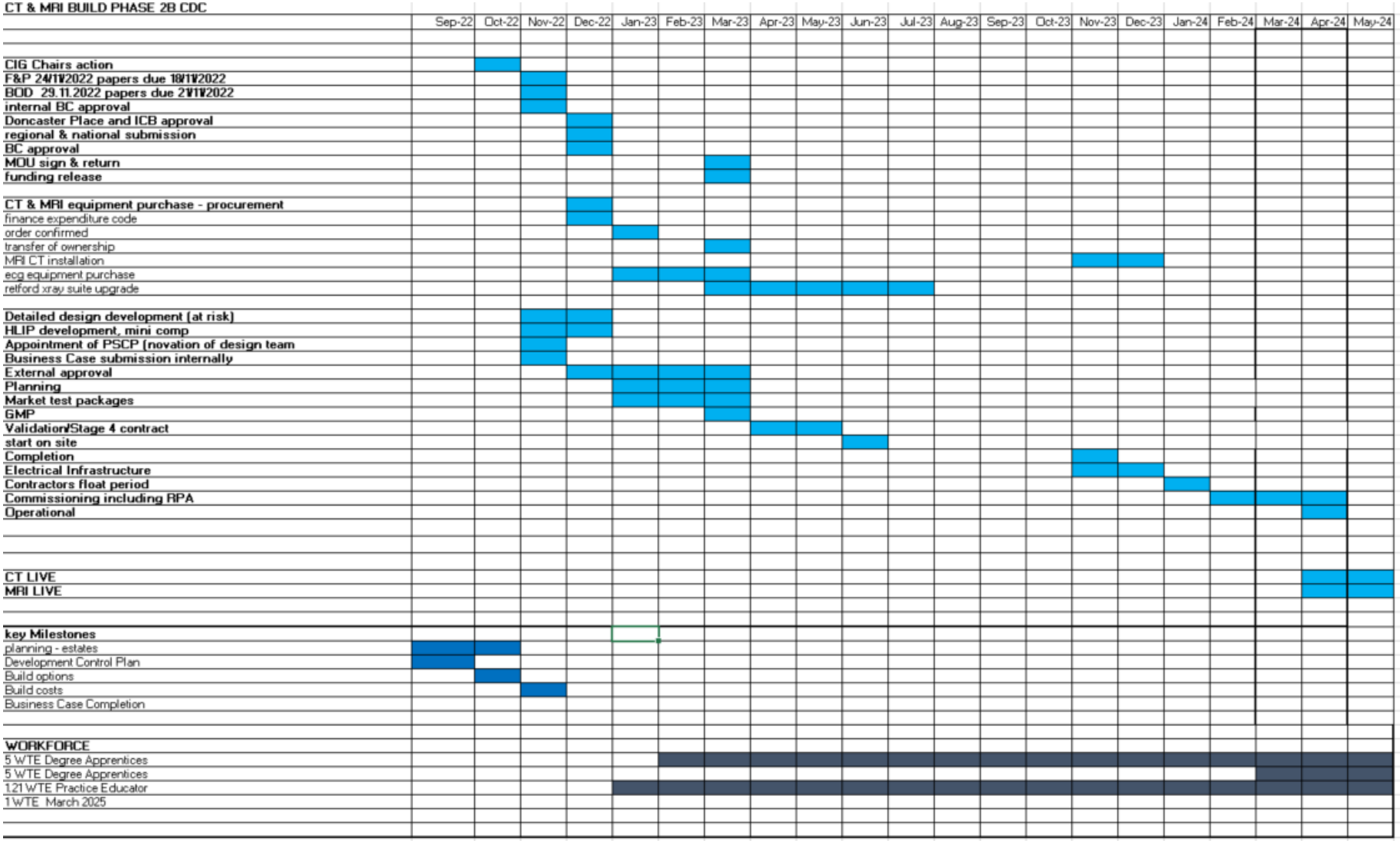
PK PS 11.10.22 1 : 100

APPENDIX 3. Construction/delivery Plan

Pre-Construction Programme

Activity	Start	Complete	Month	w/c
P23 PSCP Procurement				
Draft CITTB	24/10/22	04/11/22	2-wks	
Issue CITTB	04/11/22	04/11/22		
PSCP draft EOI	07/11/22	02/12/22	4-wks	
PSCP submit EOIs	02/12/22	02/12/22		
Client evaluates EOIs	05/12/22	09/12/22	1-wk	
P23 PSCP interviews	12/12/22	16/12/22	1-wk	
Client finalises selection	19/12/22	23/12/22	1-wk	
PSCP appointment	02/01/23	06/01/23	1-wk	
PSCP appointed	06/01/23	06/01/23		
Design				
RIBA Stage 3 design (architectural)	31/10/22	23/12/22	8-wks	
RIBA Stage 3 design (civil & structural)	14/11/22	13/01/23	8-wks	
RIBA Stage 3 design (MEP)	14/11/22	13/01/23	8-wks	
RIBA Stage 3 design (final co-ordination	16/01/23	27/01/23	2-wks	
Trust RIBA Stage 3 sign-off	30/01/23	03/02/23	1-wks	
RIBA Stage 4 design (all disciplines)	06/02/23	31/03/23	8-wks	
Planning				
Submit planning application	03/02/23	03/02/23		
Planning period	06/02/23	05/05/23	13-wks	
Planning approval (TBC)	05/05/23	05/05/23		
GMP pricing and agreement				
PSCP validation post appointment	09/01/23	03/02/23	4-wks	
Bills of quantities / pricing documents	06/02/23	17/03/23	6-wks	
Market testing	20/02/23	31/03/23	6-wks	
GMP finalisation	03/04/23	14/04/23	2-wks	
Submit GMP	14/04/23	14/04/23		
GMP review and negotiation	17/04/23	28/04/23	2-wks	
Trust approve GMP	28/04/23	28/04/23		
Construction period				
Contracts and mobilisation	01/05/23	26/05/23	4-wks	
Construction period	29/05/23	22/12/23	30-wks	
Completion	22/12/23	22/12/23		
Terminal float	02/01/24	03/02/24	5-wks	
Trust commissioning				
Commissioning & training	05/02/24	29/03/24	8-wks	
Operational "go live"	01/04/24	01/04/24		




CT & MRI BUILD PHASE 2B CDC
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
CIG Chairs action
F&P 24/11/2022 papers due 18/11/2022
BOD 29.11.2022 papers due 21/11/2022
internal BC approval
Doncaster Place and ICB approval
regional & national submission
BC approval
MOU sign & return
funding release
CT & MRI equipment purchase - procurement
finance expenditure code
order confirmed
transfer of ownership
MRI CT installation
ecg equipment purchase
retford xray suite upgrade
Detailed design development (at risk)
HLIP development, mini comp
Appointment of PSCP (novation of design team
Business Case submission internally
External approval
Planning
Market test packages
GMP
Validation/Stage 4 contract
start on site
Completion
Electrical Infrastructure
Contractors float period
Commissioning including RPA
Operational
CT LIVE
MRI LIVE
key Milestones
planning - estates
Development Control Plan
Build options
Build costs
Business Case Completion
WORKFORCE
5 WTE Degree Apprentices
5 WTE Degree Apprentices
1.21 WTE Practice Educator
1 WTE March 2025

APPENDIX 4. Estates: Construction/delivery risk register

Montagu Hospital - Community Diagnostics Centre

Risk Register Date 02/02/2022

Ref	Type	Phase	Owner	Description		Probable Likelihood	Potential Impact	Assessed Value	
1	Programme	Pre-Construction	NHS Trust	Cost Plan increases during RIBA Stage 3/4		3	4	12	
3	Programme	Pre-Construction	NHS Trust	Business Case is not approved/delayed		2	4	8	
4	Cost/Commercial	Pre-Construction	NHS Trust	ICS funding is not available		3	4	12	
5	Programme	Pre-Construction	IHP	Design Programme delayed		3	4	12	
6	Design	Pre-Construction	NHS Trust	Stakeholder Engagement - not sufficiently comprehensive		3	4	12	

7	Programme	Pre-Construction	NHS Trust	Trust availability and decisions on design	2	4	8	
8	Programme	Pre-Construction	IHP	Planning conditions imposing pre-start conditions	2	3	6	
9	Other	Pre-Construction	IHP	Delays in achieving Statutory/ Necessary consents	3	4	12	
10	Design	Pre-Construction	IHP	Design development (general)	2	3	6	
11	Design	Pre-Construction	NHS Trust	Client Change of requirements/brief	3	4	12	
12	Design	Pre-Construction	NHS Trust	Existing unknown Site/Building/services conditions impacting construction	3	3	9	
13	Design	Pre-Construction	NHS Trust	Ecological and Environmental risks	1	3	3	
14	Programme	Pre-Construction	NHS Trust	Below ground obstructions including external and internal areas (i.e. concrete encasements)	1	3	3	
15	Design	Pre-Construction	NHS Trust	Existing site/building/services conditions/locations impacting on design	3	4	12	
16	Quality	Pre-Construction	NHS Trust	Missing unavailable site information	3	3	9	
17	Design	Pre-Construction	NHS Trust	Site infrastructure capacity insufficient	1	3	3	

18	Procurement	Pre-Construction	IHP	Net Zero Carbon Requirements		3	4	12
19	Procurement	Pre-Construction	NHS Trust	Identification of accurate Group 2 and 3 equipment and within cost plan		3	3	9
20	Procurement	Construction	NHS Trust	Ability of the Trust to provide group 2/3 FF&E items on schedule		1	3	3
21	Programme	Construction	NHS Trust	Presence of asbestos/hazardous materials		3	4	12
22	Programme	Construction	IHP	Increase in procurement periods/lead ins - Impact of Covid		4	4	16
23	Procurement	Construction	NHS Trust	Site Compound affecting parking and/or traffic		3	3	9
24	Programme	Construction	IHP	Amendment to delivery restrictions imposed by the Trust		1	2	2
25	Programme	Construction	NHS Trust	Reduction in Trust capacity during construction due to decantation with no provision for temp accommodation		3	3	9
26	Programme	Construction	NHS Trust	Availability of Trust personnel during consultation period		1	3	3
27	Programme	Construction	IHP	Construction logistics constraints on site (parking, Craneage, laydown and compound)		3	4	12
28	Programme	Construction	NHS Trust	Imposed working constraints forced by other Trust activities adjacent to work areas.		4	4	16

29	Programme	Construction	NHS Trust	Trust unable to achieve access dates due to clinical activities	1	3	3	
30	Programme	Construction	IHP	Construction duration unachievable	3	4	12	
31	Design	Construction	IHP	Construction Procurement delays	4	4	16	
32	Procurement	Construction	NHS Trust	Loose equipment damaged during decant	1	3	3	
33	Other	Construction	NHS Trust	Storage of any retained material, furniture or equipment (inc between phases)	1	3	3	
34	Quality	Construction	NHS Trust	Risk of disruption/harm to patients, staff and visitors in the live hospital environment from construction works	3	4	12	
35	Design	Construction	IHP	Damage to adjacent buildings/ vehicles caused by the Main Contractor and subcontractors	1	3	3	
36	Design	Construction	NHS Trust	Increases or decreases in activity due to service reviews (locally or regionally)	1	3	3	
37	Quality	Construction	NHS Trust	Procurement of Trust equipment	3	4	12	
38	Quality	Construction	NHS Trust	Unforeseen building features affecting demolition methodology & phasing	3	3	9	
39	Design	Construction	IHP	Subcontractor/Design Team insolvency	1	3	3	
40	Design	Construction	IHP	Damage to existing services/structures caused by Contractor	3	3	9	

41	Design	Construction	NHS Trust	Additional Temp works not currently allowed for	3	3	9	
43	Design	Construction	IHP	Risk of injury to Main contractor staff - within works areas	2	3	6	
44	Health & Safety	Construction	IHP	Risk of Injury to Subcontractor Operatives - within works areas	2	3	6	
45	Health & Safety	Construction	NHS Trust	Risk of Injury to Trust Personnel - within works areas	2	3	6	
46	Health & Safety	Construction	IHP	Risk of Injury to the Public	1	3	3	
48	Health & Safety	Construction	IHP	Maintaining live services	4	3	12	
49	Design	Construction	IHP	Insufficient staff allowance/availability for the duration of the project	3	4	12	
50	Procurement	Construction	NHS Trust	Covid 19/ Virus/ Disease: Progress of the works is adversely affected by and/ or costs are increased by reason of disease, epidemic or pandemic, including Covid-19 (Coronavirus), and/ or the taking of any measures to prevent, delay, reduce or otherwise mitigate its spread and/ or its effects.	5	4	20	
52	Programme	Construction	Trust	Other major scheme occurring on site and adjacent (Elective Orthopaedic Centre)	3	4	12	
53	Cost/Commercial	Pre-Construction	Trust	Backlog maintenance requirements to the existing buildings	3	4	12	

54	Cost/Commercial	Pre-Construction	Trust	Non availability of funds for design work prior to approval affecting delivery in 22/23	3	4	12
55	Procurement	Construction	NHS Trust	Availability of Goods/ Materials: Adjustment of the programme in line with confirmed delivery dates for Goods/ materials - a mechanism for such adjustment is to be agreed.	4	4	16

Appendix 5.
Outline Business Case Scoring Methodology

The Outline Business Case (OBC) options will be assessed by individual key relevant parties and scored on the statements below.
The weighting exercise weights the importance of the below statements and informs the total calculation. The scoring sheet is formulated to calculate each options score.
Please also score the do-nothing option.

In order to help you understand what the criteria mean we have provided a statement which sets out how an option which promotes the best of that criterion might be described.

The Introduction to this document gives the context and executive summary of the MMH CDC Phase 2 Business Case, which has been developed in partnership with key stakeholders and guided by the CDC Steering group, ICS CDC SY&B ICS group and Gastro Hosted Network.

If you require further information regarding the case on context to the Options, please contact either Shahida Khalele at shahida.khalele@nhs.net or Clare Ainsley at clare.ainsley@nhs.net.

The Scoring exercise closes Wednesday 28TH September 2022, please return completed questionnaires to Shahida on the above email address by midday on that day.

SCORING KEY

Definition	Score
I strongly agree	5
I agree	4
I neither agree nor disagree	3
I disagree	2
I strongly disagree	1

CRITICAL SUCCESS FACTORS		
Strategic fit and business needs		
1.	**Clinical Standards: compliance with clinical standards leading to improved clinical outcomes and patient /carer experience**	This should be measured by its ability to meet all national, regional and local strategies together with complying with the applicable commissioning intentions of the responsible CCGs and being a good strategic fit which fulfils DBTH and CCG/ICS strategic objectives.
2.	**Supports integration of care across primary, community and secondary care and the wider diagnostics transformation programme**	Specifically a good strategic fit will retain critical mass of clinical facilities on the DBTH sites supporting an approach to have non acute care on COVID Light sites and promoting the delivery of more care in community settings. The preferred option will incorporate improvement of pathways across the community, managing the demand and working collaboratively to get the best outcomes for patients.
3.	**Reduced Infection Prevention Control risks – ability to social distance and isolate when required**	This option will maximise the environment to give optimum IPC with the abilities to social distance and isolate as well as being a COVID Light environment.
4.	**Constitutional Standards: The option will allow for improved Elective performance and flow, meeting mandated standards. Contributes to improved Faster Diagnosis Standards and Cancer Two week wait performance.**	This option will maximise opportunities to implement leading edge technology and exemplar care pathways and foster modernisation and innovation for service transformation.
5.	**Travel & transport: The option allows faster diagnosis in fewer visits as possible.**	This option gives the optimum access to multiple modalities on a non-acute site, enabling faster diagnosis in fewer visits with adequate transport links and reducing travel.
6.	**Health & Wellbeing : The option provides facilities to meet the health & wellbeing of the teams working in the area**	This option will support staff to develop the skills, values and leadership to provide high quality, efficient and effective care via developing and enhancing care facilities at MMH.
7.	**Sustainability: The option provides flexibility in use of space and allows for innovation service change.**	This option will optimise modality availability and training facilities across a wide geographical area
8.	**Health Equalities: The option addresses health inequalities across the population served**	Supporting faster diagnosis, effective signposting and the development of enhanced community based services, prevention and self-care.

	Potential value for money	
9.	**Health Economy - The option provides VFM. The option will not worsen the long term financial stability of DBTH**	Optimises Value for Money, taking opportunity in national funding and does not worsen the financial stability of DBTH.
10	**Health Economy - The option optimises social value and positively enables Net Zero and Carbon reduction**	Optimises social value to local and wider communities and positively enables Net Zero and Carbon reduction with the estate use/development and reduction in frequent appointments to a site with multiple modalities for diagnostics.
11.	**Estates/Infrastructure - The option enables future use of vacated space for service delivery**	Optimises use of estate.
	Supplier capacity and capability	
12.	**Estates/Infrastructure: The option matches ability of suppliers to deliver**	Matches ability of suppliers and contractors.
	Potential affordability	
13.	**Health Economy: The option will be achievable if funded by the National Community Diagnostic Funds and supported by CCGs/ICS Commissioners.**	Achievability with National CDC funding
14.	**Potential achievability**	
	Workforce: Workforce availability to provide the service in line with national guidance (Royal Colleges, CQC and JAG)	Gives best environment to recruit, train and retain staff to meet national guidelines.

Thank you for taking part in the scoring exercise, your input has been valuable and will help to assess the options available to the MMH CDC Phase 2 Business Case. Please ensure you return the completed scored questionnaire to Shahida Khalele, CDC Project Manager, DBTH at shahida.khalele@nhs.net by Wednesday 2nd February 2022

Appendix 6. Equality Analysis Tool

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Equality Impact Assessment

Service/Function/Policy/Project/Strategy Equality Impact Assessment	CSU/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Community Diagnostic Centre (CDC) Project at MMH – Phase 2	Clinical specialities Division	Project Manager	New	28.01.2022

1.1 Who is responsible for this policy?

Clinical Specialities Division DBTH NHS FT

1.2 Describe the purpose of the service / function / policy / project/ strategy?

The aim is to develop a Community Diagnostic Centre that is aligned to the developing Networks for Imaging, CT, MRI and Non obstetric U/S, Histopathology and Endoscopy and Physiological Measurements to increase diagnostic capacity across the system in a way that meets future diagnostic demand and improved patient outcomes.

1.3 **Are there any associated objectives?**

Improving/maintaining cancer, diagnostics and referral to treatment performance. Improving and maintaining the performance or emergency targets and supporting the future anticipated growth in activity.

Supporting ICS-wide changes, is locally sensitive to support the resolution of diagnostic challenges to aid recovery and improves equity of access to diagnostics, so as to contribute to improved health outcomes and reducing health inequalities.

1.4 What factors contribute or detract from achieving intended outcomes?

Approval of capital case.
Expanding workforce

1.5 **Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief?** No. The proposed expansion will benefit all patients. It will have easy access for all patients and will not restrict access in any way.

1.6 If yes, please describe current or planned activities to address the impact [eg. Monitoring, consultation] – N/A

1.7 Is there any scope for new measures which would promote equality? [any actions to be taken] – N/A

1.8 Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
Age	No	
Disability	No	
Gender	No	
Gender Reassignment	No	
Marriage/Civil Partnership	No	
Maternity/Pregnancy	No	
Race	No	
Religion/Belief	No	

Sexual Orientation	No	

Please provide the Equality Rating of the service/ function/policy /project / strategy by the Outcomes as defined in section 4.3.4 in the Equality Analysis Policy CORP/EMP 27 v. 2 – please tick relevant box

Outcome 1	Outcome 2	Outcome 3	Outcome 4
X			

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 3

1.9 Date for next review –

Checked by: **Date:**

Please attach a copy of this to the policy document or retain and save with the project/service change documentation.

APPENDIX 7. Quality Performance Impact Assessment

Quality Performance Impact Assessment - Quality risks to patients/services

The QPIA should be regularly reviewed for each project within the programme.

Project	What is the nature of the Impact	Consequence rating before mitigation	Likelihood rating before mitigation	Rating before mitigation	Mitigation Action	Key indicator to monitor ensuring that the Project does not adversely impact quality	By	Owner	Consequence rating after mitigation	Likelihood rating after mitigation	Rating after mitigation	Risk Status	Board Repsonsibility	CQC Domains: Duty of Quality	Patient Safety	Patient Experience	Clinical Effectiveness and Outcomes	Staff Resources	Health/ IT/Other
														Tick if there is a negative impact on CQC Domains					
Community Diagnostic Hub - MMH	Positive	0	0	0	Implementation of service improvements	KPIs of service			0	0	0	0							

Programme/Project Risks

Risks are things that might occur, with the right mitigation risks can be eradicated. If a risk becomes live, this is now an Issue and should be logged and managed under the Issues log.

Project Name		What is the nature of the Risk	Consequence rating before mitigation	Likelihood rating before mitigation	Rating before mitigation	Mitigation Action	By	Owner	Consequence rating after mitigation	Likelihood rating after mitigation	Rating after mitigation	Risk Status	Board Repsonsibility	CQC Domains: Duty of Quality	Patient Safety	Patient Experience	Clinical Effectiveness and Outcomes	Staff Resources	Health/ IT/Other
Community Diagnostic Hub - MMH		Mobile staffed units not being available	5	4	20	Using existing company links - now confirmed - MEDNEO			2	Low	Low								
		Capital and Revenue funding not being available	5	3	15	ICS fully aware and part of development			3	Medium	Medium								
		Staff model for resus not recruited in time for contrast use	4	3	12	Dependent on release of funding and timescales-funds			2	Low	Low								
		Timely release of funding	4	3	12	Business Cases submitted on time			2	Low	Low								
		Mobilisation not starting to timescales required	4	3	12	Early planning and mobilisation meetings			2	Low	Low								
		All relevant partners not signing up to schemes	4	3	12	Partners involved throughout process			3	Medium	Medium								

Doncaster and Bassetlaw Hospitals NHS Foundation Trust

APPENDIX 8.

Post Project Evaluation

Title of Project:	
Project Lead:	
Date of Completion:	
Evaluated by:	

1. Background

Provide a brief description of the project including:

- **What was the purpose of the project?**
- **What was the need for the project?**
- **In what way did the project support the Strategic Direction of the Trust?**

2. Assessment of Costs

This section should provide a comparison of the actual costs of the project compared with the project budget and outline any variance.

Where there is a variance between agreed projects costs and actual costs DFI must be informed. In cases where actual cost exceeds the cost approved by DFI an explanation must also be provided.

Initial Project Costs:	
Actual Project Costs:	
Variance:	

Explanation of variation in costs:

3. Assessment of Deliverables

This section should provide detail on what was delivered in terms of the project aims and objectives, as outline in the Business Case, whether they were met, and the quality given.

Are there any outstanding elements of the project and what action plan has been created to address these actions (please attach).

Was the project delivered on time? Yes/No
If you answered No above, please give the reasons for the delay.

4. Assessment of Benefits

This section should provide detail on the benefits provided by the project. For example:
Were the Aims of the Business Case achieved within the timescale specified?
Reasons for any delays and the impact on expected benefits should be explained
How will benefits from this project be used?
What patient benefits are expected?

5. Assessment of Risks

This section should provide detail on the risks identified for the project.
Were all risks that emerged predicted prior to the project
List new risks and potential reasons that these were not foreseen

6. Assessment of duties

This section should provide details of the division of work between staff. Evidence should be provided of whether the assistance provided matched what was required and what could have been improved?

7. Skills Transfer

What mechanisms were put in place to allow the transfer of skills and knowledge to happen?
Assess the extent to which transfer of skill and knowledge to staff has taken place and what impact has this had on staff capability?

8. Assessment of Project Management Arrangements

This section should provide an assessment of the project management arrangements. For example:
Were the monitoring arrangements put in place to manage the project satisfactory?
Was the project managed effectively?

9. Assessment of Economic/Commercial Impact

Describe the Economic/Commercial impact this project has given.
(E.g. effects on services/procurement/estates/staffing/reputation etc)

Describe how any areas of the project were selected to best meet the existing/future needs of the service and optimise value for money.

10. Conclusion and Recommendations

Conclusion

Provide a summary of what value was added by this project and assess whether, on balance, the project was a success.

Recommendations

Provide a summary of the lessons learnt and provide details on how and to whom these will be disseminated.

Lessons Learnt	Action Required	Lead

Dates for further Evaluations

Appendix 9.

Capital Equipment costs

CT Incisive	528,508
CT Installation costs	
CARDIAC MRI AMBITION X	850,000
MRI Installation costs	
FARADAY CAGE	60,000
MRI DVD	15,000
CEILING MOUNTED PUMP INJECTORS	20,000
MAGNETIC SENSORS	15,000
RETFORD XRAY	297,460
CARDIO-RESPIRATORY - ECG X2	25,000
Echo-cardiac U/S kit	110,000
2XPC CONTROL ROOM	2,000
2X PC RECEPTION	2,000
3X RADIOLOGIST WORKSTATIONS	21,000
MSK probe	2,460
Compressor & PCR	3,686
ENDOVAULT LICENSE	15,120
PIPEWORK ENDOS	16,000
washer disinfector ENDOs	70,935
Finger prints	2,348
Defib equipment	4,345
Resus Trolley	428
IT Network Cables / Digital Resources	4,000
Total	**2,065,290**

MOBILISATION PLAN - MONTAGU CDC PHASE 2B CT and MRI Build

plan is made to ensure the project is delivered – on time, on-budget, and meeting all criteria that are required for the Montagu CDC, and to enable the successful delivery of facilities and services at Montagu CDC, this taking into consideration the complexities in coordinating multiple stakeholders, strategy, operations and contractors and the critical risks that need to be considered so we can achieve a successful mobilisation of phase 2 of the CDC.

The focus throughout will therefore be on comprehensive planning, management of risk, monitoring of progress and effective resourcing. In this way, we will provide the trust the most efficient, cost-effective establishment of services with the lowest risk factor.

Mobilisation plan

1. Create a robust plan to manage and monitor all activities during the mobilisation phase. It begins with gaining a clear understanding of expectations.
2. Ensure all parties involved in the mobilisation understand their respective responsibilities, the processes to be used, and the timeframes involved.
3. Risk mitigation is of utmost importance. In this respect, we produce management information reports to help identify and monitor, and resolve early risks and issues.
4. Recruitment and– at the right time, with the right people Mobilisation of staff needs detailed planning to make sure the right people are hired for each role, recruit in stages to ensure mobilising the right people at the right time.
5. Plan for all operational aspects of our service delivery; planned, coordinated and well-managed.
6. Procurement of equipment, consumables and the setting up of service level agreements with subcontractors.
7. Due diligence and operational readiness. Every activity undertaken is subject to our robust due diligence process. Ensure checks and balances to make sure that no issues arise pre or post-handover. Through our Operational Readiness Review (ORW), create checklists from mobilisation through to service delivery.

The Montagu CDC ORW is a physical walk-through scenario which ensures no detail has been missed from staff/patient access and booking systems to delivery schedules.

Developing policies and procedures

During mobilisation, develop live operational practices, policies and procedures. These will include our general approach to the delivery of services at the CDC, but also how we will maintain the specific systems.
We will apply best practice and incorporate lessons learnt to ensure the best regime for the Montagu CDC.

Mobilisation activities

1. Estates and Facilities.
   Once finances have been approved the phase 2 work can commence

2. Staffing and Service planning.
Support from P&OD for staffing and recruitment- Radiology & Endoscopy –Booking and Admin

3. Service commissioning.
Involvement of CCG and ICS – service start up

4. Service Delivery

Mobilisation Planning Group Roles and Responsibilities

Activities	Detail	Responsible Owner

Assemble mobilisation planning group	mobilising a select team of staff to mobilise phase 2 CDC at Montagu	Strategic Programmes Manager
Establish a CDC governance board	CDC Project Board CDC Steering Group	Senior Responsible Owner Strategic Programmes Manager
Develop a mobilisation plan	-Create a robust plan to manage -monitor all activities during the mobilisation phase -Log actions from meetings and update tasks – project workbook	Strategic Programmes Manager CDC Project Manager Senior Project Officer
Determine the stakeholder map and communication plan	-Key dates for occupying or bringing the facility into use - Stakeholder Mapping Review and communication and Engagement Plan design -Key tasks in the mobilisation of services and clear lines of responsibility	Strategic Programmes Manager CDC Project Manager Lead Communications Manager
Estates and Facilities activities	Estates work	Estates – Lead Head of Capital Projects
Modality Mobilisation tasks	Modality – scanners/staff Equipment	Operational Lead – Radiology Operational Lead - Endoscopy
Maintain a risk and issues register	Monday.com /input from Modality / Estates leads & IT Team	CDC Project Manager
Procure equipment, tools and consumables	- Key dates for selecting and ordering equipment	Modality Operational Leads Estates – Senior Manager procurement
Recruitment and Training	-Mobilisation of staff and detailed planning to make sure the right people are hired for each role. Support from P&OD	Modality Operation Leads
Finalise and sign off approved subcontractors	Identify any defects prior to handover	Estates & Facilities Lead Head of Capital Infrastructure
Pre-soft opening	Site induct the workforce	IT Business Partner and Modality Operational Leads
Carry out service acceptance testing	Develop standard operating procedures and service plans	Operational Leads Estates – Senior Manager Associate Director of Operations
Eliminating snagging issues	- As part of due diligence, walk the building room-by-room with the building contractor to identify any snagging issues. - Advised in detail of any outstanding construction works, their location and when they will be carried out.	Estates – Senior Manager Operational Leads- Modality
The commissioning and service handover	Communications	Strategic Programmes Manager

		CDC Project Manager
Site-specific familiarisation of systems Full Opening	Integration of management and clinical services	Operational Leads Associate Director of Operations
Full commencement of services as the CDC phase 2 goes live	Ensure are up-and-running from day one	Operational Service Leads IT Business partner/Team Estates – Senior Manager

There are critical risks to consider. To mitigate them, we have developed a risk register, held in the project workbook. This helps us in our own internal governance, identifies risk then mitigates it – both in mobilisation and across all other components of service delivery.
A key element of a successful mobilisation is to have the right calibre of individuals to manage it.

Mobilisation Planning Group- The group's initial activities will include; developing a mobilisation plan, reviewing the transition plan and actively develop and risk assess the modality/ service re: requirements and issues.

Project Director- Senior Responsible Officer – responsible for the leadership and management of the mobilisation team and overseeing the scope of the mobilisation in line with the Business Case.

Strategic Programmes Manager– Support the SRO with management of the mobilisation team and overseeing the scope of the mobilisation in line with the Business Case. They will assign clear roles and responsibilities.

Lead Nurse for CDC/ Senior Project Change Manager – manage the mobilisation activities and clinically lead the team. Manage the service changes

Strategic Project Manager -managing all mobilisation activities in a timely manner, allowing for no slip-backs in the programme- in line with the business case. Verify risk mitigation plans and set up governance meetings, so mobilisation activities can commence smoothly.

Finance Business Partner – overall responsibility for the financial and commercial activities of the project.

Human Resource Business Partner – responsible for all recruitment and for assisting service leads with recruitment and options of workforce availability across the system activities, addressing issues and concerns, and ensuring seamless staff transfers.

Procurement Specialist – responsible for identifying and implementing procurement strategies, so as to ensure operations teams have access to appropriate suppliers and processes.

Operational Leads – Operational activities such as policies and procedures, equipment, consumables for service delivery and responsible for sourcing the appropriate calibre of candidate for each role, and that all candidates are recruited within the timescales as set.

IT Business Partner/Technical Team – responsible for technical IT solutions and preparation/advice for operations, conducting the required safety assessments and support the running service.

Governance– checks and balances- The Project board will comprise members of the SRO and senior management team. The board will hold monthly meetings to review in detail the progress on the CDC site.

- **Programme board meetings** – Monthly to review the overall performance of the mobilisation against the baseline plan, including mitigating actions for any variances.
- **CDC Estates meetings**- Meeting held weekly with Estates Project Manager and head of Estates includes PHS Architects and Accounts Managers
- **CDC Steering group meetings**–Monthly to review progress, provide feedback to the Strategic Programmes Manager, Strategic Project Manager and endorse any mitigating actions.

- **CDC phase 2 Working group meetings** – Fortnightly to ensure updates of the project and that the ownership of risks is correctly and appropriately assigned, with nominated risk owners in attendance. This is to ensure that we capture all risks and issues, and populate the project workbook with the relevant information.

Roles:

Role	Name	E-mail
Senior Responsible Owner	Jon Sargeant	jonathan.sargeant@nhs.net
Divisional Director of Operations	Andrew Potts	a.potts2@nhs.net
Strategic Programmes Manager	Clare Ainsley	Clare.ainsley@nhs.net
CDC Project Manager	Shahida Khalele	Shahida.khalele@nhs.net
Project Support	Nicolette Woodward	Nicolette.woodward@nhs.net
Radiology Operational Lead	Sara Elliott	Sara.elliott1@nhs.net
Endoscopy Operational Lead Senior Project Change Manager	Debi Oxley	Debi.oxley@nhs.net
Procurement Specialist	Kevin Lister	Kevin.lister@nhs.net
Estates – Senior Manager	Andy White	Andy.white4@nhs.net
Finance Business Partner	Laura Buckley	Laura.buckley@nhs.net
IT – Business Partner	Roz Wilson	Roz.wilson@nhs.net
Human Resource Business Partner – PO&D	Adam Evans	adam.evans2@nhs.net
Estates project manager	Simon Eaton	Simon.eatonn@nhs.net

Dates for Meetings:

CDC Estates	CDC Steering Group	CDC Phase 2 working Group
Every Friday weekly meeting	12.7.22	26.7.22
	9.8.22	23.8.22
	13.9.22	27.9.22
	11.10.22	28.10.22
	8.11.22	22.11.22
	13.12.22	27.12.22
	10.1.23	24.1.23

Timeline

Detailed design development (at risk)	Nov-Dec 22 (P+HS/CAD21
HLIP development, mini comp	Nov-Dec 22
Appointment of PSCP (novation of design team)	Jan 23
Business Case submission internally – (Note cost plan only and not GMP and no planning at this stage)	Nov 22
External approval	Dec 22 – March 23
Planning Jan-March 23	Jan-March 23
Market test packages	Jan-March 23
GMP	March 23
Validation/Stage 4 contract	April-May 23
Start on site	June 23
Completion – (assuming 7 months construction / stage 4 period)	December/Jan 23
Electrical Infrastructure (separate HLIP scheme but bundled with CDC funded project) (some commitment of CRL may be required in advance of approval?)	Nov 22 – Dec 23
Contractors float period	Jan 24
Commissioning including RPA	Feb-March 24
Operational	April 24

Project Manager Use:

MOBILISATION TRACKER CDC PHASE 2					
TASK	ASSIGNED TO Date	DUE DATE	ISSUES	STATUS	COMMENTS
Mobilisation Plan	SK Aug 2022	25/08/2022		Approved	CA
Business case timeline	SK Aug 2022	29/08/2022		Approved	CA/AP
Equipment CT MRI	SE Sept 2022	Oct 2022		Submitted	
Procurement plan	KL- September 2022	September 2022		Requested	SK/SE
Upload Monday.com	SK	September 2022		Ongoing	SK
WTE workforce Radiology	SE	September 2022		Approved	AP/CA
WTE Estates	AW	October 2022		Approved	
Estates plan update – site plan	AW	October 2022		Approved	AW/AP/CA
Architects – design	AW	October 2022		Approved	CA/SK
Finance details	CS October 2022	October 2022		Awaiting	CS
Pathways mapping	DO/SK/NW September 2022	November 2022		Planning	DO SK NW

Appendix 11.

CDC - Cost per test

Please use below template to set out the revenue costs and activity per modality in order to calculate the cost per test to support a VFM review.

Key:	Input required

Region Name	North East & Yorkshire	
ICS Name	South Yorkshire and Bassetlaw STP	
Lead Trust Name	Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust	
CDC Name	Montagu	
CDC Type	Select	*If other option(s) selected, please specify below*
CDC Location	Acute (Cold site)	
CDC Site ownership	NHS / FT Trust	
Year cost relates to	2024/25	
Total revenue cost for CDC scher	£2,808,561	

Specialty (modality group)	Modality	Notes / Comments	Revenue cost (£ value)	Activity (activity no.)	Cost per test (£ value)
Imaging	CT		764,517	7,224	£105.83
	MRI		360,765	4,824	£139.16
	Ultrasound (Non obstetric US)				£0.00
	Plain X-Ray	Part Year activity from July 2024	388,894	5,400	£72.02
Physiological measurement	Echocardiography (ECHO)				£0.00
	Echocardiogram (ECG) including 24 hr and longer tape recordings of heart rhythm monitoring				£0.00
	Ambulatory Blood Pressure Monitoring				£0.00
	Fractional exhaled nitrous oxide (FeNo)				£0.00
	Oximetry				£0.00
	Blood gases				£0.00
	Simple field tests (e.g. 6 minute walk)				£0.00
	Lung volumes and gas transfer				£0.00
	Spirometry including broncho-dilator response				£0.00
	Some sleep investigations				£0.00
Endoscopy	Gastroscopy				£0.00
	Flexi-sigmoidoscopy				£0.00
	Colonoscopy				£0.00
Pathology /phlebotomy	Phlebotomy				£0.00
	Urine testing				£0.00
	NT-proBNP				£0.00
	Point of Care Testing				£0.00
Other Tests (Optional)	Select				£0.00
	Select				£0.00
	Select				£0.00
	Select				£0.00
Central Costs	Central Costs *				£0.00
	Total		**£2,114,176**	**17,448**	£121.17

*** Central Costs - for example**
Architect and estates costs for CDC design and planning
CDC digital integration and interoperability enablers
3.5% cost of capital charges
Premise rent and lease charges
Centralised booking administration teams

Please indicate central costs here	
Description	**(£ value)**
PDC	£235,541
Depreciation	£235,897
Estates Costs	£147,427
IT Costs	£15,520
Total	**£694,385**

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	29 November 2022	**Agenda Reference:**	**G1**
Report Title:	**Corporate Risk Register**		
Sponsor:	Jon Sargeant - Interim Director of Recovery, Innovation & Transformation		
Author:	Fiona Dunn, Director Corporate Affairs/Company Secretary		
Appendices:	CRR Nov 2022		

Executive Summary	
Purpose of report:	For assurance that the Trust risk management process is being followed; new risks identified and current risks reviewed and updated in a timely way.
Summary of key issues:	Key changes to the CRR this period: • No new corporate risks rated 15+have been added or escalated from Trust Executive Group • Currently there are 99 risks logged rated 15+ across the • 11 of these risks are currently monitored via Corporate Risk register (CRR) Action required • Continuous review of existing risks and identification of new or altering risks through improving processes via Trust Risk Management Board. • Ensure link to key strategic objectives indicated within the Board Assurance Framework. • The current risk management review the Trust commissioned has completed. Recommendations considered from the report are being monitored via Monday.com. and new project governance structure via the Executive Team. • The key enabler for the recommendations will be the new Risk Management Board to be introduced and chaired by the Executive Medical Director. All recommendations for the risk management processes to be facilitated via this group.
Recommendation:	• The Board is asked to note the Corporate Risk Register

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

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

Implications	
Board assurance framework:	The entire BAF has been reviewed alongside the CRR. The corresponding TN SA's have been linked to the corporate risks.
Corporate risk register:	This document

Regulation:			All NHSF trust are required to have a corporate risk register and systems in place to identify & manage risk effectively.
Legal:			Compliance with regulated activities and requirements in Health and Social Care Act 2008.
Resources:			Actions required are currently being delivered within existing trust Resources highlighted in individual risks
Assurance Route			
Previously considered by:			TEG & Executive Team – (15+ risks)
Date:	TEG & Board Sept 2022	**Decision:**	Reviewed and updated
Next Steps:			Continuous review of individual risk by owners on DATIX risk management system
Previously circulated reports to supplement this paper:			Risks rated 15+

Appendix 4 (Level 4 detail) **Corporate Risk Register Summary November 2022**

ID	Ref	Review date	Division / Corporate(s)	Speciality(ies)	Title	Description	Risk Owner	Exisiting Controls	Risk level (current)	Rating (current)	Risk level (Target)	Last Reviewed	Movement since last review
1517	**Q&E9**	30/11/2022	Clinical Specialist Services	Pharmacy (Outpatient), Pharmacy (inpatient)	**Availability and Supplies of Medicines**	There are extraordinary stresses on the medicine supply chain which are leading to unavailability of medicines in the hospital. This could have an impact on patient care, potentially delaying the delivery of treatment, non-optimisation of treatment and decrease in patient satisfaction. It could also increase the chance of error and harm occurring The issues is causing significant disruption and increased workload of the pharmacy procurement and logistics team which compounds the problem. Disruption of work by other professionals involved in supply and administration of medicines is possible as well. There a number of issues causing it: - Manufacturing Issues - Central rationing of supplies by CMU - Wholesaler and supply chain issues - Knock on disruption of procurement and logistics teams sometimes delaying response Updated: 18/12/2020 Trust has been explicitly instructed by NHS E & DoH not to take no local action. There is an national mechanism for managing medicines shortages which has been used during the COVID-19 pandemic and will be used if required to manage any issues as a result of EUexit. Working with national and regional colleagues Esoop's team take any local actions required by the national scheme on a medicine by medicine basis -	Wilson, Rachel	**Dec/21** -Covid 19 pandemic related supply issues have now eased but national allocation arrangements remain in place for some key medicines. EU exit impact has been minimal to date but medicines shortages continue due to a combination of other issues. (A Barker). Trust has been explicitly instructed by NHS E & DoH not to take no local action. There is an national mechanism for managing medicines shortages which has been used during the COVID-19 pandemic and will be used if required to manage any issues as a result of EUexit.	Extreme Risk	15	High Risk (12)	Nov-22	⟺
2664	**PEO3**	01/12/2022	Clinical Specialist Services	Critical Care	**Staff shortage - Consultant Intensive Care**	Severe shortage of consultants in intensive care medicine (especially DRI site), caused by inability to recruit for past 6 years and two recent resignations from existing staff. Now high risk of burnout of remaining consultant staff with subsequent sick leave and possible further resignations. Negative impact on quality of patient care, team work on DCC and training of other staff, especially doctors.	Noble, Timothy / Jochen Seidel	**[13/09/2022] staffing reviewed Consultant recruitment commenced approval at CIG re psychology support and coordinators** **24/6/22** vcf approved, recruitment ongoing Can reduce risk rating once recruite**d30/11/21** Risk grading decreased from 20 to 16 with new controls in place. Full action plan in place. Substantive consultant appointed and commenced in post(dec2021). Locum post appointed for 12 months and starting early 2022. Mutual aid secured from STH from January 2022. Second offer of mutual aid being explored. Full set of wider actions focusing on short-term workforce, environment, and longer term training and workforce model.Some support from general anaesthetists and external locums.	Extreme Risk	16	High Risk (9)	Sep-22	⟺
2472	**COVID1**	31/10/2022	Directorate of Nursing, Midwifery and Allied Health Professionals	Not Applicable (Non-clinical Directorate)	**COVID-19**	World-wide pandemic of Coronavirus, which will infect the population of Doncaster and Bassetlaw (including staff) resulting in reduced staffing, increased workload due to COVID-19 and shortage of beds, ventilators. Now includes stabilisation and recovery plans etc	Trainer, Abigail	**30/8/22** Reduced risk due to on going 'return to living with covid'. Patient numbers continue to decline and staff absence decreased in last 2 months. Vaccination campaign commences in September 2022. **Covid risk to be added to SA1 due to acceptance of managing covid as part of business as usual.18/7/22** risk increased due to increased prevalnece and numbers . increased bed occupancy and staff absence, mask reintroduced . **17/5/22** risk reduced. visiting reinstated as current infection rates reduced and "return to living with COVID" guidance. Elective work slowly recovering. Bed occupancy with COVID reduced (AT) **20/3/22** existing controls in place and recovery plans monitored via COO and delivered to F&P & Board. New IPC guidance in place to allow 1mrule to support elective recovery. Updates regularly to CQC via engagement meetings.ay	Extreme Risk	15	High Risk (10)	Aug-22	↓
11	**F&P1**	31/03/2023	Directorate of Finance, Information and Procurement	Not Applicable (Non-clinical Directorate)	**Failure to achieve compliance with financial performance and achieve financial plan**	Failure to achieve compliance with financial performance and achieve financial plan leading to : (i) Adverse impact on Trust's financial position (ii) Adverse impact on operational performance (iii) Impact on reputation (iv) Regulatory action	Alex Crickmar	**[22/11/2022] Continued scrutiny & monitoring via committees.no change in controls.** **24/3/22** full discussionre new plans to F&P **13/5/21**:New controls : Budget process linked to capacity planning; Additional Training Programmes for managers; Perf Assurance Framework; Close working with ICS and Provider DoF's	Extreme Risk	16	High Risk (8)	Nov-22	⟺
7	**F&P6**	02/01/2023	Chief Operating Officer	Not Applicable (Non-clinical Directorate)	**Failure to achieve compliance with performance and delivery aspects of the SOF, CQC and other regulatory stanadrds**	Failure to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards leading to: (i) Regulatory action (ii) Impact on reputation	George Briggs	**13/9/22 -**ICB now in place as overarching structure for SYB 30/11/21 . Controls still applicable as in March. Refreshed board performance report in progress to reflect H2 priorities and to improve transparency of performance against key metrics. Improved benchmarking approach in place using data from NHSE/I, nationally published data and dashboards. Trust wide engagement approach with consultants/SAS and Divisional leaders regarding H2 requirements including UEC roadshow.[10/03/2021] IQPR, Performance assurance framework goes to Sub committees, At divisional level = activity & performance meetings & wider governance framework. Accountability framework also in place at Organisational level. CQC regular engagement meetings & CQC action plan complete (Feb	Extreme Risk	16	High Risk (9)	Sep-22	⟺

Appendix 4 (Level 4 detail) **Corporate Risk Register Summary November 2022**

ID	Ref	Review date	Division / Corporate(s)	Speciality(ies)	Title	Description	Risk Owner	Exisiting Controls	Risk level (current)	Rating (current)	Risk level (Target)	Last Reviewed	Movement since last review
19	**PEO1 (Q&E1)**	13/12/2022	Chief People Officer	Not Applicable (Non-clinical Directorate)	**Failure to engage and communicate with staff and representatives in relation to immediate challenges and strategic development**	Failure to engage and communicate with staff and representatives in relation to immediate challenges and strategic development	Zoe Lintin	**[13/09/2022] Strategic approach to engagement in 2022 staff survey agreed and in place, including timely sharing of feedback with teams and involvement in identifying actions.** **Board visits schedule introduced from Sept 2022.** **New People Strategy to be developed from 2023 aligned with the NHS People Plan.(ZL)** **2/12/21** -Regular updates provided to Partnership Forum and JLNC in respect of service and Trust level changes being planned. Deputy Director of P&OD has weekly meetings with staff side chair and secretary and attends the staff side meetings and the Director of P&OD meets regularly with the LNC Chair. The Communications team share regular updates using Facebook, general and targeted emails and posting on the Trust website and The Hive to ensure all colleagues in the Trust are updated on key issues - recent examples include during the Covid pandemic. In addition the monthly team brief sessions have moved on line with a recording of the Chief Executive being posted on facebook and The Hive. The Executive Team meets weekly with the Head of Communications in attendance; in addition there are monthly Trust Executive Group meetings and quarterly senior leadership meeting with the Chief Executive. The Chief Executive holds regular listening events with all Divisions and directorates virtually to which all staff are invited.[	**Extreme Risk**	**12**	Moderate Risk (8)	Sep-22	⟺
12	**F&P4**	28/04/2023	Estates and Facilities	Not Applicable (Non-clinical Directorate)	**Failure to ensure that estates infrastructure is adequately maintained and upgraded in line with current legislation**	Failure to ensure that estates infrastructure is adequately maintained and upgraded in line with current legislation, standards and guidance. Note: A number of different distinct risks are contained within this overarching entry. For further details please consult the E&F risk register. leading to (i) Breaches of regulatory compliance and enforcement (ii) Claims brought against the Trust (iii) Inability to provide safe services (iv) Negative impact on reputation (v) Reduced levels of business resilience (vi) Inefficient energy use (increased cost) (vii) Increased breakdowns leading to operational disruption (viii) Restriction to site development	Howard Timms	**09/10/2022** Howard Timms] **Asset Capture in progress as part of 7 Point Plan. MMH Complete.** Howard Timms] Implementation of Maintenance Strategy Review (7 Point Plan) FY 22/23 £16.7 Million Capital Investment identified for 22/23 Project Team working on Development of new Hospital Build for Doncaster. **[16/11/2020** Sean Alistair Tyler] - DBTH not included on list of 40 new hospitals, Board decision required on continuing developing case in preparation for bid for further 8 new hospitals mid decade.	**Extreme Risk**	**20**	High Risk (10)	Oct-22	⟺
1410	**F&P11**	31/03/2023	Information Technology	Not Applicable (Non-clinical Directorate)	**Failure to protect against cyber attack**	Failure to protect against cyber attack - leading to: (i) Trust becoming non-operational (ii) Inability to provide clinical services (ii) Negative impact on reputation The top 3 DSP risk areas have been recognised as: (1) Insider threat (accidental or deliberate) (2) New / zero day vulnerability exploits (3) Failure to wholly implement patch management (4) Disaster recovery and business continuity testing (5) Control of device (not user) access to the network (6) Configuration management and process documentation) (7) Backup management and storage capacity (8) Logging and retention of log information (infrastructure) (9) Failure to wholly implement patch management (10) Visibility of networked devices and systems as they relate to notified vulnerabilities (e.g. CareCERT advisories) As a result the above could lead to temporary closure of systems access, infection of key software and/or related operational issues. This would need significant remedial work and might require forensic response that would need to be funded from cyber liability insurance. Negative press coverage would follow and investigation by national bodies would be likely.	Anderson, Ken	**[21/09/2022] All supported servers are now on a regular patching interval.** **Immutable storage / backup configured and working OK with all compatible / supported systems enrolled. Further systems will be enrolled as servers are upgraded and can be included. Separate arrangements are needed for PACS - to be included in a business case for 23/24.** **A small number of Windows 7 stations remain due to the systems they run not being compatible with Windows 10. Procurements are underway to replace the systems concerned. Extended support or other mitigation arrangements (segmentation / restriction of use) has been applied to Windows 7 stations in the meantime.** **Network Access Control remains on hold due to resource constraints to implement.** **NHS Secure Boundary on hold pending business case to procure replacement perimeter equipment in 23/24.** **Log retention configured and working for Firewall and Domain Controllers only at this time.** **DSPT for 21/22 - requirements met.** **7/2/22 -U**pdated ordering of risks to reflect work done on patching, asset management and log retention and analysis, which has reduced risk in these areas. More work remains on those points, but other risks now have a greater priority. Work is ongoing to update unsupported software in the organisation, with further investment requested in 22/23 to continue the work needed. Investment has also been requested in the top 2 risk areas and other identified areas of risk identified.**[17/05/2021** 10:10:16 David Linacre] The server patching work has been subject to delays, with divisional system administration contacts not responding to requests from IT to arrange regular monthly maintenance windows. A decision was taken in April to	**Extreme Risk**	**15**	Moderate Risk (4)	Sep-22	⟺

Appendix 4 (Level 4 detail) **Corporate Risk Register Summary November 2022**

ID	Ref	Review date	Division / Corporate(s)	Speciality(ies)	Title	Description	Risk Owner	Exisiting Controls	Risk level (current)	Rating (current)	Risk level (Target)	Last Reviewed	Movement since last review
16	PEO2 (F&P8)	13/12/2022	Chief People Officer	Not Applicable (Non-clinical Directorate)	**Inability to recruit right staff and ensure staff have the right skills to meet operational needs**	Inability to recruit right staff and have staff with right skills leading to: (i) Increase in temporary expenditure (ii) Inability to meet FYFV and Trust strategy (iii) Inability to provide viable services	Zoe Lintin	**[13/09/2022 KPMG Workforce Planning tool project now underway (to be managed through Monday.com).** **International recruitment - additional cohorts agreed for nursing this year and other professional groups being explored.** **Work ongoing on agency controls and processes** **Risk rating discussed at length at People Committee on 06/09/22, agreed to increase target risk rating to 12 for 2022/23 given current context. Longer term aim is to decrease to 8.** **02/12/2021** - Regular reports to the People Committee in relation to vacancy levels and training plans. Refreshed Trust level workforce plan being developed detailing hot spot areas and planned actions. Electronic workforce planning tool being investigated to support divisional/specialty workforce planning. Workforce planning forms part of business planning process. Apprenticeship group in place which reports through the Training and Education committee to the People Committee. Workforce Planning committee now in place with representation from divisions and key staff groups to explore how we maximise our recruitment and training opportunities.**[12/02/2021]** People Committee now in place to review vacancy data and obtain [09/10/2022 Howard Timms] Lift Refurbishment Project for EWB Lift 3 and 7 commenced March 22. Further Lift Refurbishment Planned 22/23 including South Block Lifts 3 and 4, W and C Lifts 1 and 2 and Mexborough Pain Management. [**29/03/2022** Howard Timms] Lift Refurbishment Programme delayed due to COVID. Lift Refurbishment Project for EWB Lift 3 and 7 commenced March 22. Further Lift Refurbishment Planned 22/23 including South Block Lifts 3 and 4, W and C Lifts 1 and 2 and Mexborough Pain Management. [**08/04/2021**] - Site wide Lift survey undertaken by independent lift consultant, lifts 3 and 7 in the EWB identified for upgrade and included	Extreme Risk	16	High Risk (12)	Sep-22	⟷
1807	F&P20 / Q&E12	28/02/2023	Estates and Facilities	Not Applicable (Non-clinical Directorate)	**Risk of critical lift failure**	Risk of critical lift failure leading to: (a) Reduction in vertical transportation capacity in the affected area (b) Impact on clinical care delivery (c) General access and egress in the affected area	Howard Timms	[**09/10/2022** Howard Timms] Lift Refurbishment Project for EWB Lift 3 and 7 commenced March 22. Further Lift Refurbishment Planned 22/23 including South Block Lifts 3 and 4, W and C Lifts 1 and 2 and Mexborough Pain Management. [**29/03/2022** Howard Timms] Lift Refurbishment Programme delayed due to COVID. Lift Refurbishment Project for EWB Lift 3 and 7 commenced March 22. Further Lift Refurbishment Planned 22/23 including South Block Lifts 3 and 4, W and C Lifts 1 and 2 and Mexborough Pain Management. [**08/04/2021**] - Site wide Lift survey undertaken by independent lift consultant, lifts 3 and 7 in the EWB identified for upgrade and included	Extreme Risk	20	High Risk (8)	Oct-22	⟷
1412	F&P12	29/04/2023	Estates and Facilities	Not Applicable (Non-clinical Directorate)	**Risk of fire to Estate**	Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the Regulatory Reform (Fire Safety) Order 2005 and other current legislation standards and guidance. Note: a number of different distinct risks are conatained within this overarching entry. For further details please consult the EF risk register. leading to : (i) Breaches of regulatory compliance could result in Enforcement or Prohibition notices issued by the Fire and Rescue Services (ii) Claims brought against the Trust (iii) Inability to provide safe services (iv) Negative impact on reputation	Howard Timms	**[09/10/2022 Works in Progress as part of 22/23 Fire Capital Plan. Works also form part of Ward / Department upgrades** [**29/03/2022** Howard Timms] EWB and W&C Block Fire Enforcement Notices Rescinded and replaced with Fire Action Plans Fire Improvements W&C investment 21/22 £4.1 million Further Fire Improvement Works scheduled investment 22/23 £3.0 million **07/04/2021** SYFR wrote to CEO on 1st April to rescind both notices for EWB and W&C and replace with action plans to be complied with	Extreme Risk	15	High Risk (10)	Oct-22	⟷
13	ARC01	28/02/2023	Directorate of Finance, Information and Procurement	Not Applicable (Non-clinical Directorate)	**Risk of econmic crime against the Trust by not complying with Government Counter Fraud Functional Standard GovS 013**	Risk of econmic crime against the Trust by not complying with the Government Counter Fraud Functional Standard GovS 013 – Counter Fraud leading to (i) Impact on Trust's finance (ii)Negative impact on reputation (iii)action from Cabinet Office re failure to comply with standard	Alex Crickmar	[**04/04/2022]** Regular communication via ARC and Trust Counter Fraud champion and CF Specialists. Trust assessed against the standards and documented for compliance in (LOCAL FRAUD RISK ASSESSMENT Version 11 (Valid from 1st April 2022 until 31st March 2023. Submitted and approved at ARC via the Counter Fraud Operational Plan 24th March 2022. Individual risk assesment attached to risk. Actions added to individual risk owners. 12 is highest risk attahced to Bank madate fraud (i) Local Counter Fraud Specialist work plan and investigations (ii) Fraud awareness training. (iii) DH Counter-Fraud regime and oversight (iv) Liaison with DOF and Chair of ANCR (v) Staff fraud questionnaire. (vi) Board level awareness, October 2018.	Extreme Risk	12	Moderate Risk (4)	Oct-22	⟷
3103	ARC02	09/12/2022	Chief Operating Officer	Not Applicable (Non-clinical Directorate)	**DBTH ability to comply with National COVID-19 Inquiry**	DBTH ability to comply with the national enquiry . There is a national review of the Covid 19 pandemic management DBTH will be expected to take part in the enquiry. The Trust will be required to collate and present evidence this will require non disposal of evidence notes minutes etc. There will be a requirement to archive and collate data	George Briggs	**[13/09/2022 13:35:14 George Briggs] Agreement of Trust lead officer** **Guidance from national team available** **national seminar to be attended in October 22** **review of proposed data by EPRR team** **introductory update to inform bard Sept 22** **All data to be retained by DBTH** **Non disposable of notes and logs electronic and manual**	High Risk	10	Moderate Risk (6)	Sep-22	⟷
3104	PEO4	17/01/2023	Chief People Officer	Not Applicable (Non-clinical Directorate)	**Impact on our workforce of the economic context/cost of living including risk of potential industrial action**	Impact on our workforce of the economic context/cost of living including risk of potential industrial action: - wellbeing of our colleagues - sickness absence - workforce availability	Zoe Lintin	**17/11/22 Discussed at People Committee Nov22. Risk grading reviewed by CPO and remains as Likely likelihood. Outcome of RCN ballot known, other ballots still ongoing[13/09/2022 Zoe Lintin]** Wellbeing offer and financial management support being refreshed and recommunicated, e.g. Vivup, Wagestream Initial discussions at ICB and Place level Wellbeing support including financial management wellbeing Mileage rates reviewed and increased	High Risk	12	High Risk (9)	Nov-22	⟷

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	29 November 2022	**Agenda Reference:**	**G2**
Report Title:	**Use of Trust Seal**		
Sponsor:	Fiona Dunn, Deputy Director of Corporate Governance / Company Secretary		
Author:	Fiona Dunn, Deputy Director of Corporate Governance / Company Secretary		
Appendices:	None		

Report Summary				
Purpose of report:	The purpose of this report is to confirm use of the Trust Seal, in accordance with Section 14 of the Trust's Standing Orders.			
Summary of key issues/positive highlights:	Seal No 130	Description Lease Relating to part Ground & First Floor, 28-50 Ryton St, Worksop, Nottinghamshire S80 1AA. Contract Trillium (RMF) Limited and Doncaster & Bassetlaw Teaching Hospitals NHS FT	Signed Richard Parker OBE Chief Executive Alex Crickmar Interim Director of Finance	Date of sealing 26 October 2022
Recommendation:	The Board is requested to approve the use of the Trust Seal			

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

Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**

Implications	
Board assurance framework:	n/a
Corporate risk register:	n/a
Regulation:	Board of Directors Standing Orders
Legal:	
Resources:	none

Assurance Route			
Previously considered by:	Executive Team		
Date:	26/10/2022	**Decision:**	Approved
Next Steps:	none		
Previously circulated reports to supplement this paper:			

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	29 November 2022	**Agenda Reference:**	**G3**		
Report Title:	**NHS Consultations Update:** ○ NHS Enforcement Guidance ○ Provider Licence				
Sponsor:	Richard Parker, Chief Executive Officer				
Author:	Fiona Dunn, Director Corporate Affairs/Company Secretary				
Appendices:	See hyperlinks to documents for reference				
Executive Summary					
Purpose of report:	To give a brief update to the Board of Directors on two recent consultations launched by NHS England. These include changes to: • the NHS provider licence • the NHS enforcement guidance				
Summary of key issues:	NHS England have launched two consultations on changes to the NHS provider licence and revised NHS enforcement guidance. The documents set out the requirements on providers in providing care, as well as the consequences of non-compliance. Short briefings on each of the 30+ page documents are provided in the summary report below. It is not proposed to respond to either consultation, which both end 9 December 2022, but they have been brought to Board for corporate awareness so that the Board is sighted on their obligations. NHS Providers facilitated a session with NHS England on 24 November for Company Secretaries to allow feedback on the proposed changes to the provider license. In addition, NHS England has also finalised three governance documents it consulted on over the summer (Briefed to board in July 22 meeting): • Code of governance for NHS provider trusts • Guidance on good governance and collaboration • Addendum to Your statutory duties – reference guide for NHS foundation trust governors: System working and collaboration: role of foundation trust councils of governors				
Recommendation:	This is just as short briefing report to outline the key changes to the guidance documents. The Board is asked to note the two consultations.				
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:	N/A
Corporate risk register:	N/A
Regulation:	NHS England Enforcement,
Legal:	Compliance with regulated activities and requirements in Health and Social Care Act 2008, Health and Care Act 2022
Resources:	Actions required are currently being delivered within existing trust Resources

Assurance Route			
Previously considered by:	N/A		
Date:	N/A	**Decision:**	To note
Next Steps:			
Previously circulated reports to supplement this paper:	Update on Corporate Governance Changes Report to Board July22		

NHSE Consultations Briefing (2022)

At the end of October, NHS England launched two six-week consultations on changes to the NHS Provider Licence and revised NHS Enforcement Guidance which end on 9 December 2022. These follow the recently published NHS operating framework. Neither consultation changes the NHS Single Oversight Framework (where the Trust is in segment 2).

1 Changes to the NHS Provider Licence

Link to main document: https://www.engage.england.nhs.uk/consultation/changes-to-the-nhs-provider-licence/ for reference.

The provider licence forms part of the oversight arrangements for NHS providers, serves as the legal mechanism for regulatory intervention, and underpins mandated support at the most challenged providers. The NHS Oversight Framework details the overall principles, responsibilities, and ways of working for oversight, the key metrics and factors NHSE consider when determining support needs and the circumstances in which they consider formal regulatory intervention may be necessary to address particular issues.

The current licence consists of six sections, each containing high level conditions that providers must meet. The first four sections contain conditions that apply to all licence holders and cover general conditions, pricing, integrated care and patient choice and competition. Additional conditions then apply to providers of Commissioner Requested Services (CRS) to ensure they continue to provide services should they get into financial difficulty. Finally, specific governance conditions apply to NHS foundation trusts.

The main changes proposed are as follows:

Supporting system working	Reflecting expectations around collaboration and co-operation – through a new licence condition outlining expectations of how NHS trusts, foundation trusts and NHS Controlled Providers should work together across the newly formed Integrated Care Systems to deliver core system objectives. This includes planning, service delivery, service improvement, delivering system financial objectives and agreeing and delivering system workforce plans. Reflecting the Triple aim and health inequalities – through a new licence condition that mirrors the expectations set out in the 2022 Act, for NHS trusts, foundation trusts and NHS Controlled Providers to consider the Triple Aim and health inequalities in their work Reflecting digital obligations to enable system working and promote digital maturity – through a new licence condition and a separate amendment to the governance conditions. These reflect expectations already set out in legislation and guidance. Reframing integrated care as a positive obligation to integrate service provision and reduce health inequalities – to encourage providers to actively participate in service integration to improve the quality of health care services, provide place-based integrated care, and reduce inequalities of access and outcomes. Reflecting the importance of personalised care – by expanding the patient choice condition

	Removing the competition condition – to reflect a shift in healthcare priorities from competition to collaboration and the fact that NHS England does not have statutory functions relating to competition oversight.
Enhancing the oversight of key services provided by the independent sector	Broadening the range of providers where continuity of services (CoS) conditions will apply to include hard to replace providers Expanding the scope of CoS conditions to include quality governance standards to enhance risk mitigation and co-operation with NHS England in the event that an independent sector provider is experiencing serious quality issues which threaten service delivery. Mechanisms already exist to address quality concerns in NHS trusts and foundation trusts.
Addressing climate change	Tackling climate change and delivering Net Zero – by reflecting expectations set out in the 2022 Act for NHS trusts and foundation trusts and in guidance around net zero and climate change ambitions in the governance conditions.
Technical amendments	Modifying costing conditions and separating them from the other pricing conditions – reflecting wider role understanding costs plays in supporting integration and improvement as well as the pricing NHS services. Amending the pricing conditions to reflect changes to national policy and pricing legislation – by referencing the National payment scheme and removing the condition related to local modifications Streamlining reporting requirements – by removing requirements around self-certification for NHS trusts and foundation trusts due to duplication with annual reporting requirements and to reduce regulatory burdens. Applying existing core conditions on all licensees and foundation trusts to NHS trusts and updating language to reflect the current statutory framework – including inserting references to NHS trusts and reflecting the change of Monitor to NHS England as the regulatory body for the provider licence. Removing obsolete conditions – including those setting out the payment of fees to NHS England. Amending the Fit and Proper Persons condition – in line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and as per the statutory consultation conducted in 2021.

These proposed changes have been co-developed and refined through early engagement with providers, system leaders and key representative groups.

2 Revised NHS enforcement guidance

Link to main document: https://www.england.nhs.uk/long-read/consultation-on-the-revised-nhs-enforcement-guidance/ for reference.

The revised enforcement guidance sets out how NHS England intends to exercise its enforcement powers.

The guidance applies to all Integrated Care Boards (ICBs) and providers of NHS healthcare services in England subject to the provider licence. It explains that ICBs are expected to take oversight of and trouble-shoot local issues but enforcement will remain at NHS England level.

Enforcement could mean several things, some of which the Trust has experienced in the past, such as regulatory undertakings. Several other measures may be imposed including discretionary requirements, governance licence conditions, monetary penalties and, in extreme circumstances, revocation of licence.

The main changes proposed are as follows:

- Removal of references to enforcement action for breach of competition rules as Monitor's competition functions were removed by the Health and Care Act 2022 (Chapter 1 of the current enforcement guidance).

- NHS England's shift away from rigid application of the 'prioritisation framework' that Monitor used to inform its decisions on whether or not to begin or continue ongoing cases. The framework has since fallen out of use and the guidance has been updated to reflect current best practice and the legal framework by which NHS England oversees ICBs and providers (Chapter 2 of the current enforcement guidance).

- NHS England's shift away from formal investigations where possible. The revised guidance reflects the collaborative process NHS England will follow with ICBs and providers when gathering information and investigating any concerns (Chapter 4 of the current enforcement guidance).

Other additions to the guidance are as follows:

- Inclusion of enforcement relating to NHS trusts, to reflect the extension of the provider licence to NHS trusts on commencement of relevant provisions under the 2022 Act (paragraph 36 of the revised enforcement guidance).

- Creating guidance to cover enforcement in relation to ICBs as well as providers. The proposed revised guidance would include a new approach to ICB enforcement that includes the use of undertakings entered into by ICBs as the first step of enforcement action. The guidance also sets out the options and process for using ICB directions (paragraphs 32-35 of the revised enforcement guidance).

- NHS England's enforcement powers relating to patient choice provisions. Monitor had an oversight role and enforcement powers over clinical commissioning groups and NHS England in relation to compliance with The National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013 and certain provisions in the NHS Standing Rules. Under the Health and Care Act 2022, when the provisions come into force, NHS England will have a similar oversight role and enforcement powers over ICBs in relation to compliance with patient choice provisions (paragraph 31 of the revised enforcement guidance)

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	29 November 2022	**Agenda Reference:**	**H1**		
Report Title:	**Chair & NEDs Report to Board**				
Sponsor:	Suzy Brain England OBE, Chair of the Board				
Author:	Suzy Brain England OBE, Chair of the Board				
Appendices:	None				
Executive Summary					
Purpose of report:	To update the Board of Directors on the Chair and NED activities since September 2022's board meeting.				
Summary of key issues:	This report is for information only.				
Recommendation:	The Board is asked to **note** the contents of this report				
Action Require:	~~Approval~~	**Information**	~~Discussion~~	~~Assurance~~	~~Review~~
Link to True North Objectives:	**TN SA1:** *To provide outstanding care for our patients*	**TN SA2:** *Everybody knows their role in achieving the vision*	**TN SA3:** *Feedback from staff and learners is in the top 10% in the UK*	**TN SA4:** *The Trust is in recurrent surplus to invest in improving patient care*	

Implications	
Board assurance framework:	None
Corporate risk register:	None
Regulation:	None
Legal:	None
Resources:	None

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

Chair's Report

NHS Providers

Since my last report, I have attended NHS Providers' check in" and full board meetings. An overview of activity to influence and extend the voice of providers is shared via the Executive Team report and a summary of support offered via the annual conference, learning and development and network programmes.

In addition to the regular updates from the executive team, sub-committee reports and management accounts were presented to November's full board meeting along with the annual report and accounts 2021/2022 and 2022's staff survey results. The recruitment of the Chief Executive was ongoing, and more recently has been announced as Sir Julian Hartley, Chief Executive of Leeds Teaching Hospital. I look forward to working with Sir Julian when he commences in post on 1 February 2023.

Governors

In early October I hosted a virtual South Yorkshire Integrated Care System governor event. The session was very well attended and governors were able to hear from the Chair and Chief Executive of the South Yorkshire Integrated Care Board, Miriam Deakin, NHS Providers' Director of Policy & Strategy and the Chairs of South Yorkshire Acute Federation and the Mental Health, Learning Disabilities and Autism Alliance. Engagement was excellent and I am now progressing plans to host a similar event for Nottingham & Nottinghamshire Integrated Care System.

1:1s & Introductory Meetings

In addition to my regular meetings with the Chief Executive, I have taken part in one-to-one discussions with the Non-executive Directors, Lead and Deputy Lead Governor and Company Secretary. I have also met with the Director of Midwifery and Interim Deputy Chief Operating Officers. As a group of non-executives, we also meet on a monthly basis. Along with our clinical non-executive, Jo Gander, I welcome the international nurses as part of the Trust induction, extending a warm and supportive welcome to them as they start an exciting journey with the Trust.

Celebratory Events

It was my pleasure to attend the Trust's Star Awards last month, where members from across the organisation come together to celebrate individual and team successes. It was great to see everyone enjoying the evening, and as usual, the Communications team did an amazing job in organising the event, so a special thank you to everyone for making this a night to remember.

This month, along with my fellow NEDs I will join the international nurses to mark completion of the Objective Structured Clinical Examinations (OCSEs) and also join the volunteers to say a special thank ahead of the Christmas break for the enormous contribution they make in giving their time to support the smooth running of the hospital.

Last but by no means least, Richard Parker and I were privileged to attend the civic ceremony to confer city status on the borough of Doncaster on 9 November, when King Charles III and the Queen Consort bestowed letters of patent.

Recruitment

Last month I supported the recruitment of the Chief Nurse, a robust selection process supported by Gatenby Sanderson which resulted in the appointment of Karen Jessop, Deputy Chief Nurse at Sheffield Teaching Hospitals. Karen will join the team in early January 2023 and as part of her transition will spend a couple of days a week at the Trust until her official start date. I look forward to working with Karen and ask you all to extend your usual warm welcome.

Other meetings and events

Since my last report I have chaired September's Council of Governors meeting, October's Board and a Nominations & Remunerations Committee to consider recruitment of non-executive directors. The Annual Members Meeting was a pre-recorded event, accessible via YouTube, the Trust's website and its Facebook page, members were able to hear from myself, the Chief Executive and Acting Director of Finance as we reflected on the trust's activity and financial position for 2021/2022 and the Annual Report & Accounts 2021/22 were received. A question and answer session allowed members to submit questions prior to the event and receive responses from directors.

Along with fellow Chairs and Chief Executives I attended a regional recovery event at York Racecourse. I continue to be actively involved in the South Yorkshire Acute Federation Board meetings and join my South Yorkshire Chairs at a monthly meeting with Integrated Care Board Chair, Pearse Butler. An alternative date for the Acute Federation Board development session, originally due to take place on the day of the Queen's funeral, will take place in early December. Along with Board members each trust has invited clinicians to join the discussions and a pre-meet with myself, the Chief Executive and the clinicians will take place towards the end of the month to ensure they are well informed on the work of the Acute Federation and the Trust's role in this.

Finally, myself, the Chief Executive and the Acting Director of Finance have met separately with the Doncaster and Bassetlaw Place Directors and their Directors of Finance to understand how we best work together, including engagement with non-executive and governor colleagues.

NED Reports

Mark Bailey

Since the last Board report, Mark has participated in the board sub-committees for Finance & Performance, People, Quality & Effectiveness, Audit & Risk and Nominations & Remuneration and also chaired the Teaching Hospital Board.

As part of our widening participation agenda Mark attended the formal partnership ceremony with Retford Oaks Academy in Bassetlaw as they became the UK's second Foundation School in Health. Along with the Executive Medical Director, Mark was also pleased to meet and listen to the experiences of the theatre, paediatrics and maternity teams at Bassetlaw Hospital.

Assurance and 'buddy' calls have been held with the Chair, Executive and Non-Executive colleagues. Individual 'buddy' calls with Governors continue along with attendance and presentation of the development of our Charity at the Council of Governors.

On-site and virtual meetings have included assurance work as the interim NED Safety Champion for Maternity with the Director of Midwifery, familiarisation with the Simulation Centre capabilities at Montagu, updates on the latest implementations in our digital healthcare programme and discussions on our health and well-being and people priorities. With the Deputy Chief Executive, a further briefing on the future strategy for the Trust Charity has been held with executors of the Fred and Ann Green Legacy.

Mark chaired the interview panel for consultant appointment in Trauma & Orthopaedics and was a member of the panel for the appointment of our new Director of Education & Research.

Finally, Mark was delighted to attend the Trust's Star Awards held at the Doncaster Dome to recognise some of the outstanding achievements of our teams in the last year.

Kath Smart

Kath has attended her regular committee meetings including Board, Finance & Performance, Quality & Effectiveness and Charitable Funds and alongside other Board members she has attended the Council of Governors Annual Members Meeting. She also attended the Board briefing and development sessions on training on Advisory Appointment Committee panels for consultant interviews and Health & Safety. As part of the handover of the Quality & Effectiveness Committee Chair to Jo Gander, Kath has attended meetings to discuss agenda setting, the annual workplan, and clinical audit.

She has taken part in one-to-one meetings with the Chair, Chief Nurse, and NED colleagues. She has also had her buddy meeting with one of the governors and the Chief Operating Officer. She was delighted to attend the Trust's Star Awards along with a number of NED colleagues and appreciated the opportunity to see excellence recognised in such an interactive way.

As part of the Board to Ward programme, Kath visited Mexborough Montagu Hospital (Rehabilitation Wards 1 & 2) with Zoe Lintin and heard about patient care, rehabilitation, & patient activities alongside the continued challenges of discharging patients back into the community. She also attended the recent Qi Report Out event on 17 November, which received feedback from three Qi projects; the health & safety Granger Report; thermoregulation in newborns; and discharge prescriptions (TTO's) all of which presented areas where improvement is underway.

Finally, she chaired the October meeting for the Audit & Risk Committee, took part in the Audit & Risk Committee effectiveness review, met with the Trust's internal auditors (360 Assurance) and has reviewed and revised the Audit & Risk Committee workplan for 2023/24 with the Company Secretary.

Neil Rhodes

Since his last report Neil has attended an interview training session, he also represented the Chair at a Yorkshire and Humber Chairs' meeting. He attended the Council of Governors' meeting and the Annual Members' meeting and has chaired two consultant selection interview panels.

Representing the Chair, he has attended four meetings in support of the Nottingham and Nottinghamshire ICS including chairing a meeting of the Acute Provider Collaborative meeting. In addition, Neil has chaired two Finance and Performance Committee meetings including the range of

agenda setting and pre-meetings associated with it. He has attended the Charitable Funds Committee and Nominations and Remuneration Committee. Along with other NED colleagues he had a detailed briefing from the Chief Executive in relation to strategic events and pressures affecting the Trust. The Finance & Performance Committee meeting on 27 October was Neil's final meeting, handing over responsibility to Mark Day. In a similar manner he has handed on his responsibilities for supporting the Nottingham and Nottinghamshire ICS on behalf of the Chair to Hazel Brand.

Mark Day

Mark is now well established as a member of the DBTH team, contributing effectively to the work of the Board and its Committees.

As well as attending Board in September and October, Finance and Performance Committees, the Audit & Risk Committee, and Remuneration Committee Mark has chaired his last People Committee before moving on to lead the Finance and Performance Committee from November. Additionally, he has attended NED training, NHS Provider's network events, and deputised at meetings for the Chair, including Doncaster Chamber, a key local partner of the Trust.

In November Mark had the opportunity to visit Wards 24 and 18 at Doncaster Royal Infirmary seeing for himself the great work of teams in gastroenterology, hematology and cardiology. As with all visits of this type observations and staff feedback will be shared with senior management to support the continuous improvement process.

Hazel Brand

Hazel has continued to develop relationships with colleagues in Nottingham & Nottinghamshire ICS (N&N ICS) and Bassetlaw Place. She attended a N&N ICS Partners Assembly for statutory and voluntary groups to provide input to the emerging ICS strategy. It was good to see one of our governors there. Subsequently, she has met the Programme Director for the N&N Acute Providers Collaborative for a briefing, which included the wider N&N ICS, and with the Director and Programme Director of Bassetlaw Place for a similar briefing. The N&N Integrated Care Partnership (ICP) has issued its draft strategy; following on from that, Bassetlaw Place is holding a Place Plan workshop in the new year, which she hopes to attend, to look at how it will deliver locally what's in the strategy. She has also attended other forums under the Nottingham & Nottinghamshire banner.

Hazel takes over chairing the Charitable Funds Committee in the new year and has had a briefing from outgoing chair, Mark Bailey, and attended the agenda-setting meeting to meet other members of the team.

A workshop for NEDs run by NHS Providers was a useful opportunity to hear the organisation's take on the current and future financial prospects for the NHS and to meet other NEDs online. Hazel also attended a two-day NED induction run by NHS Providers.

In her role as the non-executive lead for Speaking Up (SU) Hazel has attended a staff SU Forum to get a better idea on the issues staff are dealing with. This has been backed up with an online session with the National Freedom to Speak Up Guardian, and a further update with our Chief People Officer, Zoe Lintin.

Jo Gander

Since the last board meeting Jo has taken on the role of Chair of the Quality & Effectiveness Committee, following a handover from Kath Smart, and is supporting executives with updating the workplan. She is working closely with the Audit & Risk Committee Chair and the clinical audit lead to inform future committee meetings. She has attended two Clinical Governance meetings to understand, in more detail, the challenges being faced by clinical teams across the trust, which has been further informed by her on site visit to Bassetlaw Hospital and Doncaster Royal Infirmary with Zoe Lintin, Chief People Officer.

Jo has supported the Chair at two international nurse welcome events and their OSCE celebratory event. She has attended the Quality Improvement Level 2 graduation and the South Yorkshire Integrated Care System Allied Health Professionals event which showcased new initiatives being led by AHPs as well as sharing some of the workforce challenges faced across the system.

Jo is a regular attendee of the Charitable Funds Committee, People Committee, Audit & Risk Committee and the Nominations & Remuneration Committee of Board. She has attended several meetings linked to the health inequalities agenda, as well as maternity safety champion meetings. Linked to the Safety agenda Jo has also attended a Patient Safety Incident Response Framework webinar.

Finally, Jo has also attended two Board development sessions and completed the handover of health and wellbeing NED responsibilities from Mark Bailey and has attended initial health and wellbeing discussions to develop her understanding.

Chief Executive's Report
October 2022

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

An update on the Trust's response to COVID-19 and activity

Throughout the past number of weeks, the Trust's COVID-19 activity has remained relatively low and at the time of writing, we are caring for approximately 20 patients with active COVID-19. This is a similar number to last month.

As a result, we have not required to increase certain restrictions within our sites at bay, such as access for visitors. We do however continue to ask colleagues to test for the illness if they believe they are symptomatic, and we also require the wearing of face masks in all clinical areas – and we anticipate this will continue.

Over the last month we have been offering colleagues both the COVID-19 and flu vaccination and we will be continuing with these vaccination drives throughout the coming winter.

Our second Foundation School in Health Partnership

This month, we entered a formal partnership with Retford Oaks Academy, the newest Foundation School in Health (FSiH), marking a strengthened relationship between education and healthcare in the region.

Like our existing partnership with Hall Cross in Doncaster, the new partnership intends to develop opportunities and widen participation for pupils from the Bassetlaw area who wish to pursue a career in the health service.

This will see an increased involvement from health professionals at the school, work experience and internship opportunities for pupils with a tailored approach to the Bassetlaw youngsters.

One of only six NHS anchor institutions chosen, the Trust were awarded an incredible £25,000 start-up funding for the FSiH project being supported by The Health Foundation and NHS England and NHS Improvement.

As part of the Health Anchor Learning Network (HALN), we hope to share the framework, encouraging other NHS Trusts nationally to initiative similar partnerships with their local education providers.

Specialist instrument donation to help endometriosis patients

We have embarked upon a transformative way to treat local patients with early-stage endometriosis thanks to the donation of a unique treatment for this chronic condition which affects 1.25 million women in the UK.

Donated by the Friends of the Hospital charity, the Helica Thermal Coagulator (TC), has so far allowed 65,000 operations in the UK. It is is unique in that it provides a solution for new sufferers of the condition, mitigating the requirement for years of hormone therapy, painkilling treatment, and a range of associated conditions.

With approximately 55,000 new cases of endometriosis diagnosed each year in the UK, the treatment provided by the Helica TC has the potential to effectively put an end to the condition's impact within 15 years – but only if it is diagnosed and treated sufficiently early.

Endometriosis frequently progresses to the point that no course of treatment – whether that be drugs, surgery, or hysterectomy – can alleviate the pain. We are delighted that the Friends of the Hospital's donation of Helica TC not only heralds a new chapter in Doncaster's early treatment of the disease, but also highlights the importance of a wider understanding of its symptoms amongst the local GP community.

Endometriosis can only be effectively diagnosed via minimally invasive laparoscopic examination, at which stage there is surgical possibility of removing the diseased cells and alleviating the problem long-term. GP training to help identify early-stage endometriosis plays a critical role in the potential eradication of the condition.

Modular Theatre Units installed at Bassetlaw Hospital

In October, a project began to replace reinforced autoclaved aerated concrete (RAAC) roofing panels within Bassetlaw Hospital's mental health and theatre blocks.

Three modular theatre units have been placed at Bassetlaw Hospital as work gets underway to replace roofing panels as well as enable an expansion and development of the site's Emergency Department.

Considered a revolutionary new building material at the time, RAAC panels were installed as a lightweight roofing solution, but recent issues have arisen in parts of the country leading to a national programme of replacement. Following extensive surveys, it was found that the panels installed at Bassetlaw were in very good condition, however these are to be replaced as part of a national initiative. Consequently, we received funding of £15.944 million to replace the affected roofs by 31 March 2023.

To ensure disruption is kept to a minimum and planned and emergency procedures can continue the Trust took the delivery of three modular operating theatres, provided by Vanguard Health Solutions. The Vanguard units are compliant with all appropriate health and safety standards as well as all relevant air flow and filtering requirements.

An update on the Serenity Suite appeal

Our Serenity Suite Appeal, which is raising funds to create a specialist bereavement suite within our maternity facilities has received two significant donations this month.

£25,000 was donated from a local Mental Health Nurse in memory of her second baby Ernie and £33,000 has been donated by Thorne Rural and Tickhill & District Lions.

The Serenity Suite will create a space for families to spend time together in a safe, secure, and serene space where they can grieve the loss of their baby with the support of specialist Bereavement Midwives.

Some of the funds raised will also help us to procure a mobile scanner meaning those families who may be suffering a miscarriage could remain in the Early Pregnancy Assessment Unit (EPAU) for an ultrasound diagnosis, instead of moving to the busy scan department and sitting amongst those awaiting standard scans.

We have had fantastic support for this project since its launch and we know that it will make a real improvement to maternity bereavement care and support.

Appointments and departures at the Trust

Welcoming our new Chief Nurse

After an extensive and robust recruitment process, Karen Jessop will soon join us as our new Chief Nurse.

Karen is currently the Deputy Chief Nurse at Sheffield Teaching Hospitals (STH), a position she has held since October 2017.

Qualifying as a Registered Nurse over 25 years ago, Karen joined Hull University Hospitals in 1995 where she spent the next two decades, holding a variety of roles within critical care and surgery. Karen eventually progressed to become a Matron and a Divisional Nurse Manager, also qualifying as a Registered Midwife and completing a Master's Degree in Health Care Leadership with the University of Birmingham.

In 2016, Karen joined STH as Nurse Director for Operating Services, Critical Care and Anaesthesia, before moving on to become Deputy Chief Nurse 18 months later.

We are delighted to welcome Karen to Team DBTH. In our new Chief Nurse, we believe we have someone with a wealth of experience, and someone who has a track record of delivery throughout her career – always ensuring the patient comes first.

New Director of Education and Research

After an extensive and robust selection process, Dr Sam Debbage has been appointed Director of Education and Research, commencing in post from 1 November.

Sam is currently the Deputy of Education and Research at the Trust, a position she has held since 2015, and will step into the role vacated by Dr Alasdair Strachan.

Originally from Norfolk, Sam joined the NHS almost 30 years ago as a Registered Nurse at Sheffield Teaching Hospitals. Passionate about education early on, Sam complimented her clinical work by completing a Master's Degree in 1998, before progressing to, and earning, a doctorate (PhD) in 2009.

A number of education, research and leadership roles followed, before Sam finally joined what was Doncaster and Bassetlaw Hospitals in 2015 and was part of the team which helped the Trust gain its 'Teaching Hospital' accreditation in 2016.

We are confident that our Education and Research team, with Sam at the helm, will continue their amazing work, ensuring we continue to provide the very best mentoring, support and learning for our students, as well as fostering an open environment for colleagues to get involved in ground-breaking research which will benefit the NHS locally, regionally, and nationally.

DBTH Digital Transformation

NHS Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Integrated Quality & Performance Report

Reporting Period - October 2022

Report Purpose	Data Source(s)	Report Created	Report Layout Modified	Report Owner	Contact Details	Training
To understand the Trust's current position with respect to the services they deliver.	Mega Cube Data Warehouse MS Forms	31/10/2022	16/10/2022	Executive Director of Restoration, Innovation and Transformation	dbth.informationservicesrequests@nhs.net	Regular training sessions are held, please email for more information.

DBTH Performance - Trust Level View

Oct 22

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

DBTH Health

11 %

(Last Month 18%)

(0 + 0 + 32 + 13 / 400 = 11%)

Finance

NOT AVAILABLE

Coming Soon

People

Unvalidated

0 %

0 out of 6 KPI's

SET Training	83.32 %
Completed Appraisals	77.36 %
Employee Turnover	1.36 %
Sickness Absence	6.84 %
Workforce Vacancies	11.00 %
Consultants with Signed Off Job Plans in EJP	34.70 %
Time to Fill Vacancies	71 Days

Health Inequalities

0 %

0 out of 1 KPI's

Health Inequalities	0/1

Patients

32 %

8 out of 25 KPI's

IPC	4/6
Patient Safety	1/4
Patient Experience	0/3
HSMR	1/3
Falls	0/1
Friends and Family	0/2
Medical Examiner	0/1
Audit & Effectiveness	0/2
Skin Integrity	2/2
VTE	0/1

Performance

13 %

8 out of 61 KPI's

Urgent and Emergency Care	0/11
Waiting List	0/6
Cancer	3/8
Activity Against Plan	1/8
Elective Recovery Fund	0/6
Stroke	3/6
Elective Outpatients	0/9
Elective Theatres	1/7

Index

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Finance

Coming Soon

People

- People
- People Forms Data
- People Forms Data 2

Health Inequalities

- Ethnicity Recorded

Patients

- IPC
- HSMR
- Patient Safety
- Skin Integrity
- Falls
- Patient Experience
- Claims
- Friends and Family Test
- Audit and Effectiveness
- VTE
- Reducing Length Stay
- Medical Examiner

Performance

Urgent & Emergency Care	Urgent & Emergency Care Trends
Waiting List	Waiting List Trends
Cancer	Cancer Trends
Activity Against Plan	Activity Against Plan Outpatients Trends
	Activity Against Plan Inpatients Trends
Elective Recovery Fund	Elective Recovery Fund Trends
Stroke	Stroke Trends
Elective Outpatients	Elective Outpatients Trends
Elective Theatres	Elective Theatres Trends

All Performance KPIS Trends

Urgent & Emergency Care Oct 22

ED Attendances
16223

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Data refresh | D | All KPIs on this page are refreshed on daily basis.

Ambulance Handovers

Ambulance Handovers Within 15 Mins
33.19 % !
Goal: 65.00 %

Ambulance Handovers Within 30 Mins
55.79 % !
Goal: 95.00 %

Ambulance Handovers More Than 60 Mins
25.13 % !
Goal: 0.00 %

EM Wait Times

A&E: Max wait 4 hours from arrival/admission/transfer/discharge
68.03 % !
Goal: 95.00 %

% Patients with Total Length of Stay in Emergency Department More Than 12 hours
6.56 % !
Goal: 2.00 %

Self Arrivals - Initial Assessment Within 15 Mins
50.92 % !
Goal: 95.00 %

Unvalidated

Critical Time Standards

STEMI Heart Attack - to be seen within 1 hour
Not Available

Early Stroke Intervention - to be seen within 1 hour
Not Available

Acute Physiological (RAPID) Asthma - to be seen within 1 hour
Not Available

Admission Wait Times

TOTAL - % patients leaving A&E from clinically ready to proceed to admission within 60 Mins
14.69 % !
Goal: 95.00 %

Specialty Item Category	A&E Attendances Count	Patients leaving A&E from clinically ready to proceed to admission within 60 Mins
PAEDIATRICS	132	60.71 %
GYNAECOLOGY	90	34.78 %
OTHER	408	29.13 %
GENERAL SURGERY	280	10.08 %
GENERAL MEDICINE	1153	9.27 %
TRAUMA AND ORTHO SURGERY	153	7.84 %
Total	**2216**	**14.69 %**

Non Admission Wait Times

(For Monitoring Only)

TOTAL - % patients leaving A&E from clinically ready to proceed to Departure within 60 Mins
61.95 % !
Goal: 95.00 %

Attendance Disposal Item	A&E Attendances Count	Patients leaving A&E from clinically ready to proceed to departure within 60Mins
ESA - Referred to Ambulatory Care	94	100.00 %
FDASS - Referred to Ambulatory Care	59	100.00 %
Navigation - Referred to Ambulatory Care	44	100.00 %
Referred to Bassetlaw Urgent Care Services (GP OOH)	341	100.00 %
Referred to Paediatric Assessment (CHOU)	51	75.00 %
Discharged	10093	63.77 %
ESA - Referred to	60	54.55 %
Total	**14007**	**61.95 %**

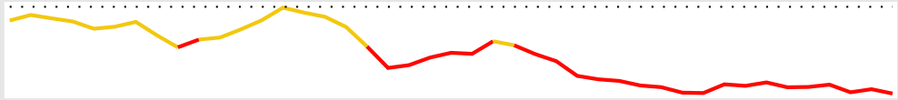
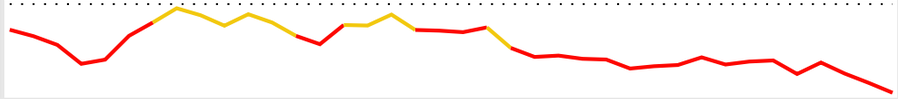
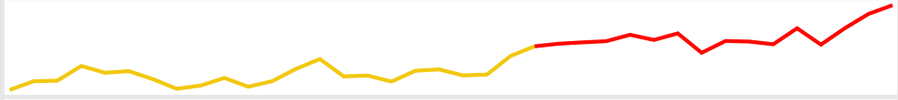
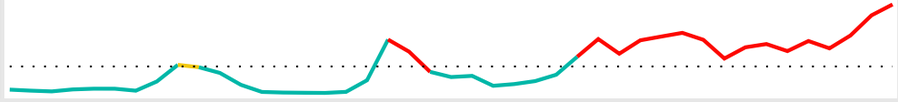
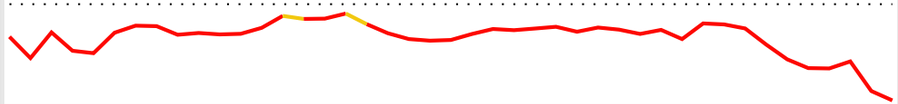
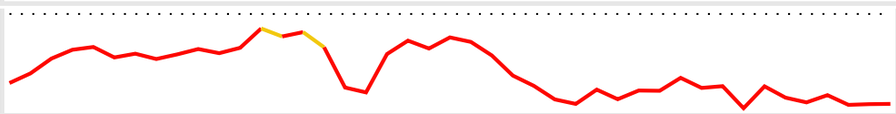
Hospital

Click here for EM Trends →

Urgent & Emergency Care

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh	(D) All KPIs on this page are refreshed on daily basis.

Metric Name	Current Value	Comparison Value	KPI Status	Sparklines
A&E: Max wait four hours from arrival/admission/transfer/discharge	68.03 %	95.00 %	!	
Ambulance Handovers Within 15 Minutes	33.19 %	65.00 %	!	
Ambulance Handovers Within 30 Minutes	55.79 %	95.00 %	!	
Ambulance Handovers More Than 60 Minutes	25.13 %		!	
% Patients with Total Length of Stay in Emergency Department >12 hours	6.56 %	2.00 %	!	
TOTAL -% patients leaving ED from clinically ready to proceed to admission within 60 mins	14.69 %	95.00 %	!	
Self Arrivals - Initial Assessment Within 15 Mins	50.92 %	95.00 %	!	

Waiting List

Oct 22

Active RTT waiters (Total Incomplete Pathways)

51066

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Data refresh | M | All KPIs on this page are refreshed on monthly basis.

RTT Waiters

RTT Number of 52 Weeks Waiters

1384

RTT Number of 78 Weeks Waiters

83

Target 0

RTT Number of 104 Weeks Waiters

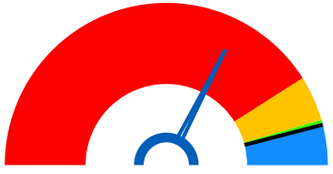
1

Target 0

% of patients waiting less than 18 weeks from referral to treatment

65.12 % !

Goal: 92.00 %



Waiters - Diagnostic Activity

% of patients waiting less than 6 weeks from referral for a diagnosti...

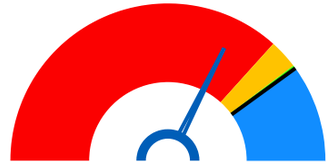
59.92 % !

Goal: 99.00 %

Trust - % DM01 Diagnostic Activity vs 19/20 levels

97.10 % !

Goal: 120.00 %



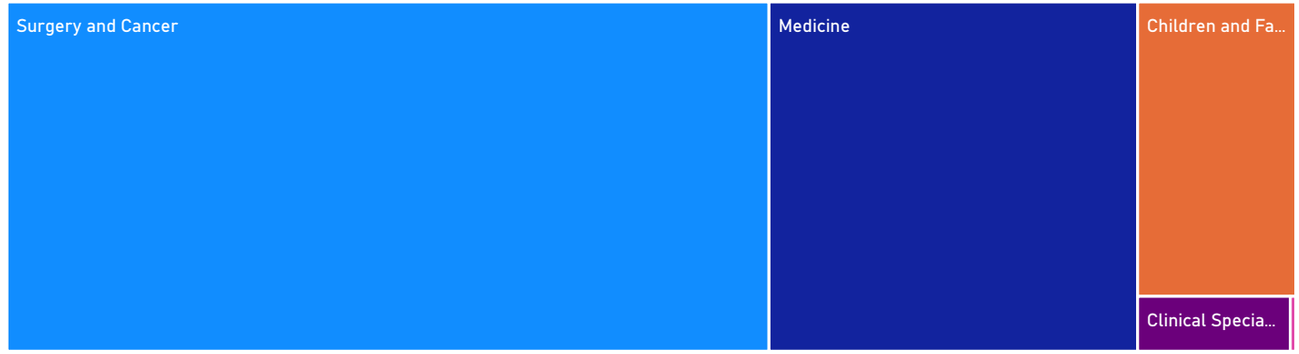
RTT Clock Stop Activity

Clock Stop Activity (% against 19/20)

88.12 % !

Goal: 110.00 %

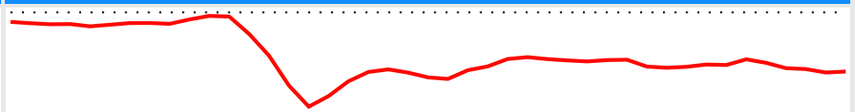
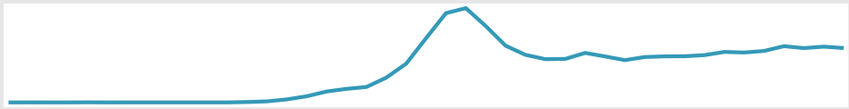
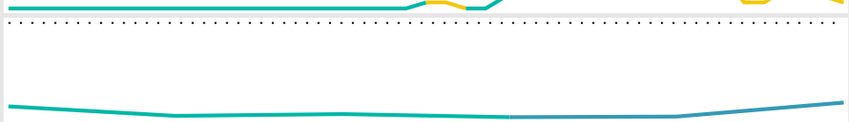
Division (Drill Down For Speciality)



Click here for RTT Waiters Trends →

Waiting List

Data refresh	(M) All KPIs on this page are refreshed on monthly basis.

Metric Name	Current Value	Comparison Value	KPI Status	Sparklines
% of patients waiting less than 18 weeks from referral to treatment	65.12 %	92.00 %	!	
RTT Number of 52 Weeks Waiters	1384			
RTT Number of 78 Weeks Waiters	83			
RTT Number of 104 Weeks Waiters	1		▲	
% of patients waiting less than 6 weeks from referral for a diagnostics test (DM01)	59.92 %	99.00 %		
Clock Stop Activity (% against 19/20)	88.12 %	110.00 %	!	

Cancer

Sep 22

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh	(M) All KPIs on this page are refreshed on monthly basis.

Day 28 Faster Diagnosis Standard (patients received diagnosis or exclusion of cancer within 28 da...

75.20 %✓

Goal: 75.00 %

Maximum 31 day wait from decision to treat to first definitive treatment for all cancers

85.30 %!

Goal: 96.00 %

Maximum 31 day wait for subsequent treatment - Surgery

94.10 %✓

Goal: 94.00 %

Maximum 31 day wait for subsequent treatment - Drugs

100.00 %✓

Goal: 98.00 %

Maximum 62 day wait for patients on 2ww pathway to first definitive treatment

59.60 %!

Goal: 85.00 %

Maximum 62 wait from referral from NHS cancer screening service to first definitive treatm...

88.00 %!

Goal: 90.00 %

Cancer Waiting Times Open Suspected Cancer Pathways 63 - 104 Days

60.00!

Goal: 22.00

Cancer Waiting Times Open Suspected Cancer Pathways 104 Days +

14.00!

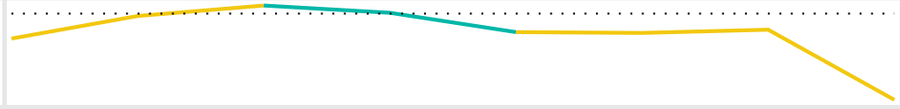
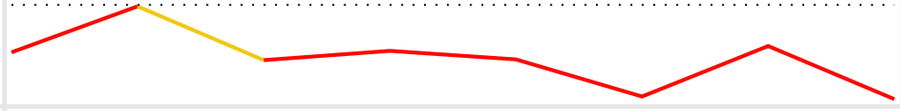
Goal: 0.00

Click here for Cancer Trends →

Cancer

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh	(M) All KPIs on this page are refreshed on monthly basis.

Metric Name	Current Value	Comparison Value	KPI Status	Sparklines
Maximum 31 day wait for subsequent treatment - Drugs	100.00 %	98.00 %	✓	
Day 28 Faster Diagnosis Standard (patients received diagnosis or exclusion of cancer within 28 days)	75.20 %	75.00 %	✓	
Maximum 31 day wait from decision to treat to first definitive treatment for all cancers	85.30 %	96.00 %	!	
Maximum 31 day wait for subsequent treatment - Surgery	94.10 %	94.00 %	✓	
Maximum 62 wait from referral from NHS cancer screening service to first definitive treatment	88.00 %	90.00 %	▲	
Maximum 62 day wait for patients on 2ww pathway to first definitive treatment	59.60 %	85.00 %	!	
Cancer Waiting Times Open Suspected Cancer Pathways 63 - 104 Days	60.00	22.00	!	
Cancer Waiting Times Open Suspected Cancer Pathways 104 Days +	14.00		!	

Activity Against Plan

Oct 22

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh	Daily Refresh (D)	Monthly Refresh (M)

Inpatients

TOTAL Activity against plan

46185 !

Plan: 52183 (-5998)

M

Non Elective Activity - Discharges (for monitoring)

4810

D

Endoscopy Activity against plan

1249 !

Plan: 1467 (-218)

M

Day Case Theatre Activity against plan

836 !

Plan: 1,052 (-216)

D

Non-Theatre Elective Activity - excluding Endoscopy against plan

246 ✓

Plan: 245.0863 (+1)

M

In Patient Elective Theatre Activity against plan

410 !

Plan: 467 (-57)

D

Outpatients

Outpatient Procedures (For Monitoring Only)

6,822

D

Outpatient New Activity - face to face Including Procedures against plan

11,074 !

Plan: 12,524 (-1,450)

D

Outpatient Follow Up Activity - face to face Including Procedures against plan

19,602 !

Plan: 26,632 (-7,030)

D

Outpatient New Activity - Virtual against plan

2,301 !

Plan: 2,398 (-97)

D

Outpatient Follow Up Activity - Virtual against plan

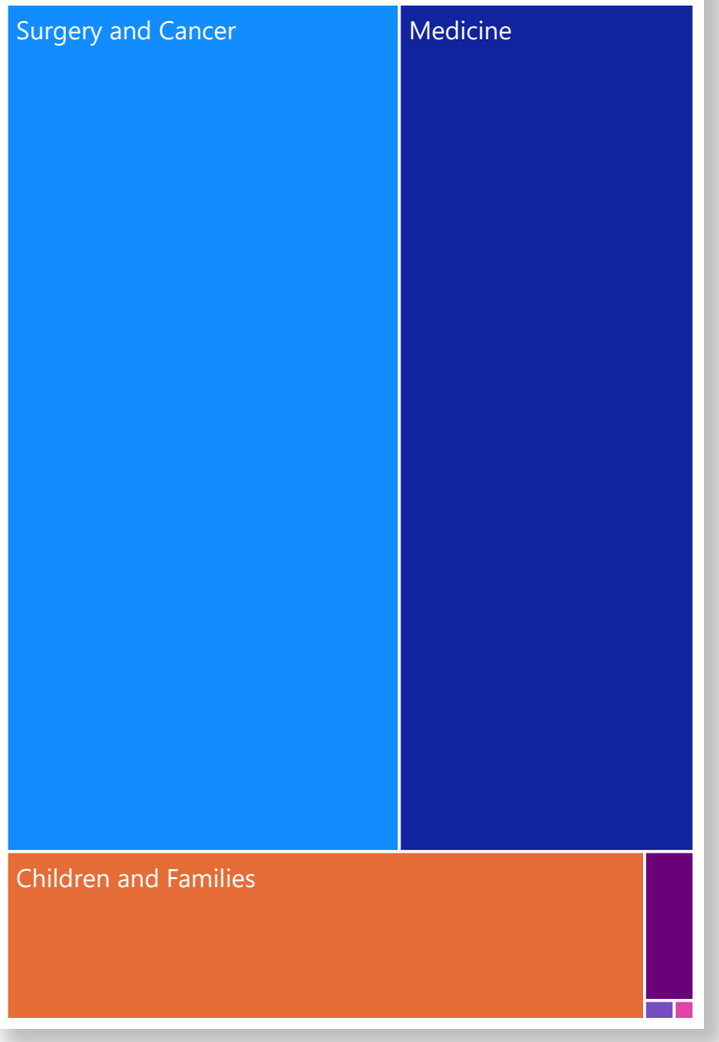
4,201 !

Plan: 5,097 (-896)

D

Click here for Activity Against Plan Trends

Division (Drill Down Currently Not Available for Inpatients Section)

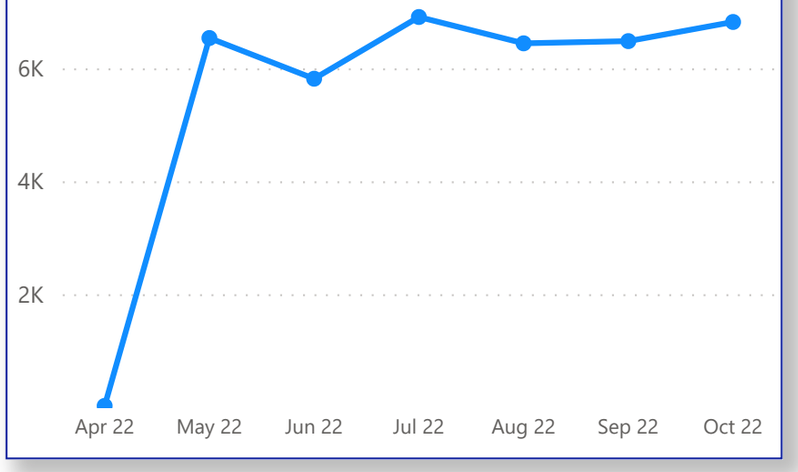


Activity Against Plan Trends - Outpatients

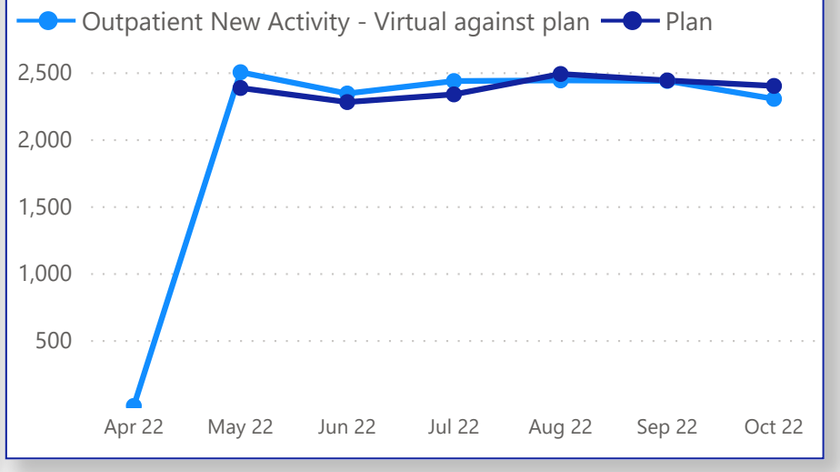
Data refresh	D All KPIs on this page are refreshed on daily basis.

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

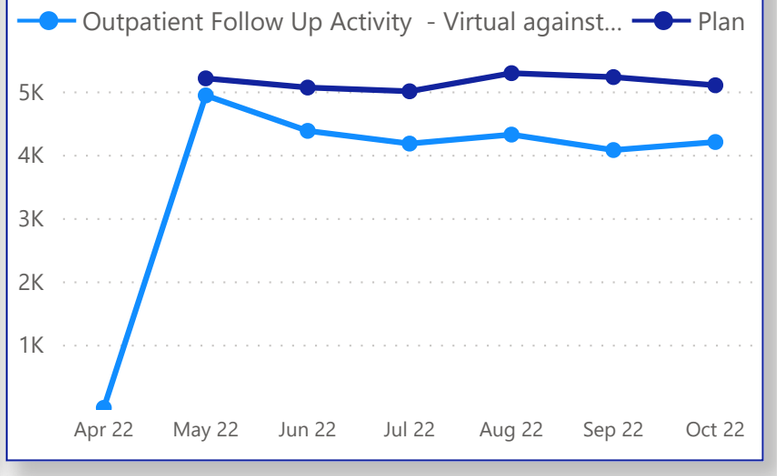
Outpatient Procedures (For Monitoring Only)



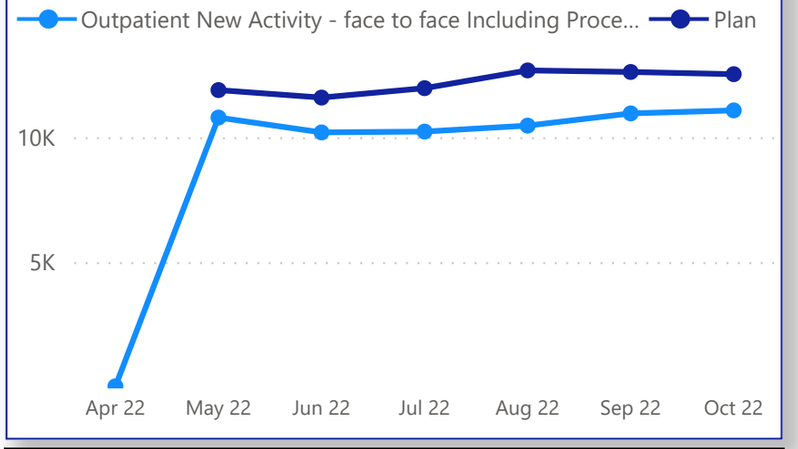
Outpatient New Activity - Virtual against plan



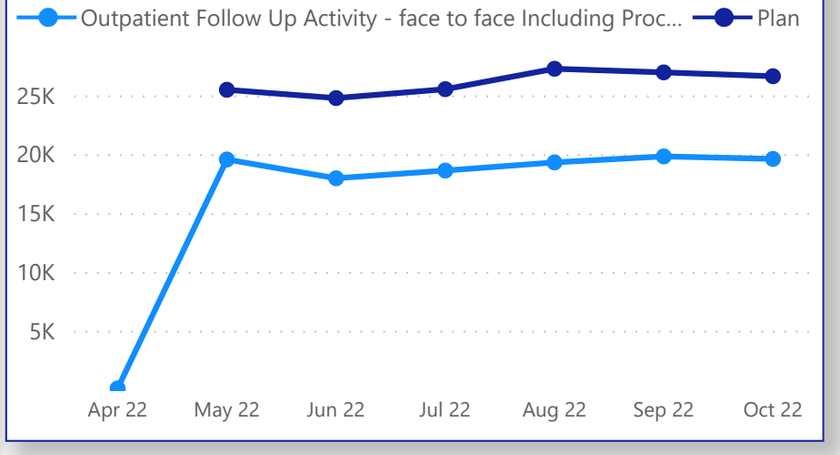
Outpatient Follow Up Activity - Virtual against plan



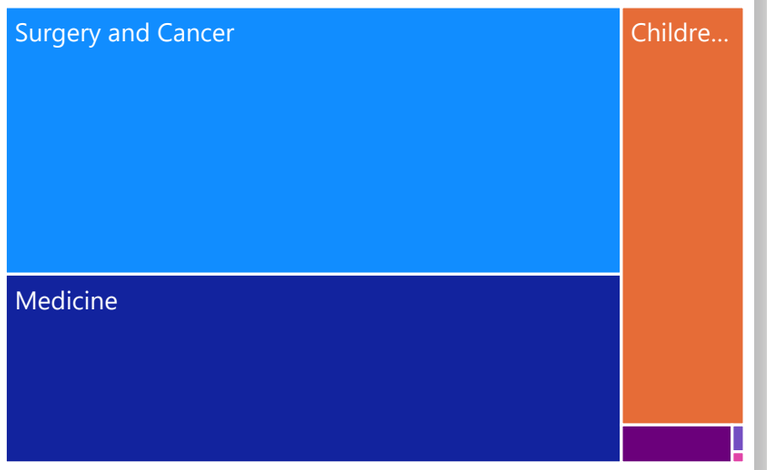
Outpatient New Activity - face to face Including Procedures against plan



Outpatient Follow Up Activity - face to face Including Procedures against plan



Division (Drill Down For Speciality)



30/04/2022 31/10/2022

Click here for Intpatients Trends

Activity Against Plan Trends - Inpatients

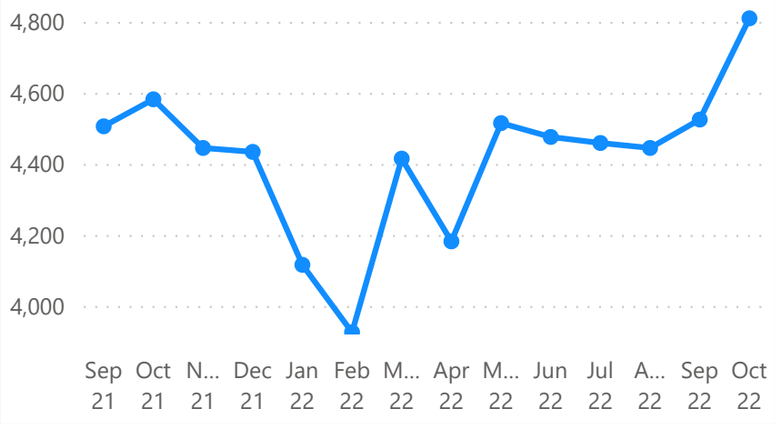
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (D) All KPIs on this page are refreshed on daily basis.

TOTAL Activity against plan

Not Available

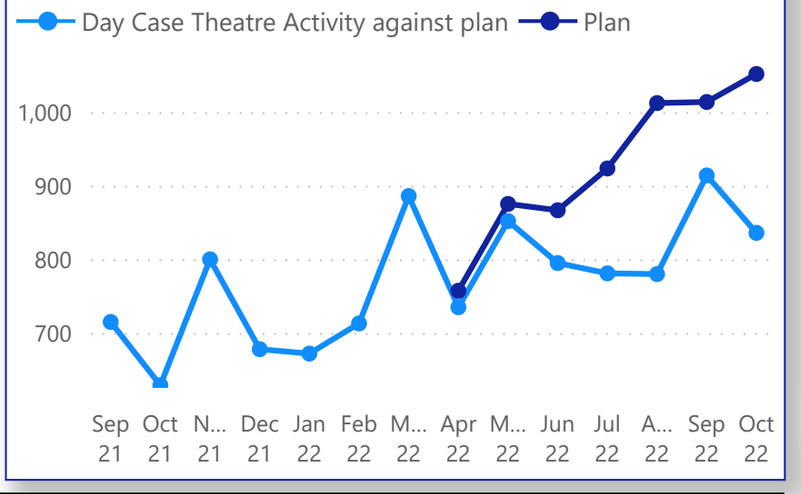
Non Elective Activity - Discharges (for monitoring)



Endoscopy Activity against plan

Not Available

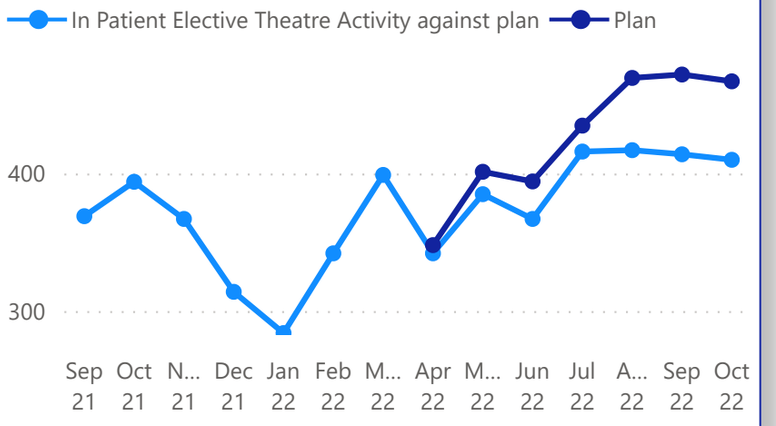
Day Case Theatre Activity against plan



Non-Theatre Elective Activity - excluding Endoscopy against plan

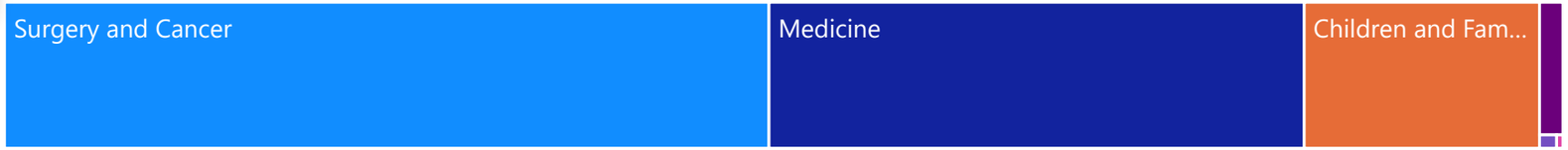
Not Available

In Patient Elective Theatre Activity against plan



01/09/2021 31/10/2022

Division (Drill Down For Speciality)



Elective Recovery Fund

Oct 22

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh	(M) All KPIs on this page are refreshed on monthly basis.

Core Activity

TOTAL Activity Value (% against 19/20)

Not Available

TOTAL Core Activity Value (% against 19/20)

87.47 % !

Goal: 104.00 %

Outpatient New Core Activity Value (% against 19/20)

87.80 % !

Goal: 104.00 %

Day Case Core Activity Value (% against 19/20)

102.32 % !

Goal: 104.00 %

Outpatient Follow Up Core Activity Value (% against 19/20)

83.46 % !

Goal: 75.00 %

Outpatient Procedures Core Value (% against 19/20)

82.38 % !

Goal: 104.00 %

In Patient Elective Core Activity Value (% against 19/20)

75.83 % !

Goal: 104.00 %

TOTAL Independent Sector Activity Value (Sum of Price Actual)

£497,874.31

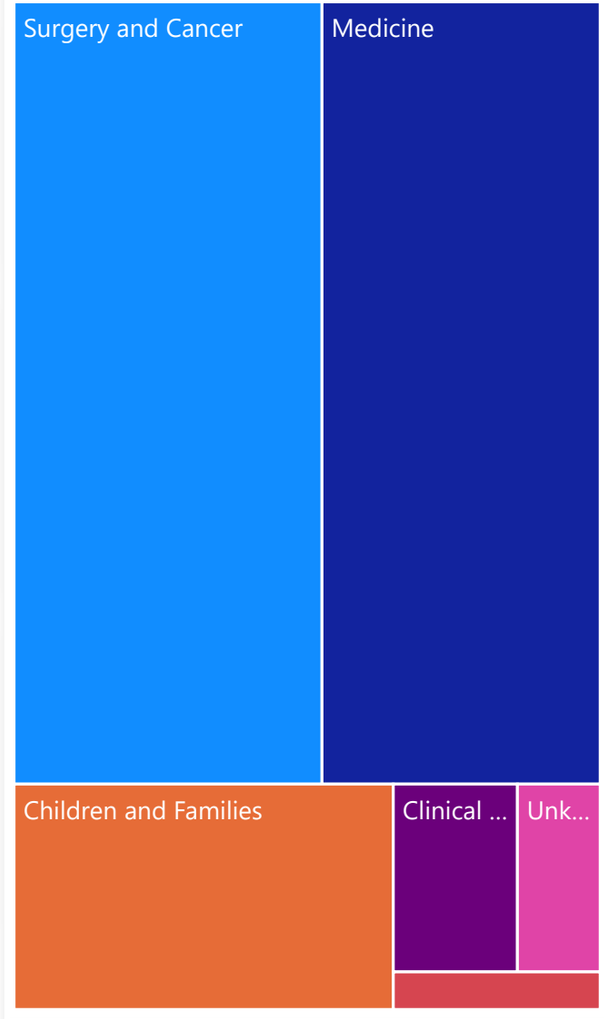
TOTAL Independent Sector Activity Value (Sum of Total Income)

£483,245.57

Attendances Outside Clinic (AOC) (Sum of Price Actual)

£198,115.00

Division (Drill Down For Speciality)

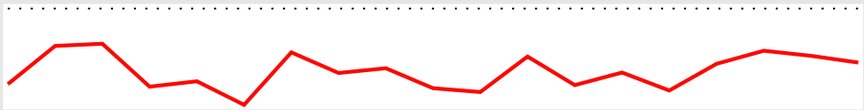
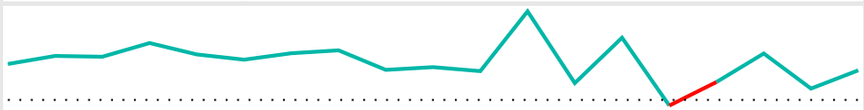


Click here for Elective Recovery Fund Trends →

Elective Recovery Fund Trends

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh	(M) All KPIs on this page are refreshed on monthly basis.

Metric Name	Current Value	Comparison Value	KPI Status	Sparklines
Day Case Core Activity Value (% against 19/20)	102.32 %	104.00 %	▲	
In Patient Elective Core Activity Value (% against 19/20)	75.83 %	104.00 %	!	
Outpatient Follow Up Core Activity Value (% against 19/20)	83.46 %	75.00 %	✓	
Outpatient New Core Activity Value (% against 19/20)	87.80 %	104.00 %	!	
Outpatient Procedures Core Value (% against 19/20)	82.38 %	104.00 %	!	
TOTAL Activity Core Value (% against 19/20)	87.47 %	104.00 %	!	

Stroke

Aug 22

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Data refresh	(M) All KPIs on this page are refreshed on monthly basis.

Percentage treated by a stroke skilled Early Supported Discharge team

64.58 % ✓

Goal: 24.00 %

Overall SSNAP Rating

B ✓

Goal: B

Proportion directly admitted to a stroke unit within 4 hours of clock start

41.67 % !

Goal: 75.00 %

Proportion of patients scanned within 1 hour of clock start (Trust)

45.83 % !

Goal: 48.00 %

Percentage discharged given a named person to contact after discharge

62.50 % !

Goal: 80.00 %

Percentage of eligible patients given thrombolysis

100.00 % ✓

Goal: 90.00 %

Click here for Stroke Discharges Trends (Not Available) →

Elective Outpatients

Oct 22

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh	Daily Refresh (D)	Monthly Refresh (M)

Utilisation

Central - Out Patient Booking % Appointments Booked 2 weeks Prior
72.90 % !
Goal: 95.00 %
(D)

Unvalidated

Divisional - Out Patient Booking % Appointments Booked 2 weeks Prior
69.81 % !
Goal: 95.00 %
(D)

Unvalidated

Utilisation - % Booked Out Patient Clinic Slots Attended
75.33 % !
Goal: 90.00 %
(D)

Unvalidated

Number of Registered Referrals not Appointed
29,319
(M)

Attended Appointments

New to Follow Up Ratio 19/20 Comparison
-0.06 !
Goal: -25.00 %
(D)

Unvalidated

TRUST - % of OP appointments delivered virtually (video or telephone)
17.49 % !
Goal: 25.00 %
(D)

% of First Out Patient Appointment via ERS Advice & Guidance Activity
5.17 % !
Goal: 16.00 %
(M)

Unvalidated

Not Attended Appointments

Out Patients: % Provider Cancellation Rate (less than 6 weeks notice)
77.51 % !
Goal: 5.00 %
(D)

Unvalidated

Out Patients DNA Rate 19/20 Comparison
0.02 % !
(D)

Out Patients: DNA Rate (First Appointment)
11.28 %
(for monitoring only)
(D)

Out Patients: DNA Rate (Follow Up Appointment)
9.98 %
(for monitoring only)
(D)

Typing Turnaround

Typing Turnaround Time (dictation to letter sent) (Trust Contract) within 2 WD

Unvalidated

Patient Initiated Follow Up Pathway

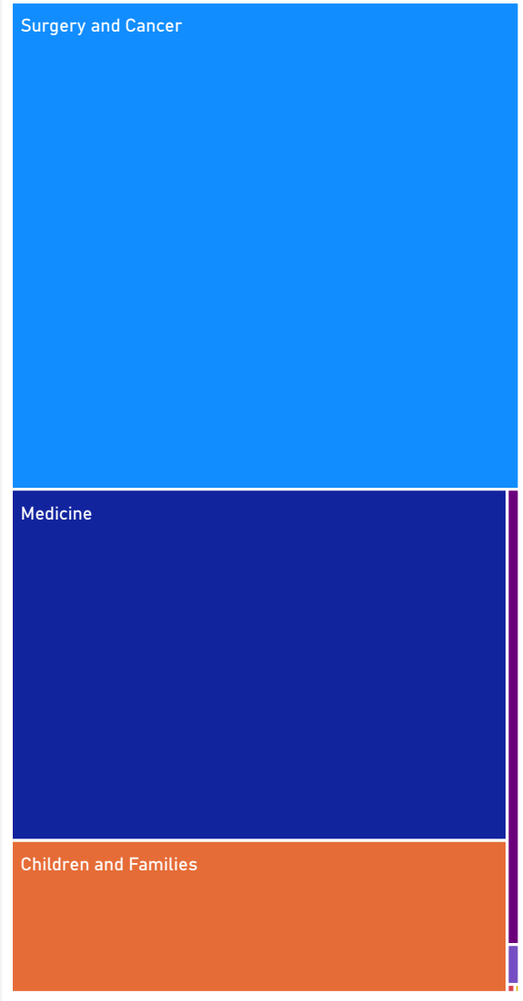
TRUST - % patients dicharged onto Patient Initiated Follow Up Pathway in Month
1.21 % !
Goal: 5.00 %
(D)

Data Quality

Number of Unreconciled Appointments 14 days +
1148 !
Goal: 0
(D)

Unvalidated

Division (Drill Down For Speciality)

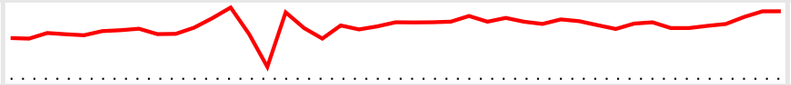
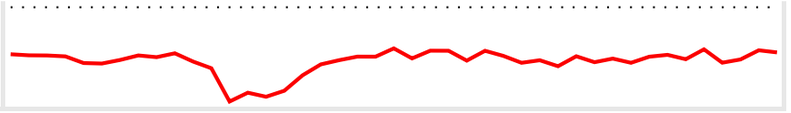
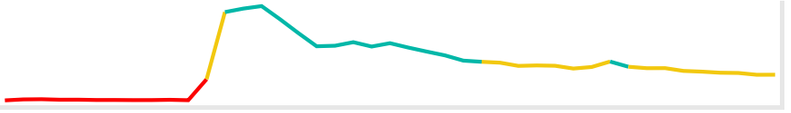
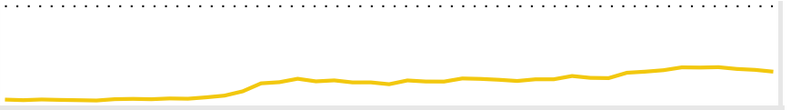
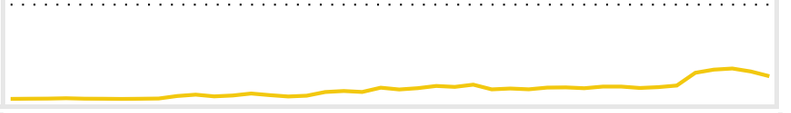
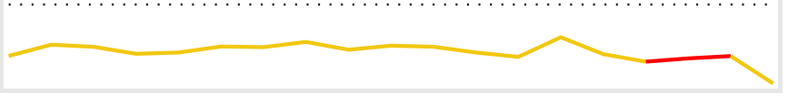


Click here for Elective Outpatients Trends →

Elective Outpatients Trends

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh	Daily Refresh (D)	Monthly Refresh (M)

Metric Name	Current Value	Comparison Value	KPI Status	Sparklines
Out Patients: % Provider Cancellation Rate (less than 6 weeks notice) (D)	77.51 %	5.00 %	!	
Central - Out Patient Booking % Appointments Booked 2 weeks Prior (D)	72.90 %	95.00 %	!	
Divisional - Out Patient Booking % Appointments Booked 2 weeks Prior (D)	69.81 %	95.00 %	!	
TRUST - % of OP appointments delivered virtually (video or telephone) (D)	17.49 %	25.00 %	▲	
% of First Out Patient Appointment via ERS Advice & Guidance Activity (M)	5.17 %	0.00 %	▲	
Number of Registered Referrals not Appointed (M)	29,319	0		
Typing Turnaround Time (dictation to letter sent) (Trust Contract) within 2 WD (D)	Unvalidated			
Number of Unreconciled Appointments 14 days + (D)	1148			
TRUST - % patients dicharged onto Patient Initiated Follow Up Pathway in Month (D)	1.21 %	5.00 %	▲	
Utilisation - % Booked Out Patient Clinic Slots Attended (D)	75.33 %	90.00 %	!	

Elective Theatres | Oct 22

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

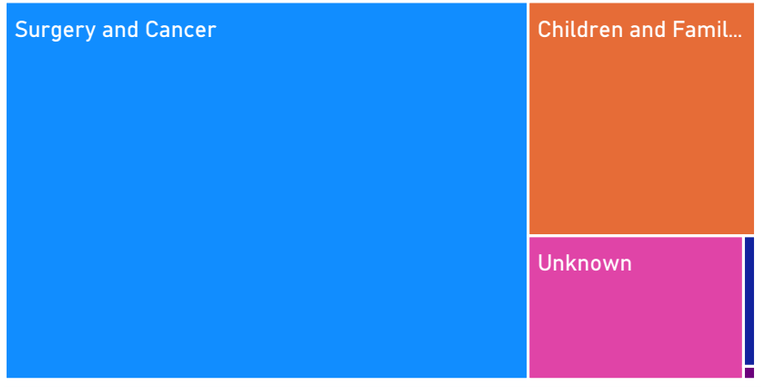
Data refresh	Daily Refresh (D)	Monthly Refresh (M)

Trust: Operating Theatre Booking - % of available time booked 1 week prior
87.16 % !
Goal: 95.00 %
(D)

Trust: Operating Theatre Booking - % of available time booked 2 weeks prior
75.09 % ✓
Goal: 75.00 %
(D)

Trust: Operating Theatre Booking - % of available time booked 4 weeks prior
45.69 % !
Goal: 50.00 %
(D)

Division (Drill Down For Speciality)



% Cancelled Operations on the day (non-clinical reasons) (M)

		Goal
Trust View	2.56 % !	1.00 %
Surgery & Cancer	3.65 % !	1.00 %
Children & Families	4.06 % !	1.00 %
Medicine	0.62 % ✓	1.00 %

Cancelled Operations Not Rebooked within 28 Days (M)

		Goal
Trust View	11 !	0
Surgery & Cancer	10 !	0
Children & Families	1 !	0
Medicine	0 ✓	0

Number of Priority 2 Patients waiting 28 days + for surgery from date of listing or P2 Categorisation (M)

		Goal
Trust View	675 !	0
Surgery & Cancer	661 !	0
Children & Families	14 !	0
Medicine	0 ✓	0

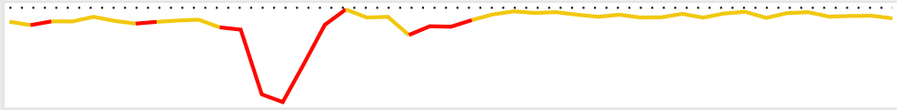
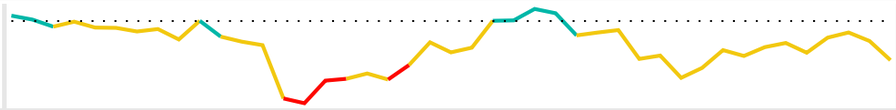
% of available Operating Theatre Time Utilised
78.24 % !
Goal: 85.00 %
(D)

Click here for Elective Theatres Trends

Elective Theatres Trends

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh	D All KPIs on this page are refreshed on daily basis.

Metric Name	Current Value	Comparison Value	KPI Status	Sparklines
Operating Theatre Booking - % of available time booked 1 week prior	87.16 %	95.00 %	▲	
Operating Theatre Booking - % of available time booked 2 weeks prior	75.09 %	75.00 %	✓	
Operating Theatre Booking - % of available time booked 4 weeks prior	45.69 %	50.00 %	▲	
% of available Operating Theatre Time Utilised	78.24 %	85.00 %	▲	

Patients: IPC

Oct 22

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh	M	All KPIs on this page are refreshed on monthly basis.

Hospital Acquired MRSA (Colonisation) Cases Reported in Month

Trust View

6 !

Goal: 0

Medicine Division

2 !

Goal: 0

Surgery & Cancer Division

4 !

Goal: 0

Children & Families Division

0 ✓

Goal: 0

Clinical Specialities Division

0 ✓

Goal: 0

Hospital Acquired MRSA (Bacteraemia) Cases Reported in month

Trust View

0 ✓

Goal: 0

Medicine Division

0 ✓

Goal: 0

Surgery & Cancer Division

0 ✓

Goal: 0

Children & Families Division

0 ✓

Goal: 0

Clinical Specialities Division

0 ✓

Goal: 0

Patients: IPC

Oct 22

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh	(M) All KPIs on this page are refreshed on monthly basis.

Number of Hospital Onset Healthcare associated (HOHA) C.Diff cases in month and YTD

Trust View

In Month	YTD
2 ✓	16 !
Goal: 2	Goal: 14

Medicine Division

In Month	YTD
1 ✓	11 ✓

Surgery & Cancer Division

In Month	YTD
1 ✓	3 ✓

Children & Families Division

In Month	YTD
0 ✓	0 ✓

Clinical Specialities Division

In Month	YTD
0 ✓	2 ✓

Number of Community Onset Healthcare associated (COHA) C.Diff cases in month and YTD

Trust View

In Month	YTD
1 ✓	5 ✓
Goal: 2	Goal: 14

Medicine Division

In Month	YTD
1 ✓	3 ✓

Surgery & Cancer Division

In Month	YTD
0 ✓	2 ✓

Children & Families Division

In Month	YTD
0 ✓	0 ✓

Clinical Specialities Division

In Month	YTD
0 ✓	0 ✓

Patients: HSMR

Aug 22

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

Hospital Services Mortality Rate (HSMR): (rolling 12 Months - Combined Sep 21 - Aug 22)

111.89 !

Goal: 100.00

Hospital Services Mortality Rate (HSMR): Elective (rolling 12 Months- Sep 21 - Aug 22)

42.58 ✓

Goal: 100.00

Hospital Services Mortality Rate (HSMR): Non-Elective (rolling 12 Months- Sep 21 - Aug 22)

110.76 !

Goal: 100.00

Patients: Patient Safety | Oct 22

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

Number of SI actions more than 1 month overdue

Trust View	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
56 !	19 !	11 !	0 ✓	6 !
Goal: 0	Goal: 0	Goal: 0	Goal: 0	Goal: 0

Number of SI actions overdue

Trust View	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
56 !	28 !	13 !	0 ✓	15 !
Goal: 0	Goal: 0	Goal: 0	Goal: 0	Goal: 0

Patients: Patient Safety

Oct 22

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

Serious Incidents Reported in Month (For Monitoring Only)

Trust View	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
3	1	1	0	1

Number of open overdue incidents greater than 3 months in Datrix (Excluding patient experience, SI, Inquests and HSIB)

Trust View	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
1,004 !	829 !	25 !	25 !	125 !
Goal: 0	Goal: 0	Goal: 0	Goal: 0	Goal: 0





Patients: Patient Safety

Oct 22

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

Never Events - Reported in month

Trust View

0✓

Goal: 0

Medicine Division

0✓

Goal: 0

Surgery & Cancer Division

0✓

Goal: 0

Clinical Specialities Division

0✓

Goal: 0

Children & Families Division

0✓

Goal: 0

Patients: Skin Integrity | Oct 22

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

YTD Hospital Acquired Pressure Ulcers (HAPU) Category 2 and above - 20% reduction on 20/21 by March 2023

Trust View

In Month	YTD
50 ✓	298 ✓
Goal: 56	Goal: 392

Medicine Division

In Month	YTD
30 ✓	178 ✓

Clinical Specialities Division

In Month	YTD
5 ✓	25 ✓

Surgery & Cancer Division

In Month	YTD
11 ✓	66 ✓

Children & Families Division

In Month	YTD
0 ✓	4 ✓

Non Inpatient Areas

In Month	YTD
4 ✓	25 ✓

Patients: Falls

Oct 22

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

Inpatient Falls resulting in low Moderate or Severe Harm reported in month

Trust

46
(25 Last Year)
+84 % !
Goal: -10%

Medicine

34
(22 Last Year)
+55 % !
Goal: -10%

Surgery & Cancer

9
(3 Last Year)
+200 % !
Goal: -10%

Children & Families

3
(0 Last Year)
!
Goal: -10%

Clinical Specialties

0
(0 Last Year)
0% !
Goal: -10%

Patients: Patient Experience | Oct 22

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

Complaints - New in month

Trust	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
65	30	27	3	5
(45 Last Year)	(22 Last Year)	(10 Last Year)	(4 Last Year)	(9 Last Year)
+44 % !	+ 36% !	+170 % !	-25% ✓	-44% ✓
Goal: -10%	Goal: -10%	Goal: -10%	Goal: -10%	Goal: -10%

Complaints Resolution Performance (% achieved closure in agreed timescales with complainant)

Trust	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
33.00 % !	30.00 % !	33.00 % !	50.00 % !	40.00 % !
Goal: 95.00 %	Goal: 95.00 %	Goal: 95.00 %	Goal: 95.00 %	Goal: 95.00 %





Complaints Upheld / Partially Upheld by Parliamentary Health Service Ombudsman

Trust View	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
35 !	17 !	11 !	2 ✓	5 !
Goal: 4				





Patients: Claims

Oct 22

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

Claims CNST (patients) - new in month

Trust View	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
6	2	4	0	0

Claims LTPS - (staff) new in month

Trust View	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
0	0	0	0	0

Patients: Friends and Family Test

Oct 22

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

Friends & Family Response Rates (ED) Increase response by year end

0.91 % !

Goal: 10.00 %

Friends & Family Response Rates (Inpatients) Increase response by year end

6.70 % !

Goal: 15.00 %

Patients: Audit and Effectiveness

Oct 22

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

Mixed Sex Accommodation - reported breaches in month

Trust View	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
2 !	0 ✓	0 ✓	2 !	0 ✓
Goal: 0	Goal: 0	Goal: 0	Goal: 0	Goal: 0

NICE Guidance Response Rate Compliance

Trust View	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
89.70 % !	97.20 % !	98.50 % !	92.80 % !	80.90 % !
Goal: 100.00 %	Goal: 100.00 %	Goal: 100.00 %	Goal: 100.00 %	Goal: 100.00 %

NICE Guidance % Non & Partial Compliance (For Monitoring Only)

Trust View	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
10.20 %	4.20 %	98.00 %	92.80 %	44.20 %

Patients: Medical Examiner | Oct 22

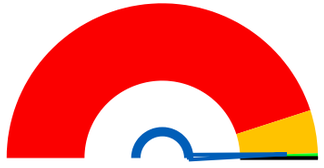
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

% Over 18 in-hospital deaths scrutinised by Medical Examiner Team

99.00 % !

Goal: 100.00 %



Patients: VTE

Oct 22

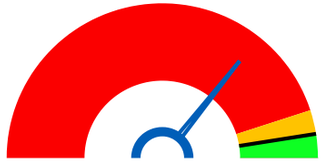
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

VTE - % of patients having a VTE Risk Assessment

71.33 % !

Goal: 95.00 %



Patients: Reducing Length Stay | Oct 22

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (D) All KPIs on this page are refreshed on daily basis.

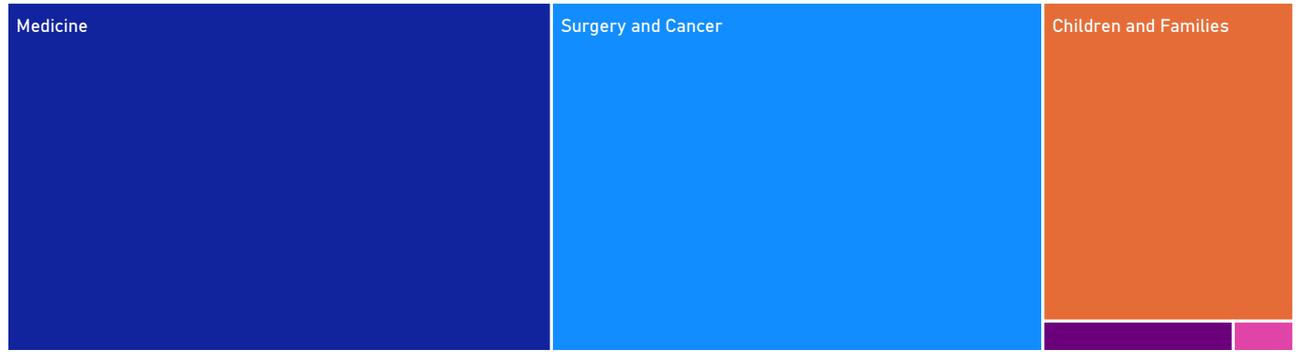
Days - Reducing length of stay for patients in hospital for 21 days +

-7.46 % ✓

Discharges - Reducing length of stay for patients in hospital for 21 days +

0.41 % !

Division (Drill Down For Speciality)



People

Oct 22

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

Unvalidated

Employee Turnover

1.36 % !
Goal: 0.83 %

Completed SET Training

83.32 % !
Goal: 90.00 %

Completed Appraisals

77.36 % !
Goal: 90.00 %

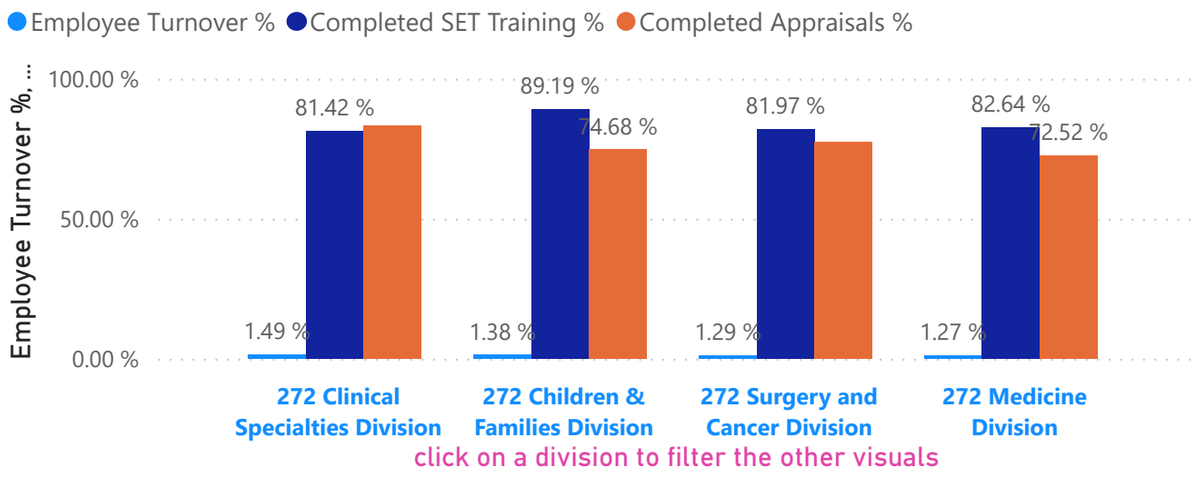
Open Cases

163

Cases Closed in Month

14

Division



Type Of Case	Open Cases	Cases Closed In The Month
Capability UHR	54	9
Capability No UHR	47	1
Disciplinary	25	3
Flexible Working	12	0
Grievance	11	0
Further Stages Appeal	9	1
Further Stages Tribunal	4	0
Harassment	1	0
Total	**163**	**14**

People Forms Data | Oct 22

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

Overall Staff Sickness Absence
6.84 % !
Goal: 3.50 %

Overall Staff Vacancies
11.00 % !
Goal: 5.00 %

Consultants with Signed Off Job Plans in EJP
34.70 % !
Goal: 90.00 %

Medicine Division Sickness Absence
7.87 % !
Goal: 3.50 %

Children & Families Sickness Absence
7.37 % !
Goal: 3.50 %

Medicine Division Workforce Vacancies
13.00 % !
Goal: 5.00 %

Children & Families Workforce Vacancies
7.00 % !
Goal: 5.00 %

Medicine Division Consultants with Signed Off Job Plans in EJP
47.00 % !
Goal: 90.00 %

Children & Families Consultants with Signed Off Job Plans in EJP
12.00 % !
Goal: 90.00 %

Surgery & Cancer Sickness Absence
6.19 % !
Goal: 3.50 %

Clinical Specialties Sickness Absence
6.39 % !
Goal: 3.50 %

Surgery & Cancer Workforce Vacancies
11.00 % !
Goal: 5.00 %

Clinical Specialties Workforce Vacancies
9.00 % !
Goal: 5.00 %

Surgery & Cancer Consultants with Signed Off Job Plans in EJP
17.50 % !
Goal: 90.00 %

Clinical Specialties Consultants with Signed Off Job Plans in EJP
47.00 % !
Goal: 90.00 %

People Forms Data | Oct 22

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

Time to Fill Vacancies (from TRAC authorisation - unconditional offer) A4C posts only

71 !
Goal: 47 Days

Medicine Division - Time to Fill Vacancies (Days)

93 !
Goal: 47 Days

Children & Families - Time to Fill Vacancies (Days)

46 ✓
Goal: 47 Days

Surgery & Cancer - Time to Fill Vacancies (Days)

61 !
Goal: 47 Days

Clinical Specialties - Time to Fill Vacancies (Days)

66 !
Goal: 47 Days

Health Inequalities

Oct 22

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

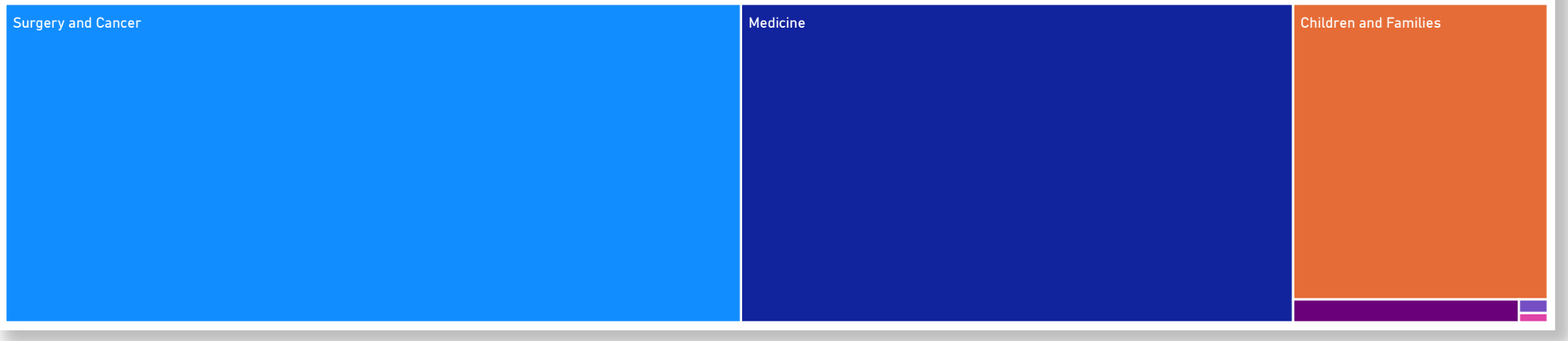
Data refresh (D) All KPIs on this page are refreshed on daily basis.

% Patients on CAMIS with Ethnicity Recorded

94.69 % !

Goal: 100.00 %

Division (Drill Down For Speciality)



KPI Trends

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Self Arrivals - Initial Assessment Within 15 Mins (Unvalidated)

Ambulance Handovers within 15 Minutes

Ambulance Handovers within 30 Minutes

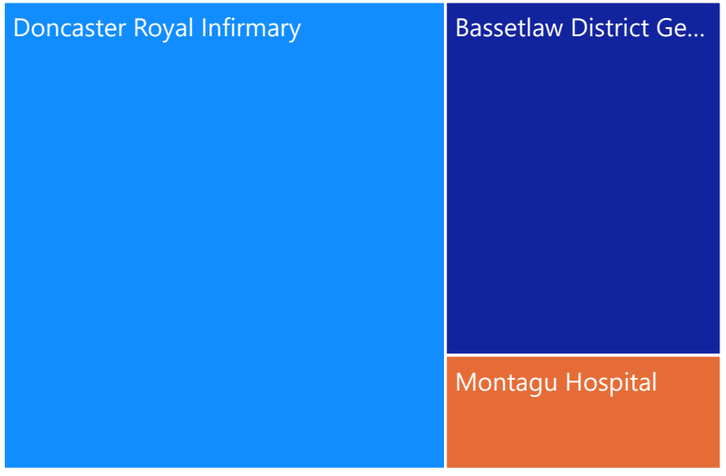
Ambulance Handovers More Than 60 Minutes

TOTAL -% patients leaving Emergency Department from clinically ready to proceed to admission within 60 mins

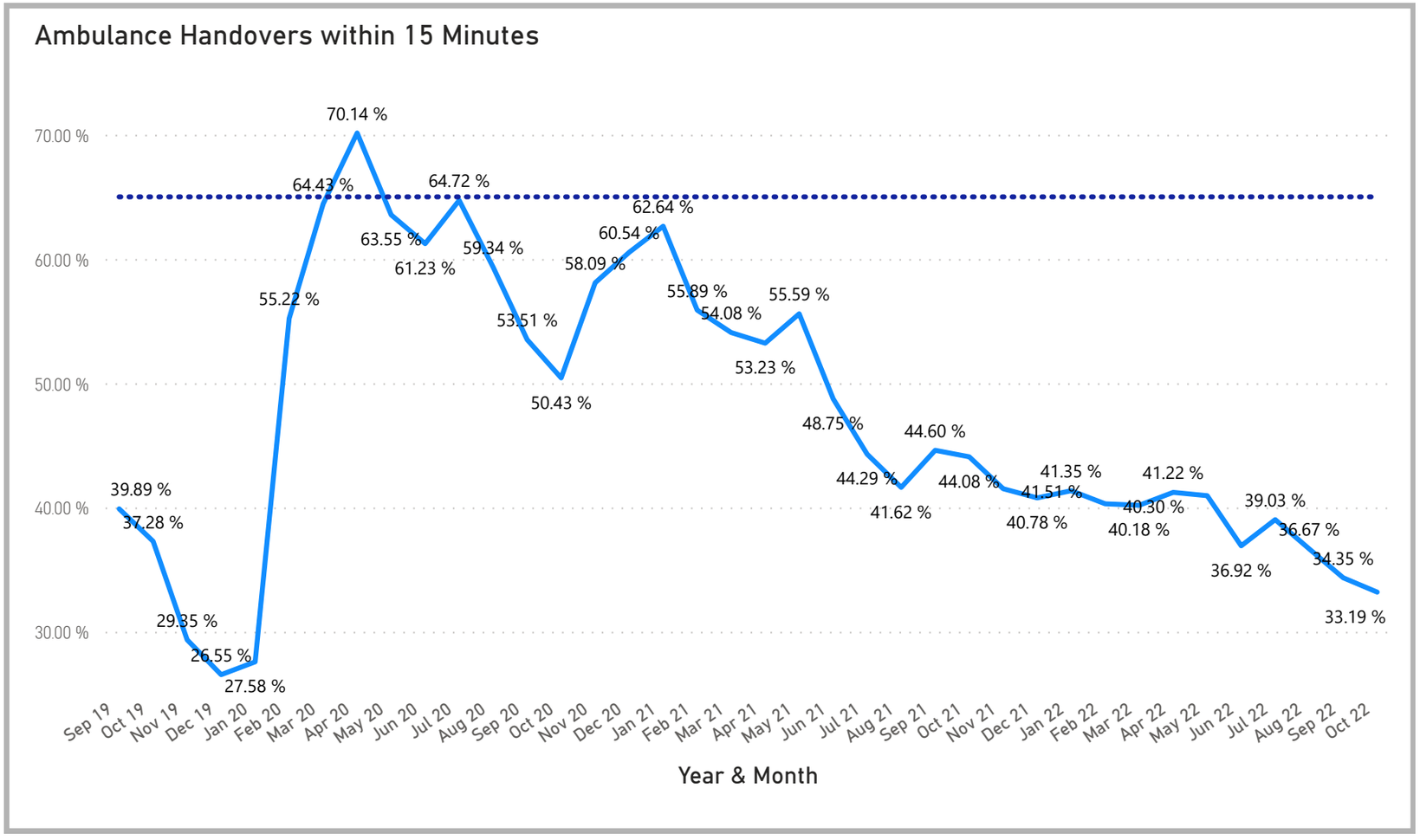
A&E: Max wait four hours from arrival/admission/transfer/discharge

% Patients with Total Length of Stay in Emergency Department >12 hours

EM Hospital



Urgent & Emergency Care | Waiting List | Cancer | Elective Outpatients - Not Available | Elective Recovery Fund | Activity Against Plan - Outpatients | Activity Against Plan - Intpatients | Elective Theatres



Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

FINANCE AND PERFORMANCE COMMITTEE

Minutes of the meeting of the Finance and Performance Committee held on Thursday 21 July 2022 at 09:00 via Microsoft Teams

Present:	Mark Bailey, Non-executive Director Alex Crickmar, Acting Director of Finance Neil Rhodes, Non-executive Director (Chair) Kath Smart, Non-executive Director	
In attendance:	Simon Brown, Acting Deputy Chief Nurse (agenda item E4) Fiona Dunn, Deputy Director Corporate Governance/Company Secretary Divyesh Gadhia, Associate Director - Archus (agenda item D4) Anouska Huggins, Associate Director - Archus (agenda item D4) Joseph John, Medical Director for Operational Stability and Optimisation Paul Mapley, Efficiency Director (agenda item D2) Angela O'Mara, Deputy Company Secretary (minutes) Andrea Squires, Divisional Director of Operations - Urgent and Emergency Care (agenda item B1) Chris Turner, Executive Director - Archus (agenda item D4)	
To Observe:	Andrew Middleton, Public Governor – Doncaster Lynne Schuller, Public Governor – Bassetlaw	
Apologies	George Briggs, Interim Chief Operating Officer Mark Day, Non-executive Director Gillian Marsden, Deputy Chief Operating Officer – Elective Jon Sargeant, Interim Director of Recovery, Innovation and Transformation	
		ACTION
FP22/07/A1	**Welcome, Apologies for Absence and declarations of interest (Verbal)**	
	The Chair welcomed members and those in attendance to the meeting and the above apologies for absence were noted. In view of the absence of the Interim Chief Operating Office, the Deputy Chief Operating Officer and the Interim Director of Recovery, Innovation & Transformation, the Chair explored alternative options to seek assurance as part of the meeting. No declarations of interest were declared.	
FP22/07/A2	**Requests for any other business (Verbal)**	
	No items of other business were declared.	

FP22/07/A3	**<u>Action Notes from Previous Meeting (Enclosure A3)</u>**	
	<u>Action 1 – FP22/02/C2 – Health and Safety Board</u> – action closed **<u>Action 2 – FP21/11/G1 – Datix, Complaints and Risk Management Position Update</u>** – included on today's agenda **<u>Action 3 – FP22/05/C1 - Integrated Performance Report</u>** – to be retitled - Urgent & Emergency Care Recovery Programme - not yet due **<u>Action 4 – FP22/05/D1 – Financial Performance – Month 2</u>** – a meeting date of 12 August had been set for the temporary/agency workforce spend to be considered. A**<u>ction 5 - FP22/06/B1 - Integrated Performance Report</u>** - to be retitled – Incentive Rates for Consultants. Update to be provided	
	The Committee: - ***Noted the above updates***	
FP22/07/B1	**<u>Emergency Department Performance, including Ambulance Handovers</u>**	
	In the absence of the Interim Chief Operating Officer and his deputy, the Divisional Director of Operations for Urgent and Emergency Care summarised the operational context against which the Trust's operational performance for June 2022 had been reported: • The prevalence of Covid and high staff absence had continued to impact flow and subsequent service delivery across the organisation • Attendance levels in the emergency department remained high • Emergency demand and staffing pressures had impacted the progress of elective recovery, but a programme had been maintained throughout the month The report provided the headline data for emergency, elective and cancer performance, including planned next steps. It was noted that the Trust continued to experience significant operational challenges and plans would continue to focus on safety, sustainability and supporting its people and patients. In respect of the 4 hour access standard, the Trust had achieved 70.08%, against the national target of 95%, a very small increase had been seen from the previous month, but the Trust's benchmarked regional position was reported to be "in the pack". Waits in excess of 12 hours had increased from a total of 148 across both sites in May 2022, to 277 in the month of June, this was attributed to a lack of flow and extended length of stay. During June the challenge in respect of ambulance handovers continued, patients waiting less than 15 minutes for ambulance handover had deteriorated from 41.69% to 36.82%, with an increase from 13.62% to 18.33% of patients waiting over 60 minutes. However, since week ending 26 June, an improving position had been reported, week on week. Kath Smart noted the report narrative was similar to previous months and asked how the Committee could track the improvement which was not obvious from the presented data. In order to demonstrate the movement over time the Divisional Director of Operations shared	

	a series of graphs contained within the ambulance handover report which highlighted change throughout the month. Kath Smart indicated it would be helpful from an assurance perspective for the outcome evidenced in the visual aids to be explicitly referenced in the paper and requested this be fed back to the Chief Operating Officer for inclusion in future reports. The implementation of an early senior assessment at the front door had positively impacted on the four hour and ambulance handover performance. The change had been introduced in June as part of a Plan-Do-Study-Act (PDSA) cycle and was being embedded into practice. The overarching urgent and emergency care improvement plan was currently being reviewed by the Senior Management Team, before final sign-off by the Interim Chief Operating Officer. Kath Smart noted that the specialties workshop facilitated by the Medical Director to support flow out of the department had seen minimal engagement and sought assurance of the next steps/escalation process. The Divisional Director of Operations confirmed the matter had been escalated to the Executive Team to consider next steps to increase engagement, current staffing challenges were known to be a key issue, and in surgery colleagues were often in theatre and unable to attend, the importance of a resource to provide in-reach into the emergency department had been reinforced. In respect of work related to delayed discharge and no right to reside, Kath Smart highlighted a focus on the red to green initiative seen in internal communications and sought feedback on progress. The Divisional Director of Operations confirmed that whilst the roll out was progressing, as the initiative was implemented ward by ward, it was a slow process. In respect of those medically fit for discharge, it was reported further work was required, links with a neighbouring trust had been established to share learning, the issue of letters to patients on arrival in hospital would be pursued to set out expectations on the likely journey from point of admission to discharge. A refresh of the dashboards would enable a single view of key data to focus attention on the required areas to free up capacity. This work was led by the Deputy Director of Nursing for Operations and Kath Smart suggested to the Chair this discussion be explored further with the Interim Chief Operating Officer when reviewing future papers. The Chair of the Board had raised two matters with Neil Rhodes for discussion: the first related to delayed discharges, due to doctor waits and the second was where patients had been brought into the emergency department by ambulance, treated and subsequently discharged, rather than be treated in the community or by the paramedics. The Divisional Director of Operations confirmed the Trust was working with partners at place to ensure alternative care provision was signposted. In addition, the introduction of the early senior assessment would support referrals either to Same Day Emergency Care (SDEC) or the Urgent Treatment Centre. Yorkshire Ambulance Services also had the opportunity to direct referrals to SDEC by utilising the consultant connect to identify the most appropriate point of care. In response to the issue of doctor waits, the Divisional Director of Operations confirmed this mostly related to the absence of a consultant between midnight and 7am. Tier 4 colleagues provided cover but continuing workforce challenges, particularly when resus was at full capacity, impacted upon this. A robust improvement plan to upskill existing doctors as part of a consultant mentorship programme was in place.	

	The Acting Director of Finance acknowledged that the issue of patients attending the emergency department and being discharged without the need for diagnostic tests was not a new issue, in terms of the extent to which this had changed over time, the Divisional Director of Operations agreed to review and provide a short update at the next meeting. Mark Bailey welcomed the implementation of the early senior assessment at the front door. In respect of the red to green initiative, he enquired if there was a focused approach for the roll out, which the Divisional Director of Operations confirmed was based upon those areas known to have extended lengths of stay and delayed discharges. A dashboard identified the progress and impact of the roll out and provided further data following completion to identify areas of challenge. The Divisional Director of Operations agreed to provide a short paper to summarise progress and outcomes of the roll out to date. The team were working closely with Informatics to identify the impact of change, via statistical process control charts. Mark Bailey confirmed his expectation that high level data be provided on those key areas of focus, in order that there was clear evidence of a drive to deliver performance improvements. The Chair expected that this clarity would be provided from the involvement of the Interim Chief Operating Officer at future committee meetings, and it was agreed no further action was required in advance of September's committee. The Medical Director for Operational Stability and Optimisation joined the meeting.	**AS** **AS**
	The Committee: - ***Noted and took assurance from the Emergency Department Performance, including Ambulance Handovers***	
FP22/07/B2	**<u>Elective Performance, including Recovery Plan Update</u>**	
	In the absence of the operational team, the Acting Director of Finance confirmed that the Trust was in the lower quartile for elective performance in the region, and a significant amount of work was required to improve the position. On return from their leave, the Interim Chief Operating Officer and the Interim Director of Recovery, Innovation & Transformation would be developing an elective recovery plan and a number of actions had been agreed with the Division of Surgery & Cancer to improve performance. In addition to the challenges faced by the Trust, the independent sector was also not delivering against their agreed plan and this position had been escalated. The key areas of focus continued to be outpatient and elective work and a range of options, including the possibility of offering consultant incentives continued to be pursued to support recovery. Focused discussions took place as part of the weekly Executive Team meeting, as well as scrutiny at the Board and its sub-committees. The Chair sought the Medical Director for Operational Stability and Optimisation's view on the challenges faced and a refreshed level of support and leadership was felt to be required, including an understanding of why the required progress had not been made. The Chair reinforced the need to gain the support and commitment of the divisional leadership teams to buy into the improvement journey. Alongside the Performance, Overview and Support Meetings there were also monthly meetings with the Executive Medical Director and the Divisional Directors, and these were focused on the required recovery.	**GB/JS**

	Kath Smart shared her concern with regards to the elective performance data, including the waiting list numbers, referral to treatment, 52 week waits, and diagnostic performance which appeared to be on a downwards trend. In addition to this, she noted funds had not been spent due to the lack of activity in the independent sector. The key actions in previous plans did not reference improved leadership, so a robust, back-to-basics, all-encompassing action plan would be required. The Acting Director of Finance confirmed that the Interim Director of Recovery, Innovation & Transformation, as contract lead for the independent sector, would be seeking assurance regarding prioritisation of the Trust's work. It was anticipated that the independent sector would be facing similar challenges in respect of workforce and covid related absence.	
	The Committee: - ***Noted and took assurance from the Elective Performance, including Recovery Plan Update***	
FP22/07/C1	**<u>Recovery Update</u>**	
	The Committee received the Recovery Update, in view of the Interim Director of Recovery, Innovation & Transformation's absence the report was taken as read. The report indicated that the first Transformation Board had been stood down due to the number of apologies, in response to a question from the Chair with regards to impact of this, the Acting Director of Finance confirmed there was no immediate cause for concern, as the majority of the meetings reporting into the Transformation Board were taking place. The Performance, Overview and Support meetings had commenced and with each division attending on a rotating fortnightly basis, there had been at least two full rounds completed. The Corporate Investment Group was also conducting its business, however, arrangements for the Risk Board had not yet been formalised and this had been escalated to the Executive Medical Director for resolution. In response to a question from the Chair, in respect of the incentive scheme for consultants to support the recovery plan, the Acting Director of Finance confirmed a proposal was still being worked up. The Medical Director for Operational Stability and Optimisation was exploring the various options, the impact of which had been reviewed by the medical HR and by the finance team from a costing perspective. A review of the additional session rates had also been benchmarked against the Trust's peers. It was expected that a proposal would be shared with the Executive Team within the next couple of weeks for their consideration. The Medical Director for Operational Stability and Optimisation summarised his work to date and referenced the approach routinely adopted by Trusts to undertake additional activity, which usually involved an external company sourcing trust staff to undertake the work on the trust's premises. The company would usually be paid at the tariff price plus an uplift of c10%, and whilst this achieved a reduction in the waiting list there was no financial benefit. Going forwards, it was proposed that the Trust could contract individual consultants as the provider, they would be responsible for sourcing clinical support, and would make use of the trust's facilities, out of hours, to avoid any impact on their job planned activities. They would be required to provide appropriate assurance from a clinical governance perspective, which would be monitored by the Trust to ensure consistency in service delivery and outcomes. In	

	addition to the review by medical HR, the finance team would need to provide assurance that the process was financially viable and subsequent approval granted via the Executive Team and potentially the Board. A pilot could be trialled in Trauma & Orthopaedics, with the potential for this to be implemented at speed and to deliver a rapid reduction in the waiting list. The tariff agreed would be below that agreed with an external company and the offer would be equitable, allowing all consultants the opportunity to participate. Arrangements in respect of tax and national insurance would be the responsibility of the contracted individual. The Chair confirmed that should the Trust require an external company to facilitate the incentive, then the option of utilising the Wholly Owned Subsidiary (WOS) could be explored, he welcomed the work and the principles of fairness and equity. In response to a question from Kath Smart with regards to liability, should an issue arise either from a member of staff or patient perspective, the consultant would require NHS indemnity cover, as they would be conducting NHS work on NHS premises. This would be stipulated as part the contract. In respect of the recently introduced meeting governance, Mark Bailey asked if an overview of trust wide themes from the Performance, Overview & Support meetings could be shared with the non-executive directors. A separate paper was not required but feedback could be included in the update from the Recovery, Innovation & Transformation directorate, or the Chair suggested that it may be possible for a non-executive director to join the meeting as an observer. The Acting Director of Finance agreed to raise the matter with the Interim Director of Recovery, Innovation & Transformation for consideration. The Chair thanked the Medical Director for Operational Stability and Optimisation for his comprehensive update.	**AC**
	<u>The Committee:</u> - ***Noted the Recovery Update***	
FP22/07/D1	**<u>Financial Performance – Month 3</u>**	
	The Acting Director of Finance summarised the month three financial position. The deficit of £1.5m was in line with the plan and largely driven by an overspend on pay, this was due to continued high usage of temporary staff due to the vacancy position and operational pressures with high levels of covid and staff absence requiring backfill. Year to date, the deficit financial position was £4.3m, adverse to plan by £1.1m. Agency spend in month three was c£1.9M, double that of pre-pandemic levels, the Acting Chief Nurse and her deputy were now reviewing this, and a single item agenda of the Finance & Performance Committee would take place next month to consider this. Capital spend in month was £759k against the plan of £2,802k, although there was an underspend across estates, medical equipment and IT, the Acting Director of Finance was not overly concerned as the majority of the capital schemes had now been approved through the Corporate Investment Group. The main concern was the timely progress of medical equipment plans through the divisions.	

	The cash balance at the end of June 2022 was £27.7m, a slight increase had been seen from month 2 but overall, the balance was in line with the 2022/23 forecast. The Trust had delivered £1.05m of savings, as compared to the £1.17m in plan. Plans continued to be developed with divisional colleagues to explore other efficiencies and the Director of Efficiency would expand on this later in the meeting. In response to a question from the Medical Director for Operational Stability and Optimisation, the Acting Director of Finance indicated the funding of the pay award had not yet been confirmed. As further information became available the trust position would be established and reported back to the next Finance & Performance Committee. In respect of the spend associated with the Covid Medicines Delivery Unit, the Acting Director of Finance confirmed there was no more funding available. He agreed to pick up with the Medical Director for Operational Stability and Optimisation outside of the meeting with regards to appropriately capturing the costs for delivery of the service. In respect of demand driven temporary staffing costs, the Chair encouraged a system level conversation to manage the rates of pay. The Acting Director of Finance confirmed he had shared this with the ICS and a review to consider the escalating rates to ensure best value for money and transparency was in hand. In response to a question from Kath Smart, relating to increasing utility costs, the Acting Director of Finance confirmed that consideration would be given to the contract terms for the next 12 months and whether that would be as part of a variable or fixed rate arrangement. Nationally, the contracting of utilities would be looked at, to establish if they could be brought under one NHS contract. Forecasting utilities spend would be extremely challenging in the current climate and the position was not anticipated to change in the short term. Kath Smart sought the Acting Director of Finance's level of confidence of the effectiveness of the enhanced financial monitoring of the Medicine and Children and Families divisions, the Acting Director of Finance confirmed he had been encouraged by the divisions' positive and open-minded approach, particularly in view of the time that had elapsed since previous grip and control meetings had taken place. Attendance and engagement was good and a series of actions had been agreed and delivery against these and the subsequent impact would be monitored through the Performance, Overview & Support meetings. The recruitment and workforce challenges were known to be more difficult to influence and not completely under the division's control for Children & Families. In respect of the revision to the Trust's deficit plan, the Acting Director of Finance assured Kath Smart that a verbal update to reflect the revised plan would be provided at next week's Board meeting. In response to a question from Mark Bailey, relating to the financial position if elective performance continued in line with current activity, the Acting Director of Finance confirmed this position had not been forecast, but a fair assumption would be to extrapolate the position at the end of Q1. When the elective recovery plan was determined, the finance team would forecast for the impact of this, however as funding was unknown and with winter approaching there could be a potential shift between planned and unplanned activity.	**AC** **AC/JJ**

	The Acting Director of Finance advised that should the financial plan not be delivered the difference between planning assumptions and actuals would be provided.	
	The Committee: - ***Noted and took assurance from the Financial Performance Month by Month Report***	
FP22/07/D2	**Cost Improvement Programme Plan**	
	The Efficiency Director reported a CIP target of £19.3m for 2022/23, c4% of the Trust's income, and although in line with national levels, was the highest the Trust had set and one of the highest across the Integrated Care System. A number of schemes had been developed, and currently identified schemes totalled £11.5m. Further opportunities to bridge the gap were required and the Trust had commissioned the support of KPMG to undertake a rapid CIP diagnostic, which should be completed by August 2022. The following areas were considered, referencing the plan and current forecast against each: • Elective Recovery • Temporary Staffing • Non-pay containment and procurement savings • Un-identified To date delivery of efficiencies was on target, with £3.5m savings delivered, however there would be a significant step up in H2, and at this point a gap may materialise if more schemes were not worked up. In terms of next steps, the key areas of focus were to maximise CIP delivery , engage and support divisions with the greatest gaps but recognise some of these areas were challenged in terms of capacity. The Chair took assurance from the presentation and welcomed the lens through which the CIP was being considered, recognising the 4% efficiency target was challenging. In response to a question from the Chair, the Director of Efficiency confirmed that with increased focus the Trust had the potential to close between 30-40% of the gap, beyond those more difficult choices would need to be made. In respect of the level of engagement, as expected, this was variable but where engagement was below optimum this was largely due to operational pressures and discussions were picked up via the Performance, Overview & Support meetings. In respect of the extent to which these efficiencies were sustainable, the Efficiency Director identified that they were not all at recurrent levels, work around ERF and embedding the process change of patient pathways in respect of patient initiated follow up and theatre work was sustainable and if delivered could make a marked change which had the potential to impact future years. Wider schemes were more likely to be one-off savings, which could potentially mean a challenging CIP target for next year. In response to a question from Kath Smart, the Director of Efficiency confirmed learning from the national Getting It Right First Time programme had been considered within the elective recovery plans. Reference to patient-level information and costing systems (PLICS) was more	

	difficult to use as operating costs during the pandemic had been impacted and were out of line with "normal years". Kath Smart enquired of any opportunities at place to make efficiencies, the Chair confirmed consultants had been engaged to identify efficiencies between the Trust and RDaSH and an action for Jon would be to consider the current state of play with his work and report back to September's meeting. The Efficiency Director confirmed for the unidentified cases that financial analysis was being undertaken, cases tracked via Monday.com and Senior Responsible Officers assigned to ensure clear ownership and accountability. The CIP diagnostic work with KPMG and benchmarking may provide opportunities to test out with the divisions, rather than a reliance on self-generated ideas. Mark Bailey welcomed the approach to the cost improvement programme, in previous meetings the Interim Director of Recovery, Innovation & Transformation had discussed a focused approach to improvements, to manage the volume of change, did this mean there were paused items which had the potential to be restarted? The Director of Efficiency confirmed identified projects followed an agreed governance process which would identify assigned priorities. In respect of efficiencies to be gained via automation it was confirmed there was a scheme within the corporate area relating to the digital transformation of HR processes. The Chair requested a further update be provided by the Efficiency Director at the September meeting.	**JS** **PM**
	<u>The Committee:</u> - ***Noted and took assurance from the Cost Improvement Programme Plan***	
FP22/07/D3	**<u>Award of Contract for Flexible Resource Pool</u>**	
	Following a review of the current flexible resource pool contract (staff bank), a system wide tender process, in line with the Crown Commercial Services framework, had been conducted. Following this robust process, NHS Professionals (NHS P), the incumbent supplier had been identified as the preferred bidder and the Committee were asked to support the award of the contract. The contract would offer a small saving opportunity for all trusts. In view of the contract value approval would be sought at the confidential Board meeting in July. The Committee commended the award of the contract to Board for approval.	
	<u>The *Committee:*</u> ***- Commended the award of the contract to Board for approval***	
FP22/07/D4	**<u>Bassetlaw Emergency Village Outline Business Case</u>**	
	The Chair welcomed Archus colleagues to present the Bassetlaw Emergency Village Outline Business Case(OBC) for the Committee's scrutiny and recommendation to the Board of Directors.	

	The purpose of the Bassetlaw Emergency Village (BEV) project was to deliver a modern, fit-for-purpose emergency care facility at Bassetlaw Hospital. The current facilities provided insufficient capacity, had poor service adjacencies and an aged infrastructure, which impacted upon service delivery. Funding of £17.6m had been secured via a successful bid for wave 4 STP monies and the Trust had commissioned the services of Archus in December 2021, to provide a project director and strategic healthcare planning support to the Trust's internal team. Chris Turner introduced his colleagues, who would provide an overview of the approach and work undertaken to date in development of the OBC. The OBC had been prepared using standards set out in NHS Improvement's capital regime investment guidance, using the five-case model. The current provision of urgent and emergency services at Bassetlaw was provided in a number of locations across the site and this no longer met the Trust's preferred clinical model. The model of care reflects the discussions and has gained the support of relevant services involved in its development. In line with best practice, a rigorous options appraisal was conducted in line with HM Treasury's Green Book framework, alongside an affordability review and a statement of accommodation. From this a shortlist of four options were identified: business as usual, do minimum, preferred way forward and a more ambitious way forward. An economic appraisal identified the best value for money option was the preferred way forward. Those areas in scope of the business case would require an investment of £17.98m, as compared to the £17.6m funding. Options to manage down the costs to address the funding gap would need to be considered. The project would be affordable over the long term but would be dependent upon the benefits to be secured from the adjacencies and due to affordability constraints SDEC, the assessment and treatment centre and the fracture clinic would not be incorporated into this business plan. The business case was dependent upon completion of the Reinforced Autoclaved Aerated Concrete work, which had to be completed within similar timescales and this had been identified as a risk in view of the impact on delivery of benefits. Subject to Board's approval the OBC would be submitted to NHSE/I by 29 July 2022 and was expected to be received at their October board for review and approval, the deadline for central funding to be spent was March 2024. In response to a question from the Chair, it was confirmed that a traditional method of construction had been selected, due diligence has been completed and the timeline and financial envelope identified this in preference to a modular solution. In response to a question from the Chair with regards to the "trade off" required to reach the affordable position, Anouska Huggins confirmed that the seed funding of 1.2m had been excluded; it had also been assumed that car park and substation works and backlog maintenance, which totalled approx. £2.2m would be covered by capital resource limit (CRL) funding. The other highlighted risk was noted to be hyper-inflation, however, this had not been included in accordance with current guidance.	

	In response to a question from Mark Bailey in respect of the work required on the workforce model , Anouska Huggins identified that when the strategic outline case had been developed benefits from rota efficiencies had been identified, due to the adjacencies. The development of the workforce model had not yet been completed and this would need to be addressed as part of the full business case. Since the change in Trust leadership confirmation of the new overarching clinical lead for the project was required. The Acting Director of Finance acknowledged that as part of NHSE/I's review the Trust should expect challenge around the expected benefits. Considering the detail and todays discussion the Chair sought confirmation from the Committee that they were happy to commend the OBC to the Board and unanimous support was received. The Chair thanked Archus for their presentation and looked forward to continuing working with them as part of the development of the full business case.	**JS**
	T*he Committee:* - ***Commended the Bassetlaw Emergency Village Outline Business Case to the Board for approval.***	
FP22/07/E1	**Board Assurance Framework SA1 and SA4**	
	The Acting Director of Finance highlighted a correction to the risk trend which should show as unchanged. A number of updates had been incorporated to the risks, highlighted for ease of reference and discussed as part of the financial update, which included: the significant financial challenge of a £10m deficit plan, the identified gap year to date, continuing pressures arising from Covid (high absence rates and vacancies), and the high temporary/agency spend which would be discussed in more detail at the single item committee meeting on 12 August. The potential impact of inflationary pressures on capital projects with allocated funding, such as the Bassetlaw Emergency Village and Electronic Patient Record was noted. In respect of corrective actions, the Acting Director of Finance confirmed all audit recommendations had been implemented on time. In the absence of the Interim Chief Operating Officer and his deputy there was no verbal update on the Board Assurance Framework for Strategic Aim SA1 , which would be covered at the next meeting and updated at next week's Board.	
	The Committee: - ***Noted the Board Assurance Frameworks***	
FP22/07/E2	**Corporate Risk Register**	
	The Company Secretary reported an increase in the risk rating for risk ID2472, from 15 to 20. The risk related to Covid management and reflected the rise in infection rates for both patients and staff. The Board Assurance Framework (BAF) had been updated in line with this increased risk.	

	In respect of the actions required following the external review of risk management by KPMG, which impacted upon the Head of Internal Audit Opinion work, the Company Secretary confirmed that the formation of the Risk Board had been escalated for resolution to the Executive Medical Director and meetings were expected to be set up imminently. The draft terms of reference had been reviewed by the Trust Executive Group and she was working through revisions to the risk management policy. The internal auditors, Chair of the Audit & Risk Committee and the Acting Director of Finance were all sighted on the work in progress. Once the meetings were in place progress would be seen with the review of risks rated 15+, through agreed validation and mitigation measures. The Chair shared his appreciation with the Company Secretary for her work in respect of the BAF.	
	The Committee: - ***Noted and took assurance from the Corporate Risk Register***	
FP22/07/E3	**Corporate Objectives – Performance**	
	The Chief Operating Officer's objectives were noted and would be received for approval by Board on 26 July 2022.	
	The Committee: - ***Noted the Corporate Objectives***	
FP22/07/E4	**Datix Update**	
	The Chair welcomed the Acting Deputy Chief Nurse to the meeting and noted that the content of the paper had been helpful in clarifying the situation and the Committee would be looking to gain assurance as part of today's discussion that Datix was fit for purpose. The Acting Deputy Chief Nurse identified the requirement to update Datix, which had become apparent due to an issue with dashboard availability and system functionality. The Datix system was supported by a single server, and in order to offer a more stable solution there was a need to move the live data from the test system. Unfortunately, this had caused the accuracy of the data to be skewed and the work had been paused. In order to proceed with the server upgrade the Trust Executive Group had approved the removal of the live data from the test system and for it to be stored elsewhere, which had received the appropriate sign off by information governance. A standard operating procedure had been signed off and the Head of Nursing for Corporate Services had met with the project team to agree a plan for the extract of the data and the subsequent server upgrade. Once this had been completed the dashboards and functionality would be updated and additional security/encryption introduced. With the implementation of the Patient Safety Incident Response Framework (PSIRF) and the learning from patient safety events, it would also provide the opportunity to consider the need for an iCloud-based system or a decision to continue with Datix.	

	In response to a question from the Chair, with regards to Datix being captured as a risk, the Acting Deputy Chief Nurse confirmed it was included on the risk register, the paper to the Trust Executive Group had also included a quality impact assessment if the live data was not removed from the test system to allow the upgrade to proceed. Following the upgrade, it was expected that the risk rating would be reduced. In response to the question what aspect of Datix keeps the Acting Deputy Director awake at night, he confirmed the failure of the server prior to the data migration, but a plan was in place to progress this. The Chair thanked the Acting Deputy Chief Nurse for the assurance he had provided.	
	The Committee: - ***Noted and took assurance from the Datix Update***	
FP22/07/E5	**Assurance Summary (Verbal)**	
	The Committee were assured on the items discussed at today's meeting, a detailed discussion on the elective recovery position was not possible today, due to the absence of relevant colleagues. The support of the Medical Director of Operational Stability and Optimisation and the Acting Director of Finance had been welcomed.	
FP22/07/F1	**Governor Observations**	
	The Lead Governor welcomed the progress being made with the Corporate Risk Register. In respect of opportunities across the ICS to benchmark recovery plans, the Lead Governor enquired how the Trust would benchmark across organisations in order to identify cross learning; and to what extent do staff "doing the work" understand the emphasis on making sustainable change and the effect that cultural change can have on this. The Chair asked that the Director of Recovery, Innovation & Transformation answer this outside of the meeting. The Deputy Lead Governor reinforced the need for all colleagues to embrace organisational change, which required ongoing data reinforced communications. Recovery plans were noted to be aspirational and the importance of keeping the wider organisational team engaged and informed was critical. The Deputy Lead Governor recognised the effectiveness of the Committee and the robust challenge from non-executive directors.	**JS**
FP22/07/G1	**Any Other Business**	
	No items of other business were raised.	
FP22/07/G2	**Performance Report Appendixes**	
	The performance report appendices were noted.	

FP22/07/G3	**Granger Report Quarterly Update**	
	The Committee: - ***Noted and took assurance from the Granger Report Quarterly Update***	
FP22/07/G4	**Minutes of the Sub – Committee Meetings (Enclosure G4)**	
	The minutes of the sub-committees of the Finance & Performance Committee were received and noted.	
FP22/07/G5	**Minutes of the meetings held on 30 June 2022**	
	The minutes were agreed as a true record. **Post meeting** a correction was made to add Mark Day as present at the meeting of 30 June 2022.	
	- ***The Committee approved the minutes of the meetings held on 30 June 2022, subject to the above change.***	
FP22/06/G5	**Date and time of next meeting (Verbal)**	
	Date: Thursday 26 September 2022 **Time:** 09:00 **Venue:** Microsoft Teams	
FP22/07/H	Meeting closed at: 12:19	

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

FINANCE AND PERFORMANCE COMMITTEE

Minutes of the Extraordinary Meeting of the Finance and Performance Committee held on Friday 12th August 2022 at 13:00 via Microsoft Teams

Present:	Alex Crickmar, Acting Director of Finance Neil Rhodes, Non-executive Director (Chair) Kath Smart, Non-executive Director Abigail Trainer, Acting Chief Nurse	
In attendance:	Kirsty Clarke, Acting Deputy Chief Nurse Claudia Gammon, Corporate Governance Officer (Minutes) Joseph John, Medical Director for Operational Stability and Optimisation Angela O'Mara, Deputy Company Secretary	
To Observe:	Andrew Middleton, Public Governor – Doncaster Lynne Schuller, Public Governor – Bassetlaw	
Apologies	Mark Bailey, Non-executive Director George Briggs, Interim Chief Operating Officer Jon Sargeant, Interim Director of Recovery, Innovation and Transformation Fiona Dunn, Deputy Director Corporate Governance/Company Secretary	
		ACTION
FP22/08/A1	**Welcome, Apologies for Absence and declarations of interest (Verbal)**	
	The Chair welcomed members and those in attendance to the extraordinary, single agenda item meeting, the above apologies for absence were noted. As there was no full Finance and Performance meeting in August the month 4 finance paper would be circulated to members electronically.	
FP22/08/A2	**Requests for any other business (Verbal)**	
	No items of other business were declared.	
FP22/08/B1	**Agency Spend**	
	The Acting Chief Nurse discussed the presentation, and that safety and service delivery must come first and was key priority. The current agency spends had a large impact on the organisation. The situation in July was that:	

	○ For adults there were 144 vacancies across medicine and surgery not including maternity leave which was extremely high in some areas ○ Some areas weren't completely funded for hours they were open or at all, this adds additional pressure for staff requirements ○ The Trust required a workforce that was made up of staff that weren't agency due to costs, quality, and stability ○ In July there had been 16 new starters for surgery and 37 for medicine. ○ The ICB and NHS Professionals had engaged with the international nurses to work alongside them50 international nurses had been recruited with another 2 cohorts expected taking the total to 70International nurses have to pass an English exam and an Objective Structured Clinical Examination (OSCE) prior to starting at the Trust. Further support was provided on the wards, with a Stay and Thrive Matron to assist and help staff retention, currently funded via charitable funds ○ The Acting Chief Nurse and Deputies sit on the NHS Professionals (NHSP) groups and were involved with register and un-registered nurses. In response to a question from the Chair, the Acting Chief Nurse confirmed that ward 22 was a potential extension ward opened to support winter pressures. The Trust maybe provided with the money for staff however, the issue was if the Trust could fill those vacancies. This means that bank and agency staff were used to support flow in the organisation. The Acting Deputy Chief Nurse confirmed that Ward 19 was the organisation support to put back in the surgery bed base pre covid. The Acting Chief Nurse discussed the neonatal services vacancy position and although it wasn't a large risk there was a high percentage of maternity leave. Recruiting neonatal nurses was difficult along with bank and agency staff. In July there were 9% of staff on maternity leave, 6% of registered midwives on maternity leave. There were a higher number of patients with more complex issues seen at both Doncaster and Bassetlaw. International midwives were harder to recruit due to not passing the English tests, further work was being carried out to support them into the organisation. The current situation within this area was: ○ Additional beds in medicine were funded recruitment remains challenging ○ Higher vacancies within midwifery, medicine, and surgery ○ Additional unfunded beds which added to the vacancy position ○ Higher than usual sickness levels – driven by Covid-19 and health and wellbeing ○ High levels of maternity leave In response to a question from Kath Smart regarding the temporary workforce NHSP/DBTH governance structure, it was confirmed that this wasn't fully operational, regular meetings with NHSP had been arranged. The internal processes had changed ○ Weekly and daily safe staffing planning meetings took place ○ The Workforce Matron was conducting meetings from 22nd August. ○ NHSP join operational meetings with the divisional directors attend ○ Monthly divisional meets with nurse directors. ○ Chief nurse ICS meetings discuss working with agencies and workforce. ○ NHSP rates prior to Covid-19 were paid at mid-point for any extra shifts. Incentives were put in to pay at normal pay plus 20%. This was being investigated and to include a business-as-usual rate. Returning to mid-point would be difficult due to the rise in the cost of living. Due to costings the recommendation was that the Trust would come down from the top of band plus 20% on a phased plan.	

	The Acting Chief Nurse explained about the agency challenges and that there were many agencies used across the Trust, from September Nutrix would no longer be used due to costs. The Deputy Chief Nurse explained that the agencies had set their prices which keep rising. There was a cascade in place that was reviewed monthly. The cascades were that from September 2022 there would be: o Three tiers of agencies o Tier 1 – agencies within the price cap o Tier 2 – agencies outside of the price cap to lower the price o Tier 3 – enhanced rate agencies o There would be a padlock in place that means that any shift would be sent out at 10 days and would be seen via eRoster o After 10 days if the shifts were still unfilled, they would cascade to tier 1. Then to tier 2 at 7 days. o At day 5 the shift was vital, and directors/matrons must approve them to be cascaded. o Senior management can remove the golden key that stops the shift progressing on to a higher tier o Out of hours clear guidance was being investigated and how it can be managed. There needs to be a more robust process in place o The Intensive Care Unit staff use higher cost agencies The Acting Chief Nurse described the mitigating actions: o The safer nursing care tool which showed patient acuity vs hands per shift o Further work was to be carried out with band 7's and the safer nursing tool o Safer care issues should be resolved, this shows staff required, shift by shift. This would enable staffing to be used more effectively in busier areas. o The Deputy Chief Nurse would attend Newcastle Hospital to observe use of the Safer Nursing Care Tool t. The next steps were: o System working to standardise rates o Cultural work in the organisation to attract and retain staff. o Working with finance and the wider ICB to make decisions that may not have been made previously. The Chair asked the Acting Director of Finance to provide the financial figure for the agency spend, how much of the budget and how much of the agency spend was excessive. The Acting Director of Finance provided average figures that compared pre Covid-19 (2019/2020) to now (202/2023): o Temporary staffing was split into bank and agency o During 2019/2020 the average spend for bank midwifery and nursing staff was £700k a month o The average spend in 2022/23 for bank midwifery and nursing staff was £1.6m a month o During 2019/2020 the average agency spend was £987,000 in total including medics of that £114,000 a month was on nursing and midwifery. This equated to 11% o 2022/2023spend was just under £2m on agency staff. Nursing and midwifery were £800,000 which was 41% o 30/40% of agency and bank staffing combined was temporary nursing and midwifery	

	o Trajectories were required along with the financial impacts, recruitment plans, sickness plans and what the outcomes were within Monday.com. o International recruitment was expensive due to not receiving full funding o High vacancies for registered and unregistered nurses o 50% of temporary spend was on Health Care Assistants due to vacancy levels. o Understanding the bed pressures ahead of winter o Agency cap was based on the pre Covid-19 spend in 2019/2020 plus the CIP, this would be challenged by NHS/IE Kath Smart asked why safe care had been turned off, the Acting Chief Nurse confirmed it had been turned off due to it not assisting with the movement of staff around the Trust. A large amount of work had gone into health care recruitment with challenges with cost of living. An executive decision had been made that once the foundations in care was complete staff would then work as band 2. International recruitment was an expensive way of working with one cohort in September and one further in March. Kath Smart added that the Trust understands it's issues and that it had a plan to address issues with clear timelines and using Monday.com to track the trajectories. The Medical Director for Operational Stability and Optimisation praised the report asking how much an agency charges the Trust and what were NHS Professionals hourly rates in comparison. It was confirmed that NHS Professionals hourly rates were cheaper and 98% of the shifts picked up via NHSP were by Trust staff. It was difficult to attract staff as agencies pay more but take a larger percentage. The Acting Director of Finance added that the most expensive agency charged the Trust triple the rate. Some shifts through NHSP were double dependent upon area. The Chair commented that it was about finding a balance and managing this rather than paying an agency who then take a percentage. It was clarified that the percentage obtained by the agency wasn't a large amount. The Acting Chief Nurse highlighted the need to balance additional shifts against the impact on colleague's health and wellbeing. The Chair wished to discuss the pay, procurement and incentivisation regularly at Finance and Performance meetings. Looking across the system to ensure Trusts were not competing against each other. Trusts need to work together to ensure that the higher priced agencies don't have a way of getting into the market. The exploring of culture was important and the difficult places and finding ways of changing any cultural issues. The Chair added that data was reviewed, and the amount of money being spent on agency however, the Trust don't look at staff that aren't at work due to maternity leave and sickness don't appear in the Finance and Performance data. The Acting Chief Nurse concluded that the Trust should also take the unaccounted beds into consideration that aren't funded as this had a large impact. Beds that weren't open also had a large impact on the overspend, with beds being opened if ambulances were waiting. Further discussions would be made for this to be set up via Monday.com. Behaviours and culture require exploring further. The Chair concluded that some points would be discussed further at the next Finance and Performance meeting.	
	The Committee: - ***Noted and took assurance from the Agency Spend***	
FP22/08/C1	**<u>Assurance Summary (Verbal)</u>**	

	The Committee is asked if it is assured, on behalf of the Board of Directors on the following matters. Any matters where assurance is not received, would be escalated to the Board of Directors: o Matters discussed at this meeting, o Progress against committee associated Executive's objectives, o Are there any emerging new risks identified?	
FP22/08/D1	**Governor Observations**	
	Andrew Middleton praised the presentation and that the relevant officers were helping to provide assurance. It was asked if the Trust could investigate the exit interviews more efficiently as it appeared staff were leaving and joining agencies due to the flexibility. A further comment was made that regular financial data was received but workforce data wasn't. The Chair confirmed that the People Committee shared the workforce data regularly. Lynne Schuller also praised the report and thanked all those involved.	
FP22/08/E1	**Any Other Business**	
	No items of other business were raised.	

FP22/08/E2	**Date and time of next meeting (Verbal)**	
	Date: Thursday 26 September 2022 **Time:** 09:00 **Venue:** Microsoft Teams	
FP22/08/F	Meeting closed at: 14:12pm	

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

FINANCE AND PERFORMANCE COMMITTEE

Minutes of the meeting of the Finance and Performance Committee held on Monday 26 September 2022 at 09:00 via Microsoft Teams

Present:	Mark Bailey, Non-executive Director George Briggs, Interim Chief Operating Officer Alex Crickmar, Acting Director of Finance Mark Day, Non-executive Director Jo Gander, Non-executive Director Neil Rhodes, Non-executive Director (Chair) Jon Sargeant, Interim Director of Recovery, Innovation and Transformation Kath Smart, Non-executive Director	
In attendance:	Fiona Dunn, Director Corporate Affairs /Company Secretary Claudia Gammon, Corporate Governance Officer (Minutes) Paul Mapley, Efficiency Director (Items B1 & D4)	
To Observe:	Andrew Middleton, Public Governor – Doncaster	
Apologies	Joseph John, Medical Director for Operational Stability and Optimisation	
		ACTION
FP22/09/A1	**Welcome, Apologies for Absence and declarations of interest (Verbal)**	
	The Chair welcomed members and those in attendance to the meeting and the above apologies for absence were noted. No declarations of interest were declared.	
FP22/09/A2	**Requests for any other business (Verbal)**	
	No items of other business were declared.	
FP22/09/A3	**Action Notes from Previous Meeting (Enclosure A3)**	
	Action 1 – FP22/05/C1 - Urgent & Emergency Care Recovery Programme Awaiting an update from the Chief Operating Officer **Action 2 – FP22/05/D1 & FP22/06/D1 – Temporary/Agency Nursing Spend** Following the meeting on the 12th of August this was discussed in detail and therefore the action could be closed.	

	Action 3 – FP22/06/B1 – Incentive Rates for Consultants – Elective Recovery Update to be provided within the agenda **Action 4 – FP22/07/B1 – Ambulance Attendances @ ED where primary care solution was appropriate** Update required by the Chief Operating Officer **Action 5 – FP22/07/B1 - Red to Green Roll-out – Progress Update** Update required by the Chief Operating Officer **Action 6 – FP22/07/B2 - Elective Recovery Plan** Update required by the Chief Operating Officer **Action 7 – FP22/07/C1 - Trust-wide Themes from the Performance, Overview & Support Meeting** An email would be circulated amongst the NEDs for an expression of interest to attend the POSM meetings. Further update to be provided at the October 2022 meeting **Action 8 – FP22/07/D1 - Impact of Pay Award** Update to be provided within the agenda – this action could be closed **Action 9 – FP22/07/D2 - Update on the efficiency work between RDaSH & DBTH** Update to be provided within the agenda – this action can be closed **Action 10 – FP22/07/D2 – CIP Update** Update to be provided within the agenda – this action could be closed **Action 11 – FP22/07/D4 - Bassetlaw Emergency Village Project – Clinical Lead** Update, the clinical lead had been identified and was going through the process. – this action could be closed.	
	The Committee: - ***Noted the above updates***	
FP22/09/B1	**Demonstration of Monday.com**	
	The Efficiency Director provided a demonstration on the Monday.com workflow tool for project management. Two key changes were made to the Trusts approach to program management with the new Directorate to help facilitate this. • deployment of Monday.com • and the change to the overall approach to project management and then embed that within the system itself. Key benefits of the system were: 1. system benefits o improved visibility, o one centralised location o automation. 2. Approach benefits o were prioritisation of work, o gateway management	

	○ standardisation. The system was able to monitor approved project/plan requests and scored via objectives which scored dependent on how it meets the targets. Each project would go through different workflow phases prior to completion/closure. For each project there were Senior Responsible Officers, project leads and operational leads. Communication was all available through Monday.com to manage projects. Risks, issues, and a steering group dashboard was available to view. The Chair praised the demonstration, explaining the "now" ability to show project management. The Chair asked how easy the system was to use and was the communication facility easier than email. The Efficiency Director answered that it had been received well with staff and that senior leadership was important to help champion the process. Small projects could also be used via Monday.com and the request for further licenses has been made. Mark Day asked how the information was entered and was the scoring standardised. The Efficiency Director answered that the system was easy to use, and staff would enter their own updates which would then be discussed within the Transformational Board to either approve or reject the scoring. The Company Secretary added that the KPMG risk management actions and the corporate objectives were all being managed via Monday.com. Updating the information in one area was more efficient.	
	The Committee: - ***Noted the Demonstration on Monday.com***	
FP22/09/B2	**<u>Emergency Department Performance</u>**	
	The Interim Chief Operating Officer provided an update that the Emergency Department performance was at 70 % across both sites. Key issues were ambulance waits and handovers. Patient flow continues to be an issue, with 267 12-hour trolley breaches being reported in August. The Emergency Assessment Unit would be reinstated within the Trust to assist with the flow within the Emergency Department. Extra space was being created within ward 22 to assist with the Emergency Department. Improvements would then be made with 12 hour waits. Extra spaces for ambulances were to be created to provide more patients to be seen within the Emergency Department. The 4 hr wait target would remain in progress with the secretary of state un till April 2023. Following a question from the Chair about if other Trusts were seeing increases within the Emergency Department as the Trust was. Sheffield figures were worse than the Trust, the aim was to be alongside Rotherham and Barnsley. The Chair asked on behalf of Suzy Brain-England if some patients were coming into the Trust that could have been treated at the scene. It was answered that looking at data there were too many patients coming into the Trust and wasn't easy for ambulance staff as patients requested to be brought into the Trust. Patients being seen via the Emergency Department had increased due to long appointment waits with consultants and GP's.	

	A small improvement within the area would be visible at the end of October with further updates into November. Mark Day asked if the Trust had access to any data internally and with the wider partners. It was confirmed that data was received from the Yorkshire Ambulance Service daily, including a report on the North of England's length of stay. The data was reviewed daily and was highlighted to the wider system then raised with the lead at twice weekly meetings. The Chair requested an action plan for the October Finance and Performance Committee meeting showing Emergency Department performance data and how this was fed into Monday.com and a comparison with other Trusts.	
	Action: - ***Action plan to show the Emergency Department performance data, how it was fed into Monday.com and a comparison with other Trusts***	**GB**
	The Committee: - ***Noted and took assurance from Emergency Department Performance Update***	
FP22/09/B3	**<u>Elective Performance Update</u>**	
	The Interim Chief Operating Officer confirmed that the elective recovery programme action plan was within Monday.com. Monthly elective recovery meetings took place with items for approval being raised at Corporate Investment Group or Executive Team meeting. Once the Emergency theatre used for gynaecology was relocated next to ward 19 an additional theatre within the main block could open. The temporary modular theatre work was on track for completion in 5 weeks. Staffing these additional beds was ongoing. Work had begun to maximise the use of gynaecology theatres on the weekends. As the trajectory for October was missed dependent on the Elective Recovery Fund money the capacity would be increased in November. The Chair requested an updated/refreshed elective recovery plan to be presented at the October 2022 meeting as this action was not fulfilled. The Elective Recovery fund money was received for the first part of 2022. A key concern was the opening of the maternity modular build that was extended to the 29th of October 2022 from July 2022. A plan in place but no resource was available. Mark Day asked about Genomic testing resulting in a 62day delay in the first treatment and was this slowing down the process. Sheffield could only assist with the results of this test; however, the demand was high, but the Trust hoped to see an improvement in the next 6 months. Acute oncology services were also being investigated.	
	Action: - ***from previous for October on elective surgery***	
	<u>The Committee:</u>	

	- ***Noted and took assurance from the Elective Performance Update***	
FP22/09/B4	**<u>Red to Green Roll-Out Progress Update</u>**	
	The Interim Chief Operating Officer explained that "Red to Green" was a national programme, working alongside the departments. Red days were those where a patient was in bed with no progress and a green day was when a patient was making progress and could be discharged. This initiative had been driven across the wards with a weekly wednesday meeting to review the data and dashboards. Collating the progress data had made a difference in addressing the discharge process. Social services were also reviewing care packages and a more efficient way of issuing them. The Chair raised a question on behalf of Suzy Brain England regarding the Trust receiving value for money with them paying 10% towards the better care fund. The Interim Chief Operating Officer would contact Suzy Brain England with an answer.	
	<u>The Committee:</u> - ***Noted and took assurance from the Red to Green Roll-Out Progress Update***	
FP22/09/C1	**<u>Recovery, Innovation & Transformation Directorate Update</u>**	
	The Interim Director of Recovery, Innovation and Transformation provided an update on the several projects that had started. A business case for the planning of quality improvement strategy had been presented to CIG. The service line review was being worked on along with the site strategy. The new Doncaster hospital site would be the second emergency centre. Montagu was to be investigated to ensure enough regional investment and support from the Acute Federation and both ICS'. Partnership work with RDASH and receiving external support along with working together with the estates team and use of premises. Focus would be completing the outstanding tasks and implementing the key outputs. The Montagu Elective Orthopaedic Centre (MEOC) was a joint project with Rotherham and Barnsley. The area would provide 10 new beds and 1 new theatre in the modular build, although on the Montagu site it would be ICS usage. Inflation on the build costs had been an issue and it wasn't therefore possible to stay under the regional limit and build what was required. After meetings with the Trusts, it had been agreed to look at designing a centre of excellence. This would be a larger facility; purpose built and move all orthopaedic work to Montagu. This was affordable of the £15m site plan for Montagu and could include a hydro pool. Sustainable trauma services had become highly complex with the requirement for more beds. There was an issue with only 70% of all trauma surgery having radiology support. A further issue was a shortage of anaesthetists support and finally a delay in start times for theatre causing them to overrun. Trauma had no discharge planning until patients were able to be discharged once receiving a discharge pack. A trauma score card would be produced to ensure the best outcome. The Trust Annual plan had been signed off by Board and was available via the Hive. A small summary of the report would be created. The plan included the recovery plan and the ERF with	

	very little changes to in previous years. Mark Bailey asked how the annual plan links in with the risk register. This was answered that the plan outlines the strategic risks and aligns with the risk register. The Performance, Overview and Support (POSM) meetings had begun and required further work from the divisions. Score cards were created to assist with the divisions and resolving issues. The key areas would be identified and monitored via the POSM meetings. Clear processes were required to identify the issues and the impact within the divisions. There were tools provided to create the data along with working alongside the sub-committees of Board. Escalation process was being investigated and agency spends. Jo Gander volunteered to attend the POSM meeting to see the issues within clinical areas and report any risks back to the Quality and Effectiveness meeting. An idea was raised that all NED's take it turns to attend each week. The outcomes of the POSM meeting would filter into the Trust Executive Group. The Chair raised about the Nottinghamshire and South Yorkshire ICB meetings and the lack of visibility and updates made to the committee.	
	Action – - ***Presentation to be provided to the committee on the Nottinghamshire and South Yorkshire ICB updates***	
	The Committee: - ***Noted and took assurance from the Recovery, Innovation & Transformation Directorate Update***	
FP22/09/C2	**Capital Schemes Update**	
	This item was discussed within C1	
	The *Committee:* - ***Noted and took assurance from the Capital Schemes Update***	
FP22/09/D1	**Financial Performance – Month 5**	
	The Acting Director of Finance highlighted the Trusts key areas; the deficit for month 5 was at £2.7m, £1.0m adverse to plan. Year to date the overspend was £4.7m due to temporary staffing issues to cover staff sickness. Agency spend was high at £2.2m. Grip and control meetings had been attended with clear plans being required for patient safety. Part of the pressures are off set offset by non-pay underspends against elective recovery (£2.4m) including the independent sector and a number of non-recurrent benefits against plan. This includes VAT reclaims, £1m insurance proceeds relating to the W&C incident and other non-recurrent benefits including a gas rebate (£0.2m) and review of prior years' balances on the balance sheet (c.£0.6m).	

	The Trust is also seeing pressures on excluded devices and non-PbR drugs where spend is higher than plan, especially insulin pumps due to a change in NICE guidance. In the past these costs have been recovered through the contract, however given it is blocked this year, this pressure will sit with the Trust. It should be noted that the position reported includes all year-to-date Elective Recovery Funding given there is no clawback of funding in Q1 and Q2 despite the Trust not delivering electivity activity targets. An update on the rules for Q3 and Q4 ERF is not yet known at this stage. If the Trust's financial position was restated in line with the ERF rules at the beginning of the financial year and the impact of early year non-recurrent benefits is removed, the Trust would be closer to c£7-8m off plan Capital spend year to date was at £3.6m against a plan of £7.3m. The cash balance was at £27m and had increased by £2.9m since the previous month due to the receipt of quarterly income from Health Education England, non-NHS cash expenditure going back to average levels and limited capital expenditure in month. The pay 2022/23 Pay award had been paid in September and backdated, totalling an annual cost pressure of £0.3m. Mark Day commented that after looking at the finance report, the improvement report and understanding the year end position was the CIP required to be added. It was confirmed that the year against the cost forecast would be presented back to Finance and Performance committee. The Chair added that this would overlap with the People Committee. Allocate was being used to ensure the correct number of staff were used and creating a medium term and a long-term strategy however, issues with Covid-19 could effect this.	
	T*he Committee:* - ***Noted and took assurance from the Financial Performance Update***	
FP22/09/D2	**National Cost Collection**	
	The submission for the National Cost Collection submission had been made on the 8th of August 2022. In 2020/2021 the Trusts National Cost Collection index was 90 which indicated that the Trust's costs were below the national average. It was consistent with previous years despite the unit price of 52% that was impacted by Covid-19. In 2021/2022-unit costs had decreased due to more activity however, they were still 22% higher than the 2019/2020 pre-pandemic levels. The Trust submissions were being reviewed by NHS England with further updates to be provided at a future meeting once these are concluded.	
	The Committee: - ***Noted and took assurance from the National Cost Collection*** - ***Noted that the submission was complete, and all steps had been taken***	
FP22/09/D3	**HFMA Audit**	

	The Acting Director of Finance presented the Trusts self-assessment of the HFMA- Getting the basics right checklist. He explained that the self-assessment had been completed against a requirement across all 72 questions (across the 8 domains) and had undertaken a detailed review of 12 of the questions, by the end of November 2022. 360 Assurance would be focusing on 12 of the 72 questions the audit would be undertaken by the end of November, with the results reported to Audit and Risk Committee	
	<u>The Committee:</u> - ***Noted and took assurance from the HFMA Audit***	
FP22/09/D4	**<u>CIP Update</u>**	
	The Efficiency Director provided an update on the cost improvement programme, highlighting the key issues below: o Trust CIP Target – identified schemes has increased with a gap in target of £3.3M o Elective Recovery – continuing and improved delivery is dependent upon wider elective recovery plan development and embedding improvement activity (Plan £5.5m, Forecast £3.4M) o Reduction in Temporary staffing spend– delivery challenged due to ongoing Covid sickness rates and operational pressures. Plan £1M, Forecast £0.1M) • Ongoing areas of focus to identify further opportunities and ensure delivery include: ▪ A dedicated 'Agency Management Workforce Grip Control' Workstream has been established following the KPMG review ▪ Monitoring of recruitment trajectories at POS Meetings ▪ Review of highest earning substantive, locum and agency staff- ▪ Finance business partner ensuring trusts SFIs are followed in grip and control meetings o Non-pay containment and procurement savings. Plan £0.75M, Forecast £0.3M)– areas of focus to identify further opportunities and ensure delivery outlined in report o Unidentified savings – work continues with areas behind plans with areas of focus to identify further opportunities and ensure delivery. Next steps were to provide support within divisions and corporate areas, continuing SY acute trust collaboration on efficiency schemes and a focus on recurrent schemes. Gaining the culture of the divisions to get more engaged with the CIP's more important especially as this hadn't been around for the past 2 years due to Covid-19. Keeping the focus on the agency spends, recurrent vs the non-recurrent savings was important. The £19.3m within the CIP was made up of recurrent and non-recurrent. Mark Day asked if the CIP was achieved in 2022 what this meant for 2023. This was difficult to answer as the Trust don't know the position for next year and ensuring that delivering the same service moving forward. Further guidance would be received in December 2022/January 2023. Discussions were being taking place to prepare for 2023. Due to the Trust now being part of a system this created more complicated work.	

	The Committee: - ***Noted and took assurance from the CIP Update***	
FP22/09/D5	**Agency Spend Update** This item was taken as read and noted	
	The Committee: - ***Agreed with the above on the Agency Spend Update***	
FP22/09/E1	**Corporate Risk Register**	
	This item would be explained at the board meeting on the 27th sept	
	The Committee: - ***Noted and took assurance from the Corporate Risk Register***	
FP22/09/E2	**Assurance Summary (Verbal)**	
	The Committee was asked if it was assured, on behalf of the Board of Directors on the following matters. Any matters where assurance was not received, would be escalated to the Board of Directors: o Matters discussed at this meeting, o Progress against committee associated Executive's objectives, o Are there any emerging new risks identified?	
FP22/09/F1	**Governor Observations**	
	Andrew Middleton observed that the meeting was informative and that further issues on workforce would be presented at the Board meeting on the 27th of September. It was requested if governors could have further information on better care funds. Andrew Middleton added that further information would be appreciated on the Nottinghamshire and South Yorkshire ICB.	
FP22/09/G1	**Any Other Business**	
	No items of other business were raised.	
FP22/09/G2	**Performance Report Appendixes**	
	The performance report appendices were noted.	
FP22/09/G3	Minutes of the Sub – Committee Meetings (Enclosure G3)	
	The minutes of the sub-committees of the Finance & Performance Committee were received and noted.	
FP22/09/G4	Minutes of the meetings held on 6th June, 21st July & 12th August 2022	
	- The Committee approved the minutes of the meetings held on 6th June, 21st July & 12th August 2022	

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FP22/09/G5	Date and time of next meeting (Verbal)	
	Date: Thursday 27 October 2022 Time: 09:00 Venue: Microsoft Teams	
FP22/09/H	Meeting closed at: 12:14pm	

Final

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

PEOPLE COMMITTEE

Minutes of the meeting of the People Committee
Held on Tuesday 5th July 2022 at 09:00am via Microsoft Teams

Present:	Mark Day, Non-Executive Director (Chair) Mark Bailey, Non-Executive Director Zoe Lintin, Chief People Officer Dr Tim Noble, Executive Medical Director Kath Smart, Non-Executive Director Abigail Trainer, Acting Chief Nurse	
In attendance:	Jayne Collingwood, Head of Leadership and Organisational Development Dr Sam Debbage, Deputy Director of Education and Research Kelly Fairhurst, Head of Recruitment and Medical HR (Item D2) Claudia Gammon, Corporate Governance Officer (Minutes) Paula Hill, Freedom to Speak up Guardian Dr Nick Mallaband, Medical Director for Workforce and Speciality Development Tully Monk, Senior People Business Partner (Item D4) Angela O'Mara, Deputy Company Secretary Adam Tingle, Deputy Director of Communications and Engagement Christine White, HR Services Business Partner (Item D1)	
To Observe:	Mark Bright, Public Governor – Doncaster Kay Brown, Staff Governor	
Apologies	Fiona Dunn, Director Corporate Affairs/Company Secretary Alexis Johnson, Governor	
		ACTION
PC22/07/A1	**Welcome, apologies for absence and declarations of interest (Verbal)**	
	The Chair welcomed the members and attendees. The Chair introduced himself to the committee as this was his first meeting as Chair. Apologies for absence were given. No conflicts of interest were declared.	
PC22/07/A2	**Requests for Any Other Business (Verbal)**	
	There was one request for any other business from Kath Smart regarding an action from Audit and Risk Committee.	
PC22/07/A3	**Actions from previous meeting (Enclosure A3)** **Action 1 – PC21/11/D1 – People Strategy** Closed on the agenda	

	<u>Action 2 – PC21/11/C6 – Pre-Registration Learners</u> Closed on the agenda under the Education and Workforce paper **<u>Action 3 – PC22/05/C2 – Exit Questionnaire</u>** Closed on the agenda **<u>Action 4 – PC22/05E2 – Health and Wellbeing Update</u>** Mark Bailey, this is required to go to the main Charitable Funds Committee – Closed **<u>Action 5 – PC22/05/F1 – Freedom to Speak Up Annual Review</u>** Acting Chief Nurse there would be a restructure of the information to patients which would include the freedom to speak up annual report – Closed	
	The Committee: - ***Noted the updates and agreed, as above, which actions would be closed.***	
PC22/07/ B1	**<u>Staff Survey</u>** The Chief People Officer presented the enclosed paper and explained the survey results received highlighting what the Trust could do to improve moving forward with planning of the next survey. The ambition was to achieve at least the 63% response rate that was achieved in 2021. The next steps would be discussed via the next Trust Executive Group meeting. The Head of Leadership and Organisational Development added that the Trust was a finalist in the Good Company Benefits Awards with the aim to win this award next year. She explained that there was a pilot taking place around the Team Engagement and Development (TED) tool. The engagement and development of this tool were part of a National scheme across Lancashire hospitals to build on the results of the staff survey. This was being carried out by team leaders across the Trust with workshops being held to support this. A masterclass was held with 12 people expected however, over 80 people attended. The inaugural Reciprocal Mentoring Programme RMP is ending with a celebratory graduation in July 2022 with a second cohort due to be recruited. Kath Smart queried the value-based recruitment approach and requested an update on this. She also asked about the staff survey and how the positive comments were captured and discussed within the teams. The Chief People Officer commented that it was important to keep the survey a live document instead of an action plan. Leaders are a key part in this with keeping their teams up to date. A central oversite would also be part of the plan and would include progression. The Head of Leadership and Organisational Development explained value-based recruitment and that the Trust needed to look at more scenarios. The Head of Recruitment and Medical HR concluded that it was something that the Trust wish to look at and work closer with other departments alongside the polices. The Trust values were being looked at to embed these. The Executive Medical Director commented about the positive areas and that the Trust needs to praise those involved more. The Chair asked why the target for appraisals was 90% and not higher, also if there could be a target for the staff survey results. The Chief People Officer confirmed that this would be set up for the future.	

	The Committee: - ***Noted and reviewed the Staff Survey***	
PC22/07/ C1	**<u>People Strategy</u>** The Chief People Officer explained that the current People Strategy was due for review this year. Since the People Strategy was originally written there had been a lot more work completed on this nationally, with the People Promise and the NHS People Plan being in place. This would now need to be reported at System level. Therefore, the local people strategy would concentrate on the Trust's delivery vision and would detail how it would align to the national framework and how the Trust looks after its people. This work would begin from Quarter 3 onwards. Mark Bailey asked if there was a way for the committee to feedback. The Chief People Officer confirmed that there was via HR directors' groups and forums. The most recent piece of work completed had a lot of engagement and feedback from the service.	
	The Committee: - ***Noted the People Strategy Update***	
PC22/07/ C2	**<u>Board Assurance Framework – True North SA2 & 3</u>** The Chief People Officer discussed the Board Assurance Framework with the committee and if it provided sufficient information. Kath Smart answered that it was useful to see the framework with changes now highlighted. One of the key risks discussed was about the level of sickness and absence with an in-depth conversation had at the previous meeting. This was documented as assurance received however several actions were outstanding and required more support. Following a question from the Chair about the risk controls, some dates required reviewing as they were not "on going". On strategic aim 3 it was asked whether there was deterioration in staff relationships and was this a generic risk or within a specific area. The Freedom to Speak up Guardian mentioned that there had been some changes in the speaking up areas which had caused concern within relationships but were being addressed.	
	The Committee: - ***Noted and took assurance from the*** **Board Assurance Framework – True North SA2 & 3**	
PC22/07/ C3	**<u>Corporate Objectives</u>** The Chief People Officer explained that the corporate objectives were originally received at Board in April but had now been updated with outcome measures for Quarter 1 added. This was fully supported, along with all other objectives to be provided at the July Board meeting with the Directors' comments. The new sections on the objectives were the people strategy and the outcomes.	

	Further to a question from Kath Smart about the impact this would have on the sickness and absence rates for health and wellbeing. The Chief People Officer answered that will be added to the objectives and a focus would be kept on this area. Mark Bailey asked about the people strategy and the engagement around surveys and can they be linked to the two frameworks to enable it to become one. The Chief People Officer confirmed that it would be reviewed and investigated further.	
	The Committee: - ***Noted and reviewed the Corporate Objectives***	
PC22/07/ D1	**<u>Workforce Assurance and Education Report</u>** The HR Services Business Partner provided highlights from the report regarding exit interviews, turnover levels, retirement data, appraisal data, and absence levels. The exit interview questions process was successfully rolled out on ESR in February 2022. There was now an opportunity to improve the response rate and to capture and review what was said within the conversations. As more data is received it would be reviewed and feedback agreed as how best to deliver this. The Head of Leadership and Organisational Development commented that the conversations had been around career development opportunities and that these now be part of the appraisal process. Following a question from Kath Smart about how the Trust looked at a sample of 42 compared to the number of leavers and what the Trust can do to keep staff. The Chair questioned if there was a target that the Trust were trying to achieve for completion rate. The HR Services Business Partner answered that there wasn't a target although one could be created to improve the response rate. The Head of Leadership and Organisational Development concluded that it was about how we gain information from the data and how it was triangulated to develop learning. The HR Services Business Partner discussed the staff turnover section of the report. The data in the report was larger than the target turnover rate of 10%. The data also highlighted that staff were retiring fully or flexibly and that 144 staff were due to reach 67 years of age within the next 12 months. The Executive Medical Director asked if the medical and dental data included the junior doctors as the turnover looked high. The HR Services Business Partner would investigate this after the meeting. Mark Bailey asked about the 144 over 67-year-olds, and what does the Trust do, are they spoken to ahead of retiring. The Chief People Officer answered that this would be possible, and then staff would have options for flexible retirement. The Chair asked about the staff that were on the system and could take their pension at 60, do they have to wait until they are 67 to be asked about retiring. The HR Services Business Partner answered that some staff that can retire at 55 with a pension, this would need to be investigated if further detail is required. The Executive Medical Director added that it may be a good idea to look at the percentage instead of the number as it maybe a larger percentage in some areas than others.	

	Mark Bailey asked if there was a process to look at critical roles and the difficult areas to recruit. The HR Services Business Partner explained that there wasn't centrally, but it is happening divisionally and amongst the directorates. The Head of Recruitment and Medical HR commented about the retirement table and explained that there could be more comparable data as to show the status of those staff that have flexibly retired compared to those that have fully retired. The Deputy Director of Education and Research provided an update on the statutory and essential training. The first area of focus was on the medical and dental figures and would be presented at the next Trust Executive Group ensuring that "passporting" of training was carried out correctly. The second area of focus was resus training as this had a level of risk with risk assessments carried out within the areas and would be completed by September/October. Kath Smart commented about the potential of a CQC inspection and how the Trust look at set training and the evidence to support the resus training and if there was an inspection that the information would be accessible online. The Deputy Director of Education and Research confirmed that everything was located on ESR, with an action plan drawn up after the Trust Executive Group. The Chair asked if there was a sanction if staff didn't complete their set training, could they miss out on pay progression. The Deputy Director of Education and Research confirmed that if training was cancelled due to clinical pressures, then the staff member can't be blamed and was discussed in. The Chair added that if data was there and if it was the organisation that requests the staff to skip training that this was documented. The Deputy Director of Education and Research explained about the role specific training and that there were additional topics that were available to staff. There were a lot of these and therefore it would be a business challenge. Mark Bailey asked about the corelation between the staff levels and the amount of outstanding training. The Deputy Director of Education and Research confirmed that this was to be investigated to ensure it was clear to support topics at board level. The Medical Director for Workforce and Speciality Development added that the Trust need to look at the staff further with a push on medics. The Freedom to Speak up Guardian commented about the annual report and that one thing that was mentioned was to look at the training and how this was carried out. Level 2 discussed around patient safety how the Trust responds to incidents and the number of people to be released and enable training. The Acting Chief Nurse added that some areas don't have a training percentage built in and more and more areas had more complex training for certain patients and areas. Therefore, staff were completing this outside of work, it was a wider issue than staff not completing the training. With staff completing the training outside of hours then taking time back. The Deputy Director of Education and Research added that one focus area was looked at to see the requirements within the area and present it back as a business model. This would be a step forward to look at the wider picture. Kath Smart mentioned about the paper on sickness absence and when an update would be received. The Chief People Officer confirmed this would be investigated further outside of the meeting.	

	The Deputy Director of Education and Research added that there were 4 areas with updates: o Pre-registration learner feedback – continued work to scrutinise the data produce an annual report o Self-assessment had been received back from health education England and due for submission by the 30th of September – on track to complete and would raise any areas of concern. o Monitoring/learning environment training booked for 15th December o We care into the future event – hosted at Doncaster Dome to showcase the organisation in a simulated education pathway. With 1200 year 8 students aged 12 & 13, 46 stands show casing all roles along with universities, colleges, and health education England. Kath Smart praised the event, with all stalls including finance and estates. The Chief People Officer concluded that the huge amount of work that had gone into the event and inspired students to work for the NHS.	
	Action: - ***An overview of role specific training and the impact of staffing time***	***SD***
	The Committee: - ***Noted and took assurance from the*** **Workforce Assurance and Education Report**	
PC22/07/ D2	**<u>Recruitment Activity Report</u>** The Head of Recruitment and Medical HR provided information about the report, the data was provided from the TRAC recruitment system between October 2021 and March 2022. The key areas within recruitment were: o The volume of recruitment was high with 578 adverts which equated to 986.44 positions, this was due to some adverts recruiting more than one staff member. o The fill rate in quarter 3 was at 63% but had gone down to 48% in quarter 4. o There were different stages within the recruitment process which take different amounts of time. Some take 10/20 days, but others take 50/100 days o International staff takes longer due to visa and other checks o A quality improvement project was taking place to investigate the process and procedures, to then speed up recruitment and post adverts quicker. o International nurse recruitment had been a big success along with the Health Care Assistant's o A bid had also been put in for international allied health care professionals o Another bid had been raised for 75 international nurses to be recruited by December 2022. o A pilot would be running for the digital staff passport looking at doctors in training across different trusts to speed up the recruitment process. The Deputy Director of Education and Research enquired about the offers that were made around work experience/apprenticeships and if there was any data to show if any of them now worked at the Trust. The Head of Recruitment and Medical HR answered that this may be possible and that a conversation would be had outside of the meeting. The Chief People Officer commented that there was a lot of work around innovation and improvement, this was also linked into capacity and the pre-employment checks raised. Kath Smart commented about the end-to-end recruitment and if there was any data from when someone hands their notice in to how long the process takes to recruit the new person. The Head	

	of Recruitment and Medical HR added that managers need to begin the recruitment process once they have received a staff notice. This would reduce the delay in recruitment. The Freedom to Speak up Guardian added that there had been challenges with the clearance of staff via occupational health. However, the international nurse cohorts, health care assistant recruitment and work experience staff wouldn't have had the original screening for clearance as they are entry level staff. The staff that have been in care previously had already had some checks and therefore the process was quicker. Mark Bailey questioned the regional challenges that the Trust has within the system level, could the Trust work collaboratively to take part in one check. Also, within the process are there groups of people that were required every year and could the Trust be more proactive. Mark Bailey also added if other Trusts had already looked at the quality improvement aspect. The Head of Recruitment and Medical HR confirmed that the quality improvement covered the sharing of policies and procedures. Contact had been made with other trusts in the region to look at sharing data via Trac with regular meetings. The Chief People Officer added that the Trusts all share the same system standards and changing it operationally which the digital passport will help with. The Acting Chief Nurse added that there was an issue with the recruiting of international nurses and Health Care Assistant's due to the length of time for them to start. Due to the timings and that a role cannot be advertised until the current person has given notice. It then becomes difficult to backfill the role. The cost of living is difficult especially for the lower paid positions. It was confirmed that finance was included in a further meeting to discuss speeding up the recruitment process. The Freedom to Speak up Guardian added that across the ICS a self-declaration had been implemented to allow staff to declare if they have worked for the Trust previously that this then speeds up the process. Kath Smart commented about over recruitment and where the Trusts stance was with this for areas that are difficult to fill. It was suggested that it may be helpful to see at this committee with a proposal. The Medical Director for Workforce and Speciality Development added that in some areas this was useful to make the True North recruitment objectives work.	
	The Committee: - ***Noted and reviewed the*** **Recruitment Report including KPIs**	
PC22/07/ D3	**<u>Staff Claims (Annual)</u>** The Chief People Officer asked the committee if the report was acceptable as the annual report and if there was anything else that was required. Kath Smart added that one was a specific request about how the incidents would impact staff and this would then feed into the terms of reference. Kath Smart added that the things that happen at a health and safety level especially violence and aggression that sit underneath the health and safety committee and what the people committee need to see from a health and wellbeing perspective. The Chief People Officer agreed that this would sit under the health and safety committee as well as the violence and aggression work. A group that would assist with looking at this in further detail with people committee involvement. Kath Smart added that conversations should be made as to whether this sits with Audit and Risk committee or People committee.	

	Action: - ***Whether oversight of the Violence Prevention Standards sits best with Audit and Risk or the People Committee***	**ZL**
	Action: - ***Assurance to sort so that health and safety committee are considering the people aspects of staff claims***	
	The Committee: - ***Noted and took assurance from the*** **Staff Claims**	
PC22/07/ D4	**<u>Casework Activity Report</u>** The Senior People Business Partner discussed the volume of case work and that there continues to be an increase, with 600 in the previous financial year. The performance was still good with the ones going to appeal still low. Sticking to timescales and completing the casework was difficult within Doncaster and was being reviewed. The development and employment relations trackers were being worked on to enable the delivery of casework, with a better focus on and to report KPIs. Once the tracker goes live there would be more visibility on this area with over 350 toolkits. One key theme that continued to trend was sickness absence with 88% on the tracker relating to short and long-term sickness. There is continued support from the health and wellbeing champions encouraging all areas to have discussions with staff. The sickness absence policy and unplanned absence policies is being reviewed, to look at a positive and more proactive way to reduce unplanned absence. Further work was being carried out with the occupational health and support team to encourage staff to speak to them. The next steps, to continue the development and use of the tracker, work around the training offer and separating this delivering the case work and supporting staff. The Freedom to Speak up Guardian added that there had been large piece of work around the sickness absence review and engagement to make it more streamlined and link into prevention. The Chief People Officer observed that there should be more work around the just culture and were the Trust supporting this enough. The Senior People Business Partner replied that there was currently a lot of work surrounding the disciplinary and the grievance policy. The quality improvement project was in progress with the conduct processes to ensure the just culture processes were imbedded within work to support managers. The Freedom to Speak up Guardian explained that there had been a national revised freedom to speak up policy, looking at Trusts using one national policy. This would encourage staff to speak up and improve relationships. Mark Day concluded that there should be a focus and attention on the sickness absence policy.	

	The Committee: - ***Noted and took assurance from the* Casework Activity Report**	
PC22/07/ D5	**<u>On call Exemptions</u>** This item was not discussed there will be another meeting held to discuss the data further.	
PC22/07/ D6	**<u>People Committee Annual Report</u>** Mark Day asked the committee for any observations which none were made.	
	The Committee: - ***Noted and reviewed the* People Committee Annual Report**	
PC22/07/ E1	**<u>Health and Wellbeing Update</u>** The Head of Leadership and Organisational Development raised several key points: o The sickness absence was a work in progress, supporting those staff that were unwell. o 'Know Your Numbers' campaign had been successful and had helped staff o The tea trolleys on the wards provided positive feedback when visiting the patients. o Continued high usage of reiki was being used, with on average 70/80 staff a month. Single tender waiver was required to benchmark the costs. o Dr bike had been on site to encourage staff to use their bikes. The Deputy Director of Education and Research observed that with a small amount of resource this had been achieved and how the Trust captures and supports this. The Head of Leadership and Organisational Development added that the team were funded by the ICS around wellbeing, 'know your number' and therapies. When the staff survey results were received during the third wave of pandemic, staff felt supported around wellbeing. Following a question from Kath Smart about the ICS resource and were the Trust using this fully it was answered that there was more funding available for this year and the Trust would be pitching more ideas. Mark Bailey asked if it would be possible to gain an overview of the costs of the funding and where it was sourced to look at how much the Health and Wellbeing items were costing	
	Action - ***Obtain an overview of the costs and services within the Health and Wellbeing offer to consider future sustainability.***	**JC**
	The Committee: - ***Noted and took assurance from the Health and Wellbeing Update***	
PC22/07/ F1	**<u>Freedom to Speak up – Trauma and Orthopaedics Update</u>** The Executive Medical Director explained that a letter had been received in 2020 from some orthopaedic surgeons after which a series of meetings took place. An investigation then followed to discuss their concerns along with discussions about job planning. As a result of these investigations, 15 recommendations were made and implemented. A freedom	

	to speak up representative had been assigned within the specialty. This was continued work and would address issues within the area. The Freedom to Speak up Guardian added that there had been a lot of focus medically with staff wishing to become involved more. Further to a question from Kath Smart if the staff had been asked via the staff survey and feedback provided at the programme board. This had been answered that feedback was ongoing and further ways of obtaining the information was ongoing. The Executive Medical Director asked whether there was something proactive that could be done to ensure this didn't happen again and have a better understanding of the specialties. The Chief People Officer added that there were other tools accessible to help look at the outcomes including the TED tool. A question was raised, at what point can the Trust move forward as business as usual and could there be a joint report with trauma and orthopaedics and the emergency department. The Head of Leadership and Organisational Development confirmed that the TED tool would be used to explore the information further and to capture staff using the Trusts behaviours.	
	Action: - ***A joint report of the common themes between Trauma and Orthopaedics and the Emergency Department data***	**TN NM**
	The Committee: - ***Noted the Freedom to Speak up – Trauma and Orthopaedics Update***	
PC22/07/ F2	**<u>Freedom to Speak up - Emergency Department Update</u>** The Medical Director for Workforce and Speciality Development highlighted that the emergency department was like the trauma and orthopaedics issue, however there was collaborative work across the area encouraging working together. From the previous meeting there was a recommendation from the report that the "high five app" was used for positive feedback. There had been a lot of staff sickness issues because of Covid-19 which had impacted on staffing culturally. It was recommended that there was to be a 6 monthly update for the next 12 months. Following a question from Kath Smart whether it would be beneficial to look at the staff survey; this was confirmed as yes, beneficial. Mark Bailey asked if there were any specific areas to look at alongside the behaviours. The Medical Director for Workforce and Speciality Development confirmed that looking at this day to day and not just via appraisals was difficult to achieve this within the emergency department. The Freedom to Speak up Guardian added that further work with the leaders and the teams had happened to support them on a regular basis. The Chief People Officer concluded that there had been an executive sponsor idea that would be presented at Board and then to Trust Executive Group. This would include patient, staff and learner experiences with priority teams at an executive level.	

	The Committee: - ***Noted the Freedom to Speak up – Emergency Department Update***	
PC22/07/ G1	**<u>Corporate Risk Register – Workforce 15+ Risks</u>** Kath Smart explained that this had been presented at the previous Board meeting, the risk actions hadn't changed within the report with further updates being required.	
	The Committee: - ***Noted and reviewed the Corporate Risk Register***	
PC22/07/ G2	**<u>Training and Education Terms of Reference</u>** Mark Day queried the quoracy on the terms of reference as the membership required investigating The Deputy Director of Education and Research confirmed that this wasn't the final version and would be included and presented at the next meeting.	
	The Committee: - ***Noted and reviewed the*** **Training and Education Terms of Reference**	
PC22/07/ H1	**<u>Equality, Diversity, and Inclusion Audit Updates</u>** The Head of Leadership and Organisational Development explained that internal auditors, 360 Assurance were auditing the actions against the Race Code action plan looking at the reaccreditation against the race code. The outcomes of this would be shared once received.	
	The Committee: - ***Noted and reviewed the*** **Equality, Diversity, and Inclusion Audit Updates**	
PC22/07/ I1	**<u>Governor Observations (Verbal)</u>** Mark Bright asked that the event at Doncaster Dome for 1200 pupils, was this advertised more broadly in the press. The Deputy Director of Communications and Engagement answered that a press release was sent prior to the event without success. Footage had been produced to hopefully have some put on to local news. Kay Brown commented about the Doncaster Dome event and how the places were allocated to the local schools as from a personal experience some schools were provided with a questionnaire, they are maybe other roles within the hospital that children aren't aware of.	
	The Committee: - ***Thanked the Governors for their observations.***	
PC22/07/ J1	**<u>Minutes of the Sub-Committee Meeting (Enclosure J1)</u>**	
	The Committee noted: i. Equality, Diversion & Inclusion – March 2022 ii. Health & Wellbeing – April 2022 iii. Training and Education Committee – iv. Freedom to Speak up Forum – March 2022	

PC22/07/ K1	**<u>Any Other Business (Verbal)</u>** Kath Smart raised that from the annual governance report from Ernst Young (ISA260) there was a recommendation that starters and leavers were checked as they couldn't find all the documentation required. Kath Smart asked if this was the same recruitment plan or different, this couldn't be answered at the Audit and Risk meeting. What the issues are and what is happening need to monitor this within the management team.	
	Action - ***Documentation to be investigated for starters and leavers within the ISA 260***	**ZL**
PC22/07/ K2	**<u>Minutes of the Meeting held on 3rd May 2022</u>**	
	The Committee: - ***Approved the minutes of the meeting held on 3rd May 2022.*** The membership should include executive directors and the non-executive directors to be added to the present list. Add the job titles within the minutes rather than names.	
PC22/07/ K3	**<u>Items of escalation to the Board of Directors (Verbal)</u>**	
	There were no items of escalation to/from: i. People Sub-Committees ii. Board Sub-committees iii. Board of Directors	
PC22/07/ K4	**<u>Assurance Summary (Verbal)</u>**	
	The Committee was asked by the Chair if it was assured, on behalf of the Board of Directors on the following matters. Any matters where assurance was not received, would be escalated to the Board of Directors: - Matters discussed at this meeting, - Progress against committee associated Executive's objectives, - Divisional compliance with the Trust's risk management process.	
	The Committee were assured on behalf of the Board of Directors on: ***- Matters discussed at this meeting, with the exception of the staff survey results which would be escalated to the Board for discussion,*** ***- Progress against committee associated Executive's objectives,*** ***- Divisional compliance with the Trust's risk management process.***	
PC22/07/ K5	**<u>Date and time of next meeting (Verbal)</u>**	
	Date: Tuesday 6th September 2022 **Time: 9.00am** **Venue: Microsoft Teams**	
	Meeting closed at: 12:00pm	

Final

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

PEOPLE COMMITTEE

Minutes of the meeting of the People Committee
Held on Tuesday 6th September 2022 at 09:00am via Microsoft Teams

Present:	Mark Day, Non-Executive Director (Chair) Mark Bailey, Non-Executive Director Zoe Lintin, Chief People Officer Dr Tim Noble, Executive Medical Director Kath Smart, Non-Executive Director	
In attendance:	Suzy Brain England, Chair of the Board Kirsty Clarke, Acting Deputy Chief Nurse Jayne Collingwood, Head of Leadership and Organisational Development Dr Sam Debbage, Deputy Director of Education and Research Fiona Dunn, Deputy Director Corporate Governance/Company Secretary Kelly Fairhurst, Head of Recruitment and Medical HR (Item D2) Claudia Gammon, Corporate Governance Officer (Minutes) Anthony Jones, Deputy Director of People and Organisational Development Tully Monk, Senior People Business Partner (Item C7) Angela O'Mara, Deputy Company Secretary Gavin Portier, Head of Leadership, EDI, and Wellbeing Christine White, Senior People Business Partner	
To Observe:	Mark Bright, Public Governor – Doncaster	
Apologies:	Kay Brown, Staff Governor Abigail Trainer, Acting Chief Nurse	
		ACTION
PC22/09/A1	**Welcome, apologies for absence and declarations of interest (Verbal)**	
	The Chair welcomed the members and attendees. Hazel Brand was also introduced in her newly appointed role as a Non-Executive Director. Apologies for absence were given. No conflicts of interest were declared.	
PC22/09/A2	**Requests for Any Other Business (Verbal)**	
	No requests for any other business well provided	
PC22/09/A3	**Actions from previous meeting (Enclosure A3)**	

	Action 1 – PC21/22/D1 – People Strategy A new People Strategy was on target to start going through the approval process in January 2023 and would be in line with the national NHS People Plan. The People Plan would be circulated. **Action 2 – PC22/07/D1 – Workforce Assurance and Education Report** This action was due in November **Action 3 – PC22/ 07/D3 – Staff Claims (Annual)** This item was closed, and the committee were happy for and item on the violence and prevention standards to be added to the November people committee agenda **Action 4 – PC22/ 07/D3 – Staff Claims (Annual)** Verbal updated included within the agenda – This item can be closed. The added that there was further work being carried out via the Health and Safety committee and the occupational health team. **Action 5 –PC22/07/E1 - Health and Wellbeing Update** Included within the agenda – this item can be closed **Action 6 – PC22/07/F1 & PC22/07/F2 - Freedom to Speak up – Trauma and Orthopaedics Update & Freedom to Speak up - Emergency Department Update** Included within the agenda – this item can be closed **Acton 7 – PC22/07/K1 - Annual Governance Report – ISA 260** The Chief People Officer explained that the personal files were kept with the line managers and further checks had been added to ensure the process for using contracts was robust. A piece of work was beginning in relation to using contracts in an automated way.	
	The Committee: - ***Noted the updates and agreed, as above, which actions would be closed.***	
PC22/09/ B1	**Board Assurance Framework** The Chief People Officer explained that the feedback that had been provided by 360 Assurance had been incorporated into the Board Assurance Framework along with further actions. PE02 was a high risk with a rating of 16, this was regarding workforce availability and had a target rating of 8 by March 2023. The Chief People Officer felt this was overly ambitious to achieve within the year given the amount of external factors involved outside of the Trusts control and suggested an interim target of 12. The Company Secretary added that the strategic risks linked in with the board assurance framework must be reviewed to ensure the targets were realistic within the timeframe of the BAF with the mitigating actions included. Following a lengthy discussion on PEO2 risk, a level of 12 was agreed for 2022/2023 this particular risk by the committee. It was confirmed that the overall longer term ambition was to reduce to 8. A discussion around the ratings was had paying attention to consequence and likelihood. The Company Secretary added that the PEO2 risk was regarding the ability to recruit the right numbers of staff with the right skills and meet operational needs. Due to the likelihood of the Trust being unable to recruit means that this was high risk. Mark Bailey commented that the Trust should be looking at where they were trying to get to including realistic targets.	

	The Company Secretary explained that the new risk management policy was to be agreed at Board, and added the importance around discussing the risk targets, and how they can change over time as they are required to be realistic and achievable. Hazel Brand asked that as this was a live document, whether the target rating could be achievable over two years instead of a financial year. The Chair explained that this was an issue and there was a need to reduce the risk and adjust the target. In future, the decision around risk ratings would be agreed via the Risk Management Board. The Chair mentioned the job planning item as this was within SA2 and queried the timeline of implementation as it had been included on the Board Assurance Framework for a long time. The Executive Medical Director confirmed there was now a task group to look at the timescale and trajectories for job planning within divisions. Once all information was collated it could then be circulated and would have a plan in place by 10th October 2022. It was agreed that the report would be presented at the next People Committee.	
	Action: - ***Follow up report to be presented back to People Committee in November 2022.***	**TN**
	The Committee: - ***Noted and took assurance from the Board Assurance Framework – True North SA2 & 3***	
PC22/09/ C1	**<u>Staff Engagement</u>** The Chief People Officer discussed that staff engagement was important to improve staff survey results so would be a standard agenda item for the Committee. The report presented provided an oversight into different areas of engagement with a focus on highlighting key areas for improvement. The staff survey season was about to start and the survey would go live at the end of September 2022 with communications being introduced to encourage colleagues to complete the survey. The Chief People Officer indicated that a piece of work was due to be started, focusing on the culture around flexible working within the Trust and indicated that a working group would be set up. Further details would be brought to the Committee as this progressed. The Deputy Director of Education and Research enquired about how managing staff expectations around engagement for the future would impact on the additional investment needed to ensure this is embedded. Potentially this could be huge and highlighted there would need to be a balance between investment and output along with the importance of this. It was noted that any learner and staff experience feedback would also be recorded. The staff survey is only one feedback mechanism. Mark Bailey questioned if the staff survey provided engagement scores. It was confirmed that engagement scores were received and are cross referenced against the annual survey and the quarterly "pulse" survey. Nine questions were collated from the survey this year which then provided the engagement scores. The board to ward visits introduced was an outcome linked with the staff survey around visibility of senior leaders. Hazel Brand requested "thankyou" postcards for the Non-Executive Directors to enable them to send to the areas after their ward visits. It was also added that the Non-Executive Directors could	

	also use the Trust "high 5 app" for feedback to colleagues. Jayne Collingwood agreed to arrange this.	
	The Committee: - ***Noted and took assurance from the Staff Engagement***	
PC22/09/ C2	**<u>Education Report</u>** The Deputy Director of Education and Research provided an update on three areas: • SET data was improving and would show significant changes within the next couple of months. • The GMC training survey with a detailed action plan would be presented at the November People Committee meeting. • the HEE-Self Assessment Tool- delegated report would be supported by People Committee ahead of going back to Health Education England. A visit from HEE would commence in December with a detailed report prior to this. Following a question asked by Hazel Brand with regards to the resus modules and reasons why they hadn't been completed, the Deputy Director of Education and Research answered that this was being reviewed as part of job planning and there were challenges in releasing of colleagues from clinical duties. Mark Bailey asked about the capacity for delivering training as well as the capacity of those receiving training. This was answered that if there were enough trainers and space then this would increase the capacity. The Chair raised an issue concerning the escalation of door access for learners. This was discussed at the Trust Executive Group meeting and Estates were looking into a plan to resolve this over the next 3 months. Although there was a shortfall on resus training figures, the committee were assured that there was continued progress. The Committee approved the Health Education England plan.	
	Action: - ***Approved minutes of Teaching Hospital Board to be provided for information at every People Committee meeting***	**<u>SD</u>**
	The Committee: - ***Noted and took assurance from the*** **Education Report**	
PC22/09/ C3	**<u>Health & Wellbeing Update</u>** The Head of Leadership, EDI and Wellbeing described the schemes that were introduced during Covid-19 more recently, the introduction of Wage stream, the investment in additional resource to undertake pre-employment checks within Occupational Health and the engagement with people on wellbeing on social media. The biggest challenge was securing the financial investment for the wellbeing offer on a longer-term basis. The Deputy Director of People and Organisational Development added that there a lot of ongoing work around support for the cost-of-living crisis for colleagues within the ICB with opportunity to share ideas with other organisations. The Chief People Officer added that further work is being	

	undertaken to understand how the financial support can be maintained for the wellbeing offers for the future with further conversations also being held within the ICB system. The new Head of Leadership, EDI and Wellbeing asked if colleagues accessing Wage Stream regularly, would be a risk and if the Trust could be proactive in its approach. This was being investigated to look at ways of supporting staff. Due to an anticipated reduction in funding from the ICB the ability to obtain support via charitable funds and the staff lottery would be investigated to support the wellbeing offers. Once a proposal was put together it would be presented to the executive team, then Trust Executive Group and be brought back to People Committee at the next meeting.	
	The Committee: - ***Noted the Health and Wellbeing Update and took assurance from the funding***	
PC22/09/ C4	**<u>Appraisal Season (Verbal)</u>** The Chief People Officer provided an update that the recorded figure to date was 46% completion of non-medical appraisal. Some areas may not have recorded the appraisals on ESR which is likely to affect the figures. The Chief People Officer highlighted the fact that as long as the focus was around Divisions having the conversations with their team members, then the paperwork could follow. The medical appraisals were recorded differently and were submitted via GMC and an internal database showed 98% compliance over a rolling 12 months. Support meetings were in place for each division to discuss further. The Company Secretary added that both the Step Progression appraisal and the General Performance appraisal were both required to be added via ESR when appropriate and added that further information was needed to ensure the consistency of this as there had been some confusion in some areas. It was noted that areas with high vacancy rates found it difficult to complete the appraisals due to low staffing within clinical areas. An action had been added to the Board Assurance Framework around the risk of completing the appraisals in a timely manner and a further report would be presented at the November People Committee following the end of the appraisal season.	
	The Committee: - ***Noted and took assurance from the Appraisal Season***	
PC22/09/ C5	**<u>Internal Audit Report – Race Equality Code</u>** The Head of Leadership, EDI and Wellbeing explained that the relevant actions from the Race Code action plan would be incorporated within the overarching inclusion, equality, and diversity plan. This was an outcome of the internal audit report. The new EDI action plan would be presented to the People Committee regularly for assurance. A Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) paper had already been presented to Board and actions will link with the Race Code plan.	

	The Chair observed the amount of EDI work that had taken place and the progress with meeting the actions and validating them. The Trust were the first to be accredited on the Race Equality code and were due to be reaccredited at the end of September 2022. The Head of Leadership, EDI and Wellbeing highlighted the key areas for focus and attention. These were around; Board level representation (BAME), representation in senior leadership roles, improve recording for existing colleagues, capacity for support and development. Ongoing conversations were had regarding Board representation, data collection and what can be done differently. The Chair asked for more focus on the agenda next time to be added to the People Committee meetings with a focus around EDI and how it fits together with a more strategic overview to change the perception of working at the Trust eg has the accreditation helped us with the EDI agenda	
	Action: - ***More focus around EDI, how it fits together with a more strategic overview to change the perception of working at the Trust to be added as an agenda item for November meeting***	**ZL**
	The Committee: - ***Noted and took assurance from the*** **Internal Audit Report – Race Equality Code**	
PC22/09/ C6	**<u>On Call Exemptions Report</u>** The Chair explained that this report would be discussed at a future confidential meeting.	
PC22/09/ C7	**<u>Update on Covid-19 National Terms and Conditions</u>** It was explained by the Senior People Business Partner that from 29 June 2022 the government had changed the way in which NHS employees would be paid for Covid-19 related absence within their terms and conditions. The Trust supported all colleagues via occupational health and wellbeing. The Chair praised that a number of actions had been completed to support this transition and had impacted only a small number of colleagues.	
	The Committee: - ***Noted and took assurance from the*** **Update on Covid-19 National Terms and Conditions**	
PC22/09/ D1	**<u>Widening Participation</u>** The Deputy Director of Education and Research highlighted from her report that widening participation and particularly apprenticeships continue to be a priority within DBTH workforce plans to widen access and ensure that the use of apprenticeship levy funds aligns with workforce requirements. The current aim for DBTH is to continue to support socio economic recovery whilst enabling workforce growth by attracting talent from the surrounding communities and providing existing colleagues with a ladder of development opportunities. The Deputy Director of Education and Research explained that the draft levy data report had been issued by the government. Further discussions had been held locally regarding the apprenticeship and health care assistant entry level pay. There had been regional conversations within the ICB regarding apprenticeships.	

	There are national targets which change however, the Trust aligns its targets against the DBTH workforce requirements. Following discussions, it was agreed it would be helpful to have a target in relation to apprenticeship levy spend. Spending and investing the apprenticeship levy money would be a Trust target and aligning it to the new People Strategy.	
	The Committee: - ***Noted and took assurance from the Widening Participation Update***	
PC22/09/ D2	**<u>Workforce Pipeline (Verbal)</u>** The Deputy Director of People and Organisational Development provided the People Committee with an update on progress with International Nurse Recruitment and the expected arrival of Newly Qualified Registrants. The focus has been on the delivery of a quality induction to DBTH and adjusting to living in the UK as well as thorough preparation for the NMC Objective Structured Clinical Examination (OSCE) to enable people to work as fully qualified nurses on the wards and in the theatres of DBTH. In September 2022 the Trust is expecting to welcome 94 newly qualified Nurses, Midwives and AHPs to the organisation. The Deputy Director of People and Organisational Development indicated that looking at other staffing groups was key for planning in the future. Further work had commenced with the recruitment of midwives, paediatric nurses, and radiographers. Piloting would begin for the new starters to be entered onto e rostering to enable data to be viewed. There had been a positive outcome with international nurses with some progressing into other areas and senior roles after joining the Trust. After 12months the areas were discussed further with colleagues to ensure they remain working at DBTH. The Chair asked about the 94 newly qualified nurses and was there a level of risk with the nurses not starting at the Trust. It was confirmed that the numbers were static at present. Further work had been done to retain the starters by continually communicating with them. The Trust were supporting the plans for a future technical college. There were a broad range of pathways including colleges to assist with people wishing to begin a profession within healthcare. Other pipelines into the Trust would be presented at a future People Committee meeting. The Chair of the Board enquired if welcome packages and support provided for the international nurses at the beginning of the programme assisting with their accommodation could be used to recruit those colleagues locally and within the UK. This had been looked at for medical colleagues on occasion and would be reviewed for the future for other staff groups to consider how feasible this would be.	
	The Committee: - ***Noted and took assurance from the Workforce Pipeline***	

PC22/09/ D3	**<u>Overview of Improvement Projects</u>** The Head of Recruitment & Medical HR/the Senior People Business Partner provided the Committee with an update in relation to the progress being made on two specific pieces of improvement work: Recruitment Process and the implementation of the KMPG Workforce Planning Tool. The recruitment quality improvement event held on the 19 July was attended by over 30 stakeholders. Improvements were to be investigated to make the recruitment process smoother and quicker. Several actions had been collated, and some completed, along with KPI's and training packages. The feedback from stakeholders on the QI work was positive. The Chief People Officer added that the survey feedback and metrics were important to measure improvement in the process. The projects is being managed via Monday.com which would enable for support and creation of reports for Transformational Board. The Senior People Business Partner highlighted that the workforce planning tool was built on scenarios and was bespoke to engage with staff groups, to design and create scenarios about the workforce. The scenarios can be added, edited, and removed with no limit within the tool. A data discovery report from KPMG was imminent after the analysis of the activity data within phase 1, engagement would then begin across the key staff groups. RDaSH would collaborate with the Trusts AHP's staff group on the workforce planning tool being on track for early 2024. Hazel Brand asked if the workforce data was received by other medical professions within the area and if this was collated nationally. It was answered that this was fed back to the ICB and reviewed.	
	The Committee: - ***Noted and took assurance from the Overview of Improvement Projects***	
PC22/09/ E1	**<u>Themes within Trauma and Orthopaedics and Emergency Department</u>** The Executive Medical Director provided the Committee with a brief overview on the reflections and learning from the work undertaken in both T&O and ED. Two significant pieces of work have been undertaken in the specialty areas of T&O and ED, commissioned by the Executive Team as a result of issues and concerns escalated through direct communication with the Chief Executive Officer and the Freedom to Speak Up Guardian. Common themes had been investigated across both trauma and orthopaedic specialties. Freedom to speak up elements were raised within both areas. The themes across both areas were changes in leadership, learning of the behaviours, the awareness, and the impact this may have. It was therefore important to have an effective leadership team in progress. It was commented that other specialities would be investigated earlier to implement learning sooner.	
	The Committee: - ***Noted and took assurance from the Themes within Trauma and Orthopaedics and the Emergency Department***	

PC22/09/ F1	**<u>Equality and Diversity Committee Terms of Reference</u>** It was confirmed that the terms of reference were to be ratified at the People Committee	
	The Committee: - ***Noted and approved the Equality and Diversity Committee Terms of Reference***	
PC22/09/ F2	**<u>Training and Education Committee Terms of Reference</u>** It was confirmed that the terms of reference were to be ratified at the People Committee	
	The Committee: - ***Noted and approved the Training and Education Committee Terms of Reference***	
PC22/09/ G1	**<u>Governor Observations (Verbal)</u>** Mark Bright asked about the GMC survey and the educational supervision. This was answered that it was about the trainees and the number of consultants. Further work and support was being carried out with this throughout the duration of their training programme.	
	The Committee: - ***Thanked the Governor for their observations.***	
PC22/09/ H1	**<u>Minutes of the Sub-Committee Meeting (Enclosure J1)</u>**	
	The Committee noted: i. Equality, Diversion & Inclusion –23rd May 2022 ii. Health & Wellbeing – 20th June 2022 iii. Training and Education Committee – iv. Freedom to Speak up Forum –2022	
PC22/09/ I1	**<u>Any Other Business (Verbal)</u>**	
	No items raised.	
PC22/09/ I2	**<u>Minutes of the Meeting held on 5th July 2022</u>**	
	The Committee: - ***Approved the minutes of the meeting held on 5th July 2022.***	
PC22/09/ I3	**<u>Items of escalation to the Board of Directors (Verbal)</u>**	
	There were no items of escalation to/from: i. People Sub-Committees ii. Board Sub-committees iii. Board of Directors	

PC22/09/ I4	**<u>Assurance Summary (Verbal)</u>**	
	The Committee was asked by the Chair if it was assured, on behalf of the Board of Directors on the following matters. Any matters where assurance was not received, would be escalated to the Board of Directors: - **Matters discussed at this meeting,** - **Progress against committee associated Executive's objectives,** - **Are there any emerging new risks identified**	
	The Committee were assured on behalf of the Board of Directors on: ***- Matters discussed at this meeting*** ***- Progress against committee associated Executive's objectives,*** **- Are there any emerging new risks identified ?** The Chief People Officer highlighted a new Risk had been created to capture the impact of the cost of living on staff and potential industrial action by staff – RISK ID 3104	
PC22/09/ I5	**<u>Date and time of next meeting (Verbal)</u>**	
	Date: Tuesday 8th November 2022 **Time: 9.00am** **Venue: Microsoft Teams**	
	Meeting closed at: 11:42am	

Final

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

QUALITY AND EFFECTIVENESS COMMITTEE

Minutes of the meeting of the Quality and Effectiveness Committee
Held on Monday 5th September 2022 at 14.00 via Microsoft Teams Videoconferencing

Members:	Mark Bailey, Non-executive Director Hazel Brand, Non-executive Director Jo Gander, Non-executive Director Dr Tim Noble, executive Medical Director Kath Smart, Non-executive Director (Interim Chair) Abigail Trainer, Acting Chief Nurse	
In attendance:	Richard Canetti, Interim Deputy Director of Strategy & Improvement (Item D3) Kirsty Clarke, Acting Deputy Chief Nurse Fiona Dunn, Director Corporate Affairs/Company Secretary Claudia Gammon – Corporate Governance Officer (Minutes) (CG) Heather Jackson, Director of Allied Health Professionals Angela O'Mara, Deputy Company Secretary Jane Smith, Business Manager for Education and Research (Item E1) Richard Woodhouse, Strategy, and Improvement Project Manager (Item D3)	
To Observe:	Peter Abell, Public Governor Bassetlaw Lynne Logan, Public Governor Doncaster	
Apologies:	Simon Brown, Acting Deputy Chief Nurse Marie Hardacre, Head of Nursing for Corporate Services Lois Mellor, Director of Midwifery Alasdair Strachan, Director of Education and Research	
		ACTION
QEC22/09/A1	**Welcome, apologies for absence and declarations of interest**	
	The Chair welcomed the members, attendees, and governor observers. The Chair introduced and welcomed the new members of the committee to the meeting, Hazel Brand, Non-Executive Director, Jo Gander, Non-Executive Director, and Heather Jackson, Director of Allied Health Professionals. Due to the number of apologies for August's meeting, this replacement date had been arranged with an abridged agenda to ensure the Committee were able to consider the business of the meeting.	
QEC22/09/A2	**Conflicts of Interest (Verbal)**	
	No conflicts of interest were declared.	

QEC22/09/A3	**Actions from previous meeting (Enclosure A3)** **Action 1 – QEC21/12/C1 - Board Assurance Framework – Patient Experience** Closed would be included within the agenda. **Action 2 – QEC21/12/C2 – Quality Framework** The Acting Chief Nurse provided an update that this action was on track for completion in October 2022. **Action 3 – QEC21/12/C2 – Quality Strategy** The Acting Chief Nurse provided an update that this action was on track for completion in October 2022. **Action 4 – QEC22/02/D2 – Respect Audit** The Acting Chief Nurse agreed to reassign the action to Simon Brown, Acting Deputy Chief Nurse. Next steps and a revised target date to be agreed outside of the meeting. **Action 5 – QEC22/04/C1 – Board Assurance Framework** The Executive Medical Director confirmed discussions with regards to divisional audit leads and the requirement for specialty leads were ongoing and may be influenced by the awaited peer review. A further update to be provided at the October meeting. **Action 6 – QEC22/04/D4 – Health Inequalities** Closed, included within the agenda. **Action 7 – QEC22/06/C5 – Maternity, Transformation, & Ockenden Update** Mark Bailey confirmed he had met with the Director of Midwifery; work was ongoing in respect of the second Ockenden report and further detail and assurance was provided in today's paper to allow the action to be closed. **Action 8 – QEC22/06/C7 –Tendable Implementation Update** Action to be closed, included within the agenda. **Action 9 – QEC22/06/C6 –Mental Health Strategy** Action due October 2022. **Action 10 – QEC22/06/D1 – Patient Experience Report** Work was being carried out and further updates would be provided in December 2022. Action reassigned to Simon Brown until Deputy Director of Nursing (Patient Experience) appointed. **Action 11 – Patient Experience – KMPG Report** Work was being carried out and further updates would be provided in October 2022. Action reassigned to Simon Brown until the Deputy Director of Nursing (Patient Experience) was appointed. **Action 12 – Board Assurance Framework** As we learn to live with Covid, the Acting Chief Nurse confirmed that the SA1-Covid BAF had been incorporated into one framework SA1. The BAF would continue to be updated as a live document. Action to be closed.	

	Action 13 – Self Assessment of the NHS funded knowledge and library services A thank you card had been sent. Action to be closed. **Action 14 – AOB: Violence and Aggression** Due to a change in personnel, the presentation would not go ahead in October. An update to be provided at the next meeting	
	The Committee: - ***Noted the updates and agreed, as above, which actions would be closed.***	
	Action: Claudia Gammon would update the Action Log.	**CG**
QEC22/09/C1	**Board Assurance Framework (BAF)** The Executive Medical Director confirmed that work to incorporate Strategic Aim 1 - Covid into the Strategic Aim 1 Board Assurance Framework had taken place. Updates to the framework were highlighted for ease of reference, the Patient Safety Incident Response Framework (PSIRF), NICE guidance for delivery of statutory audits and Tendable were introduced as measures. In respect of controls, the risk stratification of patient pathways was ongoing and the nMAbs service continued to support the fluctuating presence of Covid. The external patient safety peer review was awaited, and the first Risk Board was due to take place in September. The Company Secretary added that the format had changed due to it being part of the Trusts internal audit opinion to focus on the risks that were affecting the strategic aim. The key changes were: o The risk appetite had been agreed at Board and was split into 6 categories. o The corporate risk register was incorporated into the risk appetite, the target risk level, and the target risk rating. o The Directors would need to ensure they can provide an explanation including the current risk rating and the target. o All actions were required to ensure they were mitigated o It was important that the corporate risk register was used in conjunction with the BAF. o All mitigating actions were required to be listed o Due to it constantly being reviewed it was required to be updated prior to board with all mitigations added and reflected on. o Internal audit would be looking at the updates and the relevant timescales set. In response to a question from Jo Gander, with regards to where the trajectories for implementation of PSIRF would be tracked, the Acting Chief Nurse confirmed this would be via the Quality Steering Group Committee, which reports into the Transformation Board. In terms of how this would be feedback to the Quality and Effectiveness Committee and Board, the Acting Chief Nurse confirmed that an update would be included within the patient safety report, delivery would be tracked via Monday.com The Company Secretary confirmed in her opinion the implementation of PSIRF required its own risk assessment, which should be included in both the Corporate Risk Register and reflected in the Board Assurance Framework.	

	The Chair explained that some areas weren't required and that a simpler form was required, which stripped out some of the lesser used details (e.g.: future risks; rationale; comments) to enable focus on the key areas Full support was required from the executives to use the risk register correctly. Data Quality and Medicines Management Audit reports to be included within the BAF ahead of Board to ensure they are reflected for the Head of Internal Audit Opinion.	
	Action: - ***To provide feedback after the patient safety and legal team meeting*** - ***To undertake a risk assessment of the PSIRF, and consider its inclusion in the BAF or CRR*** - ***To consider if some areas of the BAF could be removed to enable focus on the key areas***	**AT** **AT** **FD**
	The Committee: - ***Noted and took assurance from the Board Assurance Framework.***	
QEC22/09/C2	**<u>Clinical Governance & Quality Assurance Update</u>** The Executive Medical Director provided an update: o Work was being carried out with twice monthly meetings o Each division had a clinical governance lead except for medicine that had two. o The Trust had identified a cohort of letters that had not been sent, they had been reviewed and appropriate action taken. A process was in place to avoid future occurrence. o There needed to be site of the risks in outpatients to ensure multiple cancellations don't happen. In response to a question from Hazel Brand, the Executive Medical Director confirmed in respect of the unsent letters there were no harms identified. There had been no impact on waiting lists The Chair looked forward to a raised profile for clinical audit and looked forward to receiving the clinical audit annual report. A partial review of the schemes contained within the cost improvement programme have been reviewed and no significant risk to care quality was identified. The remaining cases would be reviewed in the next week.	
	The Committee: - ***Noted the Clinical Governance & Quality Assurance Report***	
QEC22/09/C3	**<u>Patient Safety Report</u>** The Acting Chief Nurse provided some key points: o In July there were two serious incidents, one of which was regarding optimal care and the other one was medical imaging. To date To date the serious incidents number was at 15. o There were 46 hospital acquired pressure ulcers affecting 34 patients in July. o 29 cases of e coli had been identified to date. o In July there were 9 concluded inquests.	

	○ A response was being prepared to HM Coroner in respect of a prevention of future deaths. Mark Bailey questioned if there was any corelation between the rate of activity and the rate of event and how was this checked. The Executive Medical Director explained that some of the data was rate adjusted. The Chair added that it was important to see both levels of data and would it be suitable for it to be linked with Monday.com. The Acting Chief Nurse confirmed that falls and hospital acquired pressure ulcers would be reported in this way. The Chair requested an update on the open incidents that were over three months old. The Executive Medical Director confirmed that each division presents their trajectory for overdue open incidents and actions at the monthly governance meeting. The Executive Medical Director recognised that closure of some of the older cases were beyond the Trust's control but agreed to look into the matter and report back.	
	Action: - ***Further assurance was required from Clinical Governance to confirm the progression of the open incidents, including any correlation with increased activity***	**TN**
	The Committee: - ***Noted and took assurance from the Patient Safety Report***	
QEC22/09/C4	**<u>Quality Accounts</u>** The Executive Medical Director provided a summary of the trajectories: ○ One never event in 2021/22, compared to four in the previous two years. ○ Work was ongoing to lower the number of MRSA cases ○ The number of falls were down, with the assistance of yellow blankets and socks and the learning from falls panel. ○ There was also some improvement in the numbers of hospital acquired pressure ulcers ○ The hospitalised standardised mortality ratio had fallen ○ The number of missed hospitals appointments had reduced from the previous year. ○ Complaints, staff attitude and behaviour were improving. Following a question from Hazel Brand, the Company Secretary confirmed that historically the quality accounts had been published as part of the annual report and accounts. Throughout Covid-19 there had not been a requirement to submit the quality accounts to NHSE/I, in 2022a shortened version of the quality accounts were taken verbally and written as a short version. The annual report and accounts would be received at the Council of Governors/Annual Members meeting in September 2022.	
	The Committee: - ***Noted the Quality Accounts 2021/22***	
QEC22/09/C5	**<u>Safer Staffing</u>** The Acting Deputy Chief Nurse provided an update on safer staffing: ○ Currently there were over 150 band 5 nurse vacancies, mitigated by an increased usage of agencies	

	○ The trust wished to cut down on the amount agency nurses used within the Trust however to ensure safer staffing this was necessary. The nurses were pre booked three months at a time to ensure consistency where possible. ○ By the end of October, the vacancy amount would lower to 55 whole time equivalent nurses ○ Two further wards would also open, one as a winter ward in medicine and the other an elective surgical ward that would require a further 19-20 registered nurses. ○ Additional funding had been received by the Trust to assist with international nurse cohorts. ○ As requested at a previous meeting bed occupancy was now visible against the actual vs planned data. The Chair suggested the data be cross referenced to the action plan discussed at the single agenda item Finance and Performance Committee meeting in August which focused on agency spend. In response to a question from Hazel Brand the Acting Chief Nurse explained that safer staffing was considered for all staff groups. Bids had been developed by the Director of AHPs for international recruits. The Chair added that this was also part of the work force planning and job planning audit which was seen at Audit and Risk Committee. A lead for advanced clinical practitioners had been appointed looking at how they fit in with medical staffing. International staff were recruited within many areas within the Trust and hot spot areas were raised and how the Trust can attract staff. A piece of work on key met was taking place with a demonstration being put into place for governors.	
	The Committee: - **Noted and took assurance from the Safer Staffing Update**	
QEC22/09/C6	**<u>Maternity, Transformation & Ockenden Update</u>** The Acting Chief Nurse provided an update on maternity: ○ Workforce remained the largest risk within midwifery and medical staffing. ○ Despite the number of new staff, vacancies had increased due to the reassessment of birth rate plus. ○ Interviews had taken place for a Deputy Director of Midwifery with a second appointment being advertised. ○ A work plan had been set up to capture staff morale and engagement. ○ Education and training remained a risk to the Trust due to staffing numbers, with an Ockenden requirement to be completed by December 2022. ○ The Maternity Voices Programme (MVP) was a patient led group and now had a chair appointed. The Chair asked about midwifery staffing and that it was a major risk to the Trust, was there a requirement for it to be added to the corporate risk register. It was confirmed that birth-rate plus had been received with a view to looking at maternity support workers. Detailed work on the skill mix would take place within the next few weeks to decide if it was required to be added to the corporate risk register.	

	Concern had been raised around the midwife led unit being behind on completion and if it had any impact. There was a risk around this regarding staffing levels, training, and choice of birth location. Despite there being a strong number of international nurses there hasn't been interest from international midwives. Mark Bailey asked about compliance and what options the Trust could adopt to assist staff to allow them to pause any non-essential training. The Acting Chief Nurse confirmed that this was being looked at alongside birth-rate plus and that some training was mandatory, non-essential training had been stood down. The Acting Chief Nurse provided an update on Ockenden, the initial assessment was completed in April with confirmation received in August following the visit. Several actions had progressed, with no documents being requested.	
	The Committee: - ***Noted and took assurance from the Maternity, Transformation and Ockenden Update***	
QEC22/09/C7	**<u>Tendable Update</u>** In the absence of Marie Hardacre the report was taken as read, the Acting Chief Nurse confirmed that a fixed term administrative position to support the project work would be funded via charitable funds. The Chair recognised this formed a key role in quality assurance and once implemented there was a need to consider how the outcomes/impact were reported to the Quality and Effectiveness Committee. The Chair agreed she would consider this outside of the meeting with the future Chair, Jo Gander. The Acting Chief Nurse confirmed a suite of reports could be facilitated by the system.	
	Action: - ***Consideration to be given as to what outcomes/ information will give assurance to QEC once Tendable is implemented.***	**AT & MH**
	The Committee: - ***Noted the Tendable update***	
QEC22/09/C8	**<u>Infection, Prevention, and Control Update</u>** The Acting Chief Nurse confirmed the updated framework expected in May 2022 remained outstanding. The Company Secretary asked about the first framework and what was happening with the closure of this. It was confirmed that this was being refreshed and would then be presented to Quality and Effectiveness Committee. As there was no new guidance the existing guidance remained in place.	
	Action: - ***Refreshed IPC Board Assurance Framework to return to the Committee.*** -	**AT**
	The Committee: - **Noted and took assurance from the Infection, Prevention, and Control Update**	

QEC22/09/C9	**<u>Learning from Deaths Report</u>** The Executive Medical Director provided an update on the historical report from quarter 4: o The reports of deaths were submitted to Imperial College. o There were no major causes for concern from the learning disability deaths. o Throughout Covid-19 there were changes to the legal processes and the reporting of deaths Hazel Brand asked for clarity in respect of the difference in reporting on the top five causes of deaths and the Executive Medical Director agreed to look into this, which may relate to a difference in reporting period. Sharing How We Care also fed into the learning from deaths, this would be looked at as part of the new structure with further work expected from the new Head of Patient Experience and Engagement. The Chair raised that there were concerns from families around fluids and food. A learning from deaths nurse was investigating this. The Acting Chief Nurse added that work was taking place between the learning from deaths nurse, nutrition nurse and the Director of Allied Healthcare Professionals. There was a lot of background work within this area with key support within the work stream. The Director of Allied Health Professionals confirmed that there was a meeting date set up to look at framework and better assurance moving forward. The Chair added that it was a key part of quality and requested a follow up meeting to discuss the progression. Working with providers was important and a business case had been started for this as nutrition was a key factor. Work was also being carried out with Doncaster Council to also assist with nutrition and fluids amongst visitors at the Trust.	
	Action: - ***Chief Nurse/ Director of Allied Health Professionals to provide assurance to a future QEC on the standards & compliance for nutrition and hydration of patients*** -	**AT/HJ**
	The Committee: - **Noted and took assurance from the Learning from Deaths Report**	
QEC22/09/C10	**<u>Clinical Negligence Scheme for Trusts Standards/Progress of Standards</u>** The Acting Chief Nurse confirmed there remained risks around compliance with CNST standards, although some actions had moved on. There were now patient safety champions, a non-executive and executive sponsor with monthly visits taking place to the maternity unit. There was a 90% achievement rate in mandatory training.	
	The Committee: - ***Noted the CNST Standards/Progress of Standards***	
QEC22/09/D1	**<u>Patient Experience Update</u>** The Acting Chief Nurse had provided an update within other agenda items.	

QEC22/09/D2	**<u>Maternity Voices Partnership Feedback and Actions</u>** The Acting Chief Nurse confirmed there was nothing new to add and that meeting dates had been made along with the appointment of a Chair.	
	The Committee: - ***Noted and took assurance from the Maternity Voices Partnership Feedback and Actions***	
QEC22/09/D3	**<u>Health and Inequalities Update</u>** The Interim Deputy Director of Strategy and Improvement explained that: o A public health consultant had been appointed o New data analysis and scope had been worked on as a way forward o Working closely with Bassetlaw. o Stakeholder analysis was part of the plan with the current place in September as the baseline phase with further workshops until next stage. o This would also be received at future trust executive group and finance and performance committee meetings. o The strategic level would be discussed then progress on to the operational level o A lot of health and inequalities was around culture and the education for staff and patients. The Strategy and Improvement Project Manager added that following a meeting it was broken down into 3 phases. o Strategic phase – ensuring there was a communications and education plan in place. Considering the impact on patients and staff. o Operational phase – observing what was already out there and learning from this. Looking at patient engagement. o Community plan – looking at the community and working with them, place was already looking at this further. The Chair asked if the plan was to revisit this at another Quality and Effectiveness meeting in the future and provide an update on what the next steps were. This had been agreed to show the governance further, accepting that The Chair noted the reference to anchor institutions and following a previous presentation received by Board, enquired of the current state of play with this work. A reinvigoration of the anchor network was being undertaken by Doncaster Council and the Interim Deputy Director of Strategy & Improvement agreed that he would feedback to the Company Secretary post meeting in order that future updates to Board could be considered.	

	Action: - ***It was agreed that the Interim Deputy Director of Strategy & Improvement would feed cack to the Company Secretary regarding next steps/future updates focused on anchor institutions.***	**RC/FD**
	The Committee: - ***Noted and reviewed the Health and Inequalities Update***	
QEC22/09/E1	**Research and Innovation Assurance Report Summary** The Business Manager for Education and Research recognised the positive work referenced in the report. A strategic review across Research was taking place of the Trust and would be presented back to the Quality and Effectiveness committee for ratification at the December meeting after being presented to the Trust Executive Group meeting. Mark Bailey asked about the other groups for example the universities and the public health group, how the resources were used. This was confirmed that the strategic review wasn't being carried out in isolation and had been done across public health and various partners. The partnership was being stretched to ensure that all resources were used.	
	The Committee: - ***Noted and took assurance from the Research and Innovation Assurance Report Summary***	
QEC22/09/F1	**Corporate Risk Register** The Company Secretary noted the reduction in the Covid-19 risk rating, further work on the register would be progressed via the Risk Board. Work was being carried out to ensure the risk register showed a clearer view of the corporate risks. The Chair added about the mitigating actions and the scores on the risk register, consistency was required as some workforce vacancies were on the register and others weren't. It was added that further work had been put in place with the Risk Board, review of the risks and the policies. A risk manager role was currently being short listed to link in with the divisions and help support how the risks were scored.	
	The Committee: - ***Noted the Corporate Risk Register***	
QEC22/09/F2	**CQC and Regulatory Compliance Update** The Acting Chief Nurse confirmed monthly engagement meetings were held with the CQC. The Trust had been formally informed that there would be a CQC visit within maternity but were yet to receive a date. Visits to all maternity services would take place where they had not been visited since 2018. The Company Secretary highlighted the closure of CAS alerts in the insights data pack and asked that the Executive Medical Director look into this. The Company Secretary confirmed that CQC inspection approach and reporting process would be changing. Feedback on the reporting process had been provided and a request for benchmarked system data had been made.	

	The Chair had reviewed the data, noting many areas where the Trust was not performing or was performing worse than others. It was highlighted that it was important to ensure the Trust was critically appraising the data held by the CQC and querying any areas which did not match with Trust information.	
	Action: - ***Investigate into why the CAS alerts data up to April 2022 hadn't been closed*** - ***Future CQC Insight reports should be analysed by management and ensure that any areas where the Trust is an outlier/ performing worse are reviewed and known to the organisation. A covering paper is required to future QEC's to highlight any areas of concern.***	**TN** **TN**
	The Committee: - ***Noted and took assurance from the CQC and Regulatory Compliance Update***	
QEC22/09/H1	**<u>Governor Observations</u>** Lynne Logan asked about the health inequalities and whether any information would be sent to GP's and if they were carrying out any work on the health and inequalities. It was confirmed that there was a health inequalities forum that would investigate this. This was a large piece of work with changes for both ICS's. Peter Abell commented that the meeting provided an explanation of what the data means and what the key points were. One point that was made was that regarding the coordination between the multiple ICS's. Regarding the safer staffing data can we move nurses around the wards and if the Trust were aware of vacancies, that agency staff were used for three months. Peter Abell also asked how the Trust were able to provide care using agency staff but couldn't recruit full time staff. The Acting Chief Nurse answered that staffing was reviewed across all sites four times a day. It was difficult to ensure that patient safety was maintained, and that staff movement was acceptable. Work had begun on a safe care programme; this would allow senior staff to see shift by shift staffing v's patient acuity and staff skills. In answer to the question regarding agency staff this was due to agency pay being higher than the NHS, with some paying triple the amount that the NHS pay. Peter Abell added that there had been 100% retention within the international nurses by understanding where they were best fitted to work.	
QEC22/09/I1	**<u>Sub-Committee Meetings (Enclosure I1):</u>**	
	- Clinical Governance Committee Minutes – May, June & July 2022 - Research and Innovation Committee Minutes –July 2022	
	The Committee: - ***Noted the committee minutes***	
QEC22/09/J1	**<u>Any Other Business</u>** The Executive Medical Director commented about an issue that had previously been raised at the Clinical Governance meeting regarding a shortage of products that were used prior to endoscopy procedures. Work was being carried out with the ICS and patients were being triaged to ensure no further breaches occurred. Two routine appointments had breached but no harm was made to the patients. Further updates would be provided but this was progressing moving in the right direction.	

QEC22/09/J2	**<u>Minutes of the meeting held on 7th June 2022</u>**		
	The Committee: - ***Noted and approved the minutes from the meeting held on 7th June 2022.***		
QEC22/09/J3	***Issues escalated from/to:*** i) QEC Sub-Committees – Clinical Governance committee regarding the cases that had been open for a while. ii) Board Sub-Committees – Anchor institutions session from Health Inequalities iii) Audit & Risk Committee		
QEC22/09/J4	**<u>Assurance Summary</u>** The Committee was asked if it was assured, on behalf of the Board of Directors on the following matters. Any matters where assurance was not received, would be escalated to the Board of Directors: - Matters discussed at this meeting, - Progress against committee associated Executive's objectives. The paper was not brought to this meeting, hence assurance would be gained at a future QEC - Are there any emerging new risks identified?		
	<u>The Committee were assured on behalf of the Board of Directors on:</u> - ***Matters discussed at this meeting.*** - ***Progress against committee associated Executive's objectives*** - ***No new emerging risks identified***		
QEC22/09/J5	**<u>Date and time of next meeting (Verbal)</u>**		
	Date: **Time:** **Venue:**	**Tuesday 4th October** **1:00pm** **Microsoft Teams**	
	Meeting End time	5:20pm	

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

AUDIT AND RISK COMMITTEE

Minutes of the meeting of the Audit and Risk Committee
Held on Thursday 14th July 2022 at 09:30 via Microsoft Teams

Present:	Kath Smart, Non-Executive Director (Chair) Mark Bailey, Non-Executive Director Mark Day, Non-Executive Director	
In attendance:	Ken Anderson, Chief Information Officer Matthew Bancroft, Head of Financial Control Mark Bishop, NHS Accredited Counter Fraud Specialist Laura Brookshaw, 360 Assurance Alex Crickmar, Acting Director of Finance Claudia Gammon, Corporate Governance Officer (Minutes) Matthew Gleadall, Acting Deputy Director of Estates and Facilities (Items F1 & F2) Dr Noble, Executive Medical Director Dan Spiller, Ernst Young Sean Tyler, Head of Compliance (Items F1 & F2) Ruth Vernon, Assistant Director, 360 Assurance	
To Observe:	Dennis Atkin, Public Governor	
Apologies:	Neil Rhodes, Non-Executive Director Fiona Dunn, Director of Corporate Affairs/Company Secretary	**ACTION**
AR22/07/A1	**Welcome, apologies for absence and declarations of interest (Verbal)**	
	The Chair welcomed the members and attendees. The apologies for absence were noted.	
AR22/07/A2	**Actions from previous meeting (Enclosure A2)**	
	Updates were provided on the below actions: **Action 1 - AR21/10/D3 – Job Planning – Recommendation dates** Further update would be presented at the October 2022 meeting and was on the work plan. Closed **Action 2 – AR22/03/D1 – PSIRF Audit** Ruth Vernon, 360 Assurance confirmed the final terms of reference report that was included within the audit and could be closed. **Action 3 – AR22/04/D3 – Medicine Management Audit Report** The Executive Medical Director confirmed that it would feed into the clinical governance committee but would need a date for the meeting. This action could be closed.	

	Action 4 – AR22/04/D2 – Stage 3 Internal Audit No update as action due in October 2022 **Action 5 – AR22/04/G3 - Review of Internal & External Audit Effectiveness** No update as action due in October 2022 **Action 6 – AR22/05/C3 - Head of Internal Opinion & Annual Audit Report** No update as action due in October 2022 **Action 7 – AR22/05/C6 - External Audit ISA 260 Report** No update as action due in October 2022 **Action 8 – AR22/05/D1 - Quarter 4 Local Security & Management Report** This action had been received at board and added to the QEC agenda. This action could be closed **Action 9 – AR22/05/F1 - Quarter 4 Local Security & Management Report** The Acting Director of Finance confirmed that this had been raised at the violence group some were discussed at the operational meeting. The Chair added the Violence Prevention Standards work had also been discussed at People Committee and would be sighted through the PC. **Action 10 – AR22/07/D2 - Internal Audit Report** This had been moved to the People committee for discussions in September 2022.	
AR22/07/A3	**Request for any other business (Verbal)**	
	There were no requests for any other business. The Chair requested that the below items were noted for the next meeting due to absence: Standards of Business Conduct/Declaration of Interest Policy Corporate Risk Register Register of Interests, Corporate Hospitality, Sponsorship and Fit Persons Declaration Committee Effectiveness Review Corporate Objectives	
AR22/07/B1	**External Auditors Annual Report** Dan Spiller explained that the annual report would be presented to the governors at their annual meeting. This report shows that the Trusts conclusions had been closed as well as the financial position. The second part of the report, around value for money, detailed the conclusions that Ernst Young had come to with more detail in the findings that concluded across the three areas for value for money. The Chair queried the value for money opinion and the recommendation was to take a strong approach in looking at sickness absence monitoring and also the capacity at senior executive level. The Acting Director of Finance confirmed that there was a management response included within the report. It was also acknowledged that there was a significant risk with the financial	

	plan this year. This would be presented at both the executive meeting and then at Trust executive group. It was acknowledged that the senior management capacity had improved as there was now an interim Chief Operating Officer in post, a permanent Chief Operating Officer appointed and a permanent Chief People Officer in post. The Chief Nurse post would also be advertised shortly. Mark Bailey observed that everything that tied up together with the other committees. The Chair confirmed that the report would be presented to the Council of Governors, the date of this would be checked and confirmed. Dan Spiller concluded that both the Wholly Owned Subsidiary and the Charity audit would be looked at in October and then presented to charitable funds.	
	The Committee: - ***Noted the External* Auditors Annual Report**	
AR22/07/C1	**<u>LCFS Progress Report</u>** The NHS Accredited Counter Fraud Specialist explained the key areas and what was required in the plan: o The functional standard return was submitted on time and received a green rating. o Training was still achieving a high mark, including SET and an e-learning package. o Fraud survey was completed with a slightly lower response rate from 2021. Over 600 staff took part in the survey. A full survey report would be received at the next Audit and Risk meeting in October. o The new Civica declarations system would be online shortly, and all forms would be electronic as they were now paper based. o The National Fraud Initiative (NFI) was now complete with one error found that recovered £702. o Fraud prevention notices had been issued from the Counter Fraud Authority (CFA) and highlighted issues in other trusts. Finance was investigating into this and assured the Trust that there were no issues as everything was checked regularly. o Phishing emails were being looked at especially those staff that were a risk. o Receipts of payments to mortuary staff would be included within a policy. o Recruitment checks during Covid-19 was investigated and sampled staff that had access ensuing recruitment process carried out right. o 2 new referrals and 5 updates on investigations with updates to be provided in the future. Following a question from the Chair about the annual fraud awareness survey and possible survey fatigue, and whether this would be annual survey and more accessible media. It was also confirmed that there are questions within the staff survey about an open and honest culture. The Chair asked about an up-to-date declarations of interest policy and if there was a timeline on both the policy and new Civica system. The NHS Accredited Counter Fraud Specialist confirmed that the policy was awaiting approval. The Chair asked if the policy could be presented at Board for approval due to the timing of the next meeting. Also, it was noted the system was built, and all relevant information was being uploaded. The Deputy Company Secretary added that the policy was required to be added to the Civica system and Civica were awaiting test data which would be looked at weekly. Communications would also support and promote this.	

	The Chair also queried if there was anything that the Trust could do to reduce the risks of fraud. This was answered that the process had changed, with monthly updates and additional controls were in now place. The Chair also raised about the incorrect usage of the blue badges; this had been promoted via the website. The Chair concluded that whilst looking at the work plan and the reporting of the LCFS Fraud Report whether this could be done quarterly. Feedback would be provided after this was investigated	
	The Committee: - ***Noted and took assurance from the*** **LCFS Progress Report**	
AR22/07/C2	**<u>LCFS Annual Report 2021/2022</u>** The NHS Accredited Counter Fraud Specialist explained that the counter fraud functional standard which was assessed by the Counter Fraud Authority (CFA). There were 2 amber risk areas relating to the fraud risk assessment process and the metrics. Actions for these were only fully in place at the end of the financial year which was why it graded amber. The fraud identified figures showed the trust with £11,566 of identified fraud, £10,600 of that was recovered with a fraud preventative figure of £64,000. A comparative survey report would be used to benchmark the remaining two Trusts that we use.	
	The Committee: - ***Noted and took assurance from the*** **LCFS Annual Report 2021/2022**	
AR23/07/D1	**<u>Internal Audit Progress Report & Recommendation Tracker</u>** Ruth Vernon provided an update on the progress against the internal audit plan which was largely on track. There were two possible changes to the plan that require the committee approval, firstly; NHS England have requested that the Trust commissions internal audit work on financial sustainability in line with a national requirement. Secondly, further to discussions with the Trust, a timing change to the performance management audit, from Q2 to Q3, starting in November. The Acting Director of Finance added that with regards to the national Financial Sustainability audit, that it detailed 8 areas and 74 sub areas to review against. The Trust has to self-assess against this. The Chair asked about the one piece of work that had been delayed. This was the waiting list prioritisation and further work was being actioned. The committee agreed and approved the changes to the plan. Laura Brookshaw provided an update on action follow-up; the current first follow-up rate ist73% currently. The two medicine management actions were pending update. Two new deadlines were agreed for the job planning audit actions. There were also 7 historic open actions with 6 of them relating to our head of internal audit opinion/risk management work programme. The Chair was concerned about the historic actions that were due in June and the understanding of the Risk Policy, corporate risk register, and board assurance framework and if any changes had been made.	

	Mark Bailey commented that the risk registers and board assurance framework actions were to be reviewed and completed by the end of July 2022. The Chair added that there were 94 risks that were currently with the Trust Executive Group for review however, there weren't mitigating actions that the committee had been sighted on. The Acting Director of Finance suggested that an action should take place for the Company Secretary to provide an update on the action status for each of the actions that internal audit had raised in the audit opinion of 2021. Any updates were to be added by the 29th of July. Ruth Vernon continued that the 360 Assurance events programme was paused during Covid-19, however, a workshop for leads to discuss a matrix for clinical governance was planned. Another 360 event was also being planned for Board members on 29th September to be held at the Doncaster Racecourse, in partnership with the good governance institute, on the topic of "Governance Across Partnerships". Included in the progress report were the terms of reference for the head of internal audit opinion, this had been shared with the Trust Executive Group. The term of reference sets out what would be considered within the internal audit opinion. The board assurance framework is scrutinised to ensure it is discussed by Board members, used correctly, and updated in a strategic way including what controls were in place. 360 also reviews the implementation of actions and the culture around closure on time, Trust executive group were provided with updates. Original due dates were tracked with focus on high/medium-risk actions and open actions from the previous year to see if they would be closed this year. We also consider outturn/opinions of all internal audit work in the plan.	
	Action: - ***Company Secretary to provide an update that sets out the status each of the actions that internal audit had raised in the opinion in 2021. Any updates were to be added by the 29th of July.***	**FD**
	The Committee: - ***Noted and took assurance from the Internal Audit Progress Report & Recommendation Tracker***	
AR22/07/D2	**Internal Audit Report** ○ **Race Equality** Laura Brookshaw a summary of the internal audit report on Follow-up of Governance Forum Review of Race Equality. The Trust had an external review by the Governance Forum against the Race Equality Code in early 2021. The internal audit review was requested by the Chair of the Board.	

	A high-risk finding was raised as the Race Equality action plan was only received once at People Committee (from evidence received) in September 2021 and at this point only 15% of actions were complete. The action plan from April 2022 was provided which showed 23% of actions complete. 3 actions deemed complete by the Trust were assessed for evidence, only 1 was deemed fully complete and 2 were partially complete. A medium risk was raised in respect of this. An overarching action was agreed to ensure that this standalone Race Equality Code action plan is integrated into the wider EDI agenda of the Trust Mark Day agreed that the Race Equality Code should appear via the People Committee and the Chair agreed that this should be referred via the People Committee. o **<u>Data Security and Protection Toolkit</u>** Laura Brookshaw confirmed that the data security and protection toolkit report had been issued with a substantial assurance opinion. There were two low risk findings relating to back up for key systems and the completeness of the medical devices register and 3 actions were agreed to mitigate these findings with the key officers. The Chief Information Officer explained that cyber security and data issues can affect and stop the organisation in its tracks and this was his number one priority. This covers people and process with all elements being important. Several campaigns had taken place over the last 12 months taking recommendations forward. The Chair added that this provided a positive picture and keeping up to date and standards were continuingly being raised and was a good outcome for the Trust.	
	Action – - ***Refer the Race Equality action plan audit to the People Committee***	**MD**
	The Committee: - ***Noted and took assurance from the Internal Audit Report***	
AR22/07/D3	**<u>Job Planning Update</u>** The Executive Medical Director explained that the job planning audit was carried out by KPMG with support from 360 Assurance. A series of prioritised concerns were to be investigated and an action plan was created including timescales, this was being monitored monthly. Significant progress had been made with 14 out of 20 completed. Some examples of the actions and their updates were: o Action 135 - centralised filing system for job planning, this was the allocate system with 78% of all job plans held on allocate. 360 Assurance advised that this could then be marked as complete. o Actions 136 and 144 – reviewing the approval of job plans and administrative support. A business case was approved for 6 months to then access the impact of this. Admin support was crucial at pulling the data and was now in post. The action remained open to access the affect. o Action 137 – consistency in job planning and to have a consistency committee. This was permitted with high level questions asked if required. Training had commenced earlier	

	this month with all clinical directors included. The deadline was extended due to Covid-19, once complete this and could be marked as complete. o Action 138 – job planning activity, this would remain open until fully reviewed. Some form a team plan. o Action 140 – how capacity and demand was incorporated into the job plan were investigated around this and clinical sessions to see how much work was expected. Progress had been made with the capacity and demand variations. Mark Bailey queried the size of the task and the need for more assurance. The link to the capacity planning was essential going forward. The Chair questioned the job planning consistency committee and where the committee reports into. The Executive Medical Director was unsure and would find out as it does have a formal place. The Chair asked about the job planning and how the Trust can achieve a 100% completion and how many were outstanding with the divisional support meetings. This was checked every fortnight however the figures couldn't be confirmed. The Executive Medical Director confirmed that although the LNC policy wasn't approved the draft copy could be used as it had been circulated for comments. Following a question from the Chair about the clinical excellence awards and if applicants were required to have a signed off job plan, this was confirmed. The Chair asked a final question about whether the job planning audit could be moved to business as usual or was there any further information that was required. The Executive Medical Director gave his opinion that the audit should watched for progress due to the difficulties. Mark Bailey agreed and asked if there could be one further update then for this to be progressed to business as usual.	
	The Committee: - ***Noted and took assurance from the Job Planning Update*** - ***Requested a further update in October***	
AR22/07/E1	**<u>Governor Observations</u>** Dennis Atkin commented confident that he felt assured by the green rating within the cyber fraud report.	
AR22/07/F1	**<u>Quarterly Report on Security Management</u>** The Acting Deputy Director of Estates and Facilities explained that following the previous the meeting, security report had been modified to provide further assurance, with further detail added to the report implications of the report. It had been agreed that the security report would be raised bi-annually in quarters 2 and 4. The Acting Deputy Director of Estates and Facilities welcomed any feedback from committee that would help the report to give you the assurance required by the committee and would add in the 3lines of defence into the report. The Chair confirmed with the committee about moving the report to bi -annual and that it would be added to the work plan.	

	The Committee: - ***Noted and took assurance from the*** **Quarterly Report on Security Management**	
AR22/07/F2	**<u>Health and Safety Bi-Annual Report</u>** The Acting Deputy Director of Estates and Facilities explained that the report included the progress from the actions within the Granger report which included actions to improve H&S following the women and children's incident in April 2021. There were two significant recommendations; to introduce a safety management system in line with ISO45001 and the need for transformational changes within the safety culture in the organisation. Qi workshops had been held with stakeholders to look at workstreams and where improvements were required. The report also included updates on the routine Radon gas monitoring that had place across the Trust, and the conclusion was that Doncaster and Bassetlaw had no areas of concern. Still awaiting results from Mexborough, but do not anticipate any concerns. It was noted that 800 staff were screened for Tuberculosis following exposure of a member of staff to a patient with TB, with a small number of staff testing positive following this screening. This has led to a change in the vaccination policy, with a particular focus on staff under the age of 30 who potentially may have not been vaccinated already. Assurance reports were provided for electrical systems, ventilation systems, fire safety, they also included new risks and actions that further help control these risks. It was also noted that a report that confirms external audit on the Trusts water system and scheduled audit of electrical systems in Q2. Any actions were investigated via groups and estates and facilities with any progress being reported to the relevant committee for assurance. There were 6 RIDDOR incidents reported within the reporting period, with a reduction of 40% on previous report, these are now reported via Datix. Further to a question from the Chair regarding the Granger report and the recommendation from the Health and Safety to look into implementing ISO45001, it was confirmed that a quality improvement project would help with a solution in decision which standard solution the Trust will implement. The Head of Compliance confirmed that the draft framework and actions were in place at present. Refresher executive training would run and also allow a proposal in development of a H&S management training that would align to the ISO45001 framework. This would be a 5-year plan and include an internal audit and gap analysis against the framework along with external audit. A review of the framework would be received via the Health and Safety Committee, with an end presentation in September. The Chair observed that the Granger report was important and to ensure that everything was correct within it and that any updates on the policy statement or action plan were discussed at the relevant committee meeting. The Chair asked if there was any clinical learning from the TB incident around the treatment of the patient and should the trust have done something different to avoid future testing etc? This was discussed at the health and safety committee however, this was debated but was no update or action taken.	

	The Chair expressed that as the SET training was presented at People Committee then it could be removed from the report for future. The Chair acknowledged that both the water and lifts refurbishment had been allocated from the capital funds 22/23. But asked if this has further mitigated risks. Acting Deputy Director of Estates and Facilities explained that risk reduces a little, but still will remain. The water safety information was included within the report including enhanced sampling and was being monitored. The Lift refurbishment was difficult to mitigate due to the scale, costs and timescales to fix being significant.	
	Action – - ***Investigate if any learning had come from the Tuberculosis (TB) patient incident, leading to the staff testing and vaccination programme.***	
	The Committee: - ***Noted and took assurance from the*** **Health and Safety Bi-Annual Report**	
AR22/07/G1	***BAF (Full)*** The Chair and the non-executive directors discussed the full board assurance framework by committee meeting. The Chair discussed the quality and effectiveness framework SA1 providing outstanding care and the SA1 Covid-19 major incident and that they were discussed in detail at the previous quality and effectiveness meeting. The risk had reduced on the Covid-19 major incident as the numbers were decreasing and the Trust were awaiting new guidance. The new infection prevention and control guidance has still not been released; however, changes had been made that mask wearing wasn't compulsory within nonclinical areas. SA1 Also incorporated quite a few updates on patience experience and action plans now. Reassurance was sought as to whether the risk relating to staff covering other areas following the incident surrounding the Women and Children's that was still open, management have taken this away to be investigated further. The quality and patient safety strategy was also discussed as to how it would be looked a further. The patient safety incident response framework would be rolled out across the trust. The data quality report (360 report) had also been raised from the previous audit and included data around hospital assisted pressure ulcers and falls and was agreed to be included on the board assurance framework along with the action plan. Mark Day updated about the people committee board assurance framework reflecting the work and how it was progressing. Mark acknowledged that the BAF covered all that was being discussed on the People Committee agendas. Mark has agreed that the links with the BAF could be further developed, and he will take this offline with the Chief People Office. Need to bring out the "so what" now into the BAF, but progress is positive and can be assured of its content still. Mark Bailey provided an update on SA4 for Finance and Performance explaining that it was a live guidance and was observed via the board. The framework was kept up to date, reflects the significant risks, recovery, the recurrent move of the deficit and the Trusts attention on the improvement plan. Issues around getting the recovery back to 104% and other risks that link	

	in. The risks around the operational performance, safety and temporary/agency staff were noted. The BAF does drive the agendas for committees and the papers that go to them.	
	The Committee: - ***Noted and took assurance from the* BAF Update and current position.**	
AR22/07/G2	***Sub-Committees Annual Reports*** The Chair confirmed that all annual reports had been discussed as part of the sub-committee meetings. The People Committee, Quality and Effectiveness and Finance and Performance annual reports were discussed at the sub-committee meetings. The final Audit and Risk annual report would be presented at Board.	
	The Committee: - ***Noted and took assurance from the Sub-Committees Annual Reports***	
AR22/07/G3	***Update to Standing Financial Instructions, Standing Orders and Delegation of Powers*** The Acting Director of Finance explained that the standing financial instructions, standing orders and delegations of power were reviewed annually. A few changes had been made to the report including the changes to Board structure; new recovery, innovation and transformation directorate and the non-executives, this would be interim review and may need to change due to interim positions. A piece of work within procurement and the standing financial instructions and limits have also been changed within the documents. The Company Secretary was reviewing this to ensure it was in line with the DBTH constitution which will go to board in September. Mark Day questioned if it was documented anywhere that the Trust were informed about what was to be added to the financial standards. The Acting Director of Finance referenced that NHS England were mentioned within the standing financial instructions. This would be investigated further to ensure there was nothing else to add. The Chair queried the compliance with the Standing Orders eg and the outcome of the external audit, and it would be presented to the Board in July 2022 via the Annual Report.	
	The Committee: - ***Noted and took assurance from the Standing Financial Instructions, Standing Orders and Delegation of Powers and recommend to Board for approval***	
AR22/07/H1	***Single Tender Waiver Report*** The Acting Director of Finance explained that single tender waiver are only granted in exceptional circumstances now.	
	The Committee: - ***Noted the Single Tender Waiver Report***	
AR22/07/H2	***Losses and Compensation*** The Acting Director of Finance presented the report and explained that there had been a piece of work undertaken to review these losses within the divisions in order to reduce the number of lost items.	

	Details of the losses included in the report, but hearing aids were a common item to go missing. The process review is taking place on this and the loss of patient property procedures to ensure all standards were followed. The Chair asked about the bad debt right off £413,000 and that the cash committee is recommending and that the Cash Committee reports into the Finance and Performance committee, she asked if this an annual exercise based on the "bad debt" rules. The Acting Director of Finance explained that it included in overseas visitor debts and were several years old. He confirmed that this report was acknowledging the amount and any updates would be taken via finance and performance bi-annually.	
	The Committee: - ***Noted the Losses and Compensation Report***	
AR22/07/I1	***Governor Observations*** Dennis Atkin commended staff at Doncaster for wearing face masks as within general practice they aren't required.	
AR22/07/J1	***Finalised papers for Committee to note:*** • Annual Report • ISA260 • Annual Accounts • Data Quality Policy – not discussed as 360 Assurance were required to view first***.***	
	The Committee: - ***Noted the Annual Report, ISA260, Annual Accounts and Data Quality Policy***	
AR22/07/J2	***Health and Safety Committee Minutes April 2022 & Information Governance Committee Minutes April and May 2022*** The Chair would be attending the Information Governance Committee in August and the Health and Safety Committee in October 2022.	
	The Committee: - ***Noted and approved the Health and Safety Committee Minutes April 2022 & Information Governance Committee minutes April & May 2022***	
AR22/07/K1	***Any Other Business*** There was no any other business raised	
AR22/07/K2	***Minutes of the meeting held on 27th May 2022***	
	The Committee: - ***Noted and approve the minutes held on 27th May 2022***	
AR22/07/K3	**Issues escalated from/to:** i) QEC/ F&P/ People Committees – Race equality Code would be presented at People Committee ii) ARC Sub-Committees iii) Board of Directors	

	Kath Smart, Chair		
AR22/07/K4	**<u>Assurance Summary</u>** The Committee was asked if it was assured, on behalf of the Board of Directors on the following matters. Any matters where assurance was not received, would be escalated to the Board of Directors: - Matters discussed at this meeting –Yes except for the risk management paper - Progress against committee associated Executive's objectives – Yes - Any new Emerging risks that have been identified from the meeting? – Audit recommendations		
AR22/07/K5	**<u>Date and time of next meeting (Verbal)</u>**		
	Date: Time: Venue:	**13th October 2022** **09:30** **Microsoft Teams**	
	Meeting Close:	**11:50am**	

Final

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

CHARITABLE FUNDS COMMITTEE

Minutes of the meeting of the Charitable Funds Committee
Held on Monday 20th June 2022 at 13.30 via Microsoft Teams

Trustees:	Mark Bailey – Non-Executive Director (Chair) Suzy Brain England – Chair of the Board Alex Crickmar – Acting Director of Finance Kath Smart – Non-Executive Director	
In attendance:	Richard Parker – Chief Executive Sarah Dunning – Corporate Fundraiser Matthew Bancroft – Head of Financial Control Abigail Trainer – Acting Chief Nurse Zoe Lintin – Chief People Officer Dr Joseph John - Consultant Fiona Dunn – Company Secretary Peter Brindley and Norma Brindley - Executors and Representatives of the Fred & Ann Green Legacy	
To Observe:	Mick Muddiman – Governor	
Apologies:	Jon Sargeant – Director of Recovery, Innovation and Transformation Emma Shaheen – Head of Communications and Engagement Sheena McDonnell – Non-Executive Director Dr T J Noble – Medical Director	
CFC22/06/A1	**Welcome and Apologies for Absence (Verbal)** Jon Sargeant – Director of Recovery, Innovation and Transformation Emma Shaheen – Head of Communications and Engagement Sheena McDonnell – Non-Executive Director Dr T J Noble – Medical Director	
	The Chair welcomed the members and attendees, with a special welcome to Zoe Lintin, Peter and Norma Brindley, Dr Joseph John and new governor Mick Muddiman.	
CFC22/06/A2	**Conflicts of Interest (Verbal)**	
	No conflicts of interest were declared.	
CFC22/06/A3	**Actions from Previous Meeting** Action 1 – Charitable Funds Development Committee - CLOSED The Charitable Funds Development Committee will be run by Abigail Trainer in the future. Items have been separated between patient orientated and staff orientated funding this is shown in B1 and B3.	

	Action 2 – Presentation from Fund-holder on Funded Scheme There was a further presentation regarding refurbishment and creation of a serenity area in the Emergency Department, though due to operational pressures this has been put back. Video will be shared with the operational issues have been resolved.	
	Action 3 – Annual review of Charitable Funds Policy (including Committee Terms of Reference) The Head of Communications and Engagement is to construct suitable wording for including within the Policy around the interaction between DBTH, Charity and external charities. Alex Crickmar stated that he does not think this has been completed but will follow up with Emma Shaheen when she returns from annual leave.	
	Action 4: Review of Expenditure Policy - CLOSED Alex Crickmar confirmed that the review of the expenditure policy had been completed.	
	Action 5: Review Investment Partner - CLOSED Alex Crickmar confirmed that he had contacted the Investment partner to get additional information and advice around the ongoing ethical restrictions. The Investment Partner advised that no investments were to be made where there were sanctions and exclusions stand as before. The Trust is in line with other NHS oganisations	
	Action: Matthew Bancroft would update the Action Log.	**MB**
	The Committee: - ***Noted the updates and agreed as above, which actions would be closed.***	
CFC22/06/B1	**Review of Fund Balances** Matthew Bancroft presented the paper and confirmed the position at the end of May 2022; income was £127,000 and expenditure of £446,000, with a deficit of £319,000 in a two-month period. Most of this has been driven by the work through the Charitable Fund Committee and working on getting fund balances down. Matthew Bancroft asked the committee to note that investments had not performed well in the two-month period. Alex Crickmar confirmed that in terms of the use of Charitable funds the plan is still to utilise the reserves and utilise the funding over a three-year period. Alex Crickmar agreed to bring back to the next committee meeting an update which would show how the charity is progressing this year versus the plan. Mark Bailey stated that appropriate use of funds should go through the Executive Team and is part of the departmental and nursing plans with Abigail Trainer running the sub-committee.	**AC**

	The Committee: - ***Noted the approved update for Fund Balances.***	
CFC22/06/B2	**<u>Approval of Expenditure (Verbal)</u>** <u>International Nurses</u> Alex Crickmar stated that the Trust currently supports international nurses free accommodation for three months when they join the Trust. Alex Crickmar requested a contribution from the committee to fund this and support the nurses settling in as this is over and above what we would normally do as an organisation. The proposal has been discussed at the Executive meeting and CIG, but due to timing a paper has not yet been written. If supported a paper will be written and circulated to the committee outside before the next meeting. Zoe Lintin requested that welcome packs should also be included in the package. Abigail Trainer assured Zoe Lintin that money was utilised to put in welcome packs for all international nurses. Dr Joseph John said that he appreciates the Trust going the extra mile to make the international nurses feel welcome and is sure it will improve retention. Dr Joseph John also suggested that there was a champion for international nurses. Abigail Trainer assured Dr Joseph John that a matron was in post that purely works with international nurses and that there was also an educational support post who has also gone through the process themselves, so they have insight into how the nurses are feeling coming into a different country. There is also a pastoral post, some of which is funded through NHSE but the rest through charitable funds. Richard Parker suggested that there was a twinning arrangement where the nurses were trained as recruitment retention is a key area. Richard Parker suggested that Zoe Lintin, Alex Crickmar, Abigail Trainer and Tim Noble look into this and come back to the next meeting with what a package might look like.	**ZL/AC /AT/ TN**
	<u>Medical Equipment</u> Alex Crickmar advised that in the Medical Equipment Plan which was discussed at Board there were a number of items that could potentially be funded through charitable funds. Alex Crickmar to ask Tim Noble to look at the plan through the Medical Equipment Group in the next few months to highlight what is the potential there. Tim Noble to provide an update at the next meeting.	**TN**

	Corporate Teambuilding Alex Crickmar stated that it had been a challenging few years and would be challenging in the future and that Emma Shaheen and written a paper to boost staff morale and wellbeing. The paper included indicative costs but were hoping for sponsorship or donations where possible. Two of the larger elements in the paper is around teambuilding and the 75th NHS anniversary event, which had large costs attached to them. Alex Crickmar requested that the committee support these initiatives which Emma Shaheen has set out in the paper in improving staff wellbeing. Alex Crickmar assured Mark Bailey that the Trust would ensure it was communicated that the charity had supported the initiatives and it would go through the development committee. Sarah Dunning confirmed that discussions had taken place regarding aligning this with the "We Care" message to make it clear the funds were coming through the charity. Alex Crickmar and Matthew Bancroft to update in future meetings what has been drawn down as a package. The committee supported the proposal.	**AC/ MB**
	The Committee: - ***Noted the update for Approval of Expenditure***	
CFC22/04/B3	**Charitable Funds Development Committee (Above and Beyond Committee)** The paper was presented in the pack. Matthew Bancroft summarised the paper regarding the bids that have come through and the areas that it covers. Matthew Bancroft confirmed that all bids have gone through high level scrutiny to ensure they meet with charitable objectives and the funding is being utilised appropriately. Abigail Trainer to make the process timely to let people know if bids have been successful and if not why they have not been successful. Norma Brindley asked if it could be made clearer which part of charitable funds the money was coming from.	

	Mark Bailey confirmed that the money was coming from general funds and Matthew Bancroft noted any bids that would come out of the Fred and Ann Green legacy as these are controlled funds.	
	The Committee: - ***Noted the Charitable Funds Development Committee Report.***	
CFC22/06/B4	**B4 Update on Developments for Mexborough Site (Verbal)** Alex Crickmar provided an update. There are two main schemes on the Montagu Site; the Montagu elective hub bid, to provide a further modular theatre at the Mexborough site. This will be a cross system scheme with Barnsley, Rotherham and Doncaster patients. The bid is currently in the process of being pulled together. The Trust has had approval to do the business case from the national team and the money is coming through Targeted Investment Funding (TIF), which is a national funding support elective recovery, the planned procedures in terms of recovering waiting list work. The second scheme is further developing the community diagnostics centre at the Mexborough site. Phase 1 has been completed and phase 2 is currently in the national bidding process.	
CFC22/06/C1	**Overview of Current and Planned Fundraising Activities** Serenity Suite Sarah Dunning provided an update and advised the committee that the appeal was going well and over £42,000 has been raised. Sarah Dunning is confident that the £150,000 target will be reached. There is a challenge around the overall costings. Tenders have come back much more than was originally anticipated. £150,000 was initially to cover the suite, a mobile ultrasound scanner for Bassetlaw and refurbishments to the EPA rooms at Bassetlaw and Doncaster. Alex Crickmar stated that the cost could be up to £300,000. Alex Crickmar to discuss with the Estates team why the cost has doubled. Alex Crickmar confirmed that a tender had not been awarded yet due to the level of cost. Suzy Brain-England requested that the proposal would need to be reviewed before agreeing to overwrite £300,000. The committee agreed to overwrite the £150,000 only and a further proposal to be brought back to the next meeting for the further £150,000.	**AC**

	Bassetlaw & Mexborough Sarah Dunning is working with colleagues to do an appeal for each site and working out what Charitable funds can do to support those areas. These appeals have not yet finalised. Mark Bailey requested that something more definitive is provided for the next meeting for both sites.	**SD**
	Recommendations The paper is requesting permission for specialised help for recommendations for the development and strategy of the charity. Richard Parker stated that for a sum of money we would commission that sort of help to advise us in terms of the sustainability and the growth of our work within the NHS charities profile. Money to fund it is from the NHS Charities Together, which have a development grant, therefore there would be £30,000 to support this piece of work which would be beneficial. Norma Brindley advised that when you are going out to external sources you should set a time limit on whether you have had value for money and review whether you feel that the money has been well spent. Mark Bailey asked how the Trustees and this committee would get sight of the spec and the progress and actually sign off on the direction of the charity. Sarah Dunning and Emma Shaheen have interviewed a few consultants and do have a preferred one but can provide the committee with the proposals which have been submitted. Alex said in terms of the spec the outline of the spec is in the paper. The committee will receive an update once the piece of work has been completed, the output from that will come to this committee and will update on progress at each committee meeting. Mark Bailey said that he would like the committee to be engaged in the direction of the charity. Sarah Dunning confirmed that this would be the case and that everyone on the committee would be interviewed by the consultant. This case was supported by the committee.	**SD/ES**
	The Committee: - ***Noted the Current and Planned Fundraising Activities Update.*** -	
CFC22/06/D1	Committee Workplan The committee workplan is provided in the papers. Matthew Bancroft drew the plan together for the year ahead.	

	Mark Bailey stated that discussions from today's meeting would need to be added. Kath Smart asked Matthew Bancroft to look at requirements from a compliance perspective and wrap that up into one of the annual reviews, either the annual report or charitable funds policy and to build into agendas going forward.	**MB**
	The Committee: - ***Noted the Committee Workplan***	
CFC22/06/E1	**<u>Governor Observations (Verbal)</u>** Mark Bailey welcomed Mick Muddiman to the meeting and asked him for his observations of how today's meeting had gone. Mick Muddiman said that he thought it has been quite informative. Mick Muddiman raised a question regarding International Nurses and asked that in the past as part of the induction were the nurses taken around the other sites and some of the areas in Doncaster to see where the actual patients come from. The areas of deprivation and other areas so they get some insight into where the patients live and how the housing standards are. Mark Bailey said that Abigail Trainer would respond to Mick Muddiman separately as this is not part of the charity's role. Suzy Brain-England recommended that at the council of governors, every time they meet, any questions governors ask, written answers are given and tabled on a regular basis. Suze Brain-England requested that Mick Muddiman's question be answered in writing so all governors can view this.	**AT**
CFC22/06/F1	**<u>Minutes of the Sub-Committee Meeting:</u>** <u>Charitable Funds Development Committee (Above & Beyond Committee)</u> To note.	
	<u>Minutes of the Charitable Funds Committee Meeting held on the 24th March 2022</u> Kath Smart made a comment about the minutes on page 2 of 6 regarding the desire to increase the charitable expenditure on staff. Mark Bailey approved the minutes but agreed to look at the above after the meeting.	
	The Committee: - ***Approved the minutes from the Charitable Funds Committee on the 24th March 2022***	

CFC22/06/F3	**<u>Any Other Business</u>** There was no other business.		
CF22/06/F4	**<u>Assurance Summary</u>** The Committee is asked if it is assured, on behalf of the Board of Directors, on the following matters. Any matters where assurance is not received, will be escalated to the Board of Directors. - Matters discussed at this meeting - Progress against committee associated Executive's objectives, - Divisional compliance with the Trust's risk management process.		
	The Committee: - ***Confirmed assurance.***		
CFC21/09/F5	**<u>Date and time of next meeting</u>** Thursday 15th September 2022 Via Videoconferencing Time 13:30		
	Meeting End time	15:10	

DRAFT

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS – PUBLIC MEETING

Minutes of the meeting of the Trust's Board of Directors held in Public on Tuesday 25 October 2022 at 09:30 via MS Teams

Present:	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 Jo Gander - Non-executive Director Zoe Lintin - Chief People Officer Richard Parker OBE - Chief Executive Neil Rhodes - Non-executive Director Jon Sargeant - Interim Director of Recovery, Innovation & Transformation Kath Smart - Non-executive Director	
In attendance:	Fiona Dunn - Director Corporate Affairs/Company Secretary Claudia Gammon – Corporate Governance Officer (minutes) Dr Joseph John - Medical Director for Operational Stability and Optimisation Lois Mellor - Director of Midwifery Adam Tingle - Acting Director of Communications & Engagement	
Public in attendance:	Peter Abell - Public Governor Bassetlaw Henry Anderson - Member of the Public Mark Bright - Public Governor Doncaster Lynne Logan - Public Governor Doncaster Andrew Middleton - Public Governor Bassetlaw Lynne Schuller - Public Governor Bassetlaw Mandy Tyrrell - Staff Governor Sheila Walsh - Public Governor Bassetlaw	
Apologies:	Mark Bailey - Non-executive Director Dr Tim Noble - Executive Medical Director Angela O'Mara – Deputy Company Secretary	
P22/10/A1	**<u>Welcome, apologies for absence and declaration of interest (Verbal)</u>**	
	The Chair of the Board welcomed everyone to the virtual Board of Directors meeting, including governors and the member of public in attendance. The above apologies for absence were noted. No declarations of interest were received, pursuant to Section 30 of the Trust's Constitution.	

P22/10/A2	**Actions from Previous Meetings (Enclosure A2)**	
	Action 1 - Board Assurance Framework – Strategic Aim 1 The action had now been closed. **Action 2 - Impact of Pay Award** The action had now been closed. **Action 3 – Risk Management** The action was not yet due, an update was to be provided at November's Board meeting.	
	The Board: - ***Noted the updates to the action log.***	
P22/10/B1	**Maternity Update (Enclosure B1)**	
	The Board received the Maternity Update, which provided the findings of perinatal deaths, Health Safety Investigation Branch (HSIB) referrals, training compliance, service user voice feedback and compliance in respect of the Clinical Negligence Scheme for Trusts (CNST). The Director of Midwifery summarised the key highlights from the report, noting expectant mothers would be offered whopping cough and covid vaccinations as part of their antenatal care. MAMA (Mums & Midwives Awareness) Academy wellbeing wallets were provided for antenatal notes, which included educational health messages to raise awareness through pregnancy. A trajectory had been set to achieve 90% training compliance by December 2022. The report of the independent investigation into East Kent Maternity Services had been published and would be reviewed by the maternity team to establish learning. Two of the Clinical Negligence Scheme for Trusts safety actions were reported to be at risk. In response to a question from Kath Smart, the Director of Midwifery confirmed an increase in still birth rates had been seen throughout the pandemic, potentially linked to Covid-19. Increased reporting had been seen at a regional and national level and the Trust was not an outlier. The Chief Executive acknowledged the continuing national challenges in maternity services.	
	The Board: - ***Noted and took assurance from the Maternity Update.***	

P22/10/B2	**<u>Learning from Prevention of Future Deaths Report Response</u>**	
	The Chief Executive provided an update on the Prevention of Future Deaths Report (PFD) received from Her Majesty's Coroner in June 2022. The coroner had identified that there were weaknesses in the investigation of the serious incident which occurred at Bassetlaw Hospital in 2018. The Trust had provided a full response to HM Coroner and further work was ongoing to ensure learning was shared and corrective actions identified and implemented. No questions were received in relation to this update.	
	The Board: - ***Noted the Learning from Prevention of Future Deaths Report Response***	
P22/10/C1	**<u>Ambulance Handovers (Enclosure C1)</u>**	
	The Board received the monthly ambulance handover report from the Interim Chief Operating Officer. An Increase of 30% and 40% had been seen at Doncaster and Bassetlaw respectively, in relation to the number of patients brought to hospital by ambulance, who did not require treatment. The Chief Executive noted that percentage rises should be considered alongside the actual numbers which are relatively small. Winter plans were in place to support flow through departments, with the opening of the Clinical Assessment Unit (CAU), Early Assessment Unit (EAU), Ward 22 and additional beds at Montagu. In response to a question from Neil Rhodes with regards to the impact on flow through the hospital and the number of patients brought to the Emergency Department who did not require treatment, the Interim Chief Operating Officer confirmed the data identified an increased number of referrals to hospital, impacted by availability of GP appointments. Work continued with primary care to understand the challenges faced and improve patient pathways. In response to a question from the Chair of the Board regarding patients that required social care, the Chief Executive confirmed that the pandemic had created stress across the system and similar workforce challenges and access to social care were seen by the Trust's partners. Covid-19 levels had risen across the Trust in recent weeks, which had presented an opportunity to understand and test the plans in place for winter. The Interim Chief Operating Officer identified that patients discharged without treatment or intervention at Doncaster often related to physical illnesses, as compared to mental health issues at Bassetlaw.	

	The Board: - ***Noted and took assurance from the Ambulance Handovers Update***	
P22/10/D1	**<u>Q2 2022-23 Update Corporate Director Objectives (Enclosure D1)</u>**	
	The report provided a quarter 2 update in respect of the corporate breakthrough objectives, captured by Monday.com project software. Data and supporting narrative would demonstrate progress against the objectives throughout the year. Kath Smart sought clarification of the status "stuck" relating to the Chief Operating Officer's objective **COO06** *(Develop, agree and implement robust plans to manage winter pressures and enhanced IPC measures),* the Chief Executive confirmed this was terminology used by Monday.com and highlighted the need for further work to progress the action. In respect of the Executive Medical Director's objective **MD08** *(Fully embed the Medical Advisory Committee (MAC) as the vehicle for engagement and communication with the wider senior medical workforce)* it was agreed that a visual to identify the reporting structure of the Medical Advisory Committee and the Risk Management Board would be provided. In response to a question from the Chair of the Board, it was confirmed that the sub-committees of Board would review progress against objectives between the scheduled quarterly Board updates. This would allow assurance to be gained or areas of concern to be highlighted; where a more detailed assessment was required arrangements would be made to support this. Post meeting, the Chair of the Board agreed with the Chief Executive that individual executives would meet with non-executive directors to provide an in-depth insight. In response to a question from Mark Day, the Chief Executive confirmed the quality standards and delivery of elective and emergency care would be subject to careful monitoring. The Integrated Care Board would monitor delivery of robust winter plans against national standards. In response to a question from Mark Day with regards to the appropriate resource to manage winter, the Chief Executive confirmed the aim was to ensure efficient and effective use of the workforce within agreed budgets. Additional beds had been opened earlier than expected and system partners alerted to increased activity levels.	**TN**
	The Board - ***Noted and took assurance from the Q2 2022-23 Update Corporate Director Objectives***	
P22/10/E1	**<u>Annual Emergency Preparedness, Resilience and Response Core Standards Compliance (Enclosure E1)</u>**	
	The Interim Chief Operating Officer confirmed that the national reporting of these standards had been on hold during the pandemic. A self-assessment for 2022/23 had been undertaken and a partial compliance score of 77% achieved.	

	Training for emergency preparedness, resilience and response standards and the evacuation policy were on track for completion in Summer 2023 and would be subsequently presented to the Board prior to submission to the regional/national teams. It was noted that EPRR actions should be incorporates into the corporate objectives, business continuity plans and Divisional and Directors plans. Neil Rhodes reflected on the last two years and the impact of the pandemic and the major incident in the Women's and Children's Hospital and acknowledged the standard secured. The Board confirmed its approval of the statement of compliance and supporting improvement plan.	
	The Board - ***Approved the Annual Emergency Preparedness, Resilience and Response Core Standards Compliance***	
P22/10/F1	**Any other business (to be agreed with the Chair prior to the meeting)**	
	The Deputy Lead Governor shared his support and appreciation of the Foundation School in Health partnership with Retford Oaks Academy. The Trust had been well represented at the recent launch event, with senior colleagues and board members in attendance. The Chair of the Board thanked the Deputy Lead Governor for his support.	
P22/10/F2	**Governor Questions regarding the business of the meeting (10 minutes) ***	
	The following questions were received from governors, presented by the Lead Governor: **Maternity - We note the reset of the trajectory and the improved positions in terms of training. As this is an area that is considered by CQC, if an inspection were to be announced, would this provide any concerns for the trust?** The Chief Executive acknowledged that due to the pressures within Urgent and Emergency Care and Maternity Services the Trust's training figures were not where they needed to be. This had been impacted by recovery responses and the reduction of face-to-face training. The Education Team were working with service leads to review training delivery and a trajectory to achieve compliance by the end of the financial year had been agreed. The People Committee had oversight of this performance. **Handovers - Ambulance handover, delays were typically multi factorial. What collaboration actions were being undertaken by the ICS / ICB and Place in dealing with delays. (It was noted that a full discussion was had on this subject which responded to this question). Is there any data in terms of ambulance diverts? Additional information was a member of the public contacted the lead governor asking why they had been diverted away in an ambulance from their closest hospital at Bassetlaw.** The Interim Chief Operating Officer confirmed that there were policies and procedures in place with both Yorkshire and East Midlands Ambulance Services that when services were challenged contact would be made to divert to the nearest appropriate hospital on the grounds of clinical safety. Data relating to the number of diverts was closely monitored.	

	The Board: - ***Noted the governor observations, question and feedback provided.***	
P22/10/F3	**Minutes of the meeting held on 27 September 2022 (Enclosure F3)**	
	The Board: - ***Approved the minutes of the meeting held on 27 September 2022.***	
P22/10/F4	**Date and time of next meeting (Verbal)** **Date:** Tuesday 29 November **Time:** 09:30am **Venue:** MS Teams	
P22/10/G	**Close of meeting (Verbal)**	
	The meeting closed at 10:45	