Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting Held in Public
To be held on Tuesday 31 January 2023 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 **(no active actions)** *Suzy Brain England OBE, Chair*	*Review*		
B	**PRESENTATION**			**09:40**
B1	Seasonal Communications 2022 *Adam Tingle, Acting Director of Communications & Engagement*	*Note*		15
C	**True North SA1 - QUALITY AND EFFECTIVENESS**			**09:55**
C1	Board Assurance Framework *Dr Tim Noble, Executive Medical Director* *Karen Jessop, Chief Nurse*	*Assurance*		10
C2	Executive Medical Director Update i. Q2 2022/23 Learning from Deaths *Dr Tim Noble, Executive Medical Director*	*Assurance*		15
C3	Chief Nurse Update *Karen Jessop, Chief Nurse*	*Assurance*		15
C4	Infection, Prevention & Control Board Assurance Framework *Karen Jessop, Chief Nurse*	*Assurance*		10
C5	Maternity Update *Lois Mellor, Director of Midwifery*	*Assurance*		10

D	**True North SA2 & 3- PEOPLE AND ORGANISATIONAL DEVELOPMENT**			**10:55**
D1	Board Assurance Framework *Zoe Lintin, Chief People Officer*	*Assurance*		10
D2	People Update *Zoe Lintin, Chief People Officer*	*Assurance*		10
D3	Freedom to Speak Up Bi-annual Report *Paula Hill, Freedom to Speak Up Guardian* *Zoe Lintin, Chief People Officer*	*Assurance*		10
	BREAK 11:25 – 11:35			
E	**True North SA4 - FINANCE AND PERFORMANCE**			**11:35**
E1	Board Assurance Framework *Alex Crickmar, Acting Director of Finance (SA4 Finance)*	*Assurance*		10
E2	Finance Update *Alex Crickmar, Acting Director of Finance*	*Note*		10
E3	Board Assurance Framework *Denise Smith, Chief Operating Officer (SA1/SA4 Performance)*	*Assurance*		10
E4	Operational Performance Update to include Ambulance Handovers *Denise Smith, Chief Operating Officer*	*Assurance*		20
E5	Directorate of Recovery, Innovation & Transformation Update *Jon Sargeant, Interim Director of Recovery, Innovation & Transformation*	*Assurance*		10
F	**STRATEGY**			**12:35**
F1	Research & Innovation Strategy (2023-2028) *Dr Sam Debbage, Director of Education & Research* *Jane Fearnside, Head of Research* *Zoe Lintin, Chief People Officer*	*Approve*		10
F2	Q3 2022-23 Update – Corporate Director Objectives *Richard Parker OBE, Chief Executive*	*Assurance*		10
G	**GOVERNANCE AND ASSURANCE**			**12:55**
G1	Corporate Risk Register *Angela O'Mara, Deputy Company Secretary*	*Review*		5
G2	Chair's Assurance Log i. Audit & Risk Committee ii. Finance & Performance Committee *Kath Smart, Non-executive Director*	*Assurance*		5
G3	Use of Trust Seal *Angela O'Mara, Deputy Company Secretary*	*Approval*		5
G4	Terms of Reference – Audit & Risk & Quality & Effectiveness Committee *Angela O'Mara, Deputy Company Secretary*	*Approval*		5

G5	Management of Reviews, Visits, Inspections and Accreditations Policy *Angela O'Mara, Deputy Company Secretary*	*Approval*		5
H	**INFORMATION ITEMS (To be taken as read)**			**13:20**
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 *Denise Smith, Chief Operating Officer*	*Information*		
H4	Minutes of the Finance and Performance Committee – 27 October 2022 *Mark Day, Non-executive Director*	*Information*		
H5	Minutes of the People Committee – 8 November 2022 *Mark Bailey, Non-executive Director*	*Information*		
H6	Minutes of the Quality & Effectiveness Committee – 4 October 2022 *Jo Gander, Non-executive Director*	*Information*		
H7	Minutes of the Charitable Funds Committee – 15 September 2022 *Mark Bailey, Non-executive Director*	*Information*		
H8	Charitable Funds Committee Annual Report *Mark Bailey, Non-executive Director*	*Information*		
H9	Minutes of the Trust Executive Group – 14 November & 12 December 2022 *Richard Parker OBE, Chief Executive*	*Information*		
I	**OTHER ITEMS**			**13:20**
I1	Minutes of the meeting held on 21 December 2022 *Suzy Brain England OBE, Chair*	*Approval*		5
I2	Any other business (to be agreed with the Chair prior to the meeting) *Suzy Brain England OBE, Chair*	*Discussion*		
I3	Governor questions regarding the business of the meeting (10 minutes) * *Suzy Brain England OBE, Chair*	*Discussion*		10
I4	**Date and time of next meeting:** **Date:** Tuesday 28 February 2023 **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	13:30

***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

An update on Seasonal Communications

Context

- The festive period is often one of the most difficult times for the Trust in terms of activity and related pressures.
- From 1 December to mid-January, the Trust cared for **2,672 more patients** than in the same period in 2021/22.
- Adding these challenges, this winter has seen an increase in nasty bugs and illnesses circulating which has had a knock-on effect in terms of related sickness.
- While most organisations would be looking to wind down for a period, we are a 24/7 service, and as such colleagues must spend a good portion of the season away from friends and family and at work.
- As a result, each December we try our best to help to **improve morale** through a variety of methods and ensure that despite everything, this remains **a special time for Team DBTH**.

Our general approach

- We have expended a lot of effort throughout the past number of years to improve our communications and engagement channels.
- Any efforts to improve morale would be difficult if we did not have a good platform from which to share messaging. At the Trust we are pleased to reflect that we have an extremely engaged team who access a variety of channels:

‘The Hive’

Our internal website which hosts much of our news and other content. Average monthly views of 100,000.

Facebook

The Trust operates internal groups and a public page, which has 6,500 members and 50,000 followers respectively.

Newsletters

We send two newsletters each week with a joint readership of around 4,000 colleagues for an average of five minutes.

DBTH app

Our newest channel – more than 4,500 colleagues have downloaded the app since launch in the summer.

Email

A tried and testing method – we try to minimise all-user emails to a minimum and only use for the most important announcements.

Charitable donations and gifts

www.dbth.nhs.uk

Charitable donations and gifts

www.dbth.nhs.uk

Special visits from VIPs

www.dbth.nhs.uk

Special events

www.dbth.nhs.uk

Special events

www.dbth.nhs.uk

DBTH’s Christmas Crackers

www.dbth.nhs.uk

Richard Parker
12 December 2022 ·

A Christmas gift for Team DBTH

Good evening everybody - it is my pleasure to convey a special message from the Board of Directors tonight.

In recognition of your amazing efforts throughout the past 12 months, we are delighted to announce that **every member of Team DBTH will receive a £25 gift voucher this Christmas.**

This gift is a token of our appreciation and thanks for your hard work across 2022, as well as the weeks to come as we head into the New Year.

The voucher will be del... **See more**

View insights 5.4K post reach

You, Holly Ridgeway-Bowyer, Nick Exley and 787 others 412 comments

Becky Price
11 January at 10:38 ·

Finally used my £25 Vivup voucher, along with 10% Blue Light and got this bargain for £55 @ ASDA

View insights 3.7K post reach

You, Michael Leng and 53 others 15 comments

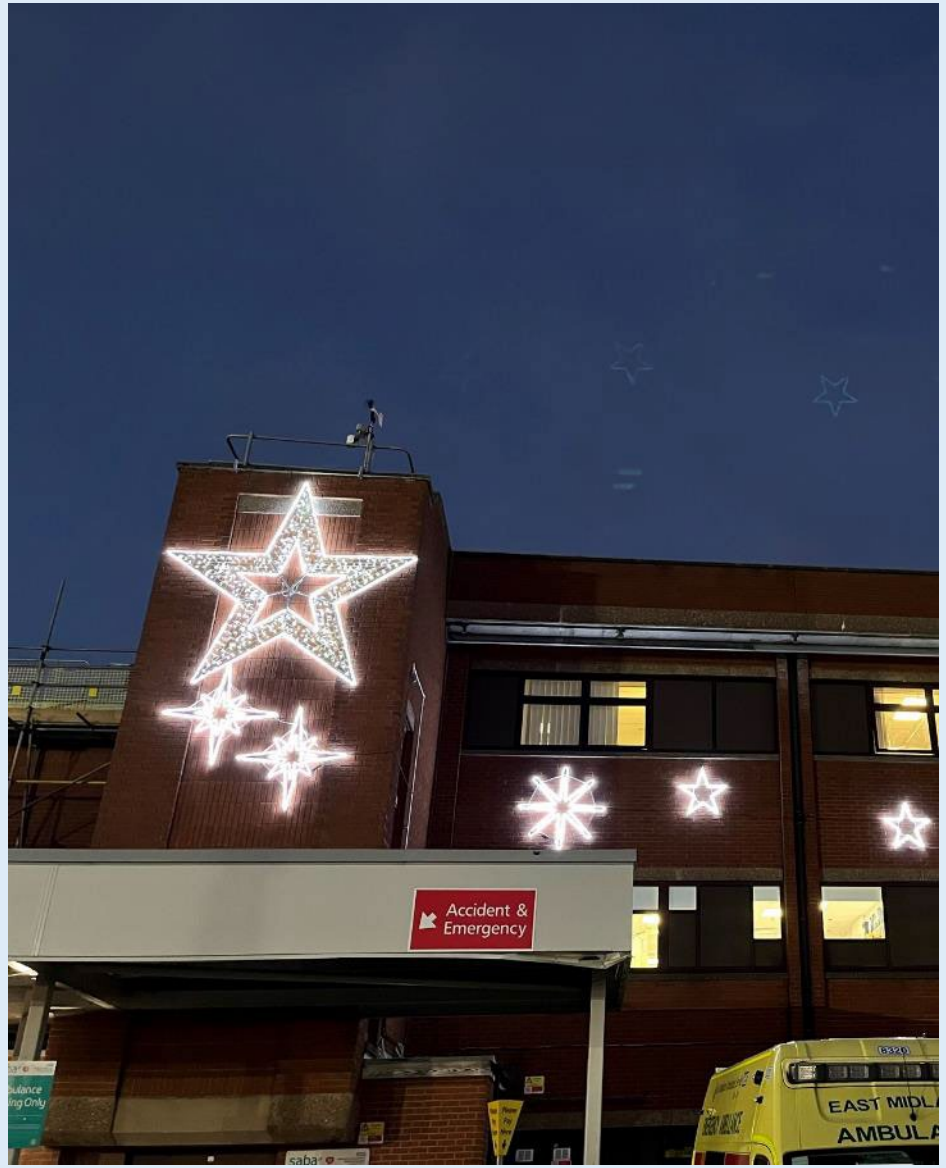
Like Comment Send

£25 gift for all Team DBTH

www.dbth.nhs.uk

Seasonal fayre

www.dbth.nhs.uk



Christmas stars on all sites

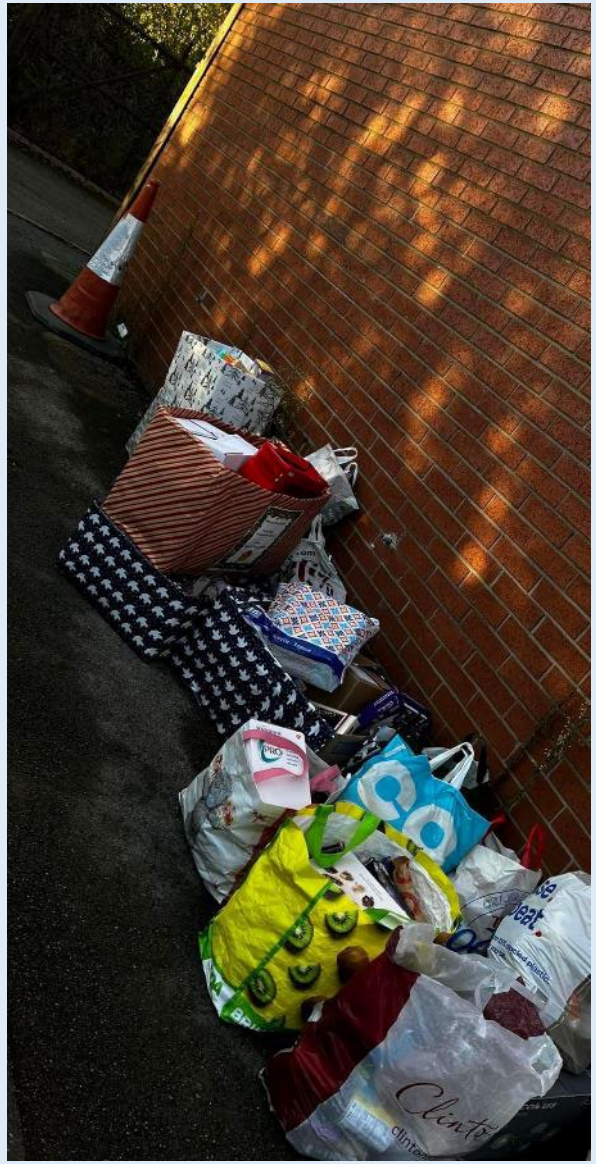
www.dbth.nhs.uk

Festive sock day

www.dbth.nhs.uk

Visiting elves

www.dbth.nhs.uk



Giving to food banks

www.dbth.nhs.uk

Encouraging positive feedback

www.dbth.nhs.uk

A few stats and comments

- Due to the way our communications channels are set-up, much of the content is crowd-sourced, meaning the time impact on the Communications team is minimal.
- **The Trust sent out 22 press releases** outlining positive stories at the Trust.
- Which resulted in more than **30 pieces of positive coverage** in publications.
- From 1 to 31 December, this resulted in reach of **362,377 people**, **55,151 reactions** and **1,211 new followers**.
- In a similar time period, our staff Facebook group saw **724 posts**, **32,428 reactions** and **16,890 comments**.
- Finally, our extranet saw **103,050 unique views**.

Any questions/comments?

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 : January 2023

Strategic Objective
To provide outstanding care and improve patient experience

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

Measures:

- *Implement PSIRF (patient safety incident framework)*
- *NICE – delivery of statutory audits of clinical effectiveness*
- *Continual role out of Tendable – ward / department quality assessment tool*
- *Evidence of "closing the loop", through sharing of learning from incidents and follow up from QI processes*
- *Focus on key safety risks – IPC Outbreaks - waits, falls, milestones set through business planning for each division aligned to the division's breakthrough objectives*
- *Feedback from patients via compliments and complaints, to include learning and engagement with stakeholders*
- *Patient survey outputs and effectiveness of action plans*
- *External review of patient safety and clinical governance which will incorporate patient experience*

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

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

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

Risk ID	Risk Description	Current CRR Risk Rating	Risk Appetite Type	Risk Appetite Level	Target Risk Rating	*Datix Linked Risk ID's*	*Comments*
QEC Risk ID 1517	**Availability and Supplies of Medicines**	***15***	**Qual**	***Open***	***12***		Recommend risk is reviewed at by the Divisional Governance team, to consider whether risk can be reduced.
F&P Risk ID 6&7	**Failure to achieve compliance with performance and delivery aspects of the SOF, CQC and other regulatory standards**	***16***	**Reg**	**Minimal**	***9***		
F&P Risk ID 8 & 16	**Inability to recruit a sufficient workforce and to ensure colleagues have the right skills to meet operational needs**	***16***	**Qual Peop**	***Open***	***8***	***26,2427,2465, 2768,2781, 3043,3104***	

Appendix Level1

QEC F&P 2472	**COVID 19 Pandemic - 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.**	***9***	**Qual Peop Finance**	***Open***	***6***	***2489***	This risk has been reviewed during December 2022 and now has rating of 9 due to the mitigations in place and the declining numbers of patients and staff affected. Therefore will be removed from the BAF unless the risk escalates again in the future.
QEC-PSIRF RISK ID 3112	**Patient Safety Incident Response Framework- compliance with meeting deadline for completing implementation of PSIRF**	***12***	**Qual**	***Open***	***3***		

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. KPMG work complete and business as usual continues through the Outstanding Outpatients forum in terms of ongoing developments, improvements and digital transformation.	September 2022	March 2023	Executive Medical Director and 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-admitted pathways underway within Digital Transformation and operationally, including the development of a patient pathway management system
External peer review of patient safety and governance complete and report received - now aligned to the PSIRF project plan.	November 2022	March 2023	Executive Medical Director and Chief Nurse	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	November 2022	April 2023	Executive Medical Director and COO	Actions & plans in place monitored through Urgent and Emergency Care Programme Board
Action plans to respond to CQC patient surveys	November 2022	March 2023	Chief Nurse and Executive Medical Director	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	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
L2,L3	Ockenden feedback received from the LMNS, action plans developed to achieve 7 key actions	Dec 21	Board	Full	Action plan in place
L1,L2	Updated IPC BAF shared with QEC on the Dec 22	Dec 22	QEC	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**	**Autumn 2022**

Review patient experience strategy and develop work plan for 2022/23	**November 2022**	**Review to commence**	**Chief Nurse**	**January 2023**
~~**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.**~~ **PSIRF implementation Project Management officer identified and first stakeholder Meeting (with TORs) planned for early February 2023**	**January 2023**	~~**Business Case started**~~ Business case for implementation team submitted to January's CIG	**Chief Nurse/Medical Director**	**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.

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:	31 January 2023	**Agenda Reference:**	**C2**		
Report Title:	**Executive Medical Director Update**				
Sponsor:	Dr Tim Noble, Executive Medical Director				
Author:	Julie Butler, Senior Manager				
Appendices:					

Report Summary				
Purpose of report:	To provide a clinical update on the areas within the Executive Medical Director's 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.			
Recommendation:	The Board of Directors is asked be assured by the content of the report.			
Action Require:	~~Approval~~	~~Information~~	~~Discussion~~	**Assurance** ~~Review~~

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

Implications	
Board assurance framework:	*No changes made*
Corporate risk register:	N/A
Regulation:	
Legal:	N/A
Resources:	N/A

Assurance Route			
Previously considered by:			
Date:		**Decision:**	For information and assurance
Next Steps:			
Previously circulated reports to supplement this paper:			

1. INTRODUCTION

This report provides a clinical update from the Executive Medical Director's office, summarising in a structured way key topics within individual Medical Directors and Associate Medical Directors' areas of responsibility.

2. MEDICAL DIRECTOR FOR WORKFORCE AND SPECIALTY DEVELOPMENT

2.1 Workforce

During this period of extreme pressure and staff working in difficult conditions, senior medical staff have been requested to support urgent and emergency care pathways by working differently, such as switching non-clinical activities to clinical where possible, working additional sessions within acute admitting areas, delivering in-reach to Emergency Departments and providing senior decision making for early and safe discharge planning to support patient flow.

Professor Sir Stephen Powis, National Medical Director, NHS England Medical Director, wrote to the profession regarding winter pressures in December 2022. This letter was shared with all senior medical staff and described the need to work differently in such challenging times and provided assurance that:

> *"your professional code and principles of practice are there to guide and support your judgments and decision-making in all circumstances. This includes taking into account local realities and the need at times to adapt practice at times of significantly increased national pressure. In the unlikely event that you are referred to your professional regulator, they will consider the context you were working in at the time, including all relevant resources, guidelines or protocols."*

The Medical Director's team continue to support colleagues through this difficult period and have diverted managerial sessions to more clinical sessions.

2.3 Job Planning

As at 4 January 2023, there were **123 job plans** signed off on the Allocate system, this fluctuates as job plans on the system become due an annual review. Activities to improve the position include:

- Continue to ensure all medical workforce information is accurate and kept up to date
- Group Job planning meetings
- Further discussion/support with individual specialties
- Awaiting the allocation of the new licences

2.4 Workforce Development and Engagement

2.4.1 Clinical Directors Development Workshops

A rolling programme of Clinical Directors' development workshops have been scheduled for 2023, being held on the following dates:

- Tuesday 7 February
- Tuesday 6 June
- Tuesday 12 September

The agenda and format for these sessions are currently being planned, and will include job planning training, leadership behaviours, culture and development.

2.4.2 New Consultant Forum

A New Consultant Forum has been established with the first meeting held in December 2022. These forums will be held three times per calendar year, and developed based on participants' feedback.

2.4.3 Medical Advisory Committee

January's Committee was stood down due to site pressures, as described in section 2.1, and the items will be brought forward to February's meeting for discussion:

- Trust operational pressures, current status and plans
- Introduction from the new Chief Operating Officer
- Update on Virtual Ward Programme

3. MEDICAL DIRECTOR FOR OPERATIONAL STABILITY AND OPTIMISATION

3.1 Getting It Right First Time (GIRFT)

In response to a request from the national GIRFT team, two Trust-wide GIRFT events have been arranged taking place on Tuesday 17 January and Tuesday 31 January. These will be attended by regional GIRFT leads, along with specialty expert GIRFT leads for each area.

The schedule for these events has been finalised, with individual specialties allocated a 50 minute time slot to present the work undertaken following their initial GIRFT reviews and recommendations, share current performance and proposals for future improvements and developments.

The first event received positive feedback from the GIRFT Team, who commended specialties on their enthusiasm and drive and reported that, as a Trust, we were ahead of other organisations in terms of progress made against GIRFT recommendations.

Linked to the GIRFT programme is the **National Consultant Information Programme (NCIP).** This is a resource for the medical profession that reflects practice in each specialty and provides consultants with granular, objective presentation of their activity and outcomes data. Metrics include volume, length of stay or day case rate, mortality and the readmission rate. Other metrics such as re-operation rates, revision rates, complication rates and mortality rates are included for procedures where they are deemed appropriate.

NCIP is prioritising surgical specialties that support elective recovery and NHS Long Term Plan's ambitions for cancer. With the support of the specialty associations, the programme is actively rolling out the following specialties across acute Trusts in England:

- Urology
- ENT
- Neurosurgery
- Oral and Maxillofacial Surgery
- Gynaecology
- General Surgery – Upper GI and Lower GI
- Spinal
- Paediatric surgery
- Thoracic Surgery
- Orthopaedic Surgery

The Medical Director will be working with clinical leads and specialty teams as part of a scheduled enrolment programme.

3.2 Risk Stratification, Clinical Validation and Prioritisation

The Medical Director continues to support the ongoing work around clinical validation, prioritisation, and implementation of a patient pathway management system.

3.3 Virtual Ward (VW)

The Medical Director has established a Trust-wide Virtual Ward Steering Group bringing together a multi-professional group of senior staff, to support the Chief Operating Officer's team in leading the Trust's VW work programme.

There is increased focus on the VW pathways, given the current system pressures being experienced, with respiratory and care of the elderly teams being the first pilot areas testing pathways, systems and support services. Governance around clinical responsibility, escalation protocols, shared records, prescribing, monitoring and patients' management plan decisions are being agreed.

There are established working groups working on specific projects such as IT systems, clinical coding, data flows, governance etc.

4. ASSOCIATE MEDICAL DIRECTOR REVALIDATION AND APPRAISAL

4.1 Appraisal Performance

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 outstanding appraisals that need to be scheduled.

2022	Q4 01/01/22	Q1 01/04/22	Q2 01/07/22	Q3 01/10/22
No of doctors due to hold an appraisal *(Month part of their yearly appraisal date falls in this quarter)*	33	116	95	157
No of doctors with appraisals actually scheduled	43	85	73	145
Total Completed Appraisals	**43 (100%)**	**65 (76.47%)**	**46 (63.01%**	**47 (32.41%)**

Updated 04/01/2023

5. ASSOCIATE MEDICAL DIRECTOR CLINICAL GOVERNANCE/PATIENT SAFETY

5.1 Clinical Governance Review

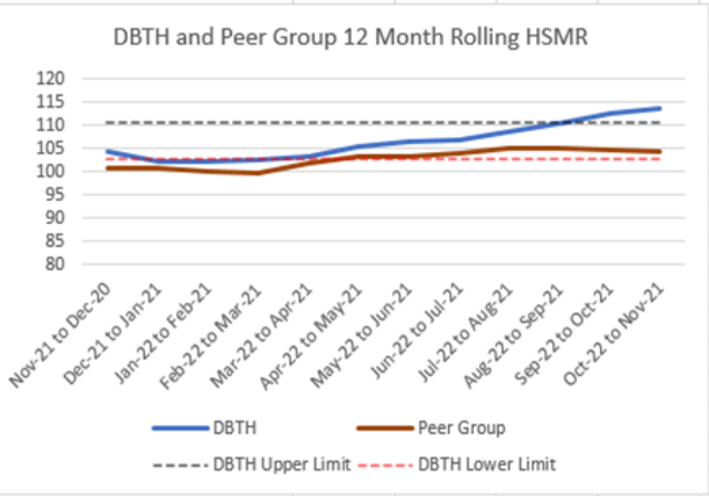
The revised clinical governance framework, which has already been approved and ratified by the Board of Directors and its sub-committees, will be formalised and implemented alongside the wider Patient Safety Incident Response Framework and recommendations from the Mason-Higgins external peer review.

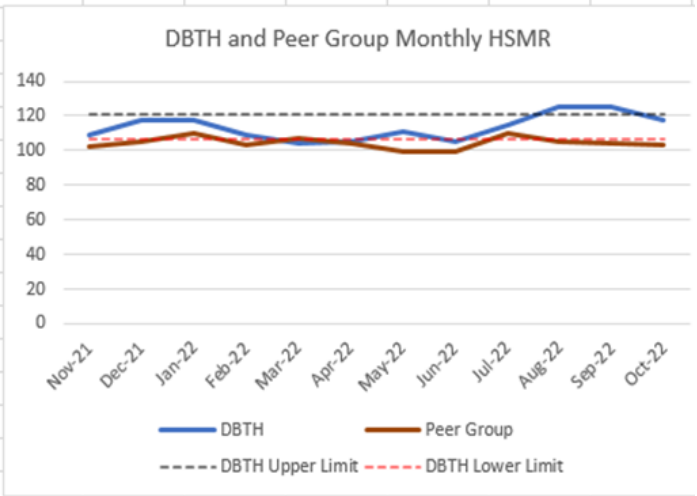
The MD team are working closely with the senior nursing team to support this project moving forward with a business case being developed for change delivery.

5.2 Hospital Standardised Mortality Ratio (HSMR) & Summary Hospital-Level Mortality Indicator (SHMI)

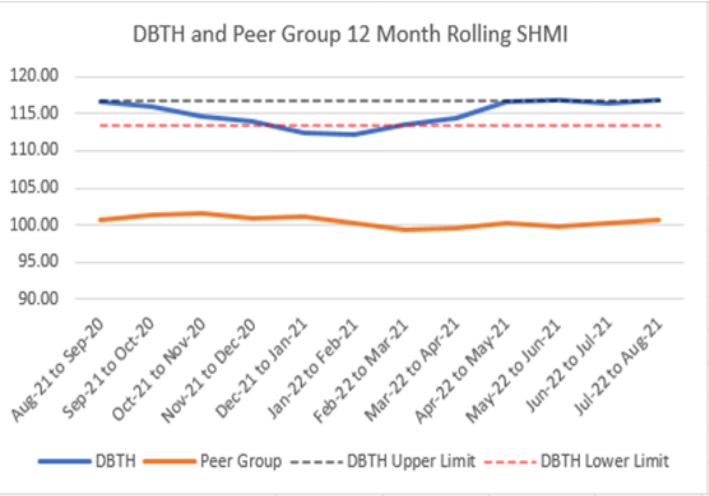
As previously reported, nationally mortality is increasing and Trust performance on HSMR and SHMI rates continue to show an increasing picture.

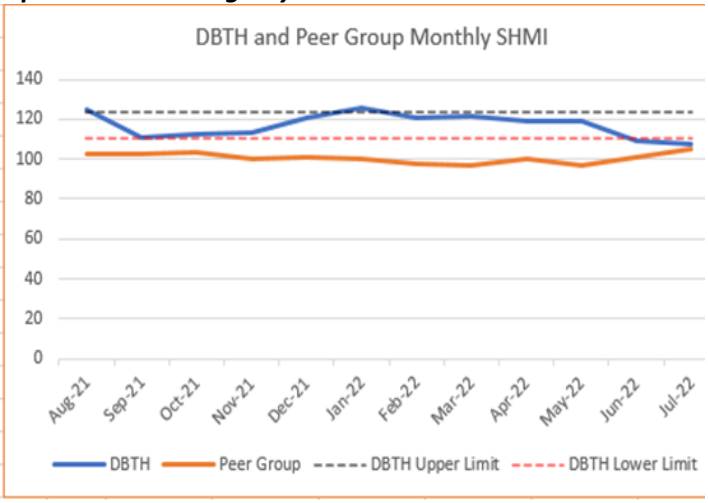
HSMR Monthly and Rolling 12 month average Reports, up to and including October 2022





SHMI Monthly and Rolling 12 month average Reports, up to and including July 2022





Top 5 cause of death recorded as 1a on MCCD in December 22

	Cause	DRI	BDGH	Total
1	Pneumonia	54	8	62
2	Cardiac related	14	7	22
3	MOF	15	6	21
4	Metastatic cancer	12	5	17
5	Sepsis	6	2	8
				130

Looking at the rolling 12 month report, the elevation of the HSMR is consequence of the increased monthly figures being reported since April and given the increased number of deaths in December, both the monthly and rolling 12 monthly HSMR are expected to go up.

The Trust Mortality Governance Group has acknowledged that these figures represent an uncomfortable trend which, although not necessarily related to the quality of our care, now deserves a more in-depth analysis. As part of the MD team investigation, a multi-professional working group has been established and work has commenced on quality assurance of the Medical Examiners work including the Structured Judgement Review process, as well as benchmarking coding practices across peers, impact of pathway changes and particularly learning from Trust where rates have improved and who benchmark well.

This will be a time-limited investigatory process, with a 3 month timescale, which will report to the Board of Directors via the Clinical Governance Committee.

5.3 Organ Donation and Transplantation

The Trust were commended by the Director of Organ and Tissue Donation and Transplantation, on behalf of NHS Blood and Transplant, on its organ donation and transplantation activity as well as quality of care in organ donation.

A full report on the work of the Organ Donation Committee and the Trust's performance in light of the new Deemed Consent Legislation for England will be presented to the Board of Directors through the Clinical Governance Committee and Quality and Effectiveness Committee.

5.4 Risk Management Board

The Trust's Risk Management Board is now established in line with internal audit recommendations and currently Chaired by the Executive Medical Director.

The Terms of Reference have been signed off including purpose of the group and its membership. The meetings are held monthly on the third Monday of the month.

The new Risk Systems Manager is now in post and is supporting the Board and the actions from its meetings. The main actions from the previous meeting:

- Trust Risk Register – ongoing review of all risks scored 15+, checking risk owner, mitigations, and score using standardised descriptors for consistency.
- New risks scoring 15 and over will be presented to the Risk Management Board, as well as those that cut across a number of areas which divisions cannot mitigate in isolation and/or need executive support.
- Risk Systems Manager to develop risk management training, learning from other areas, such as the Estates team risk assessment e-learning package.

The governance process for any items requiring escalation will be via the Trust Executive Group.

6. MEDICAL EXAMINER UPDATE

6.1 Medical Examiner (ME) update and scrutiny of all non-coronial deaths

The Medical Examiners continue to review 100% of all adult deaths in the Trust and highlight the identification of any potential care issues, led by Dr Ruth Medlock, Chief Medical Examiner.

Following a visit on the 11 November, by the National Medical Examiner, the team received excellent feedback on the systems and process in place to ensure 100% compliance with the scrutiny of all acute adult deaths.

In terms of extending scrutiny to the community, the National ME acknowledged that the team were all prepared and awaiting the digital infrastructure and contract agreements to be finalised to provide the necessary access to the GP systems, Systmone and EMIS. This step is time critical in order to ensure processes are in place to facilitate the work of medical examiners by 31 March 2023.

Implementation work is progressing internally and externally with Doncaster and Bassetlaw Places and system suppliers to ensure that by March 2023, the ME system is in place to scrutinise all community deaths, as per the new legislation effective 1 April 2023.

7. EXECUTIVE MEDICAL DIRECTOR'S CLOSING SUMMARY

This report summarises the extensive work on going to help support and shape the direction of the Trust.

7.1 Enhanced genome sequencing for hospitalised patients returning from China

A Public Health alert has been received and circulated by Dr Ken Agwuh, concerning the identification and management of Covid-19 patients who have travelled from China.

Action for Healthcare professionals:

- For patients presenting with COVID-19 symptoms compatible with SARS-CoV-2, identify whether travel from China has taken place in the preceding 14 days
- If so collect a specimen for PCR testing if individuals have symptoms compatible with SARS-CoV-2
- Include China travel details on SARS-CoV-2 PCR request forms/ electronic requests
- Alert your NHS laboratories when sending a PCR swab for SARS-CoV-2 from patients presenting to healthcare settings within 2 weeks of arrival from China, particularly if they are presenting with severe illness.

Labs are asked to:

- Ensure there are clear local arrangements, reflecting this update in guidance, for testing and sampling of suspected SARS-CoV-2 cases and identifying a relevant travel history
- Identify swabs from patients presenting to healthcare settings within 2 weeks of arrival from China and send these swabs to UKHSA labs for expedited sequencing
- Please label with travel history to allow rapid sequencing in UKHSA labs

7.2 Increased Covid/Flu/Viral Infections

At the present time there are significant numbers of patients presenting with influenza A and patients with covid. Some of the patients with influenza are particularly sick and there are pressures on isolation facilities in the Trust.

7.3 Closing Remarks / Summary

These continue to be very challenging times for the NHS and for DBTH, teams are working hard to provide care to the people we serve, despite the on-going difficulties. We remain hopeful that circumstances will be improving throughout 2023.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	31 January 2023	**Agenda Reference:**	**C2i**
Report Title:	**Quarter 2 2022/23 Learning from Deaths Report**		
Sponsor:	Dr Tim Noble, Executive Medical Director		
Author:	Julie Butler, Senior Manager		
Appendices:			

Report Summary	
Purpose of report:	This is a synthesis of the Quarter 2 (2021/22) Learning from Deaths report in accordance with the National Guidance on Learning from Deaths (March 2017).
Summary of key issues/positive highlights:	• There has been an increase in the number of deaths from 505 in Q1 to 519 this quarter. • There are more than 100 more deaths compared with the Q2 report from 2021. • The Medical Examiner team continue to scrutinise 100% of all non-coronial adult hospital deaths and are preparing for the statutory change in April 2023 to scrutinise all non-coronial community deaths. • In Q2, 15 structured judgement reviews (SJR) were requested. • There were 2 deaths of adult patients with learning disability and the SJR process concluded that the care episodes received by the patients were good.
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 - November 2022 Quality and Effectiveness Committee – December 2022
Date:	December 2022	**Decision:**	For information and assurance
Next Steps:		Presentation to Board of Directors	
Previously circulated reports to supplement this paper:			

1. INTRODUCTION

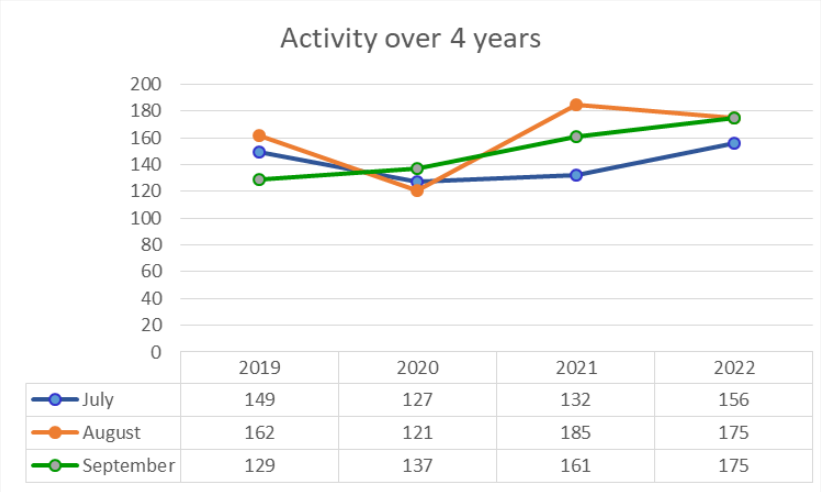
This is a synthesised version of the Quarter 2 2022/23 Learning from Deaths Report. The full report was presented to the Trust's Clinical Governance Committee in November 2022 and to the Quality and Effectiveness Committee in December 2022.

A quarterly report on Learning from Deaths has been produced since April 2017, in compliance with the March 2017 National Guidance on Learning from Deaths. The report is received by the Trusts Clinical Governance Committee and then by the Quality and Effectiveness Committee.

The Learning from Deaths Nurse (LFD) has been in post since May 2022, with the aim 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'.

2. OVERVIEW OF ACTIVITY

In quarter 2 there have been a total of 519 Trust deaths compared with 505 deaths in quarter 1. This an increase on the previous quarter and an increase on the death figures compared with this time last year.



	2019	2020	2021	2022
July	149	127	132	156
August	162	121	185	175
September	129	137	161	175

3. MEDICAL EXAMINER TEAM

The introduction of Medical Examiner (ME) teams is part of the Department of Health and Social Care's death certification reforms programme for England and Wales and will be a statutory requirement for all Trusts by April 2023.

The ME team currently scrutinise 100% of all acute adult deaths, and preparation work is progressing well with Doncaster and Bassetlaw partners and system suppliers to ensure that by March 2023 the ME team have systems and process in place to scrutinise all adult community deaths, compliant with new legislation effective 1 April 2023.

4. 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. The result is a relatively short but rich set of information about each case that can be aggregated to produce knowledge about clinical services and systems of care.

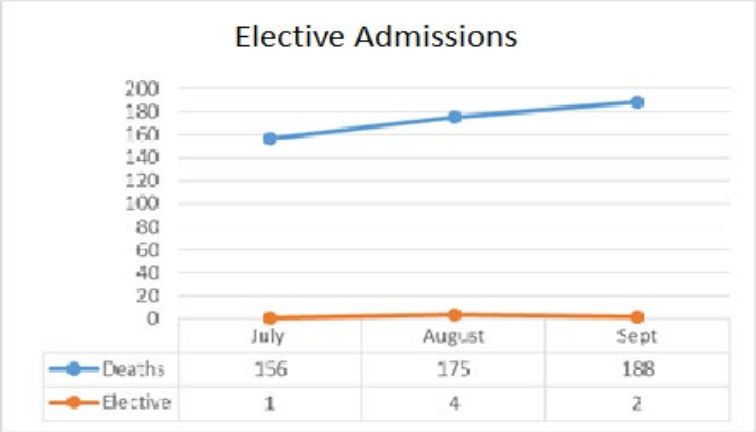
With the inception of the ME team it was identified that the National ME service suggested that SJR's should be requested in the following circumstances:

- Elective admissions
- Patients with a Learning Disability and significant mental health issues /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, 15 SJRs have been requested.

5. ELECTIVE ADMISSIONS

There were 7 elective admissions resulting in death this quarter. It is apparent that in almost all of the recorded elective deaths, these are not typical elective admissions. Most are urgently planned admissions for symptom control in a patient with a terminal illness.

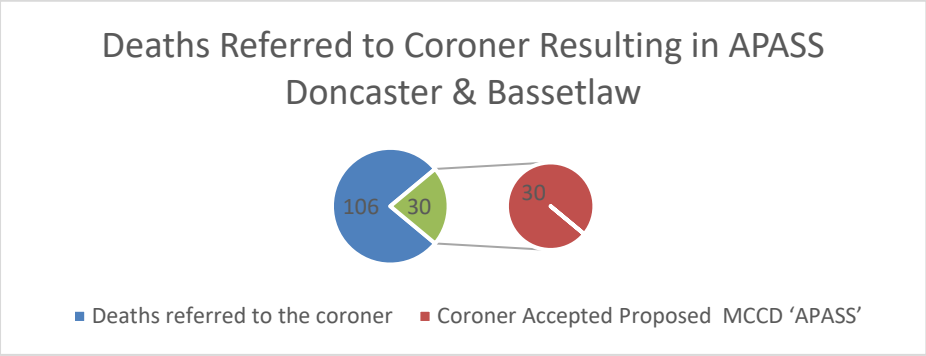


6. LEARNING DISABILITY DEATHS

The Trust experienced 2 deaths of an adult patient with a learning disability this quarter, and 1 recorded in the previous quarter. The SJR process highlighted that the care received by the patients was good. No deaths were recorded of a patient with a documented diagnosis of autism.

7. 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. This quarter, Coroner's referrals have increased slightly.



8. CAUSE OF DEATH AND HOSPITAL STANDARDISED MORTALITY RATIO (HMSR)

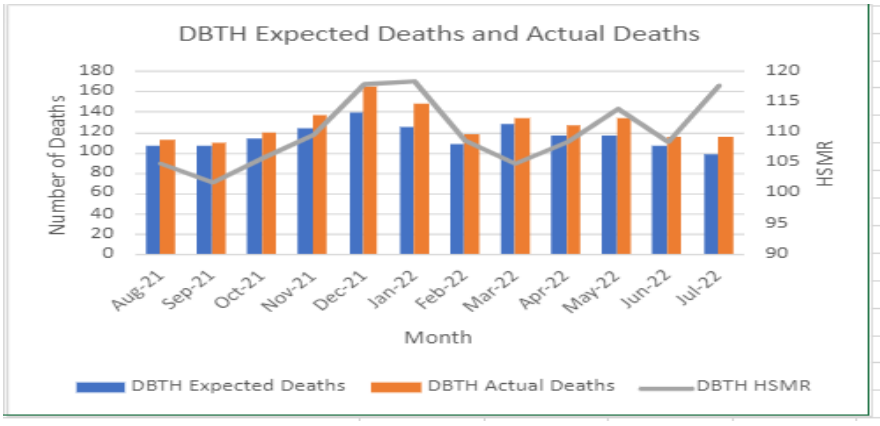
The top 5 causes of death as stated on 1a) of the Medical Certificate of Cause of Death (MCCD):

	From MCCD	Count
1	Pneumonia	121
2	Metastatic Cancer	47
3	Cardiac Related	46
4	Multi Organ Failure	29
5	Sepsis	18

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 admission diagnosis)
J181	J181: Lobar pneumonia, unspecified	59
A419	A419: Sepsis, unspecified	30
I500	I500: Congestive heart failure	29
U071	U071: Emergency use of U07.1	25
J690	J690: Pneumonitis due to food and vomit	22



9. LEARNING

All compliments or concerns, which families discuss with either MEO's or bereavement team, are highlighted to the LFD nurse to be analysed and acted on accordingly.

10. BEREAVEMENT TEAM

The Bereavement team continue to aim 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. To help with this expectation the bereavement manager has been attending the daily medical doctor's handover at 0830hrs which has had a positive impact.

There have been 3 deaths registered by the Trust with no recorded next of kin. These are dealt with by the local authority.

11. RECOMMENDATIONS

To Ensure 100% MCCD's are available to the registrar within 3 days
Process for timely returns of SJR
Introduce the scrutiny of non-acute adult deaths
The Board, via the Quality and Effectiveness Committee, to receive this report for assurance of the ongoing work to improve mortality review and the learning across the organisation.

12. CONCLUSION

Areas of learning are raised with the clinical governance teams, individual practitioners or ward teams. Any potential serious incident or potentially avoidable death has been reported via Datix and alerted to the patient safety team. The ME team has been recognised by the regional and national medical examiner's office as performing extremely well.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	31 January 2023	**Agenda Reference:**	**C3**
Report Title:	**Chief Nurse Update**		
Sponsor:	Karen Jessop, Chief Nurse		
Author:	Kirsty Clarke, Acting Deputy Chief Nurse Simon Brown, Acting Deputy Chief Nurse		
Appendices:	None		
Report Summary			
Purpose of report:	To provide an update to the Trust Board of Directors on key items in relation to the Chief Nurse portfolio.		
Summary of key issues/positive highlights:	The paper outlines the October and November outcomes in relation to the key patient safety measures identifying areas of good practice and improvement in: • Falls prevention • Prevention of hospital acquired pressure ulcers • Infection prevention and control The report also details any reportable serious incidents. 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 based on November and December, highlighting the mitigations in place and the future developments to support safety. **<u>Key Points</u>** The PSIRF implementation programme now has project management support and the first stakeholder meeting is planned during January 2023. The corporate nursing team supported a “Just Culture” event delivered by the Chief People Officer. There were 6 serious incidents reported during October and November, the details are contained within the report. The Falls team have joined a National QI project called the “reconditioning games” with a key focus of supporting patients to “Get up, Get dressed and get moving. The Hospital Acquired Pressure Ulcer reduction objective is on trajectory to achieve a 20% reduction across the Trust on Category two and above HAPUs. The Trust remains within agreed thresholds for infection prevention and control in relation to Clostridium Difficile, E Coli and MRSA bacteraemia.		

	The total care hours per patient day (CHPPD) in November was 7.85, there was a slight reduction in December to 7.66 hours which is reflective of increased capacity opened to support winter. The Chief Nurse is holding a series of divisional establishment reviews over the course of January in line with the requirements of the Developing Workforce Safeguards (NHSI 2018). Recruitment of Internationally Educated Nurse continues as per the agreed plan.				
Recommendation:	To note and take assurance				
Action Require:	Approve	**Information**	~~Discussion~~	**Assurance**	~~Review~~

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

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

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

Chief Nurse Report - January 2023

Introduction
This report provides the Trust Board of Directors with an update on the key issues, challenges and relevant information with regard to the Chief Nurses areas of responsibility

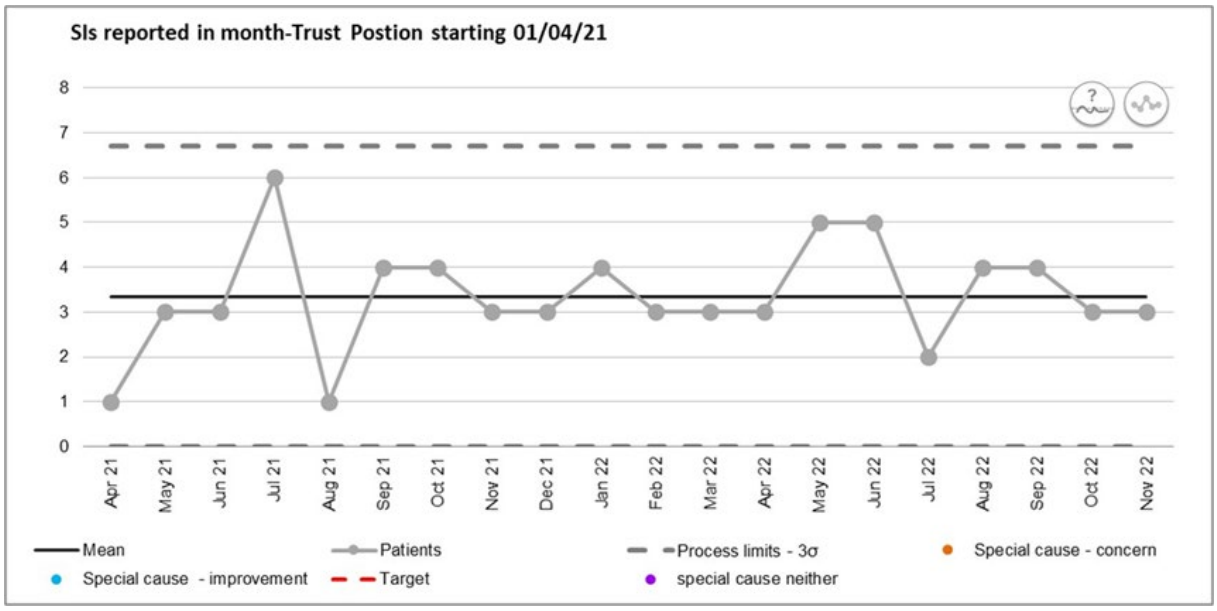
Patient Safety Incident Response Framework (PSIRF) Implementation
The Patient Safety Incident Response Framework (PSIRF) was published on 16 August 2022, it is a major piece of guidance on how NHS organisations respond to patient safety incidents and ensure compassionate engagement with those affected. All providers contracted under the NHS standard contract are required 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 was presented to QEC in December 2022 and a project manager to support PSIRF implementation has been identified. Key members of the recommended PSIRF stakeholder implementation panel have been identified (both internal and external to DBTH) and the first meeting to progress the workplan will be held in January 2023. The Corporate nursing team contributed to the delivery of a "Just Culture" event delivered by the Chief People Officer, establishing a Just Culture is one of the key principles of PSIRF implementation.

Patient Safety Reporting

Serious Incidents
There were six serious incidents logged across October and November. These relate to:

- Failure to refer to MDT & Follow-up
- Transfusion wrong blood product
- Multi factorial suboptimal care
- Ophthalmology; treatment delay after urgent referral from optician
- Suboptimal care
- Unexpected death, multiagency involvement, cause of death complications of anorexia nervosa.

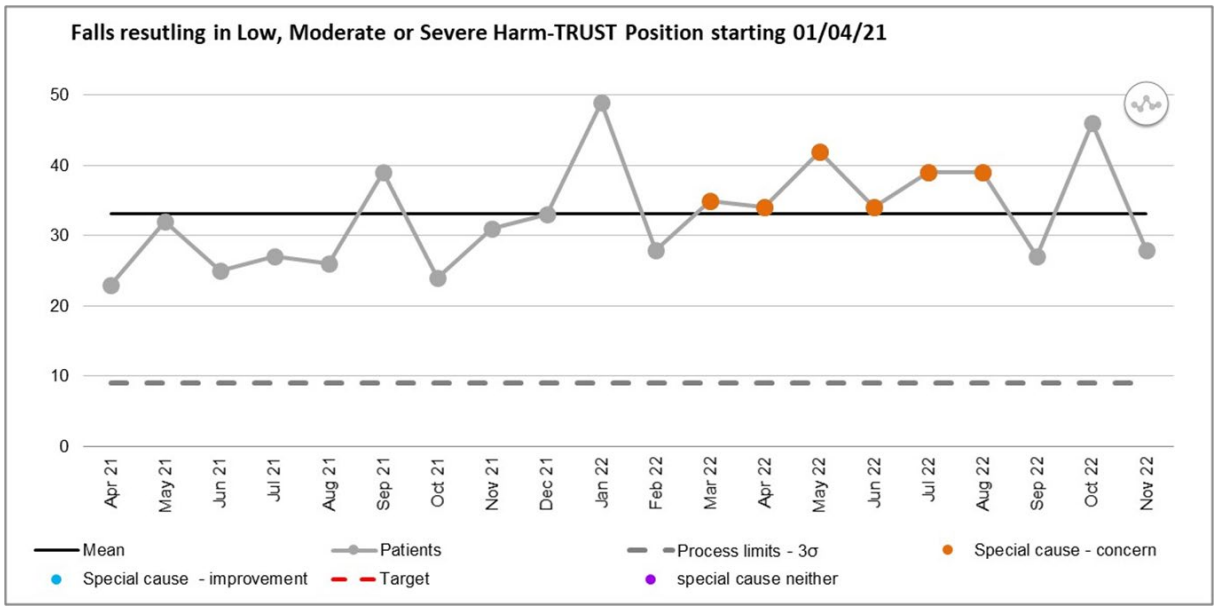
29 Serious Incidents have been identified and reported to date for 2022-23.
Year to date for comparison in 2021-22 the number of serious incidents reported was 25, for the same reporting period.



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

Falls
There were 161 falls in October and 133 in November. 215 resulted in no harm and 96 in low harm.

There were seven moderate harms, and four severe harms throughout October and November.



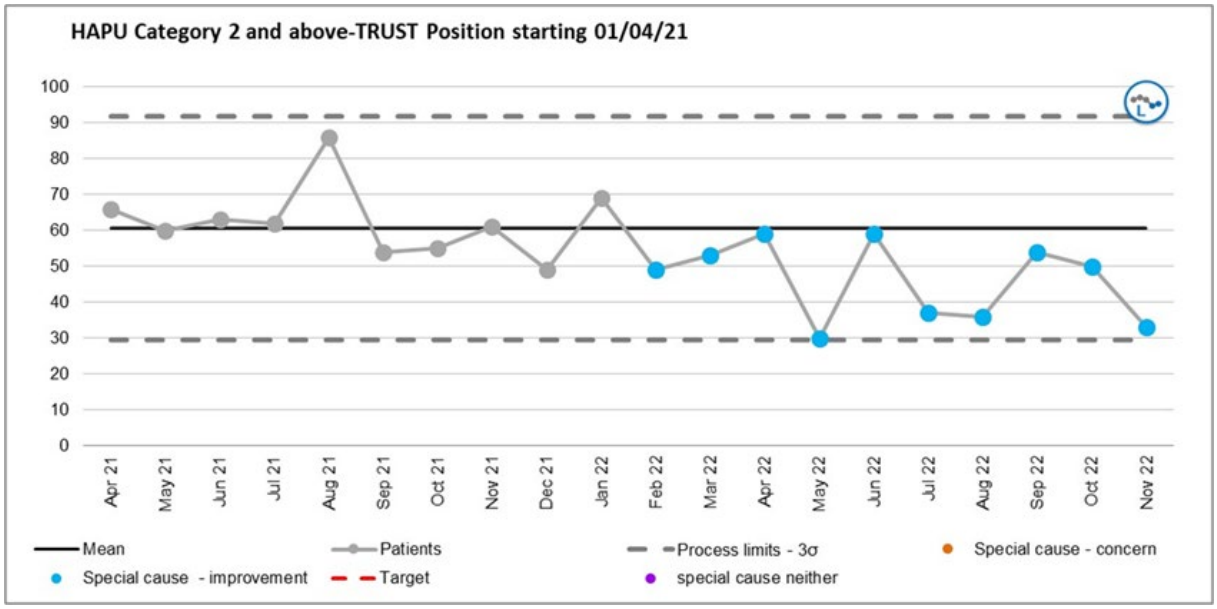
TENDABLE audits in October and November demonstrated improvement in the falls and enhanced care question sets in October and November with a positive score of 96% and 98% respectively compared to 95% on previous monthly audits. This visual assessment audit focuses on the 5 principles for falls prevention.

The falls team are commencing Quality improvement work on specific ward areas where fall numbers are high. Falls research supports the fact that the best method for reducing falls in the acute inpatient setting is promoting safer patient mobility and an MDT approach. The falls team have registered with NHS England for the QI project called the reconditioning games, the key focus of which is Get up, get dressed, and get moving.

A falls task and finish group to make changes to the current investigation processes following harm and to explore ways to improve learning commenced in November. This work is also aligned with the exploration stage of PSIRF implementation.

Hospital Acquired Pressure Ulcers (HAPU)

There were 63 HAPU's in October and 41 in November. This has affected 83 patients in total. Of these patients, zero were classified as category four HAPUs, seven were category three HAPUs and eight were unstageable HAPUs.



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.

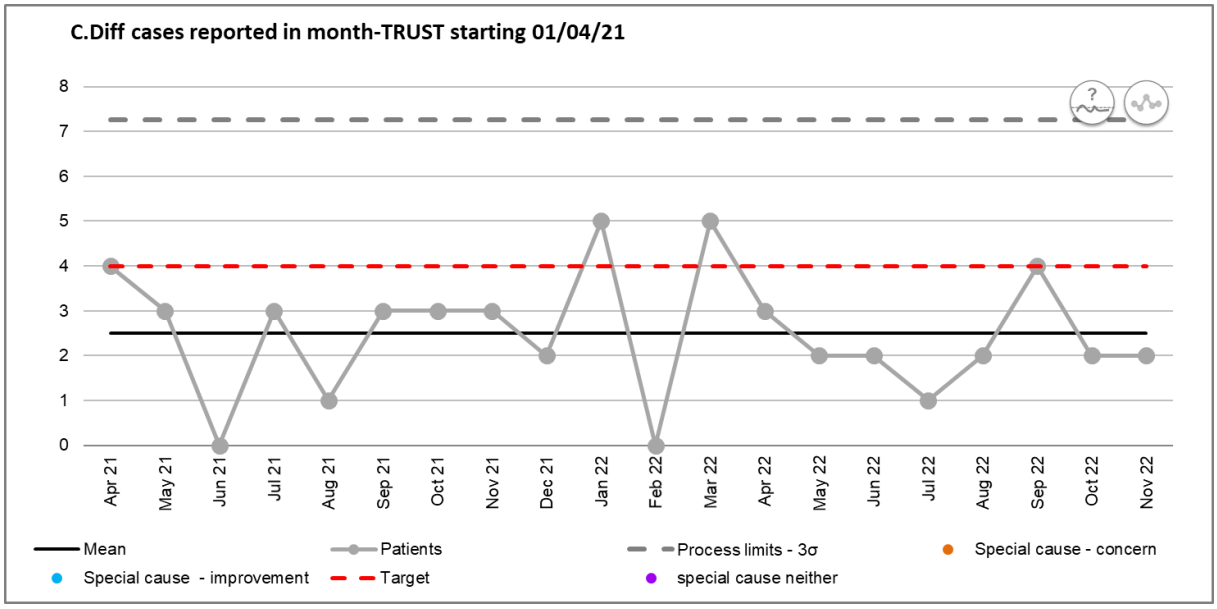
The Skin Integrity Team continue their quality improvement programme with the aim of achieving a 20% reduction across the Trust of category two and above HAPUs by the end of March 2023. The Trust remains on target with this trajectory.

TENDABLE audits in both October (94.7 %) and November (97.5%) show an improving compliance with patients in our care having an accurate turn frequency assessed and receiving the required turn and reposition schedule.

Infection Prevention and Control (IPC)

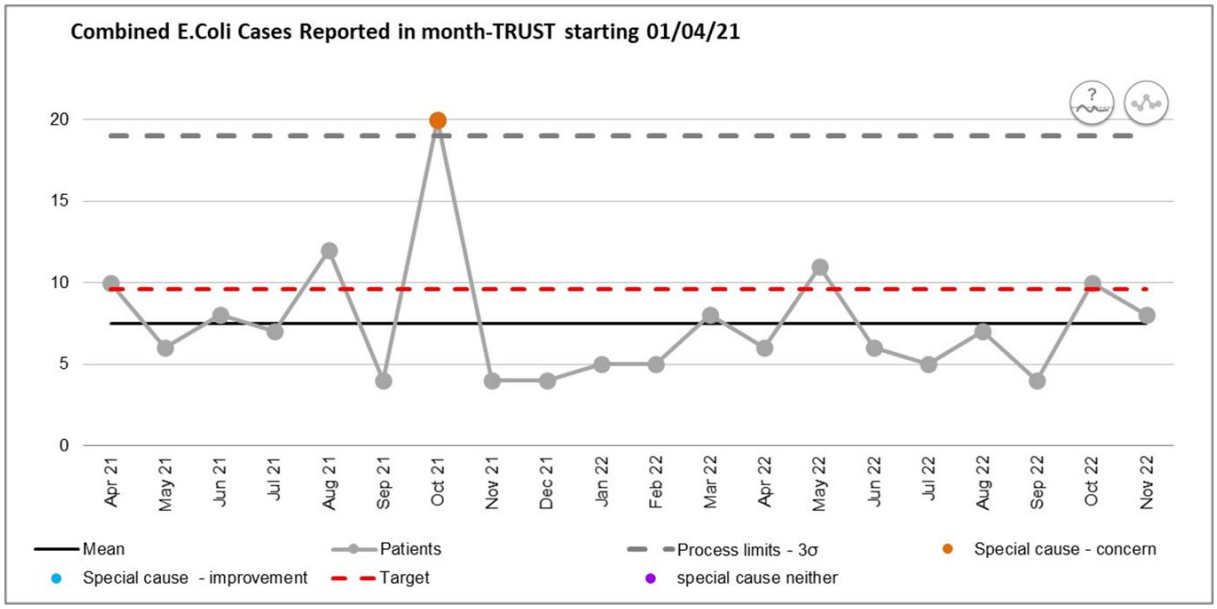
Clostridium difficile (C.diff) There were three cases of Clostridium difficile in October and two in November. Four of these were Hospital Onset, Hospital Associated (HOHA) infections, and one was Community Onset, Hospital Associated infections (COHA).

The total number of cases of Clostridium difficile for the financial year is 23, against a trajectory of 48.

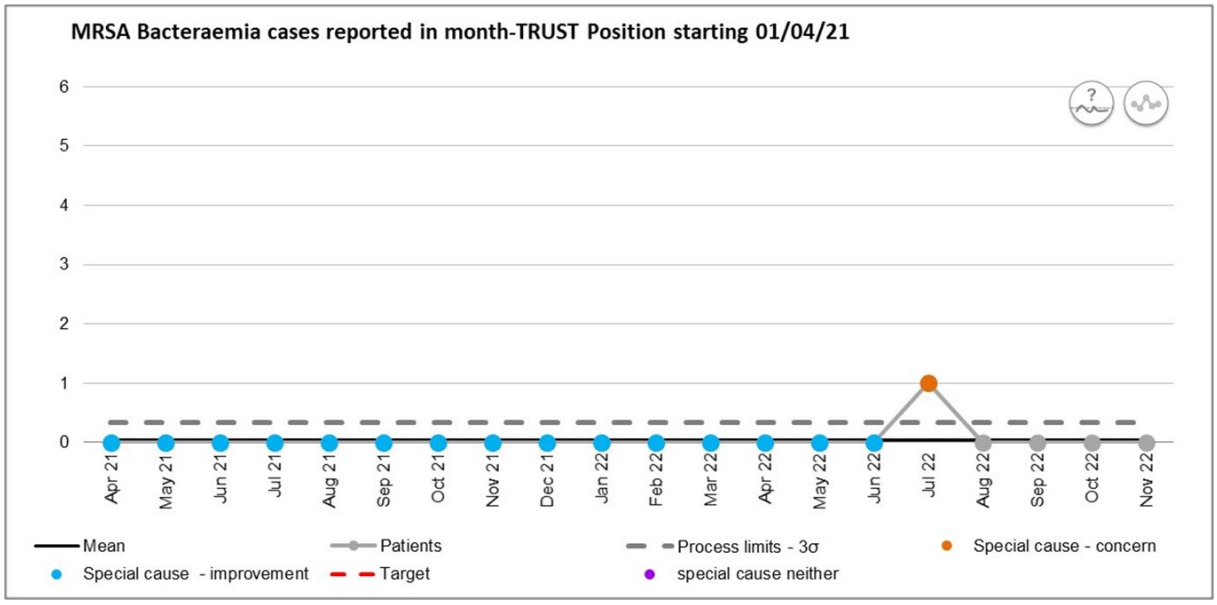


E-Coli bacteraemia: In October there were nine cases and November eight cases of E-Coli bacteraemia reported. Twelve cases were classed as Hospital Onset, Hospital Associated and five were Community Onset, Hospital Associated (COHA).

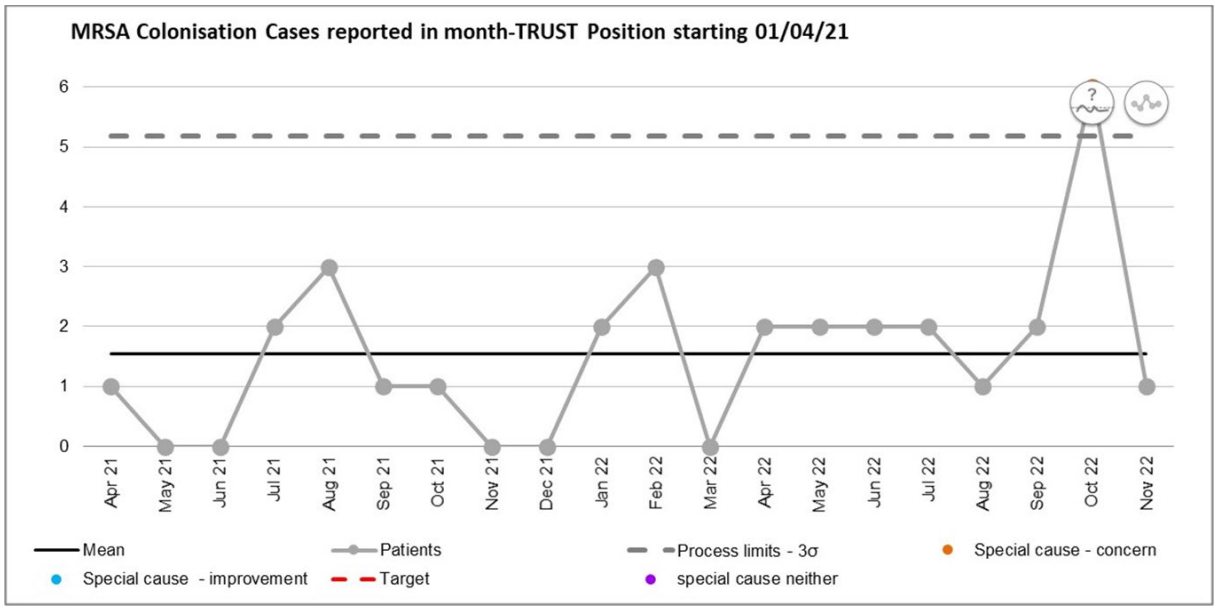
The total for the year to date is 48 against a trajectory of 87.



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



MRSA colonisation: There were six cases reported in October and one in November. This is a total of 18 cases year to date 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 remain positive the average for October and November being 99%. The assessment reviews hand hygiene before contact (99%), between tasks (97.8%), and after contact (99%). The area of focus required for all teams is identified as “between tasks”.

A revised infection prevention and control board assurance framework was received from NHS England at the end of September. This was presented to the Quality and Effectiveness Committee in December.

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.

At November's PSRG, learning was shared from an incident which resulted in hypoxic ischemic encephalopathy, following a difficult and prolonged birth. The learning themes identified included documentation, escalation and CTG training. The action plan for this has been completed and a documentation audit was conducted. The audit is now carried out on a monthly basis and the results are presented at the audit meetings, any issues identified are then acted upon accordingly. Further learning identified included a required change to labour guidelines and further CTG training developed and additional mandatory training (full day) CTG training session was implemented. Compliance for both of these is monitored by specialist foetal monitoring leads.

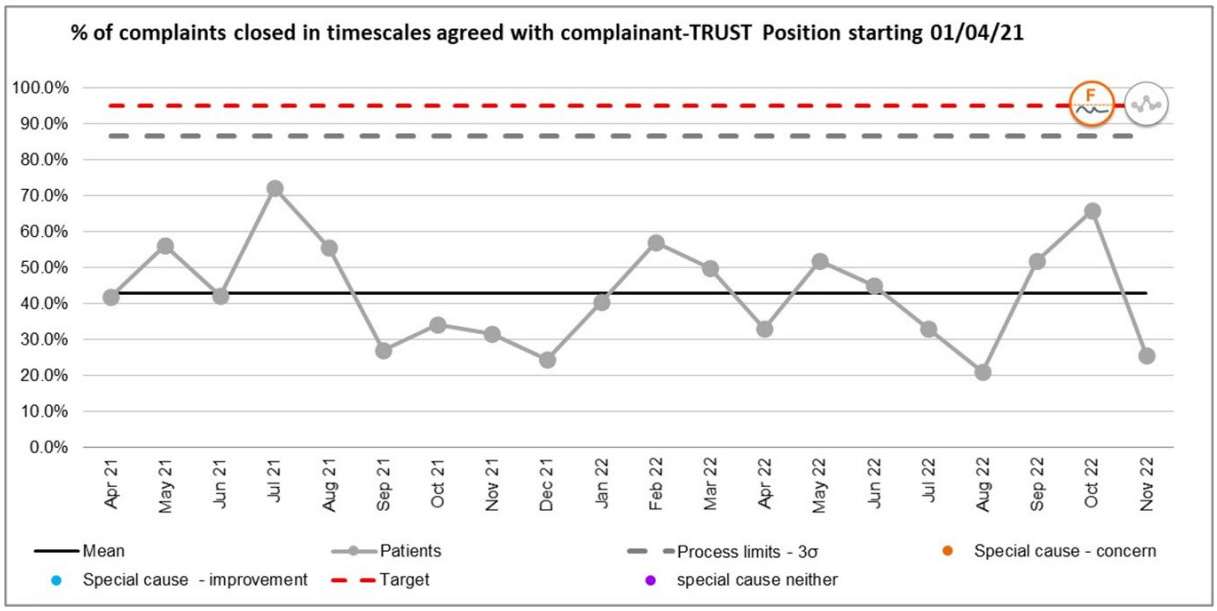
Patient Experience

Complaints
In November the number of formal complaints received was 50 a reduction from 66 in October.

The number of (informal) concerns registered were 123 which was an increase compared to October (95).

Compliance with acknowledging formal complaints within 3 working days is 98% which is consistent with previous months.

The number of complaints closed in November was 67 with a total of 37% meeting the timeframe for closure. There continues to be significant operational pressures which had a significant impact on complaints resolution performance in November.

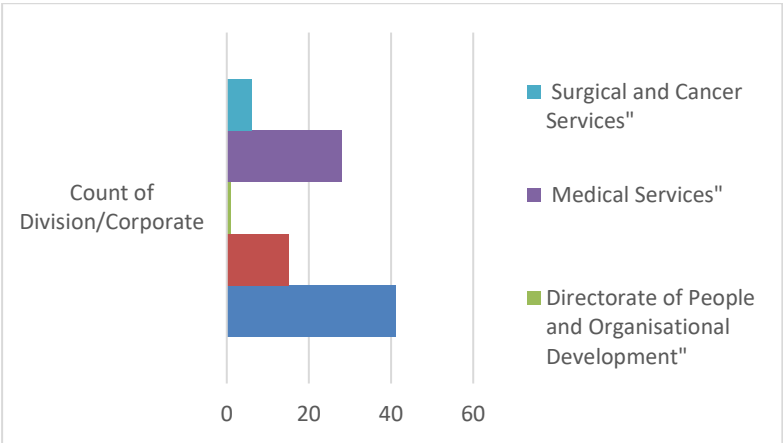


The Top 5 complaint themes for November are detailed in the table below.

Complaint Theme	Number of complaints received
Appointments Cancelled/delayed	64
Values and Behaviours	51
Diagnosis (tests, delays and missed)	40
Patient care	38
Communications	31

In November we have had 3 contacts from the PHSO all of which are requesting information to be provided prior to a decision being made about the intent to investigate. All information was provided within the timescales requested

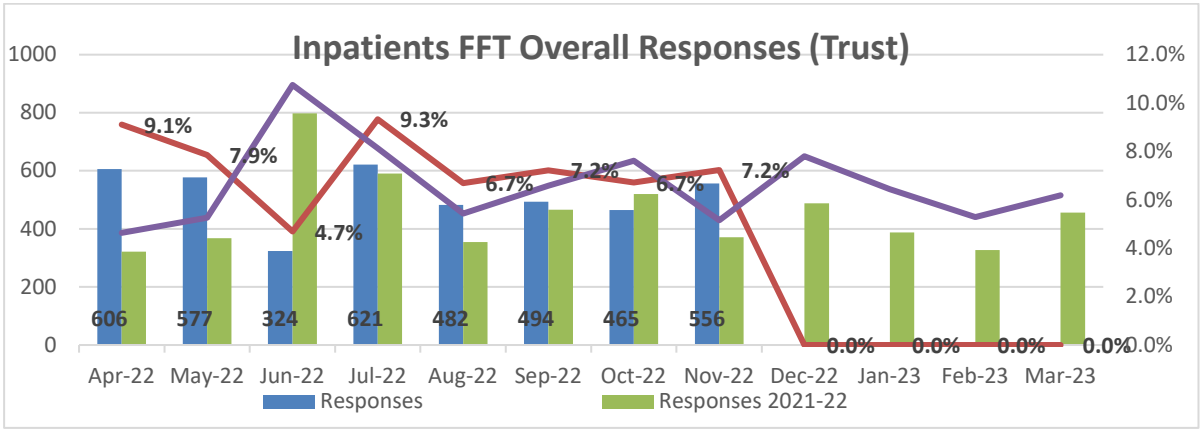
Compliments

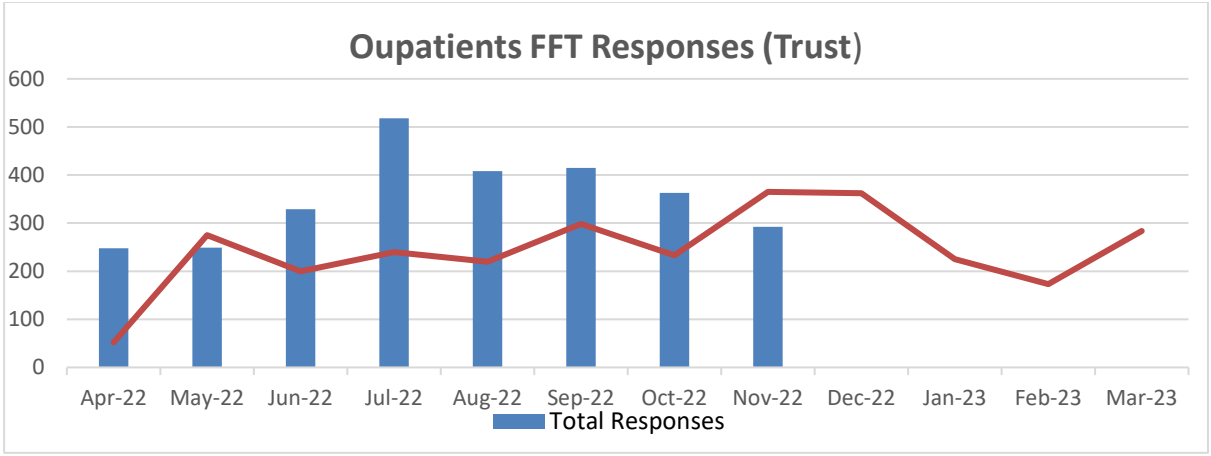


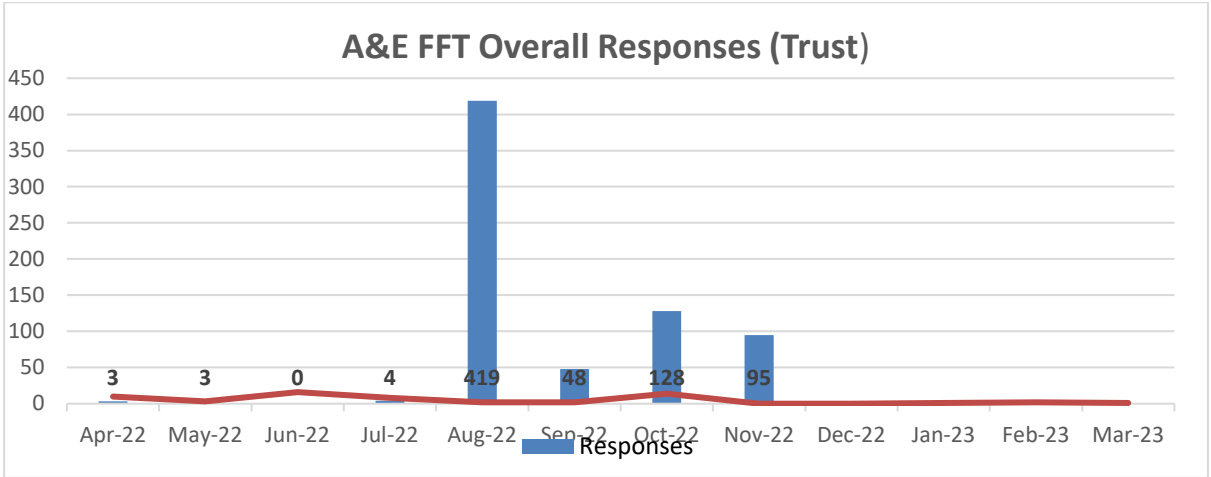
The majority of compliments received are collated by the ward staff. PALS currently upload FFT card comments received from the wards / departments.

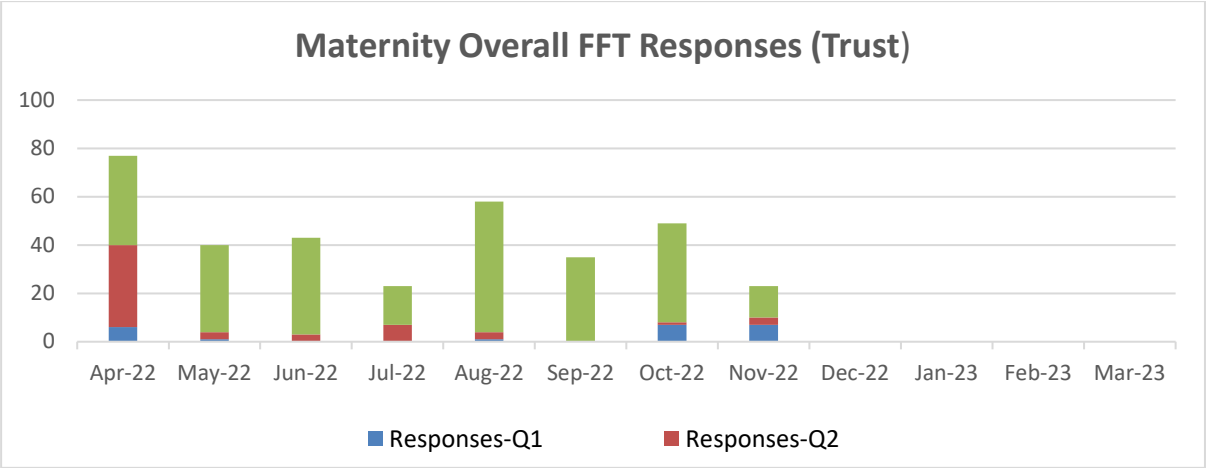
Friends and Family Test (FFT)

In November there was a 7.2% inpatient response rate to FFT. Of those patients who responded, 86.2% of inpatients rated their care as very good and 11.5% as good. Of the attendances in outpatients, almost 99% of attendees rated their care as very good or good. In maternity – (birth) just under 86% of patients rated their care as very good or good. Maternity (care on a postnatal ward) almost 93% of women rated their care as very good or good. A&E over 83% of patients 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 November 2022 and December 2022.

November 2022 data submission
There were 41 inpatient wards open throughout November 2022. Due to increased demand on emergency pathways and the requirement to maintain elective flow a number of areas utilised bed capacity above the usual funded bed base.

21 (51.2%) wards were on green for planned v actual staffing, 5 (12.2%) wards were on amber for being 5% under planned v actual staffing (A5, C1, 24, DCC, B6/ESSU).

9 (21.9%) wards were red for being 10% under planned v actual staffing (AMU, 22, 21, ITU, NNU, M1, CDS, A4, and A2). Ward B5 had approximately 8 additional beds in use across November to support medical emergency flow. Mallard and S11 reported increased enhanced care requirements above the usual funded establishment.

Care hours per patient per day November 2022 are detailed below:

CHPPD	RN (Actual)	HCA (Actual)	Reg NA (Actual)	Non Reg NA (Actual)	Total (Act)
BDH	5.27↑	3.37↑	0.05↑	0.14↑	8.84
DRI	4.29↑	3.27–	0.11↓	0.12↓	7.79↑
MMH	2.38↑	3.28↓	0.15↓	0.00	5.80↓
Total	4.33↑	3.29↑	0.11	0.11↓	7.84↑

(Arrows indicate change from October 2022 data submission)

December data submission
There were 42 inpatient wards open throughout December 2022. This includes the reopening of the Children's ward on the Doncaster site, in line with the Paediatric winter plan.

13 (30.9%) wards were on green for planned v actual staffing, 7 (16.6%) wards were on amber for being 5% under planned v actual staffing (1&3, SAW, S12, CCU/C2, ATC, Ward 20, G5).

16 (38.1%) wards were red for being 10% under planned v actual staffing (S10, Haematology, A2L, CDS, M1, C1, Ward 22, NNU, CHW, ITU, A4, AMU, B6/ESSU, Ward 21, Ward 24, A5). B5

Care hours per patient per day December 2022 are detailed below:

CHPPD	RN (Actual)	HCA (Actual)	Reg NA (Actual)	Non Reg NA (Actual)	Total (Act)
BDH	4.53↓	2.84↓	0.09↑	0.13↓	7.59↓
DRI	4.40↑	3.16↓	0.13↑	0.16↑	7.85↑
MMH	2.47↑	3.26	0.14	0.00	5.87↑
Total	4.29↓	3.10↓	0.13↑	0.14↑	7.66↓

During December 2022 in addition to utilising Ward 22 as a winter capacity contingency on the Doncaster Royal Infirmary site, additional beds were in use on B5 at Bassetlaw to support emergency pathway flow. All Orthopaedic elective activity was moved to ESSU and B5 provided a bed base for emergency trauma repatriation and emergency medicine purposes.

Towards the end of December further closed beds were opened to support with emergency pathway flow across all Trust Sites:

Site	Additional Beds open
BDGH	21 beds
DRI	10 beds
MMH	10 beds
Total	41 beds

These beds were opened on established wards and risks associated with increased staffing requirements were mitigated through utilisation of temporary staffing resources including bank and agency.

Temporary Workforce solutions
During December 2022 incentives were utilised to support delivery of safe staffing across Paediatrics, Maternity and Adult Inpatient areas and mitigate risk contributed to by seasonal staff absence increases, increased demand on services (including additional bed and discharge lounge capacity) and underlying vacancy. Plans are in place to continue these arrangements during the winter period, with monthly reviews scheduled to review the ongoing requirements.

Safer Nursing Care Data
DBTH uses the Safer Nursing Care Tool (SNCT) as a NICE endorsed evidence-based decision support 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 use 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 a small number of the ED senior nursing team have completed the training and assessments required to utilise the tool. Further training to provide a wider DBTH ED faculty to undertake the assessments is planned for February 2023 with the National SNCT team. Data collection for ED has been deferred until April 2023, by which time a larger cohort of senior staff will have completed the required Shelford ED SNCT training, which will support more effective and accurate data collection processes to be embedded and undertaken.

This data, when triangulated with professional judgement and local intelligence helps the Divisional Directors of Nursing (DDoN) and Head of Nursing (HoN) to review the ward establishment and agree the skill mix and required establishments for each area with the Chief Nurse (CN) and in collaboration with matrons and ward / dept. managers. The Chief Nurse is undertaking formal establishment reviews with each Divisional Director of Nursing, the acting deputy Chief Nurse, finance colleagues and the Erostering team in January 2023. This will establish the baseline for future reviews and is a requirement of the Developing workforce safeguards (NHSI 2018).

The latest data collection for Adult and Paediatric inpatient areas was undertaken in November / December 2022. The data is currently being validated and initial feedback at ward manager / matron sessions reflects a more accurate data set collection. The November SNCT data is currently being analysed and collated, following which this will be discussed with the Chief Nurse and a report shared through the relevant Trust committees.

Vacancy position Nursing & Midwifery
The Corporate Nursing team are progressing work to enable future reports to include the overall vacancy position for the Midwifery and Nursing workforce. Further work to agree correct budget lines and confirm staff position numbers is ongoing to support this.

International Nurse Update
DBTH continues with the recruitment of internationally educated nurses to complement our existing workforce. In addition to the planned recruitment of 70 RNs (adult) and 5 RNs (paediatric)s 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
11 - arrived Nov	13 adult 5 paediatric
12 - arrived Jan 23	12
13 - arrive Mid Feb	12 - note this off plan due to visa issues

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 this has started to impact on the first time pass rate which does impact on the period of time the recruits are unable to work within the Registered Nurse establishments.

Safe Care

Daily safe staffing meetings
The embedding of daily staffing meetings has continued at DRI / MMH with all inpatient areas and ED now attending daily meetings Monday to Friday. Weekend Safe Staffing processes are currently being refined with Matrons and the Trust Safe Staffing lead and will be finalised across January 2023.

The safe care pilot using the Allocate system is rolling out across January at Bassetlaw Hospitals and planned to be out of the pilot phase by mid-February 2023. All other areas will continue using manual data collection and processes until the roll out is complete.

The work stream continues to report through to the Trust Quality Strategy Group and by exception to the Quality and effectiveness committee.

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 provide key pieces of information for the 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

Registered nurse development
The Royal College of Nursing Staff leadership programme is on plan to offer two further programmes across March 2023. In total DBTH will have supported 90 staff nurses through the RCN leadership programme during 2022/2023. A benefits realisation appraisal of the external programme is planned for March 2023.

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

Following a hiatus of recruitment to PNA training programmes over the December to March period, adverts and engagements processes are underway to secure PNA programme places across 2023/2024.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	31 January 2023	**Agenda Reference:**	**C4**
Report Title:	**Infection Prevention and Control – Board Assurance Framework**		
Sponsor:	Karen Jessop, Chief Nurse		
Author:	Simon Brown, Acting Deputy Chief Nurse		
Appendices:	IPC BAF		
Report Summary			
Purpose of report:	This report provides an update on self-assessment of compliance against the national IPC BAF.		
Summary of key issues/positive highlights:	The BAF provides evidence of compliance with the majority of indicators in addition to the gaps in assurance and mitigating actions. The key assurance gaps to highlight are detailed below: Section 2 (pg 8) Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections - We are not currently compliant with the National Standards of Healthcare Cleanliness (2021), DBTH are compliant with the 2007 standards. The Trust applied for a derogation from the timeline for compliance until April 2023. A business case is being developed to request funding for the additional resources required to be compliant. However, we have systems in place for managing the gap in addition to policies and procedures in place detailing roles and responsibilities for cleaning. Section 2 (pg 9) Not all ventilation systems comply with HBN 03:01 and meet national recommendations for minimum air changes. Mitigations are in place and capital monies have been identified to improve ventilation. Section 3 (pg 10) Existing arrangements for antimicrobial stewardship (AMS) are maintained, however there are gaps in antimicrobial pharmacy establishment. Section 10 (pg 24) A sustainable fit testing programme is not in place for those who may need to wear respiratory protection. There are no premises available on site at the moment to provide Fit testing routinely. Education team provide some Fit Testing to students/learners based on risk assessment. FIT testing is now mandatory as part of EPRR core standard 12. There is no resource to meet the standard. A paper is being prepared for further discussion and is being led by the trust EPPR lead in conjunction with the COO.		

Recommendation:	To note and take assurance from the content of this report and the recommendation that the ongoing operational monitoring of the IPC BAF is via the Infection Control Committee with assurance monitored by QEC				
Action Require:	~~Approve~~	**Information**	~~Discussion~~	**Assurance**	~~Review~~

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

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

Assurance Route			
Previously considered by:	Quality and Effectiveness Committee		
Date:	December 2022	**Decision:**	Approved and assured.
Next Steps:	Monitor via Infection Control Committee		
Previously circulated reports to supplement this paper:	None		

Infection Prevention and Control board assurance framework

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

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure that: • A respiratory plan incorporating respiratory seasonal viruses that includes: ○ point of care testing (POCT) methods for infectious patients known or suspected to have a respiratory infection to support patient triage/placement according to local needs, prevalence, and care services	Point of care machines are available at front doors (ED – both sites, SAW, AMU, ATC, FAU) and in some areas where a positive respiratory illness may impact individual patient care and the care of others, for example, Endoscopy, Theatre Admission Unit, ESSU, Rockingham day unit. Point of care testing is in place in Paediatrics (NNU, SCBU) testing for COVID and RSV. The machines are also used to support visiting where required. All machines have been updated with new software to allow for combination testing, for COVID 19 and Influenza using one swab. Up until this current software update, separate swabs have been required to test for separate pathogens. Point of Care testing is used to support timely discharge to social care facilities. PCR is the gold standard within 48 hours before transfer to a social care facilities. If results are awaited for discharge, the Point of care testing machines are used to attain a result within 20 minutes and to support timely discharge. The IPC team have employed support staff to test patients in the community to facilitate appropriate placement. For example, due to the need for a		

	PCR to be taken within 48 hours of admission to a social care facility, service users who may be in crisis in the community who would otherwise present to ED and be admitted to DBTH are tested in the community so that they can go directly to social care placement where appropriate to do so. The IPC team will attend the service user's home, take a PCR swab (if admission to social care placement is planned) within 48 hours. If the admission to a social care facility is an emergency, the IPC team will attend the service users' home to complete a PCR, they would also take a swab, return to DBTH and run a Point of Care test, providing a COVID status within twenty minutes and facilitating transfer directly to social care rather than to DBTH. The IPC team also provide the same service to facilitate movement of service users between social care placements should this be required (eg. when a home cannot meet the service users' needs and a swift movement based on safety is required). All patients who present to ED with Respiratory symptoms are tested via PCR for COVID-19, Influenza A, Influenza B and RSV. All patients for admission, whether they have respiratory symptoms or not, are tested via the point of care test for COVID-19.		
○ Segregation of patients depending on the infectious agent taking into account those most vulnerable to infection eg. Clinically immunocompromised.	Work has been completed in ED to put glass doors (rather than curtains) on cubicles so that they can be used to segregate those with infections or those who are more at risk of contracting infectious pathogens.		

	Any patient suspected or confirmed as having an infectious illness is segregated at the earliest opportunity from those not confirmed or suspected of having an infectious illness.		
○ A surge/escalation plan to manage increasing patient/staff infections.	For COVID-19 there are yellow and blue patient pathways. Blue is for patient who are not confirmed or suspected of having COVID-19. Yellow pathway is for patients who are suspected or confirmed as having COVID-19. This is stood down when numbers a low and where the patients need to be within a certain specialty outweighs the clinical needs from a COVID -19 perspective, for example where patients are asymptomatic. All patients who are positive for any infectious pathogen are isolated or cohorted together. There are doors on most bays in the organisation which allows for escalation to cohorting should there be increasing patient infections. Where there is an increase in staff infections, there is a clear escalation process for managing staffing challenges within divisions and escalating beyond this to manage workforce challenges and maintain safe staffing levels.		
○ A multidisciplinary team approach is adopted with hospital leadership, operational teams**,** estates & facilities, IPC teams and clinical and non- clinical staff to assess and plan for creation of adequate isolation rooms/cohort units as part of the plan.	Operational meetings take place 4 times per day. At least once per day, the operations meeting has representation from IPC, estates and facilities, operations managers, senior managers, clinical and non-clinical staff to discuss challenges and risk and to formulate plans to mitigate risk through isolation/cohorting at this meeting and between meetings where required.		

• Organisational /employers risk assessments in the context of managing infectious agents are:
  ○ Based on the measures as prioritised in the hierarchy of controls.
  ○ Applied in order and include elimination; substitution, engineering, administration and PPE/RPE**.**
  ○ Communicated to staff.
  ○ Further reassessed where there is a change or new risk identified eg. Changes to local prevalence.
 	
• the completion of risk assessments have been approved through local governance procedures, for example Integrated Care
Systems.
	Organisational/employers risk assessments are based on the principles of the hierarchy of controls. An example: Surveys have been conducted and considerations are determined by estates colleagues with regard to ventilation in areas. Where risks of infection cannot be eliminated or substituted (eg. in clinical areas) engineering controls have been put in place with some extraction being built in, structurally, administration controls - windows are opened for 10 minutes per hour, air scrubbers have been put in place in higher risk clinical areas. Where other controls are not possible, and the risk remains higher than other areas, a higher level of PPE/RPE can be worn. This is continually reviewed in relation to respiratory illness seen and taking into considerations increases in prevalence in the local community and within the organisations.
	Measures are stood up and down as appropriate taking into consideration the local context.
	
	Any risks are taken through governance processes, for example, ventilation safety group, water safety group, infection control committee, feeding into Patient safety Committee and clinical Governance committee.
	Any significant risks are documented on the DATIX system risk registers.
	
	IPC have input into any risks and mitigations that are associated with infectious agents.		

• Risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with the infectious agents. • Ensure that transfers of infectious patients between care areas are minimised and made only when necessary for clinical reasons. • Resources are in place to monitor and measure adherence to the NIPCM. This must include all care areas and all staff (permanent, flexible, agency and external contractors). • the application of IPC practices within the NIPCM is monitored e.g. 10 elements of SICPs • The IPC Board Assurance Framework (BAF) is reviewed, and evidence of assessments are made available and discussed at Trust board level.	Patients with infectious organisms are not moved between areas unless clinically necessary and only where isolation/cohorting can continue. Clinical practices are audited using Tendable by divisional leadership teams. IPC team continue surveillance, monitoring and audit via Trust systems and are integrating some functions across to Tendable. This is in place through Tendable auditing, IPC auditing, Estates and Facilities auditing as well as clinical teams. Occupational health teams support in relation to staff well-being, including exclusion from work and managing prevention of exposure and occupational safety. In place Representation from senior leadership teams are present at outbreak control meetings/incident meetings and post infection reviews. Summaries are provided post meetings/incidents.	Tendable cannot collect and present the level of detail previously provided across the organisation in relation to hand hygiene.	Business case for a new IPC system is being submitted that, if approved should address this gap. If not approved, then the level of detail cannot be provided. Only basic detail will be provided.

• The Trust Board has oversight of incidents/outbreaks and associated action plans. • The Trust is not reliant on a single respirator mask type and ensures that a range of predominantly UK made FFP3 masks are available to users as required.	The Trust has several FFP3 masks available for use and for staff to be fit tested on.		
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level. • the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/room • Cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	National Standards for Healthcare cleanliness Gap analysis has been completed by Estates and Facilities. Plans are being worked through for implementation by March 2023. In place. Any changes are taken through Space Utilisation Group in accordance with policy and/or discussed at senior leadership level. Standards and frequencies are monitored through departmental auditing with action plans in place to address deficits.		

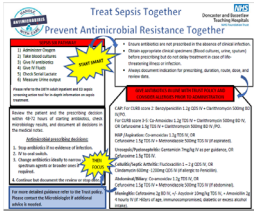
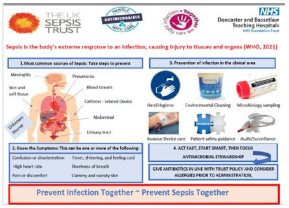
• Enhanced/increased frequency of cleaning should be incorporated into environmental decontamination protocols for patients with suspected/known infections as per the NIPCM (Section 2.3) or local policy and staff are appropriately trained.	There is a Cleaning RAG in place denoting roles and responsibilities. A3 cleaning RAG.pdf 		
• Manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.	In place. Trust approved cleaning agent is Peracide. It is applied and left to dry, this meets the contact time of one minute.		
• For patients with a suspected/known infectious agent the frequency of cleaning should be increased particularly in: ○ patient isolation rooms ○ cohort areas ○ donning & doffing areas – if applicable ○ 'Frequently touched' surfaces e.g., door/toilet handles, chair handles, patient call bells, over bed tables and bed/trolley rails. ○ where there may be higher environmental contamination rates, including: ▪ Toilets/commodes particularly if patients have diarrhoea and/or vomiting.	Areas accommodating patients with infectious organisms or where there is likely to be higher levels of contamination, enhanced cleaning is in place. For commodes in some areas where there is likely to be higher levels of contamination, a higher strength of peracide is used in accordance with manufacturers guidance.		

• The responsibility of staff groups for cleaning/decontamination are clearly defined and all staff are aware of these as outlined in the National Standards of Healthcare Cleanliness	In Place	We are not currently compliant with the National Standards of Cleaning 2021, we are compliant with the 2007 standards. The Trust applied for a derogation from the timeline for compliance until April this year. We are working through the process of getting an appropriate business case together to request funding for the additional resources required to be compliant. The gap between 2007 standards and 2021 are operationally fairly narrow and form part of the business case, this is approximately an 8 - 10% uplift of our current input hours.	Policies and procedures are in place detailing roles and responsibilities for cleaning RAG rating is available for staff to refer to but is having minor alterations unrelated to responsibilities.  A3 cleaning RAG.pdf
• A terminal clean of inpatient rooms is carried out: ○ when the patient is no longer considered infectious ○ When vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens). ○ Following an AGP if clinical area/room is vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room). ○	In Place I		

• reusable non-invasive care equipment is decontaminated:
  ○ between each use
  ○ after blood and/or body fluid contamination
  ○ at regular predefined intervals as part of an equipment cleaning protocol
  ○ Before inspection, servicing, or repair equipment.
	n Place – audited by IPC teams and Hotel services teams		

• Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	In Place – audited by IPC teams and Hotel services teams		
• ventilation systems, should comply with HBN 03:01 and meet national recommendations for minimum air changes https://www.england.nhs.uk/publication/specialised-ventilation-for-healthcare-buildings/	Some areas meet the standards		Estates are able to rebalance some areas through engineering controls. Air scrubbers are in place in higher risk areas and all wards and departments aim to open external windows for 10 minutes at least every two hours.
• Ventilation assessment is carried out in conjunction with organisational estates teams and or specialist advice from the ventilation group and/ or the organisations, authorised engineer and plans are in place to improve/mitigate inadequate ventilation systems wherever possible.	In Place		
• where possible air is diluted by natural ventilation by opening windows and doors where appropriate	Wards and departments open external windows for 10 minutes every 2 hours where possible.		Capital money has been identified for improvements to ventilation.
		Some areas do not meet the standards. This is surveyed and monitored through Estates	

		colleagues and at the Ventilation Safety Group. Advice is taken from Ventilation Expert advisor.	
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure that: • arrangements for antimicrobial stewardship (AMS) are maintained and a formal lead for AMS is nominated • NICE Guideline NG15 https://www.nice.org.uk/guidance/ng15 is implemented – Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use	There is a Consultant Microbiologist who is the organisational lead for AMR. There is an Antimicrobial Pharmacist.	Antimicrobial pharmacist establishment is not adequate	Other pharmacy colleagues take on some duties ad hoc and Consultant Microbiologists advise. AMR is discussed at bimonthly Infection Control Committee. There is an AMR committee which has been poorly attended due to operational pressures. This should improve as COVID activity declines. Attendance is encouraged but better representation is required.
• the use of antimicrobials is managed and monitored:	As above		

○ to optimise patient outcomes ○ to minimise inappropriate prescribing ○ to ensure the principles of Start Smart, Then Focus https://www.gov.uk/government/publications/antimicrobial-stewardship-start-smart-then-focus are followed	Principles are promoted via IPC team  Antibiotics Oct 22.pdf  Sepsis poster 2 (1).pdf		
• contractual reporting requirements are adhered to, and boards continue to maintain oversight of key performance indicators for prescribing including: ○ total antimicrobial prescribing; ○ broad-spectrum prescribing; ○ intravenous route prescribing;	Audit is completed by pharmacy teams and are feedback through governance processes. IPC team and Consultant Microbiologists monitor and provide advice.		

adherence to AMS clinical and organisational audit standards set by NICE: https://www.nice.org.uk/guidance/ng15/resources • Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency and external contractors).	 Pathway for Clinical Management of Susp Trust Antimicrobial guidance/protocols are available on the Intranet and through trust App. There are plans for IPC team members to receive development in this area to further promote best practice.		
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.			
• **Key lines of enquiry**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • IPC advice/resources/information is available to support visitors, carers, escorts, and patients with good practices e.g. hand hygiene, respiratory etiquette, appropriate PPE use	Resources are available on Intranet, Extranet and on site. These are updated and changed dependent on key messages and infections. Information leaflets are available. The IPC team and Consultant Microbiologists provide advice.  Covid restrictions new poster 2022.pd		

- visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors

Toilet awareness poster.pdf

WPR43232 Isolation Poster 2019 new A4.

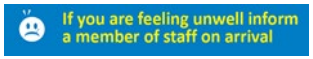
• National principles on inpatient hospital visiting and maternity/neonatal services will remain in place as an absolute minimum standard. National guidance on visiting patients in a care setting is implemented. • Patients being accompanied in urgent and emergency care (UEC), outpatients or primary care services, should not be alone during their episode of care or treatment unless this is their choice. • Restrictive visiting may be considered by the incident management team during outbreaks within inpatient areas this is an organisational decision following a risk assessment and should be communicated to patients and relatives.	Visiting currently is to have up to two visitors at a time between the times of 11:00 and 20:00. This can be any two people, not nominated individuals. Where patients have complex needs or at the end of their life, there are no restrictions. In outbreaks where infection is known to be actively spreading, there may be further restrictions to contain spread within the hospital and into the wider community. Visiting is not ceased altogether for any patients and individual circumstances are considered. In place Current guidance is embedded below. DBTH visiting is above the national guidance.  C1658_Visiting healthcare inpatient In place		

• There is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, respiratory hygiene and cough etiquette. The use of facemasks/face coverings should be determined following a local risk assessment.	In place as above See above and below Catch it Kill it Bin it.docx  Pictorial procedure for hand hygiene is available on all soap/Alcohol hand rub dispensers.		
• If visitors are attending a care area to visit an infectious patient, they should be made aware of any infection risks and offered appropriate PPE.	In place. Where visitors attend with a face covering, they are asked by wards and departments to change for a fluid repellent surgical mask. Mask dispensers are available at entrances. Hoods are available where patients have respiratory infectious illness and having AGPs. In place at ward/department level		

• Visitors, carers, escorts who are feeling unwell and/or who have symptoms of an infectious illness should not visit. Where the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting. • Visitors, carers, escorts should not be present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer/parent/guardian. • implementation of the supporting excellence in infection prevention and control behaviors Implementation Toolkit has been adopted where required C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	In place. This is checked by ward/department staff. LFTs/Abbott testing is used to mitigate risks and facilitate compassionate visiting. In place. Where this is essential, hoods are provided where visiting is essential during AGP. Resources have been used during the pandemic (examples below)  every-action-counts-staff-a4-poster-arie  every-action-counts-staff-a4-poster-dor		
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that:	In place		

• all patients are risk assessed, if possible, for signs and symptoms of infection prior to treatment or as soon as possible after admission, to ensure appropriate placement and actions are taken to mitigate identified infection risks (to staff and other patients).	Routine screening for MRSA, COVID, Flu and RSV is in place for inpatients. Patients are monitored for symptoms of infectious illness through their inpatient stay and appropriate action is taken.		
• Signage is displayed prior to and on entry to all health and care settings instructing patients with symptoms of infection to inform receiving reception staff, immediately on their arrival (see NIPCM).	In Place Covid restrictions new poster 2022.pd 		
• the infection status of the patient is communicated prior to transfer to the receiving organisation, department or transferring services ensuring correct management /placement	Wards/departments communicate with receiving organisations and transferring services. Point of care testing for COVID 19 prior to transfer to facilitate appropriate management. COVID-19 status is flagged on the Nerve centre and CAMIS. . COVID-19 status is available on electronic systems for receiving departments to see. Patients who are not COVID-19 positive but have another infectious condition are electronically flagged on Nerve centre and CAMIS.		
• triaging of patients for infectious illnesses is undertaken by clinical staff based on the patients' symptoms/clinical	In place		

assessment and previous contact with infectious individuals, the patient is placed /isolated or cohorted accordingly whilst awaiting test results. This should be carried out as soon as possible following admission and a facemask worn by the patient where appropriate and tolerated.			
• Patients in multiple occupancy rooms with suspected or confirmed respiratory infections are provided with a surgical facemask (Type II or Type IIR) if this can be tolerated.	In Place wherever possible		
• patients with a suspected respiratory infection are assessed in a separate area, ideally a single room, and away from other patients pending their test result and a facemask worn by the patient where appropriate and tolerated (unless in a single room/isolation suite).	In Place wherever possible		
• Patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting test results and a facemask worn by the patient where appropriate and tolerated only required if single room accommodation is not available.	In Place wherever possible		
• patients at risk of severe outcomes of infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room protective isolation	In Place. Immunocompromised patients are accommodated in specialist areas and are also screened for respiratory illness every week using PCR.		
• If a patient presents with signs of infection where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes.	In Place – an example of principles below in preoperative SOP  SOP pre procedure testing March 2022		
• The use of facemasks/face coverings should be determined following a local risk assessment.	The use of face masks is considered within the local context – taking into account community prevalence of respiratory illness, positive staff		

	cases within the organisation and the number of inpatients with respiratory illness. Currently, face masks are in place in any area where there will be contact with members of the public/service users with the exception of when seated in eateries to allow eating and drinking. In non-clinical areas such as offices (that are not in a clinical department/ward) masks can be removed.		
• Patients that attend for routine appointments who display symptoms of infection are managed appropriately, sensitively and according to local policy.	Patients who attend for routine appointments who display symptoms of infection are asked to speak to a member of staff.  The relevant clinician is informed and the patient is discreetly moved to another room/area where a swab can be taken.		
• Staff and patients are encouraged to take up appropriate vaccinations to prevent developing infection	In place		
• Two or more infection cases linked in time, place and person trigger an incident/outbreak investigation and are reported via reporting structures.	In Place  Outbreaks are reported via the national reporting system https://outbreak.ardengemcsu.nhs.uk/		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • IPC education is provided in line with national guidance/recommendations for all staff commensurate with their duties.	In Place. IPC training is part of SET. SET compliance is recorded on ESR. IPC team conduct face to face training outside of SET training, for example Foundations of care training, International Nurses training.		
• training in IPC measures is provided to all staff, including: the correct use of PPE	In place.		
• all staff providing patient care and working within the clinical environment are trained in hand hygiene technique as per the NIPCM and the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it (NIPCM);	In Place. Delivered via eLearning and face to face training delivered by IPC team. Competency is assessed at ward level.		
• adherence to NIPCM, on the use of PPE is regularly monitored with actions in place to mitigate any identified risk	PPE compliance is audited by the IPC team at times of increased activity and day to day via IPC team staff in clinical areas.		
• Gloves and aprons are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's.	In place		

• hand hygiene is performed:
  ○ Before touching a patient.
  ○ Before clean or aseptic procedures.
  ○ After body fluid exposure risk.
  ○ after touching a patient; and
  ○ After touching a patient's immediate surroundings.
 	
• The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination (NIPCM)
 	
• Staff understand the requirements for uniform laundering where this is not provided for onsite.
	Hand hygiene is promoted and compliance is audited by the IPC team and by Departmental/divisional leaders. Compliance is fed back to individual departments and through Infection control committee. Auditing is completed via Tendable and monthly compliance meetings are attended by ward/department leaders and divisional leaders. Action plans are put in place where appropriate.
	
	In Place. Hand air dryers are not in use in clinical areas. Disposable paper towels are used in clinical areas.
	
	In Place. This is provided through IPC training and education and messages are reinforced on an ongoing basis.
		Tendable cannot collect and present the level of detail previously provided across the organisation in relation to hand hygiene, however discussions have taken place at ICC and plans are being worked through.	Business case for a new IPC system is being submitted that, if approved should address this gap. If not approved, then the level of detail cannot be provided. Only basic detail will be provided.

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • That clear advice is provided; and the compliance of facemask wearing for patients with respiratory viruses is monitored (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs. • Patients who are known or suspected to be positive with an infectious agent where their treatment cannot be deferred, care is provided following the NIPCM.	In Place at ward/department level wherever possible. In Place. Decisions are always made based on the clinical needs of the patient.	Some patients cannot or will not wear face masks.	Patients are encouraged to wear masks where they can be tolerated.

• Patients are appropriately placed i.e.; infectious patients are ideally placed in a single isolation room. If a single/isolation room is not available, cohort patients with confirmed respiratory infection with other patients confirmed to have the same infectious agent. • standard infection control precautions (SIPC's) are applied for all, patients, at all times in all care settings • Transmission Based Precautions (TBP) may be required when caring for patients with known / suspected infection or colonization	In Place. Advice and guidance is available in relevant policies and provided in person or over the telephone via IPC team. In Place In Place		
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • Laboratory testing for infectious illnesses is undertaken by competent and trained individuals. • Patient testing for infectious agents is undertaken promptly and in line with national guidance. • staff testing protocols are in place for the required health checks, immunisations and clearance • There is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available. • Inpatients who go on to develop symptoms of infection after admission are tested/retested at the point symptoms arise. **COVID-19 Specific** • patients discharged to a care home are tested for SARS-CoV-2, 48 hours prior to discharge (unless they have tested positive	In Place In Place In Place within occupational health department In Place In Place. In Place. IPC team host the IPC service to care homes and work in collaboration with discharge		

within the previous 90 days), and result is communicated to receiving organisation prior to discharge. **Coronavirus (COVID-19) testing for adult social care services - GOV.UK (www.gov.uk)** • for testing protocols please refer to: COVID-19: testing during periods of low prevalence - GOV.UK (www.gov.uk) C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)	teams, Wards and departments and care homes to ensure standards are met and follow up advice is provided where required. Guidance is considered in all decision making.		
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that • Resources are in place to implement, measure and monitor adherence to good IPC and AMS practice. This must include all care areas and all staff (permanent, flexible, agency and external contractors). • Staff are supported in adhering to all IPC and AMS policies. • Policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	In place In place. Resources are available via policies, extranet, intranet and in person or over the telephone from the IPC team and Microbiologists. In Place DBTH outbreak management.pdf Outbreaks are reported via the national reporting system		

• all clinical waste and infectious linen/laundry used in the care of known or suspected infectious patients is handled, stored and managed in accordance with current national guidance as per NIPCM • PPE stock is appropriately stored and accessible to staff when required as per NIPCM	https://outbreak.ardengemcsu.nhs.uk/ In addition, ICB colleagues and colleagues from the UKHSA are informed by the IPC team when outbreaks occur. In place  corpfac12 (1).pdf In place		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assassurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • Staff seek advice when required from their occupational health department/IPCT/GP or employer as per their local policy. • Bank, flexible, agency, and locum staff follow the same deployment advice as permanent staff. • Staff understand and are adequately trained in safe systems of working commensurate with their duties. • A fit testing programme is in place for those who may need to wear respiratory protection.	In Place In Place In Place This is limited	There are no premises available on site at the moment to provide Fit testing routinely. Education team provide	The risk is recorded on the risk register and has been escalated up to execs. Paper to be written to establish

		some Fit Testing to students/learners based on risk assessment. FIT testing is now mandatory as part of EPRR core standard 12. There is no resource to meet the standard. IPC team provide ad hoc urgent Fit testing where there are premises in which to conduct the testing.	resource available/required to meet the standard.
• Where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: ○ Lead on the implementation of systems to monitor for illness and absence. ○ Facilitate access of staff to treatment where necessary and implement a vaccination programme for the healthcare workforce as per public health advice. ○ Lead on the implementation of systems to monitor staff illness, absence and vaccination. ○ Encourage staff vaccine uptake.	In Place. Occupational health team have procedures in place and work closely with IPC team with regard to this. There is the central sickness absence number for all staff to report sickness absence. Reasons and rates monitored. Flu and Vaccination campaign is underway currently. In place Central communications reinforce and support messages.		
• Staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to	In Place. There is no difference in requirements to follow IPC guidance and PPE for vaccinated		

follow the infection control precautions, including PPE, as outlined in NIPCM.	individuals. Policy and guidance remains the same for all.		
• A risk assessment is carried out for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza or severe illness from COVID-19. ○ A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups. ○ That advice is available to all health and social care staff, including specific advice to those at risk from complications. ○ Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff. ○ A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.	In Place: Occupational Health department/HR departments manage individual risk assessments. For example, guidance remains that any members of staff who are pregnant, from 28 weeks can choose to work non patient facing. In Place In place In Place		
• Testing policies are in place locally as advised by occupational health/public health.			
• NHS staff should follow current guidance for testing protocols: C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)	Routine, asymptomatic LFT testing for staff has been paused in accordance with Government guidance. PCR testing is provided to all staff who test positive on LFTs or where LFT is negative but the member of staff has symptoms.		
• Staff required to wear fit tested FFP3 respirators undergo training that is compliant with HSE guidance and a record of this training is maintained by the staff member and held centrally/ESR records.	All fit tests including which masks a person has failed and passed on are recorded on ESR.	Please see page 24 of this document for challenges	The risk is recording on the risk register and has been

• Staff who carry out fit test training are trained and competent to do so.		regarding ability to provide Fit testing.	escalated up to execs. Paper to be written to establish resource available/required to meet the standard.
	Staff who carry out fit testing are not all trained by a Fit2Fit accredited trainer.	It is now mandatory for all staff who carry out fit testing to be trained by a Fit2Fit accredited trainer.	
• Fit testing is repeated each time a different FFP3 model is used.			
	This principle is followed when Fit testing is provided.		
• all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks			
	This principle is followed when Fit testing is provided.		
• those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators or an alternative is offered such as a powered hood.			
	This is recorded on ESR and a passport is available for the employee.		See above
• That where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions	 mask passport blank.docx		
	In Place. All staff are tested on an approved reusableFFP3 mask.		
• Members of staff who fail to be adequately fit tested: a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm.			
	In place – conducted by occupational health department.		
• A documented record of this discussion should be available for the staff member and held centrally within the			

organisation, as part of employment record including Occupational health. • Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board. • Staff who have symptoms of infection or test positive for an infectious agent should have adequate information and support to aid their recovery and return to work.	In Place – held within Occupational health See above points regarding fit testing (page 24 of this document) In Place. IPC work closely with Occupational health to assist where necessary.		

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	31 January 2023	**Agenda Reference:**	**C5**		
Report Title:	**Maternity Update**				
Sponsor:	Karen Jessop, Chief Nurse				
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 Services				
Summary of key issues/positive highlights:	• Update on current Perinatal Mortality Review Tool (PMRT) reviews for the month • Current Healthcare Safety Investigation Branch (HSIB) cases in progress and reports received. • Education and training compliance below the 90% target due to the division continuing to catch up following operational challenges • 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 and partial compliance will be declared in February 2023				
Recommendation:	The Board is asked to note and take assurance.				
Action Require:	~~Approval~~	**Information**	**Discussion**	**Assurance**	~~Review~~

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

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

Assurance Route			
Previously considered by:			
Date:		**Decision:**	

Next Steps:	Support to continue improvements in maternity service, and develop a robust action plan for CNST Year 4 standards, and the Ockenden immediate actions
Previously circulated reports to supplement this paper:	

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Monthly Board Report

December 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

1.1 Stillbirths and late fetal loss > 22 weeks

In December 2022 there was one stillbirth, which is currently under review.

Five cases were reviewed at the perinatal mortality meeting. Areas of learning from the cases were identified as:

- Further training required for plotting of symphysis fundal height measurements (an external abdominal measurement) – Webinar being planned and will be rolled out to all staff by the end of March 2023.

Three cases were graded as good levels of care, one case has been closed and the report shared with the family. Two further reports are due to be completed by the end of February 2023.

1.2 Neonatal Deaths

No neonatal deaths have been reported.

1.3 Actions/ Learning from PMRT

Creation of a suitable environment for families that have lost a baby is an ongoing action, funding has been established and work is sequenced as part of the refurbishment of level 3, this work will create a bereavement suite. This work is due to commence in February 2023 and be completed by the end of May 2023.

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	18
Current active cases	0
Exception reporting	0

2.1 Reports Received since last report

No reports have been received.

2.2 Current investigations

None.

3. Serious Incident Investigations (Internal)

There is one ongoing SI investigation related to a term stillbirth. This is on track to be completed within the 60-day timeline by the end of January 2023.

4. Training Compliance

The service set trajectories to meet 90 % compliance with training by December 2022. This trajectory was not met, but progress is being made in all areas of training and the current figures for the priority areas of training are included below:

CTG Study Day

- The training currently delivered is in line with the recommendations from CNST Y4, the Ockenden report and HSIB investigations.
- The original trajectory of 90% of staff to be trained has not been met, and therefore a new trajectory of 90% by 31st March 2023 has been set.

The current training position is:

MDT Role	Number	Number Compliant	K2 CTG Compliance	Number of Staff Undertaken Fetal Monitoring Study Day	Study Day Compliance	Projected (based on bookings)
Consultants	12	10	**83.3%**	11	**91.7%**	**108.3%**
Doctors	21	11	**52.4%**	16	**76.2%**	**90.5%**
GP Trainees	13	5	**38.5%**	9	**69.2%**	**107.7%**
Midwives	209	184	**88.0%**	155	**74.2%**	**78.9%**
NHSP Midwives	16	15	**93.8%**	6	**37.5%**	**37.5%**
Divisional	**271**	**225**	**83.0%**	**197**	**72.7%**	**80.1%**

Which has improved from 66.7% to 72.7%.

Practical Obstetric Multi Professional Training (PROMPT) Training (Obstetric Emergencies)

The original trajectory of 90% staff complete training by 5th January 2023 has not been met, therefore a new trajectory has been set for this to be completed by 31st March 2023. This will ensure the service is in a good position prior to commencement of the training programme in 23/24.

PROMPT Data

MDT Role	Number	Number Compliant	Prompt Compliance
Consultants	12	9	**75.0%↑**
Doctors	32	28	**87.5% ↑**
Midwives	208	183	**88.0% ↑**
NHSP Midwives	25	13	**52% ↑**
Support Workers	69	56	**81.1% ↑**
Theatre Staff	83	34	**41.0% ↑**
Anaesthetists	38	29	**76.3% ↑**
Divisional	**467**	**352**	**75.3% ↑**

5. Service User Feedback

The work plan has been agreed and the equity and equality lead midwife is working closely with the MVP chair to progress the plan.

The main areas of work are:

- The maternity triage service – patient experience related to initial contact on the phone. Ensuring staff are welcoming and compassionate in their responses.

- Looking to engage the seldom heard voices in the local population to shape the future maternity services, ensuring equity for all.
- Involvement with the final touches and signage in the refurbished CDS, triage and midwife led unit – due to open in March 2023.

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

The submission for year 4 CNST is due on 2nd February 2023.

The service will be declaring partial compliance with the standards and will be submitting a robust action plan to support in the delivery of full compliance of year 5 standards.

9. Board Level Safety Champion

The new Chief Nurse has commenced in post and will now become the Board level Safety Champion, which the Executive Medical Director undertook on an interim basis. Safety champion walk rounds and post walk round meetings have been scheduled for the year ahead. The first visit with Karen Jessop and Jo Gander (Non-executive Director safety champion) and divisional representatives is scheduled for 30th January 2023, a meeting will be held immediately after the visit to discuss findings and agree any actions required, with representatives from Maternity services and Neonatal services invited. A draft Terms of Reference has been circulated to be agreed at the first meeting.

10. Perinatal Surveillance dashboard

There has been an increase in the number of delays with induction of labour on both sites in December 2022. This was due to the increased activity and attendances in the two week prior to Christmas. This experience was similar across the LMNS.

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	1:27.4	14%	
Dec	1:26.5	10.1%	

Maternity unit: DBTH – Doncaster

KPI (see slide 4)	Measurement / Target		Doncaster Rate		
			October	Nov	Dec
Caesarean Section rate	Elective	<13.2 %	18.3%	18.1%	7.4%
	Emergency	<15.2 %	20.1%	28.8%	25%
Preterm birth rate	≤26+6 weeks	0	0.37%	0.16%	0.42%
	≤36+6 weeks	<6%	8.4%	5.6%	7.4%
Massive Obstetric Haemorrhage	≥1.5l	<2.9%	4%	4.4%	2.1%
Term admissions to NICU		<6%	3.3%	5.6%	3.7%
3rd & 4th degree tear	SVD (unassist'd)	<2.8%	0.7%	2.6%	0.9%
	Instrumental (assisted)	<6.05 %	0%	5.9%	4.5%
Right place of birth		95%	95.37%	98.4%	99.5 %
Smoking at time of delivery		<11%	13.1%	17.5%	13.3%
Percentage of women placed on CoC pathway		35%	0%	0%	0%
Percentage of women on CoC pathway: BAME / areas of deprivation	BAME	75%	0%	0%	0%
	Area of deprivation		0%	0 %	0%

Month/Quarter		Red flag alert	Open > 30 days	Unactioned Datix	Maternity Serious Incidents	Maternity Never Events	HSIB cases	Still Births (All / Term / Intrapartum)			HIE cases (2 or3)	Neonatal Deaths Early	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	40	0	0	0	0	0	0	0	0	0	0	0	0	0
	Dec	0	94	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	13	35
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

KPI (see slide 4)3.9%	Measurement / Target		Bassetlaw Rate		
			October	Nov	Dec
Caesarean Section rate	Elective	<13.2 %	8.3%	10.1%	7.4%
	Emergency	<16.9 %	27.3%	28.1%	24.8%
Preterm birth rate	≤26+6 weeks	0	0.76%	0	0
	≤36+6 weeks	<6%	5.3%	5.03%	7.4%
Massive Obstetric Haemorrhage	≥1.5l	<2.9%	2.3%	3.5%	2.1%
Term admissions to NICU		<6%	3.03%	1..4%	1.6%
3rd & 4th degree tear	SVD (unassist'd)	<2.8%	2.8%	3.0%	4.6%
	Instrumental (assisted)	<6.06 %	15.4%	5.6%	6.3%
Right place of birth		95%	95.76%	100%	100%
Smoking at time of delivery		<11%	7.6%	7.2%	13.3%
Percentage of women placed on CoC pathway		35%	0	0	0
Percentage of women on CoC pathway: BAME / areas of deprivation	BAME	75%	0	0	0
	Area of deprivation		0	0	0

Month/Quarter		Red flag alert	Open > 30 days	Unactioned Datix	Maternity Serious Incidents	Maternity Never Events	HSIB cases	Still Births (All / Term / Intrapartum)			HIE cases (2 or3)	Neonatal Deaths (Early / Late)		Notification to ENS	Maternal Mortality (direct / indirect)	
2020/2021	Oct	0	41	0	0	0	0	2	0	0	0	0	0	0	0	0
	Nov	0	21	0	0	0	0	0	0	0	0	0	0	0	0	0
	Dec	0	24	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	15	35
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

NHS

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	CTG	PROMPT	CTG	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	Weight unexpectedly below the 10th centile PPH Shoulder dystocia Unexpected admission to NNU Staffing	Weight unexpectedly below the 10th centile PPH >1500ml Unexpected admission to NNU Staffing Unexpected NNU admission Availability of Pumps
Themes from Maternity Serious Incidents (Sis)	Guidance needed when professional opinions differ	Guidance needed when professional opinions differ	Management and review of diabetic pathway and management of late diagnosis/unstable GDM
Themes arising from Perinatal Mortality Review Tool	Increased SB rate No themes on toll further review being undertaken Bereavement facilities poor	Increased SB rate No themes on toll further review being undertaken Bereavement facilities poor	Diabetic management of unstable GDM USS not plotted accurately Off pathway care Partogram not being completed Poor use of translation services CDS USS requires review and aim to upgrade
Themes / main areas from complaints	Communication Delays in care	Communication Delays in care	Communication Attitudes
Listening to women (sources, engagement / activities undertaken) CQC Women's Experience	MVP ongoing, workplan in place CQC survey action plan to be developed	MVP ongoing, workplan in place CQC survey action plan to be developed	MVP Bereavement questionnaire
Evidence of co-production	New CDS	New CDS	New CDS and serenity suite appeal
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	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	Ongoing OCR meeting Ongoing skills and drills scenarios Education lead now back in post supporting education needs of staff PROMPT Pastroal care team
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	WHATS HOT Ward briefs and emails Face to face discussions with staff LMNS meetings Trust meeting	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)

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 : January 2023 after People Committee

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 17 January 2023

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:

- **Identified below. Relevant risk descriptions and ratings reviewed by Chief People Officer with Risk Manager to reflect changes, with some rewording of descriptions**
- **People Committee content with risk ratings, actions, controls and assurances at Jan PC, noting the review undertaken by the Chief People Officer and Risk Manager**

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

Risk ID	Risk Description	Current CRR Risk Rating	Risk Appetite Type	Risk Appetite Level	Target Risk Rating	*Datix Linked Risk ID's*	*Comments*
PEO1 19	**Inability to engage with and involve colleagues, learners and representatives to improve experiences at work**	***12***	Inn Peop	***Open***	***8***		
PEO2 16	**Inability to recruit a sufficient workforce and to ensure colleagues have the right skills**	***16***	Inn Peop	***Open***	***12***	***3104***	Risk PEO2 16 has been reviewed following the PC meeting and likelihood remained as 'likely' based on current position therefore no change to rating
PEO4 3104	**Impact on our workforce of the economic context/cost of living including risk of potential industrial action**	***12***	Inn Peop	***Open***	***9***		Discussion at Jan PC about whether this risk should be split into two separate ones. Agreed to leave as one as a strategic level risk encompassing the impact on our colleagues of 'external' events

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	Apr 2023	ZL	Appraisal Season launched 1 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 to 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 – March 2023	ZL/GP	No gaps identified. Approach for 2022 staff survey action planning presented to People Committee, TEG and Board in July 2022 – supported. new provider secured. Actions taken by divisions in response to survey feedback being presented at POSM. Response rate of 65% - leading amongst acute trusts nationally using our provider. Planning underway for engagement in 2022 results once available, update provided at Jan PC and Committee assured.
Staff survey action plans to ensure appraisal conversations are meaningful as defined by the staff survey	Oct 2022	2022 staff survey results – March 2023	GP	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 and Committee assured.
Communication – Staff Brief, Listening Events, Facebook	Jan 2023	Action closed as plan in place	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	GP	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. Update on development of the framework provided at Jan PC and Committee assured. Action learning sets now in place with trained facilitators.

Assurances received (L1 – Operational L2-Board Oversight L3 External) **		**Last received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
L1, L2	Feedback from the appraisal season	Nov 2022 (appraisal season)	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 2022 (update at PC)	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
L2	Staff Engagement paper and Appraisal Season report presented at September and November People Committee. Staff Engagement standing item on 2023 PC workplan at every meeting	Jan 2023	People	Full	Committee assured
L3	Annual National Staff Survey Results	Jan 2023	Confidential Board (initial results under embargo)	N/A	Final survey results to be received (expected late Feb – late Mar) and plan in place for engagement

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) Action outstanding, due March 2023	**Oct 2022 – deferred from May 2022**	**Amber -ongoing**	**TN**	**Autumn 2022 – changed to Mar 2023**
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 – on track**	**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 (for draft)**

		Draft People Strategy presented to PC and TEG at Jan meetings and also shared widely with other groups for comments. Positive feedback being received		
Design and implementation of new leadership behaviours framework for DBTH. Plan for engagement in Nov/Dec, development Jan/Feb. approval process & launch Mar/Apr. Update presented at Jan PC meeting – Committee assured	**Mar/Apr 2023**	**On track – multiple engagement sessions held in Nov/Dec 2022**	**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.
Areas in yellow highlight indicate change from last version

Appendix Level1

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

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

Risk Owner: Trust Board – Director POD
Committee: People

People, Partners, Performance, Patients, Prevention

Date last reviewed : January 2023 after People Committee

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 17 January 2023

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:

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Seek (4)	Open (3)	Minimal (1)	Open (3)	Open (3)	Open (3)

Risks:

- **Identified below. Relevant risk descriptions and ratings reviewed by Chief People Officer with Risk Manager to reflect changes, with some rewording of descriptions**
- **People Committee content with risk ratings, actions, controls and assurances at Jan PC, noting the review undertaken by the Chief People Officer and Risk Manager**

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	

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- *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 in areas
- Increased sickness levels
- Financial impact for the Trust if increased levels of absence and gaps

Risk ID	Risk Description	Current CRR Risk Rating	Risk Appetite Type	Risk Appetite Level	Target Risk Rating	*Datix Linked Risk ID's*	*Comments*
PEO1 19	**Inability to engage with and involve colleagues, learners and representatives to improve experiences at work**	***12***	Inn Peop	***Open***	***8***		
PEO2 16	**Inability to recruit a sufficient workforce and to ensure colleagues have the right skills**	***16***	Inn Peop	***Open***	***12***	***3104***	Risk PEO2 16 has been reviewed following the Nov PC meeting and likelihood remained as 'likely' based on current position therefore no change to rating
PEO4 3104	**Impact on our workforce of the economic context/cost of living including risk of potential industrial action**	***12***	Inn Peop	***Open***	***9***		Discussion at Jan PC about whether this risk should be split into two separate ones. Agreed to leave as one as a strategic level risk encompassing the impact on our colleagues of 'external' events

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	Jan 2023	Jul 2023	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. Increased number of champions including linking to Wellbeing Champions and new EDI roles; further training

				undertaken. Bi-annual Speaking Up report presented to Jan PC meeting by Speak Up Guardian and Committee assured. Updated report being presented to Jan Board meeting following PC discussion
Staff survey action plans to ensure improvement	Jan 2023	2022 staff survey results – March 2023	ZL/GP	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, new provider secured. Addition of Staff Engagement as standing agenda item for People Committee. Response rate of 65% – leading for acute trusts nationally using our provider. Plan for results to be presented to March PC meeting. Planning starting in divisions/directorates in preparation for results being published (date tbc nationally)
Communication – Staff Brief, Listening Events, Facebook	Sept 2022	Action closed as plan in place	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 regularly at Montagu. Action closed as plans in place
Development programme to include Everyone Counts/Civility	Jan 2023	Apr 2023	GP	No gaps currently identified - Leadership development offer to be reviewed following launch of Leadership Behaviours Framework
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)	Jan 2023	Mar 2023	GP	Gaps in assurance addressed – see action below
Actions to improve sickness absence, linked to ongoing health and wellbeing programme of work	Jan 2023	May 2023	AJ/GP	Actions and next steps identified in plan presented to People Committee. Health & wellbeing proposal presented to Nov PC and supported. Proposal approved by Charitable Funds Committee. Verbal H&W provided at Jan PC meeting and Committee assured.

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 and Innovation Strategy presented to Board July 2022 and being presented to Board Jan 2023 for approval	Jul 2022 – Jan 2023 to Board	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 reviewed for 2023 and gives appropriate attention given to EDI including networks. Reciprocal Mentoring Programme – graduation in July 2022, TEG supported next cohort to launch planned Sept 2022. RMP launched Jan 23
L3	KPMG Job Planning Audit	Nov 2023 - PC	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
L3	Internal Audit – 360 Assurance Race Code advisory audit	Sep 2022	People, ARC	Advisory audit	Audit report presented to People Committee in Sept 2022 – action closed, see 'corrective actions' 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. Leadership Behaviours Framework update, Business Planning & Workforce Planning and draft People Strategy presented at January PC meeting and Committee assured.	Jan 2023	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 approach. Jan PC assured by all these items presented.
L3	GMC survey	Nov 2022	People	Full	GMC survey results and analysis included in Education Report presented to Nov PC meeting. Committee assured.

Appendix Level1

L3	Annual Heath Education England 'Monitoring the Learning Environment' quality visit (visit in Dec 22)	Jan 2023	People	Full	Positive verbal feedback provided by HEE with written report to follow. To be presented to PC in March 2023 once received
L3	Annual National Staff Survey Results	Jan 2023	Confidential Board (initial results under embargo)	N/A	Final survey results to be received (expected late Feb – late Mar) and plan in place for engagement

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) Action outstanding, due March 2023	**Oct 2022 – deferred from May 2022**	**Amber -ongoing**	**TN**	**Autumn 2022 – changed to Mar 2023**
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. Planning underway for communication and engagement when embargo lifted**	**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 presented to PC & TEG Nov 22 and supported**	**GP**	**Action closed**
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 (Nov 22)** **Draft People Strategy presented to PC and TEG at Jan meetings and also shared widely with other groups for comments. Positive feedback being received.**	**ZL**	**January 2023 (for draft)**

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:	31 January 2023	**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 colleague engagement and experience together with an update on the launch of our new Board Development Programme Delegate scheme.		
Summary of key issues/positive highlights:	There is a Board commitment and ambition to improve colleague experience and engagement across DBTH in line with our True North objective to be in the top 10% in the UK for feedback from our colleagues and learners. This paper highlights some of the recent developments at DBTH and progress made against our plans in relation to cultural improvement, colleague experience, supporting our people and workforce development, including: • People Strategy 2023-27 – draft strategy has been developed and is being shared during January 2023 for feedback, with an intention to present to Board for approval in February 2023 • Leadership Behaviours Framework – engagement sessions completed during November/December 2023, now in the design phase • Just Culture – launch in January 2023 of this new workstream, jointly led between the People & OD team and Patient Safety team • Board Development Programme Delegate – work undertaken and preparations in place to launch for the first pilot cohort to start in March 2023, following agreement at Board in November 2022 • Strategic Workforce Planning Tool – collaborative working with KPMG to develop a tool bespoke to DBTH to assist with modelling of future workforce requirements based on activity and demand assumptions over a multi-year period The People Committee receives regular detailed progress reports on the key people and culture workstreams.		
Recommendation:	The Board is asked to note the actions being taken, the progress being made and to support the work programmes described.		

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

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

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

Assurance Route			
Previously considered by:	1. Some aspects considered by Trust Executive Group and People Committee 2. Board Development Programme Delegate discussed at Board – confidential session		
Date:	Jan 2023 Nov 2022	**Decision:**	1. Aspects shared and supported where required. People Committee assured. 2. Proposal supported by Board
Next Steps:	Proceed as outlined and present updates to Board in January 2023		
Previously circulated reports to supplement this paper:	Board Diversity proposal – November 2022 Board (confidential session)		

1. Introduction

The People Update reports presented to Board focus on the strategic work being undertaken to improve our people metrics and colleague experience, in pursuit of our True North ambitions to be in the top 10% in the UK for colleague and learner feedback and for everyone to know their role in achieving our vision.

This report provides an update in relation to creation of our new People Strategy, the current phase in the development of our new Leadership Behaviours Framework, launch of both the Just Culture workstream and the Board Development Programme Delegate scheme and the implementation of the Strategic Workforce Planning Tool.

2. People Strategy (2023-27)

The Chief People Officer has been seeking and taking on board feedback from colleagues, leaders, representatives and members of the People & OD and Education & Research teams about our people priorities and is also working with system partners. All this engagement and input, together with our True North objectives and strategic ambitions, helped to shape our draft new People Strategy which also takes account of the NHS People Plan, the People Promise and the Future of HR and OD in the NHS report.

The draft People Strategy (2023-27) has now been developed and is based around the four pillars of the NHS People Plan:

- Looking after our people
- Belonging in the NHS – for us, Belonging in #TeamDBTH
- New ways of working and delivering care
- Growing for the future

During January 2023, the draft has been shared for feedback with Trust Executive Group, People Committee, the People & OD and Education & Research teams, our staff networks, Partnership Forum/JLNC members, workforce leads for different staff groups and Teaching Hospitals Board. The intention is for the People Strategy to go through the approval process and to be presented to Board in February 2023.

Our People Strategy will be underpinned by a delivery plan, which will provide more detail on how we will achieve our ambitions, the actions and activities to be undertaken and how we will measure our progress and success measures. This delivery plan will be developed once the People Strategy is at the approval stage and will support the implementation of the strategy. People Committee will have oversight on delivery and progress against this plan.

3. Leadership Behaviours Framework

During November and December 2022, we completed the engagement phase of our programme to design, develop and implement a new Leadership Behaviours Framework for DBTH. Multiple engagement sessions were held, facilitated by the Chief People Officer and Head of OD, EDI and Wellbeing, including one for Board/TEG members, two for Leadership Assembly members and three open sessions which were available for any colleagues at DBTH to join. These workshops have been well attended and well received, with positive feedback from colleagues who were pleased to be asked to engage in this work.

This next phase is to develop the framework, taking into account our local feedback and strategies as well as relevant national resources and frameworks. The planned timeline is to launch the framework in March/April 2023, after which work will begin on embedding it into aspects of working life at DBTH alongside our We Care values e.g. recruitment, induction, appraisals. A full review of our leadership development offer will

also be carried out once the framework has been finalised and launched, to ensure appropriate alignment and reach.

4. Just Culture

In late January 2023, we reaffirmed our commitment to Just Culture with the launch of a workstream jointly owned by the People & OD and Patient Safety teams. This workstream will focus on the aspects of just and restorative culture linked to both employee relations and patient safety matters. We invited a wide range of colleagues, leaders and representatives to our first session, and we see this as the start of our engagement with a wider group of colleagues across the organisation.

The intention is to generate ideas through discussion which will lead to the formation of an action plan, building on the work previously undertaken at DBTH. In support of ongoing cultural change, we would like to see collective ownership of improvement actions across different groups and for individuals to understand their own responsibilities within their roles. A Board development session on Just Culture has been arranged for 27 February 2023.

5. Board Development Programme Delegate

Following discussion and agreement at the confidential session of the Board in November 2022, work has been ongoing to develop the resources to support our new Board Development Programme Delegate scheme. The Chief People Officer, Director of Corporate Affairs and senior members of the People and OD team have developed a role profile, development programme outline, learner agreement, advert and supporting web page. Details are being finalised at the time of writing and information will be shared with Board members once completed.

The Board Development Programme Delegate scheme is a novel approach designed to allow opportunities for greater diversity of thinking and representation at Board-level in DBTH whilst developing and nurturing future talent to Director-level positions, with a particular focus on supporting people with protected characteristics and from under-represented groups. The programme also supports our role as an Anchor organisation through links with our local communities.

The programme will run for five months with two cohorts running a year, each consisting of two delegates on each cohort. The programme will be open to internal and external applicants. We are on track to launch for the first cohort to start in March 2023, and this will be seen as a pilot cohort after which we will review for the second cohort later in the year.

6. Strategic Workforce Planning Tool (KPMG)

We have been collaborating with KPMG over a period of months to develop a strategic workforce planning solution for the Trust. A solution specific to the Trust's data and strategic requirements Is being built, allowing for a more detailed understanding of our current and upcoming workforce profiles and needs in relation to expected capacity, demand and activity requirements over a multi-year planning period.

The data discovery phase has been completed and we are mow moving into the implementation phase, which includes modelling of activity growth assumptions, building numerous scenarios and workforce profiles, further engagement, training and testing of V1 of the DBTH tool. This is a significant project which is being monitored through Monday.com with governance provided through regular reporting to Workforce Planning Committee and Transformation Board, as well as updates being provided to Trust Executive Group and People Committee. As the tool develops, it will complement our evolving approach towards year-round workforce planning and deep dive workshops and how these link with our annual business planning processes.

7. Recommendations

The Board can be assured that actions are being taken to continue to enhance our approach to colleague experience, with ongoing cultural improvement linked to our True North ambitions, and that good progress is being made in different workstreams. The Board can be assured that People Committee is maintaining oversight of these workstream and project areas.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	31 January 2023	**Agenda Reference:**	**D3**
Report Title:	**Speaking Up – Bi-annual Report**		
Sponsor:	Zoe Lintin, Chief People Officer		
Author:	Paula Hill, Freedom to Speak Up Guardian		
Appendices:	N/A		
Report Summary			
Purpose of report:	To provide the Board with assurance in relation to all elements of Speaking Up activity and performance.		
Summary of key issues/positive highlights:	This bi-annual report provides information to enable Board members to better understand changes in Speaking Up strategic direction and internal activity and performance. An earlier and more detailed version of this report was presented to People Committee in January 2023. This report highlights the challenges and actions being taken in relation to national requirements and timescales due to changes to oversight and Guardian capacity. This includes the opportunity to link the national work to the internal strategy review and how through wider engagement we will use the voices of our colleagues to shape the future strategy, linked to the wider cultural journey and compliance requirements. Engagement sessions are planned (using QI methodology) throughout January 2023 onwards and the information will be collated, alongside that from the Speak up Board session in November 2022, to inform our future direction. Information is provided to demonstrate the level of engagement and collaboration already undertaken and the positive response to this from colleagues including those who have spoken up and those who are supporting those who speak up. There has been a reduction in overall Speak up cases and the evidence suggests this is due to early, local conversations with managers and wider partners. All Speak up cases have been responded to within the required timeframe and most cases have been resolved without delay. However, where a small number of cases have experienced significant delays, information is provided to explain the cause and actions required to resolve these cases.		
Recommendation:	The Board is asked to be assured by the developments described and the information provided in relation to Speaking Up at DBTH and to support the delivery of the planned engagement and extensive work programme described. The People Committee was assured by the detailed report and discussion on Speaking Up at their January 2023 meeting.		

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, SA2, SA3
Corporate risk register:	No specific risks identified, links to PEO1 19
Regulation:	N/A
Legal:	N/A
Resources:	N/A

Assurance Route			
Previously considered by:		People Committee	
Date:	17.01.23	**Decision:**	The Committee were assured and supported an adapted version of the report being presented to Board in January 2023
Next Steps:		Report to Board in January 2023	
Previously circulated reports to supplement this paper:		N/A	

1. Introduction

This paper is presented to the Board to provide mid-year assurance on Freedom to Speak Up (FTSU) strategic direction and operational practice from 1 April 2022 to 31 December 2022. An earlier more detailed version of this report was presented to People Committee in January 2023 for full discussion and the Committee was assured.

The paper provides an update on national guidance and best practice to present an overview of the strategic context in which Speaking Up now operates. It also provides DBTH Speaking Up activity using local, national and partnership data to provide an insight into our performance and progress on our wider cultural journey. Both qualitive and quantitative local data is provided including learning and future actions.

The considerable number of changes that have occurred within the Speaking Up structure across the last nine months are discussed and opportunities are explored to embrace these changes to support a positive, just and learning culture, both for Speaking up and in its wider context. Finally, the paper provides information to support the positive stories, activities and improvements achieved so far this year, whilst continuing to identify future engagement and learning opportunities.

2. Strategic Context

FTSU principles continue to be mandated within the NHS contract and monitored by the Care Quality Commission under the Well-Led umbrella including the requirement to identify a FTSU Guardian, Lead Executive Director and Non-Executive Director. These roles are key to driving forward cultural change to empower all our colleagues to speak up and to ensure concerns are listened to and responded to in a timely and curious manner, working to ensure that all concerns are seen as an opportunity for improvement and learning. DBTH has seen several changes across the key Speak Up roles in the last nine months, resulting in a new Executive Lead for Speaking Up (Chief People Officer) and a new Lead Non-Executive Director. This period has also seen a return to capacity for the Lead FTSU Guardian, who is no longer supporting additional roles as part of the pandemic response.

The last nine months have seen considerable change in national strategic direction relating to Speaking Up from NHS England (NHSE) and the National Guardian's Office (NGO), including revised guidance and assurance tools and the introduction of a nationally recognised policy and engagement tools. DBTH has responded positively to the revised guidance, demonstrated by continued commitment to a partnership approach to supporting the growth of a healthy Speak Up culture and the delivery of effective Speak up services.

However, DBTH has not yet completed some of the assurance tools suggested due to an absence of specific engagement and feedback from a wider organisational perspective. Plans are in place to collate data in the coming months to allow a richer level of information to identity areas of best practice and those that require improvement.

This, combined with the timing of our planned strategy, policy review and the introduction of many national and local guidance/policy changes, creates an ideal opportunity for us to consider and reflect on our current Speak Up arrangements. This will in turn allows us to better understand the future commitment and needs of the organisation alongside what our colleagues are telling us they want from the Speak up service.

3. Performance against strategy

In order to achieve a culture where all colleagues feel empowered to have a voice, DBTH approved a three-year FTSU strategy and strategic action plan in 2019. Our achievements against this strategy to date include:

- An increased level of communication and engagement to improve awareness and understanding of what speaking up means and how everyone can access all Speak Up partners across the organisation. This has

been achieved through communication on the HIVE, in Buzz and through increased visibility across sites and within teams.

- FTSU remains firmly embedded in induction programmes with over 20 formal sessions delivered in the past nine months. In the revised Statutory and Essential Training format, speaking up will not be included. However, the same information will continue to be shared across alternative platforms including the Speak Up pages of the HIVE, DBTH App, regular feature in Buzz and through local Champions.
- Information to support managers with receiving and responding to concerns. This includes the joint delivery of messages in line with patient safety culture and responding to incidents and complaints.
- Learning from cases continues to be shared and we are now working alongside the patient safety lead and People & OD colleagues to consider how these are best shared in conjunction with wider changes in relation to the introduction of Patient Safety Incident Response Framework (PSIRF) and key employee relations guidance.
- FTSU month in October 2022 focussed on "Speak up for everyone" with a 10-week programme of sharing information, explaining how all partners across the Trust support and work to encourage Speaking up. These included themes of patient safety and experience, diversity and inclusion, quality improvement, compassionate leadership and safety culture.
- Topics planned to support engagement in January and February 2023 include an open and transparent culture of Speaking Up and sharing experiences to influence improvements.
- We continue to embed a number of slogans and pledges to promote different elements, including 'Speak Up to me', 'Speak Up to make a difference' and 'I support Speaking Up because..'
- Sessions have already taken place with the Board and some Divisional teams in relation to senior leaders' understanding, responsibilities and commitment to Speaking up, listening up and following up. However, we acknowledge there are still some gaps in effective engagement with some senior leaders and teams. The 2019 strategy is now ready for review and a period of engagement and review commenced in October 2022 on the back of the FSTU Month and further sessions are planned throughout January 2023.
- Education, learning and development plans continue to include the roll out of Health Education England's three levels of FTSU training, Speak Up, Listen Up, Follow Up. However, due to competing challenges, alternative programmes have been delivered. These are reflected in the work above and further detailed information was presented to and discussed by the People Committee in January 2023.

4. Speaking Up model and capacity

At their January meeting, People Committee members acknowledged the continued delivery of the 2019 service delivery model and the significant growth of partners that support the development of a positive Speak up culture as well as providing restorative, wellbeing activity. They also recognised the reduction in overall Guardian capacity and welcomed the continued increase in the number of champions and partners in the past year, including the introduction of Speaking Up to existing Wellbeing Champions roles and to newly appointed EDI roles. Discussions explored the roles of partners working to provide a listening ear and, in some cases, coaching methodology to provide restorative supervision to support colleagues through the changes or concerns they are experiencing. This is now being appropriately seen as a robust alternative to using the Guardian service. It was agreed that further publication of these services would take place in early 2023.

As previously highlighted, the Trust's Lead Guardian has returned from previous competing pandemic responsibilities to focus solely on the Speak Up agenda, which will of course be beneficial, but may be still limiting at a time-of-service growth and wider cultural change.

The FTSU Forum and wider partner engagement continues to be challenged due to the unprecedented strain on the organisation and its obvious multifaceted priorities.

5. Understanding Data

Improved data collection and data triangulation remains a key focus of the FTSU forum and wider partners. This focus will also now be considered by the Just Culture workstream, ensuring that all elements of information are considered when identifying which areas need support to influence staff experience and overall cultural change. The full Speaking Up Bi-annual report presented to People Committee in January 2023 provided and considered detailed data in line with the NGO revised guidance on data collection, recording and reporting (2022) including the addition of further themes and focus on outcomes. It also considered internal DBTH activity themes and trends which stimulated further assurance discussions at the Committee.

Numerical data was also supported by qualitative data derived from the use of "What three words" slogan, which allows colleagues to express the personal impact of their concerns and/or speaking up.

6. The Assessment of FTSU Issues at DBTH

DBTH has seen a reduction in the overall number of individuals Speaking up, with a total of 48 people speaking up from 1 April 2002 to 31 December 2002, compared to 64 individuals during the same timeframe in 2021. This reduction is also mirrored in the number of cases that these individuals are involved in; the overall number shows a steady decrease, with 42 cases across the three quarters, compared with 50 cases during the same timeframe in 2021. To date in 2022/23 there has also been a reduction in multiple cases raised, with one in quarter 1 and all other cases being raised individually.

Data captured to demonstrate those who speak up, shows the majority of cases (29%) being raised by Allied Health Professionals (AHPs). This is new to speaking up with no AHPs raising concerns in 2021/22. Data also shows a decrease in concerns raised by Administration and Ancillary colleagues, from 49% in 2021/22 to 25% in 2022/23 and a maintenance of concerns in relation to Nurses and Midwives. Although an increase was seen in cases brought by Medical and Dental colleagues, increasing from 5% to 11 % (based on 2021/22 figures), a reduction across the quarters this year is also evident.

The key themes from concerns don't allow accurate comparison due to the new categories introduced by the National Guardian's Office in 2022. However, it was noted that 27% of those who raised concerns identified "Worker Safety & Wellbeing" as their key concern and 25% identified Inappropriate actions and behaviours as their key issue. The terminology used in the new headings do not necessarily allow an understanding of the detail in relation to the level of concern.

The People Committee members discussed this issue and sought assurance that this will be addressed as part of the wider cultural work that is taking place across DBTH, starting in 2022 and continuing throughout 2023. Assurance was also provided in relation to the role of the Speaking Up Forum in triangulating data from all partners to allow a more detailed picture to be understood. This information provides a hypothetical "Heat Map" so appropriate conversation, escalation and action can be taken to support those individuals and/or areas in need and to inform future planning.

Of the 48 individuals (42 cases) that have been supported since April 2022, the majority of cases have been successfully resolved through:

- Colleague empowerment to work with local managers to address issues and apply any learning
- Mediation or facilitated discussion in certain divisions or departments
- Partnership working with divisional leads/leadership and OD colleagues to encourage engagement and exploration of the issues identified
- Collaboration with the wellbeing champions and Professional Nurse Advocates/Professional Midwifery Advocates (PNAs/PMAs)
- Liaison with or escalation to HR colleagues for facilitated discussions and or investigation
- Escalation to senior leaders for consideration and further review

However, where these cases have needed exploration or investigation there can still be an increase in the time it takes to resolve concerns and/or to receive feedback and supportive action. Assurance was given that this would be explored and addressed as part of the Speaking up strategy review and reflection/planning process and wider cultural work.

7. Action taken to improve FTSU culture

The FTSU Guardian is an active member of the Trust's Just Culture workstream as it is well established that a healthy speaking-up culture is also one where people feel safe and confident to:

- share their thoughts, experiences and improvement ideas
- participate in health and wellbeing conversations
- call out incivility, discrimination, bullying or other inappropriate behaviours.

These actions form the mainstay of transforming and embedding Speaking Up cultural change as they work alongside policy and process review to demonstrate any action and learning from engagement, incidents and events. In turn enabling these actions demonstrates the Trust's commitment to supporting individuals to feel empowered by the Trust's WE CARE values.

At DBTH we want all our colleagues to feel safe to have early, open conversations about anything that gets in the way of providing high-quality patient care and rewarding personal/team experience. Therefore, communication and engagement are key elements of the planned strategy and planning review, ensuring that all colleagues know all avenues for speaking up, including those partners external to guardian services.

8. Final note and recommendation

Speaking up, and having your voice heard, is critical in times of challenge and we can all acknowledge that we are now continuing through difficult times where our people are experiencing greater personal and professional challenges than ever before.

The Board is asked to support and be assured by the delivery of the planned engagement and extensive work programme in relation to Speaking Up and our wider just and learning culture journey as outlined in this report. We ask that you provide support by keeping an open mind, offering a listening ear and applying compassionate challenge when things are not right, or others appear to need help. Speak up, Listen Up and Follow up.

Throughout the above work and the completion of this report, a number of national and DBTH documents have been considered and/or produced. These are referenced in the detailed paper presented to People Committee in January 2023, which is available from the Trust Board Office on request.

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: January 2023

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)

Risks:

- The Trust's Year to Date (YTD) financial position was a deficit of £12.4m as at the end of month 9 which is adverse to plan by £1.0m and adverse to forecast by £0.9m. Therefore the Trust is at risk of not delivering its year end financial plan. The main change this month (and driving the adverse forecast position) is that the Trust have started to see increases in pay spend related to winter pressures including the opening of additional beds across both Doncaster and Bassetlaw sites including the impact of incentives being paid for temporary staffing (nursing and medics) to ensure fill rates are maintained for safe staffing. The cost pressure relating to winter if all beds were kept open and incentives maintained to the end of the financial year is c£3-4m compared to current funding received and above forecast (the pressure in month was c£0.8m). However we have had productive conversations with Doncaster PLACE regarding winter funding to mitigate some of this risk and we are currently finalising the details with them (see appendix A for letter to Doncaster PLACE). We are also meeting with Notts ICB/Bassetlaw PLACE to discuss ongoing contract issues from planning as well as winter pressures. A verbal update will be provided at the meeting.
- The ICB financial position at Month 9 is a £21.6m deficit and therefore is at risk of not delivering its break-even financial plan. A range of mitigating options are being considered and reviewed by the ICB at this point.
- The Trust's financial position has also benefited from a number of non-recurrent benefits in year and NHS England not implementing penalties for non-delivery of elective recovery targets. If this is accounted for the Trust's in year financial position is a £26.2m YTD deficit, with an underlying deficit of c£40m. This is a significant concern as we enter into the 23/24 planning process.
- Agency spend remains at historical levels and significantly above pre-pandemic levels. The area of increase in agency since pre-pandemic continues to be nursing which was very rarely used pre-pandemic. Other temporary staffing spend (nursing bank and medical additional sessions) is also causing significant pressures with incentives and rate increases in year. Planning guidance for 23/24 sets a target of 3.9% of pay spend on agency with the Trust currently spending nearly double this amount.
- 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. There is a risk that next year's inflation assumptions are not sufficient to cover the actual cost increases being seen by the Trust.
- Cash risk - the deficit this financial year along with the significant capital programme are causing cash to reduce to the end of the financial year. There is a risk if the underlying financial position does not improve in 23/24 the Trust will need central support to meet its obligations by the end of Q1. This is being closely monitored.
- 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 are yet to be reviewed for 23/24 and rebased. 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.
- Productivity reductions have been seen during COVID, where activity being delivered is significantly below pre-pandemic levels, whilst resource (especially clinical resource) has increased. The challenge moving into 23/24 is to deliver pre-pandemic levels of activity within pre-pandemic resources whilst providing safe and sustainable services. If this is not delivered the Trust's income position will be at risk as elective income for 23/24 is based on delivery of activity targets.
- Trust's underlying deficit financial position has worsened during the pandemic and is c£40m. There is increasing focus nationally on underlying positions entering 22/23.

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?*

The current risk score of 16 reflects:

- The Trust is at risk of not delivering its year end financial position as set out in the risk section opposite
- The Trust's objective to be in recurrent surplus is off plan given the Trust is in a recurrent underlying deficit position.

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.

To mitigate the in-year risk discussions are ongoing with PLACE partners to seek support along with a focus on grip and control within Divisions to control financial spend and use of resources.

23/24 planning process has commenced, with the Trust advocating for a review of allocations in funding from the ICB. The planning process will also include CIP development and a focus on improving underlying productivity and reducing temporary staffing spend. Further grip and control is needed in 23/24.

	• 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	

Risk ID	Risk Description	Current CRR Risk Rating	Risk Appetite Type	Risk Appetite Level	Target Risk Rating	*Datix Linked Risk ID's*	*Comments*
F&P1 11	**Failure to achieve compliance with financial performance and achieve financial plan**	***16***	**Fin**	***Open***	***8***		
F&P12 1412	**Risk of fire to the Estate**	***15***	***Fin Reg***	***Open***	***10***		
F&P20 1807	**Risk of Critical Lift Failure in a Number of Passenger Lifts Trust Wide**	***20***	**Qual Fin**	***Open***	***8***	***1224,1239,2681***	
ARC01 13	**Risk of economic crime against the Trust by not complying with Government Counter Fraud Functional Standard GovS 013 – Counter Fraud**	***12***	**Rep Reg**	***Open***	***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.	Dec 2022	March 2022	AC	Ongoing review of financial controls. Variability in level of grip and control in Divisions.
Budget Setting and Business Planning	Jan 22	Feb 22	AC/JS	No unexpected exceptions identified. Business planning has commenced.
Internal & External Audit programme design & compliance outcomes	Dec 2022	March 2022	AC	Last Internal Audit provided significant assurance. External Audit on 21/22 provided an unqualified audit opinion. HFMA internal audit results overall were positive with action plan in place to address gaps.
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.	Dec 2022	Feb 2022	AC/JS	Ongoing monitoring as ICB develops and Place develops. Funding issues raised in letter to ICB and ongoing discussions with ICB as start 23/24 planning.
Implementation of Granger Report Actions	Dec 2022	March 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 with forecast delivery by end of year.
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 with forecast end date of March 23.
3. Delivery of reduced temporary staffing spend especially in Nursing	Ongoing	Ongoing	JS – supported by all Exec Directors	Further work required in this area as we exit winter pressures.
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:	31 January 2023	**Agenda Reference:**	**E2**
Report Title:	**Financial Performance – Month 9 (December 2022)**		
Sponsor:	Alex Crickmar, Acting Director of Finance		
Author:	Rodney Muskett, Acting Deputy Director of Finance Finance team		
Appendices:			
Executive Summary			
Purpose of report:	To report the Month 9 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 9 (December 2022) was £1.3m, which was a £0.1m adverse variance to plan and a £0.2 adverse variance to forecast. The Trust's Year to Date (YTD) financial position was a deficit of £12.4m as at the end of month 9 which is adverse to plan by £1.0m and adverse to forecast by £0.9m. The main change this month (and driving the adverse forecast position) is we have started to see increases in pay spend related to winter pressures including the opening of additional beds across both Doncaster and Bassetlaw sites including the impact of incentives being paid for temporary staffing (nursing and medics) to ensure fill rates are maintained for safe staffing. The cost pressure relating to winter if all beds were kept open and incentives maintained to the end of the financial year is c£3-4m compared to current funding received and above forecast (the pressure in month was c£0.8m). However, we have had productive conversations with Doncaster PLACE regarding winter funding to mitigate some of this risk and we are currently finalising the details with them. We are also meeting with Notts ICB/Bassetlaw PLACE to discuss ongoing contract issues from planning as well as winter pressures. A verbal update will be provided at the meeting. The other key risk to the forecast position that has materialised relates to CNST which was forecast to be a rebate of £0.5. However, this is now unlikely as the Trust will not be compliant with the CNST standards.		

The table and narrative below set out the other key issues driving the YTD position which are similar to previous months.

	YTD		
	Plan	Actual	Variance
Surplus/(deficit) (£m)	**-11.5**	**-12.4**	**-1.0**
Variance explained by			
Maternity pay pressure. Operational and safety pressures leading to higher than normal agency.			-2.3
Pay Emergency / operational pressures. Operational pressures due to vacancies, sickness and high bed occupancy rates.			-4.1
Excess Inflation - Contracts (Fresenius and Utilities)			-1.4
COVID costs in excess of plan - driven by higher sickness levels.			-0.4
Overachievement against plan on efficiency, due to VAT reclaim, W&C insurance payment and other new local schemes.			1.8
Underspend on elective recovery (Independent sector and other planned care)			3.1
Excluded device income not recovered due to blocks			-2.3
Non recurrent releases			3.2
Capital charges funding			1.2
Pressure from pay award			-0.6
Other small items			0.8
			-1.0

The YTD financial position is largely driven by pay continuing to be overspent by £7.6m which in turn is driven by high temporary staffing usage.

- Maternity Services: use of bank and agency staff at premium rates to cover vacancies and meet operational and safety pressures (£2.3m temporary staffing premiums). As the incentives have been reintroduced from December, spend has increased.
- 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 £0.4m pressure year to date.
- The pay award for 22/23 is causing a £0.6m pressure to date.

With regards to non-pay pressures, inflation is still very high in the economy (£1.4m pressure YTD). For example, we have seen increasing pressures on utilities (c£0.2m increase on Month 8 and above forecast) 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 (£3.1m). 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), £1.5m insurance proceeds relating to the W&C incident and other non-recurrent benefits including a gas rebate and CIP delivery in excess of the target to date. In month we saw some reductions in non-pay spend (consumables etc) as less elective activity was done as a result of the impact on beds from winter pressures. A review of prior year balances on the balance sheet has resulted in a one-off benefit of in the position in line with forecast.

The Trust is also seeing pressures on excluded devices and non-PbR drugs of £2.3m 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. We are also seeing pressures with regards to GP referred Pathology tests of c£1m which we are reviewing and will be raising with Commissioners.

Therefore, in total the Trust has cost pressures of c£5.7m that are partly outside of its control (£1.4m inflation, £0.4m COVID costs, £0.6m pay award, £2.3m drugs/devices, £1m GP referred tests).

In summary the year end financial position of a £10.1m deficit is currently at risk mainly driven by additional winter pressures costs. However, we are looking to reduce/mitigate this risk though discussions at PLACE which are ongoing.

It should be noted that the position reported includes all year-to-date Elective Recovery Funding (c.£9.7m) given there is no clawback of funding in Q1, Q2 or Q3 despite the Trust not delivering electivity activity targets. Elective recovery Funding (ERF) rules for Q4 are still awaited, meaning 75% of the remaining funding for Q4 is at risk (£2.5m) however this is expected to be low risk at this point in the financial year.

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.£14.7m off plan at this point with a £26.2m deficit, 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	**11,481**	**12,445**	**964**
Non-recurrent items			
75% ERF income following national agreement to not clawback	0	7,300	7,300
Interim insurance payment relating to the W&C major incident	0	1,500	1,500
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	3,231	3,231
Underlying (Surplus)/Deficit Position for the purposes of system achievement	**11,481**	**26,171**	**14,690**

Capital

Capital spend in month was £4.09m against the plan of £4.05m giving an in-month over-performance of £0.04m. YTD capital spend is £13.6m against the plan of £23m, giving a YTD underperformance of £9.5m. The key variances to plan are underspends in Estates of £3.4m and Medical Equipment of £0.2m. Whilst the capital variance YTD is significant, all Estates and IT and MEG in plan business cases have been approved through CIG and expected to deliver by year end. The Trust is forecasting to deliver its capital plan.

Cash

The cash balance at the end of December was £20.8m (November: £20.8m), meaning cash has remained stable in the month. However, the Trust received £7m of PDC Dividend for capital schemes in the month, with only £3.4m of cash going out on capital expenditure. The other significant cash movement was £1m of prior months invoices now being paid following a contractual dispute with a supplier. This suggests the underlying revenue cash deficit in the month was around £2.5m and is indicative of the Trust's underlying financial deficit.

A cash flow forecast has been completed including sensitivity analysis for year end. This shows under a reasonable case cash is expected to fall throughout the rest of the year to c£12m as a result of the impact of the planned I&E deficit and a backloaded capital plan. However, this leaves significant capital creditors at year end of c£15m that will be due for payment in Q1 and therefore if the Trust's underlying deficit position does not improve the 23/24 Q1 cash position will deteriorate further with the potential of needing central cash support to meet its obligations. Next year's cash position will also therefore be heavily dependent on the funding allocations for 23/24 which is yet to be issued by the ICB. As reported previously there is a risk that the year end audit opinion may include an emphasis of matter section relating to going concern due to the cash position.

	CIPs In month the Trust has delivered £1.5m of savings versus the plan submitted to NHSE of £2.1m and is therefore £0.6m adverse to plan. YTD the Trust has delivered £14.8m of savings against a planned £13.0m, an over achievement of £1.8m. **ICB Financial Position** The ICB financial position at Month 9 is a £21.6m deficit and therefore is at risk of not delivering its break-even financial plan. The impact of this is the ICB (and each organisation) would go into the forecast protocol as previously circulated to the Board and the ICB would lose £7.5m of its capital allocation next financial year. A range of mitigating options are being considered and reviewed by the ICB at this point to mitigate this position ahead of Month 10, however there is no agreed plan at the time of writing. A verbal update will be provided at the meeting.
Recommendation:	The Board is asked to note: • The Trust's deficit YTD at month 9 (December 2022) was £12.4m, which was adverse to plan by £1.0m and adverse to forecast by £0.9m. • 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 9 – December 2022

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

P9 December 2022

1. Income and Expenditure vs. Budget

Performance Indicator	Monthly Performance					YTD Performance				
	Actual £'000	Variance to forecast £'000		Variance to budget £'000		Actual £'000	Variance to forecast £'000		Variance to budget £'000	
Income	(43,369)	(600)	F	(1,092)	F	(387,256)	(1,572)	F	(6,935)	F
Pay	29,359	1,237	A	1,048	A	258,180	1,250	A	7,601	A
Non Pay	14,606	(672)	F	(5)	F	136,756	957	A	278	A
Financing Costs	503	3	A	(67)	F	4,826	(19)	F	(304)	F
(Profit)/Loss on Asset Disposals	0	0	A	0	A	(97)	0	A	(97)	F
(Surplus)/Deficit for the period	**1,099**	**(33)**	**F**	**(117)**	**F**	**12,410**	**616**	**A**	**543**	**A**
Adj. for donated assets and gains on disposal of assets	220	254	A	263	A	35	246	A	421	A
Adjusted (Surplus)/Deficit for the purposes of system achievement	**1,319**	**221**	**A**	**146**	**A**	**12,445**	**862**	**A**	**964**	**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	Actual £'000		Plan £'000	Actual £'000		Plan £'000
Local	0	336	F	0	5,169	F	0
Workforce (vacancy control)	402	402	F	4,380	4,380	F	5,500
ERF productivity	458	458	A	4,125	4,125	A	5,500
Temporary staffing	100	0	A	700	0	A	1,000
Procurement	63	3	A	563	105	A	750
Non-pay cost containment	333	333	A	1,000	1,000	A	2,000
Unidentified	750	0	A	2,250	0	A	4,500
Total CIP	**2,106**	**1,532**	A	**13,017**	**14,779**	F	**19,250**

3. Statement of Financial Position

	Opening balance £'000	Closing balance £'000	Movement £'000
Non Current Assets	**246,595**	**255,625**	**9,030**
Current Assets	62,494	58,815	**-3,679**
Current Liabilities	-77,772	-80,227	**-2,455**
Non Current liabilities	-13,286	-17,131	**-3,845**
Total Assets Employed	**218,031**	**217,082**	**-949**
Total Tax Payers Equity	**-218,031**	**-217,082**	**949**

4. Other

Performance Indicator	Monthly Performance		YTD Performance		Annual
	Plan £'000	Actual £'000	Plan £'000	Actual £'000	Plan £'000
Cash Balance		20,868		20,868	18,505
Capital Expenditure	4,056	4,097	23,111	13,653	34,190

5. Workforce

	Funded WTE	Substantive WTE	Bank WTE	Agency WTE	Total in Post WTE
Current Month	6,615.79	5,772.35	353.86	227.80	6,354.01
Previous Month	6,610.20	5,731.99	374.13	194.34	6,300.46
Movement	5.59	40.36	-20.27	33.46	53.55

1. Month 9 Financial Position Highlights

Executive Summary Income and Expenditure – Month 9

	Month 9					YTD				
	Plan	Actual	Variance	Forecast	Variance	Plan	Actual	Variance	Forecast	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Income	**-42,277**	**-43,369**	**-1,092**	**-42,769**	**-600**	**-380,321**	**-387,256**	**-6,935**	**-385,684**	**-1,572**
Pay										
Substantive Pay	27,469	24,219	-3,250	24,631	-412	240,673	217,977	-22,695	217,979	-2
Bank	263	2,044	1,781	1,698	346	419	16,880	16,461	16,827	53
Agency	326	1,687	1,360	2,038	-351	2,217	17,002	14,785	17,659	-657
Recharges and Reserves	254	1,409	1,156	-244	1,654	7,271	6,320	-950	4,464	1,856
Total pay	**28,312**	**29,359**	**1,048**	**28,123**	**1,237**	**250,579**	**258,180**	**7,601**	**256,929**	**1,250**
Non-Pay										
Drugs	904	966	62	956	9	8,072	8,947	875	8,563	384
Non-PbR Drugs	1,812	1,991	179	1,902	89	16,355	17,517	1,162	17,133	384
Clinical Supplies & Services	3,134	3,596	461	3,249	347	27,367	29,847	2,480	28,967	880
Depreciation and Amortisation	1,257	1,254	-2	1,291	-36	11,314	11,127	-187	11,198	-70
Other Costs (including reserves)	6,059	5,316	-742	6,273	-957	60,357	54,576	-5,780	55,474	-898
Recharges	1,445	1,483	38	1,607	-124	13,014	14,741	1,727	14,464	277
Total Non-pay	**14,611**	**14,606**	**-5**	**15,278**	**-672**	**136,479**	**136,756**	**278**	**135,799**	**957**
Financing costs	**570**	**503**	**-67**	**500**	**3**	**5,130**	**4,730**	**-400**	**4,749**	**-19**
(Surplus)/Deficit Position	**1,216**	**1,099**	**-117**	**1,131**	**-33**	**11,867**	**12,410**	**543**	**11,794**	**616**
Less donated asset adjustment and gains on disposal of assets	**-43**	**220**	**263**	**-34**	**254**	**-386**	**35**	**421**	**-211**	**246**
(Surplus)/Deficit Position for the purposes of system achievement	**1,173**	**1,319**	**146**	**1,097**	**221**	**11,481**	**12,445**	**964**	**11,583**	**862**

The Trust's deficit for month 9 (December 2022) was £1.3m, which was a £0.1m adverse variance to plan and a £0.2 adverse variance to forecast. The Trust's Year to Date (YTD) financial position was a deficit of £12.4m as at the end of month 9 which is adverse to plan by £1.0m and adverse to forecast by £0.9m.

The main change this month (and driving the adverse forecast position) is we have started to see increases in pay spend related to winter pressures including the opening of additional beds across both Doncaster and Bassetlaw sites including the impact of incentives being paid for temporary staffing (nursing and medics) to ensure fill rates are maintained for safe staffing. The cost pressure relating to winter if all beds were kept open and incentives maintained to the end of the financial year is c£3-4m compared to current funding received and above forecast (the pressure in month was c£0.8m). However, we have had productive conversations with Doncaster PLACE regarding winter funding to mitigate some of this risk and we are currently finalising the details with them. We are also meeting with Notts ICB/Bassetlaw to discuss ongoing contract issues from planning as well as winter pressures. A verbal update will be provided at the meeting.

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COVID costs in excess of plan - driven by higher sickness levels.			-0.4
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The YTD financial position is largely driven by pay continuing to be overspent by £7.6m which in turn is driven by high temporary staffing usage.

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The Trust is also seeing pressures on excluded devices and non-PbR drugs of £2.3m 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. We are also seeing pressures with regards to GP referred Pathology tests of c£1m which we are reviewing and will be raising with Commissioners.

Therefore, in total the Trust has cost pressures of c£5.7m that are partly outside of its control (£1.4m inflation, £0.4m COVID costs, £0.6m pay award, £2.3m drugs/devices, £1m GP referred tests).

In summary the year end financial position of a £10.1m deficit is currently at risk, mainly driven by additional winter pressures. However, we are looking to reduce/mitigate this risk though discussions at PLACE and will update on this position at the meeting.

It should be noted that the position reported includes all year-to-date Elective Recovery Funding (c.£9.7m) given there is no clawback of funding in Q1, Q2 or Q3 despite the Trust not delivering electivity activity targets. Elective recovery Funding (ERF) rules for Q4 are still awaited, meaning 75% of the remaining funding for Q4 is at risk (£2.5m) however this is expected to be low risk at this point in the financial year.

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ICB Financial Position

The ICB financial position at Month 9 is a £21.6m deficit and therefore is at risk of not delivering its break-even financial plan. The impact of this is the ICB (and each organisation) would go into the forecast protocol as previously circulated to the Board and the ICB would loose £7.5m of its capital allocation next financial year. A range of mitigating options are being considered and reviewed by the ICB at this point to mitigate this position ahead of Month 10, however there is no agreed plan at the time of writing. A verbal update will be provided at the meeting.

Capital

Capital spend in month was £4.09m against the plan of £4.05m giving an in-month over-performance of £0.04m. YTD capital spend is £13.6m against the plan of £23m, giving a YTD underperformance of £9.5m. The key variances to plan are underspends in Estates of £3.4m and Medical Equipment of £0.2m. Whilst the capital variance YTD is significant, all Estates and IT and MEG in plan business cases have been approved through CIG and expected to deliver by year end. The Trust is forecasting to deliver its capital plan.

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A cash flow forecast has been completed including sensitivity analysis for year end. This shows under a reasonable case cash is expected to fall throughout the rest of the year to c£12m as a result of the impact of the planned I&E deficit and a backloaded capital plan. However, this leaves significant capital creditors at year end of c£15m that will be due for payment in Q1 and therefore if the Trust's underlying deficit position does not improve the 23/24 Q1 cash position will deteriorate further with the potential of needing central cash support to meet its obligations. Next year's cash position will also therefore be heavily dependent on the funding allocations for 23/24 which is yet to be issued by the ICB. As reported previously there is a risk that the year end audit opinion may include an emphasis of matter section relating to going concern due to the cash position.

CIPs

In month the Trust has delivered £1.5m of savings versus the plan submitted to NHSE of £2.1m and is therefore £0.6m adverse to plan. YTD the Trust has delivered £14.8m of savings against a planned £13.0m, an over achievement of £1.8m.

2. Recommendations

The Board is asked to note:

- The Trust's deficit YTD at month 9 (December 2022) was £12.4m, which was adverse to plan by £1.0m and adverse to forecast by £0.9m.
- The financial risks as outlined in the paper.

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 : January 2023

Strategic Objective
To provide outstanding care and improve patient experience

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

Measures:

- *Implement PSIRF (patient safety incident framework)*
- *NICE – delivery of statutory audits of clinical effectiveness*
- *Continual role out of Tendable – ward / department quality assessment tool*
- *Evidence of "closing the loop", through sharing of learning from incidents and follow up from QI processes*
- *Focus on key safety risks – IPC Outbreaks - waits, falls, milestones set through business planning for each division aligned to the division's breakthrough objectives*
- *Feedback from patients via compliments and complaints, to include learning and engagement with stakeholders*
- *Patient survey outputs and effectiveness of action plans*
- *External review of patient safety and clinical governance which will incorporate patient experience*

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

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

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

Risk ID	Risk Description	Current CRR Risk Rating	Risk Appetite Type	Risk Appetite Level	Target Risk Rating	*Datix Linked Risk ID's*	*Comments*
QEC Risk ID 1517	**Availability and Supplies of Medicines**	***15***	**Qual**	***Open***	***12***		Recommend risk is reviewed at by the Divisional Governance team, to consider whether risk can be reduced.
F&P Risk ID 6&7	**Failure to achieve compliance with performance and delivery aspects of the SOF, CQC and other regulatory standards**	***16***	**Reg**	**Minimal**	***9***		
F&P Risk ID 8 & 16	**Inability to recruit a sufficient workforce and to ensure colleagues have the right skills to meet operational needs**	***16***	**Qual Peop**	***Open***	***8***	***26,2427,2465, 2768,2781, 3043,3104***	

Appendix Level1

QEC F&P 2472	**COVID 19 Pandemic - 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.**	***9***	**Qual Peop Finance**	***Open***	***6***	***2489***	This risk has been reviewed during December 2022 and now has rating of 9 due to the mitigations in place and the declining numbers of patients and staff affected. Therefore will be removed from the BAF unless the risk escalates again in the future.
QEC-PSIRF RISK ID 3112	**Patient Safety Incident Response Framework- compliance with meeting deadline for completing implementation of PSIRF**	***12***	**Qual**	***Open***	***3***		

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. KPMG work complete and business as usual continues through the Outstanding Outpatients forum in terms of ongoing developments, improvements and digital transformation.	September 2022	March 2023	Executive Medical Director and 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-admitted pathways underway within Digital Transformation and operationally, including the development of a patient pathway management system
External peer review of patient safety and governance complete and report received - now aligned to the PSIRF project plan.	November 2022	March 2023	Executive Medical Director and Chief Nurse	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	November 2022	April 2023	Executive Medical Director and COO	Actions & plans in place monitored through Urgent and Emergency Care Programme Board
Action plans to respond to CQC patient surveys	November 2022	March 2023	Chief Nurse and Executive Medical Director	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	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
L2,L3	Ockenden feedback received from the LMNS, action plans developed to achieve 7 key actions	Dec 21	Board	Full	Action plan in place
L1,L2	Updated IPC BAF shared with QEC on the Dec 22	Dec 22	QEC	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**	**Autumn 2022**

Review patient experience strategy and develop work plan for 2022/23	**November 2022**	**Review to commence**	**Chief Nurse**	**January 2023**
~~**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.**~~ **PSIRF implementation Project Management officer identified and first stakeholder Meeting (with TORs) planned for early February 2023**	**January 2023**	~~**Business Case started**~~ Business case for implementation team submitted to January's CIG	**Chief Nurse/Medical Director**	**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.

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: January 2023

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)

Risks:

- The Trust's Year to Date (YTD) financial position was a deficit of £12.4m as at the end of month 9 which is adverse to plan by £1.0m and adverse to forecast by £0.9m. Therefore the Trust is at risk of not delivering its year end financial plan. The main change this month (and driving the adverse forecast position) is that the Trust have started to see increases in pay spend related to winter pressures including the opening of additional beds across both Doncaster and Bassetlaw sites including the impact of incentives being paid for temporary staffing (nursing and medics) to ensure fill rates are maintained for safe staffing. The cost pressure relating to winter if all beds were kept open and incentives maintained to the end of the financial year is c£3-4m compared to current funding received and above forecast (the pressure in month was c£0.8m). However we have had productive conversations with Doncaster PLACE regarding winter funding to mitigate some of this risk and we are currently finalising the details with them (see appendix A for letter to Doncaster PLACE). We are also meeting with Notts ICB/Bassetlaw PLACE to discuss ongoing contract issues from planning as well as winter pressures. A verbal update will be provided at the meeting.
- The ICB financial position at Month 9 is a £21.6m deficit and therefore is at risk of not delivering its break-even financial plan. A range of mitigating options are being considered and reviewed by the ICB at this point.
- The Trust's financial position has also benefited from a number of non-recurrent benefits in year and NHS England not implementing penalties for non-delivery of elective recovery targets. If this is accounted for the Trust's in year financial position is a £26.2m YTD deficit, with an underlying deficit of c£40m. This is a significant concern as we enter into the 23/24 planning process.
- Agency spend remains at historical levels and significantly above pre-pandemic levels. The area of increase in agency since pre-pandemic continues to be nursing which was very rarely used pre-pandemic. Other temporary staffing spend (nursing bank and medical additional sessions) is also causing significant pressures with incentives and rate increases in year. Planning guidance for 23/24 sets a target of 3.9% of pay spend on agency with the Trust currently spending nearly double this amount.
- 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. There is a risk that next year's inflation assumptions are not sufficient to cover the actual cost increases being seen by the Trust.
- Cash risk - the deficit this financial year along with the significant capital programme are causing cash to reduce to the end of the financial year. There is a risk if the underlying financial position does not improve in 23/24 the Trust will need central support to meet its obligations by the end of Q1. This is being closely monitored.
- 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 are yet to be reviewed for 23/24 and rebased. 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.
- Productivity reductions have been seen during COVID, where activity being delivered is significantly below pre-pandemic levels, whilst resource (especially clinical resource) has increased. The challenge moving into 23/24 is to deliver pre-pandemic levels of activity within pre-pandemic resources whilst providing safe and sustainable services. If this is not delivered the Trust's income position will be at risk as elective income for 23/24 is based on delivery of activity targets.
- Trust's underlying deficit financial position has worsened during the pandemic and is c£40m. There is increasing focus nationally on underlying positions entering 22/23.

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?*

The current risk score of 16 reflects:

- The Trust is at risk of not delivering its year end financial position as set out in the risk section opposite
- The Trust's objective to be in recurrent surplus is off plan given the Trust is in a recurrent underlying deficit position.

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.

To mitigate the in-year risk discussions are ongoing with PLACE partners to seek support along with a focus on grip and control within Divisions to control financial spend and use of resources.

23/24 planning process has commenced, with the Trust advocating for a review of allocations in funding from the ICB. The planning process will also include CIP development and a focus on improving underlying productivity and reducing temporary staffing spend. Further grip and control is needed in 23/24.

	• 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	

Risk ID	Risk Description	Current CRR Risk Rating	Risk Appetite Type	Risk Appetite Level	Target Risk Rating	*Datix Linked Risk ID's*	*Comments*
F&P1 11	**Failure to achieve compliance with financial performance and achieve financial plan**	***16***	**Fin**	***Open***	***8***		
F&P12 1412	**Risk of fire to the Estate**	***15***	***Fin Reg***	***Open***	***10***		
F&P20 1807	**Risk of Critical Lift Failure in a Number of Passenger Lifts Trust Wide**	***20***	**Qual Fin**	***Open***	***8***	***1224,1239,2681***	
ARC01 13	**Risk of economic crime against the Trust by not complying with Government Counter Fraud Functional Standard GovS 013 – Counter Fraud**	***12***	**Rep Reg**	***Open***	***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.	Dec 2022	March 2022	AC	Ongoing review of financial controls. Variability in level of grip and control in Divisions.
Budget Setting and Business Planning	Jan 22	Feb 22	AC/JS	No unexpected exceptions identified. Business planning has commenced.
Internal & External Audit programme design & compliance outcomes	Dec 2022	March 2022	AC	Last Internal Audit provided significant assurance. External Audit on 21/22 provided an unqualified audit opinion. HFMA internal audit results overall were positive with action plan in place to address gaps.
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.	Dec 2022	Feb 2022	AC/JS	Ongoing monitoring as ICB develops and Place develops. Funding issues raised in letter to ICB and ongoing discussions with ICB as start 23/24 planning.
Implementation of Granger Report Actions	Dec 2022	March 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 with forecast delivery by end of year.
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 with forecast end date of March 23.
3. Delivery of reduced temporary staffing spend especially in Nursing	Ongoing	Ongoing	JS – supported by all Exec Directors	Further work required in this area as we exit winter pressures.
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:	31 January 2023	**Agenda Reference:**	**E4**
Report Title:	**Operational Performance including Ambulance Handovers**		
Sponsor:	Denise Smith, Chief Operating Officer		
Author:	Laura Fawcett-Hall, Head of Performance		
Appendices:			
Purpose of report:	The overall integrated performance report aims to: • Deliver an executive summary – summarising the operational context, performance headlines and the forward plan. • Share the full performance metrics through the IQPR at a glance charts. • Provide the full Performance Exception report for the headline metrics.		
Summary of key issues:	**<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 and paediatric pathways • 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 December 2022. • The performance report for December 2022 is presented in this operational context. **<u>Headlines from Integrated Performance Report (December 2022)</u>** *Emergency* • **4 Hour Access** – in December 60.6% the Trust delivered 66.4% achievement against national target of 95%, which is a decrease from the November 2022 position of 66.4%. Performance for the month benchmarks "in the pack" across Northeast and Yorkshire. A wide-ranging action plan is in place. • **12 Hour Waits –** Throughout December 2022 the Trust remained in OPEL 4 which caused significant exit blocks from A&E with increased boarding times experienced as a result. The Trust are reporting 8.77% 12 hour waits from time of arrival and 3.42% of patients waited over 12 hours after the decision to admit was made. • **Ambulance Delays -** There are continued challenges across both sites and the increased numbers of ambulances continues at both Doncaster and Bassetlaw. 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. There were further impacts felt as a result of industrial action in December 2022. • **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. ECIST project to commence 23/01/23 to support improvement in flow and discharge processes.

Elective

- **Activity** - Overall, the Trust was not on plan for December 2022 and had lower activity levels compared to 19/20. In December 2022 Daycase delivered 83.8% of plan (down 6.6% points from previous month), elective delivered 79.4% of plan (7.1% points increase from previous month), first outpatients delivered 89.5% of plan and follow ups were at 74.0% of plan.

- **52 Week Breaches** – in December 2022 the Trust reported 1222 breaches due to Covid 19 delays, a notable decrease from 1301 in November 2022. The 3 specialities with the most 52 week breaches are Trauma and Orthopaedics, Gynaecology and ENT.
- **104 week waits** – At the end of December 2022, there was no patients waiting over 104 weeks.
- **Referral To Treatment (RTT)** - in December 2022 the Trust delivered 62.7% performance within 18 weeks, below the 92% standard. This position is a decrease from November 2022 (64.9%) and is still being affected by a lack of bed capacity and staffing issues. In December 2022 there were 20 working days compared with 22 in November 2022 meaning there was less opportunity for clock stops in Month. The 2% reduction in RTT performance is in line with previous Decembers.
- **The total waiting list** decreased during December 2022 to 50,232. The previous position in November was 50,960 and October was 51,066.
- **Diagnostics** – in December 2022 the Trust achieved 51.77% against a target of 99%. This is a significant decrease of performance from 61.5 in November 2022. The greatest reductions in performance were MRI and gastroscopy.

Cancer

- **Faster Diagnosis Standard –** In November 2022 the Trust achieved the FSD standard with 81% against the performance target of 75%.
- **31 Day Standard** – in November 2022 2 out of 3 nationally reported measures were achieved.
- **62 Day Standard –** in November 2022 0 out of 2 nationally reported measures were achieved.
- 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:

- Implementation of plan to digitally validate all waiting lists every 12 weeks
- Implementation of plan to continue agreed levels of outsourcing in T&O
- Present the business case for additional resource in the validation team
- Complete the procurement exercise for a digital patient tracking system and progress to implementation

	• 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 From an emergency perspective, the key next steps are: • Continue to embed SDEC criteria led referral model for ESA and YAS patients • Overnight observations and education with clinical teams to identify issues with overnight performance • Significant focus on patients with no right to reside (approx. 2 wards worth of beds) • FCMS working on direct admission pathways due to number of ambulance arrivals that are referred from ED to FCMS Overall, the Trust continues to experience significant operational challenges and will continue to focus on safety, sustainability and supporting its teams, people and patients
Recommendation	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*

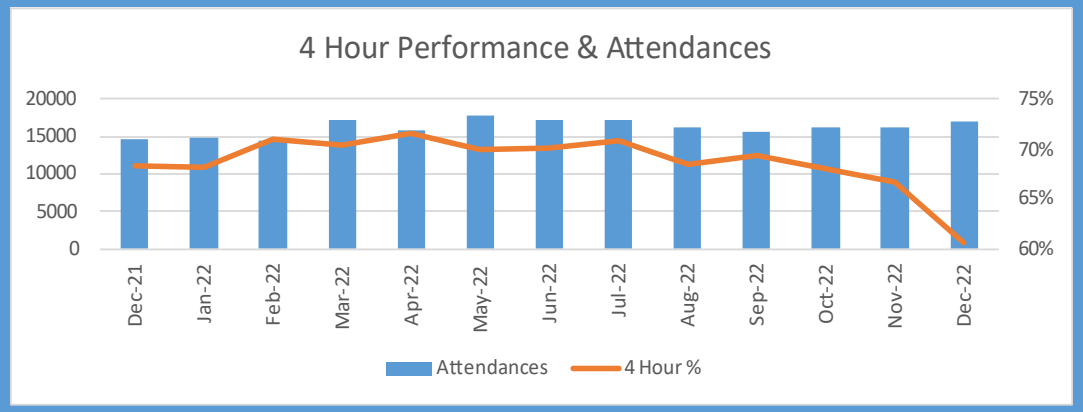
Implications	
Board assurance framework:	Changes made to SA1 to reflect risk and related to winter planning & also planning mitigation
Corporate risk register:	Report regards Risks ID 6 and 2349 on the Risk Register - F&P 6 and F&P 8. • Failure to achieve compliance with performance and delivery aspects 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

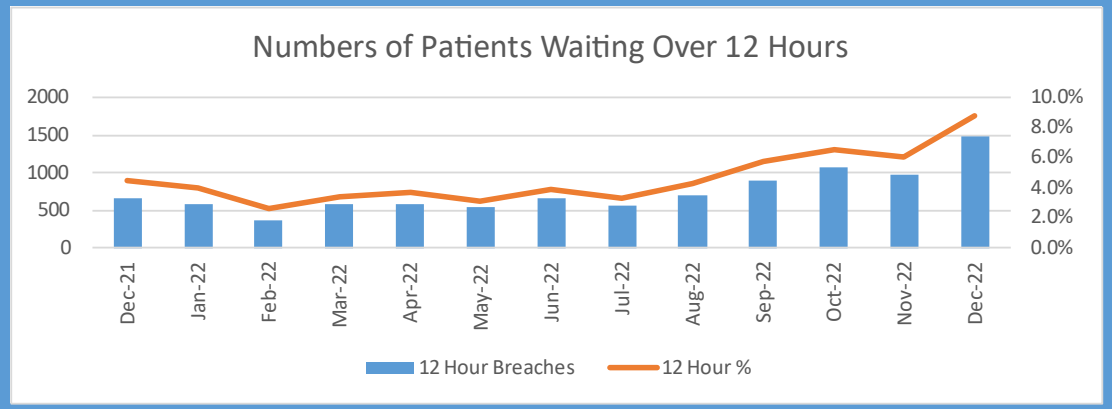
Assurance Route			
Previously considered by:			
Date:		**Decision:**	
Next Steps:			
Previously circulated reports to supplement this paper:			

Trust Integrated Exception Performance Report – December 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 60.6% for Trust. Main breach reasons continue to be doctor and bed waits
- Attendance levels remain higher than any of previous four years, with a significant increase across minors and paediatric pathways in December
- 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, sickness and vacancy
- Significant exit block impacting on flow with increased boarding times experienced as a result due to bed occupancy of 98%
- 12 hours from arrival 8.77%
- 12 hours from DTA 3.42%

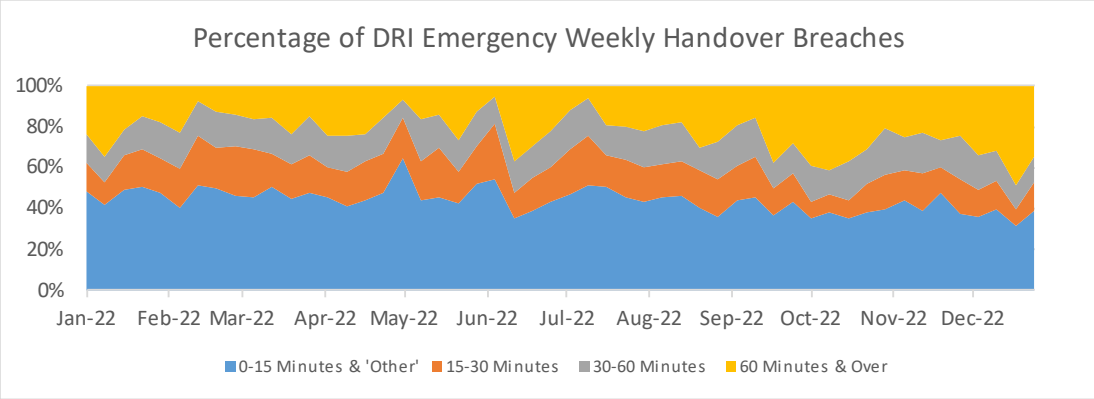
Key actions:

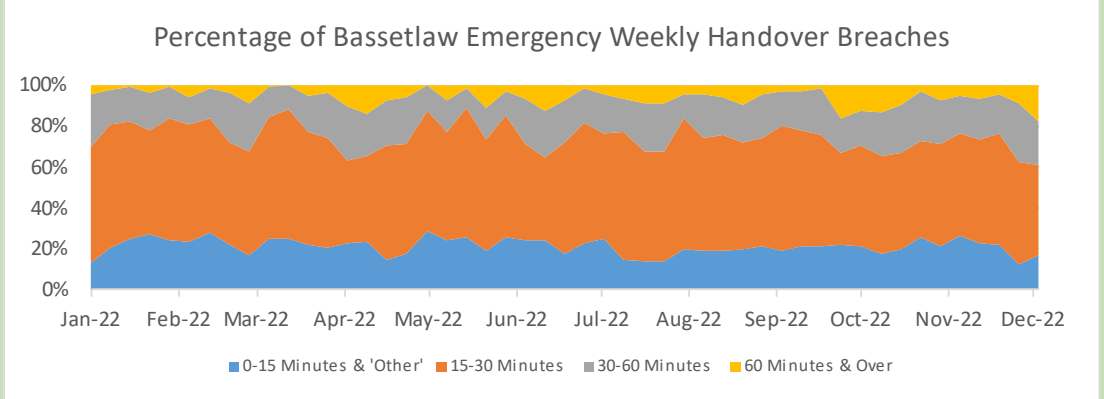
- ESA model implementation completed on the Doncaster site. Soft launch at Bassetlaw took place on 21 October.
- Re-establishment of EAU model completed 3rd Oct to help increase ED flexibility and majors flow
- Preferred options reviewed for 'Larger front Door'- increased UTC and SDEC capacity aligned with national specification being worked up 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 November
- Overnight observations with clinical teams to identify issues with overnight performance ongoing
- Care Navigation area and increased capacity in ESA now complete

December 2022 Performance

Hospital	4 Hour % Achieved	Attendances	Breaches	%Streamed From FDASS
Bassetlaw	74.68%	5111	1294	10.02%
Doncaster	57.94%	9792	4119	22.77%
Montagu	100.00%	1321	0	0.00%
Trust	66.64%	16224	5413	16.90%

2. Urgent and Emergency Care: Ambulance waits





Key issues:

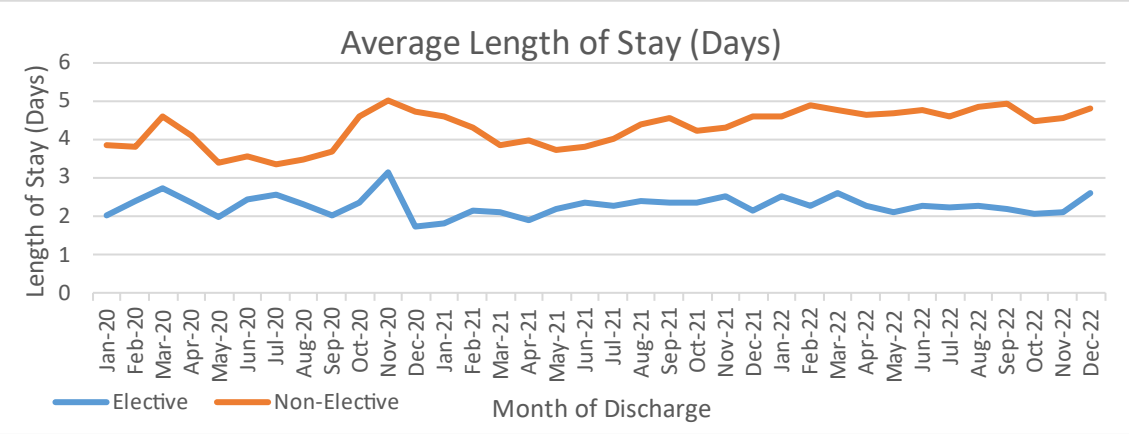
- Ambulance handover performance position continues to be challenging in December
- Increased levels of ambulances continue in the Doncaster & Bassetlaw area.
- Increasing challenges to flow of ambulances coming into and the receiving of handovers.
- Issues related to flow out of ED & wider trust continue 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
- Industrial action impacted further in December

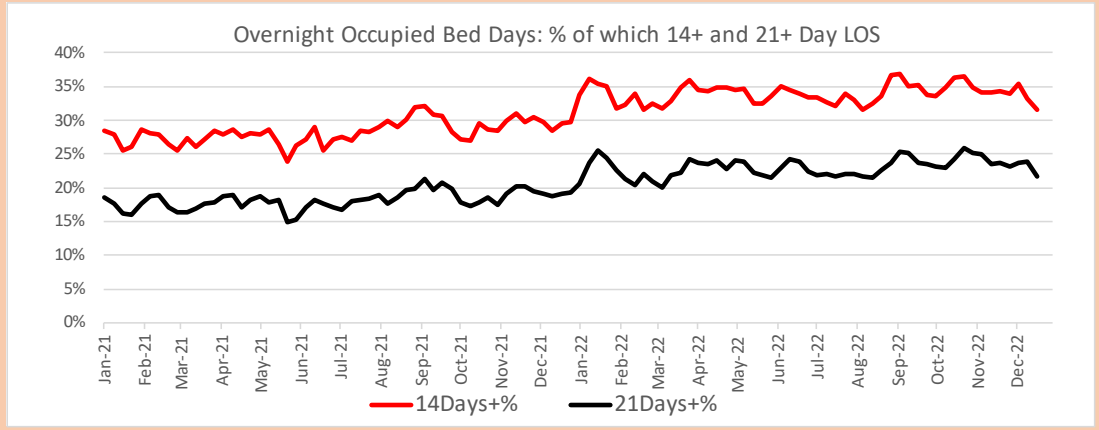
Key actions:

- 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 – now completed
- EAU re-instated 3 October
- NHSE commissioned DBTH/YAS QI project to identify improvement at pace – workshop completed, action plan in progress

Month	Hospital	Total Arrivals	%<15 Minutes	% 15-30 Minutes	% >30 Minutes	Longest Wait
Dec-22	Bassetlaw Hospital	788	14.85%	46.57%	38.58%	06:37
Dec-22	Doncaster Royal Infirmary	2090	36.27%	10.96%	52.78%	09:39
Dec-22	Trust	2878	30.40%	20.71%	48.89%	09:39

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
- ECIST project to commence 23 January 2023 to support improvement in flow and discharge processes

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

Discharges by Time of Day (Excluding Day case)

Discharge Time	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Before Noon	15.4%	14.1%	13.5%	12.0%	14.1%	13.3%	12.9%	12.1%	12.4%	12.2%	13.8%	14.0%	14.3%
Before 4PM	47.7%	47.0%	46.5%	42.9%	46.8%	46.9%	46.4%	45.5%	43.3%	44.0%	45.3%	46.0%	46.4%
After 4PM	51.7%	52.7%	53.1%	56.8%	53.1%	52.8%	53.1%	54.0%	56.3%	55.6%	54.0%	53.7%	53.3%

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 November as a result
- Single point of access now in place via Consultant Connect – work to be undertaken to increase call pick up

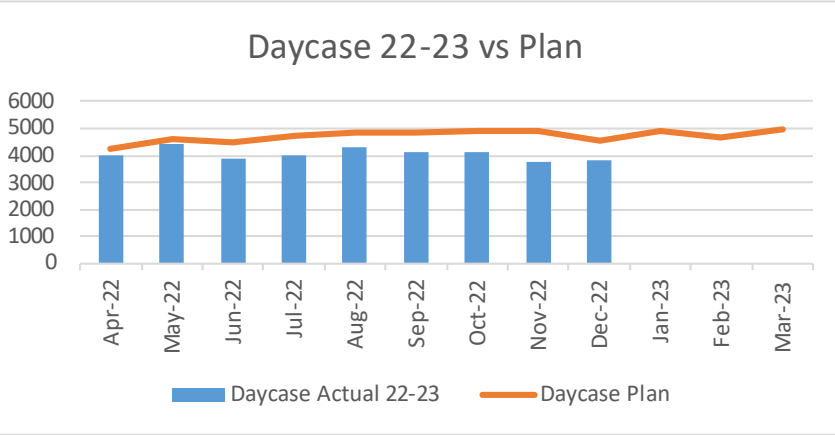
% of all Non-Elective Admissions to an SDEC Ward

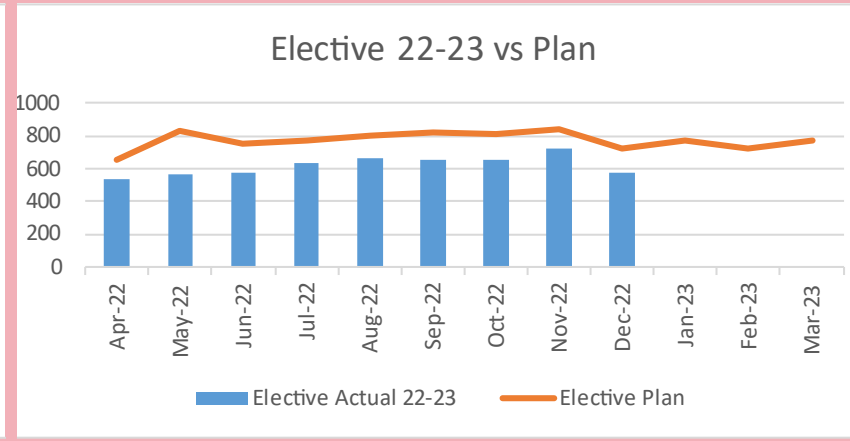
Ward	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Oct-21	Dec-22
ACUTE MEDICINE DECISIONS UNIT	3.2%	5.2%	4.5%	4.0%	3.2%	4.2%	3.5%	3.4%	2.9%	3.2%	0.1%			
AMBULATORY CARE UNIT - DONCASTER	7.5%	8.9%	8.8%	10.1%	9.2%	10.1%	11.0%	10.0%	10.1%	10.6%	10.6%	11.5%	8.1%	8.6%
EMERGENCY SURGICAL AMBULATORY CARE	5.2%	6.3%	5.0%	5.0%	5.2%	5.2%	6.0%	5.9%	5.8%	5.6%	4.3%	5.7%	4.3%	4.9%
GYNAECOLOGY SAME DAY EMERGENCY CARE	0.4%	0.3%	0.2%	0.1%	0.0%	0.5%	1.3%	1.6%	2.3%	1.7%	1.2%	1.5%	0.4%	1.2%
TRAUMA AMBULATORY CARE UNIT										0.0%				
Grand Total	16.3%	20.8%	18.6%	19.2%	17.6%	20.0%	21.8%	21.0%	21.0%	21.1%	16.2%	18.6%	12.9%	14.7%

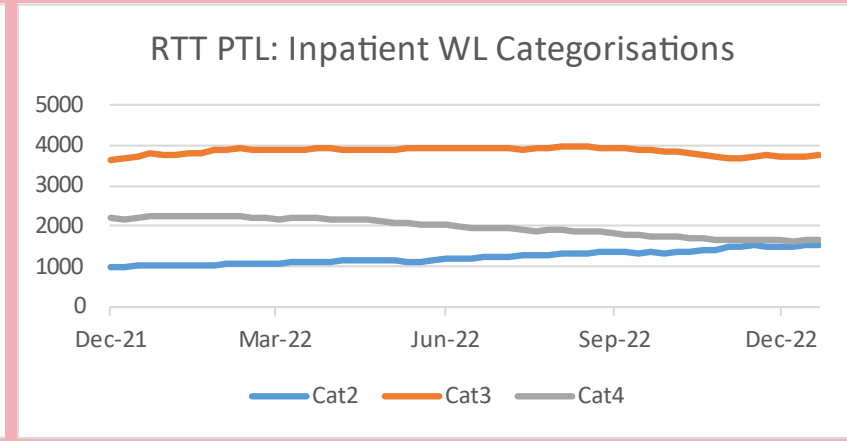
Number of Non-Elective Admissions to an SDEC Ward

Ward	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Oct-21	Dec-22
ACUTE MEDICINE DECISIONS UNIT	142	219	178	174	133	190	158	155	128	146	5			
AMBULATORY CARE UNIT - DONCASTER	330	375	347	442	389	459	493	453	445	484	509	560	377	404
EMERGENCY SURGICAL AMBULATORY CARE	231	264	198	219	219	239	269	268	258	256	208	277	202	228
GYNAECOLOGY SAME DAY EMERGENCY CARE	18	13	7	4	1	23	59	72	100	76	59	72	19	58
TRAUMA AMBULATORY CARE UNIT										1				
Grand Total	721	871	730	839	742	911	979	948	931	963	781	909	598	690

5. Elective: Daycase and Inpatient Elective







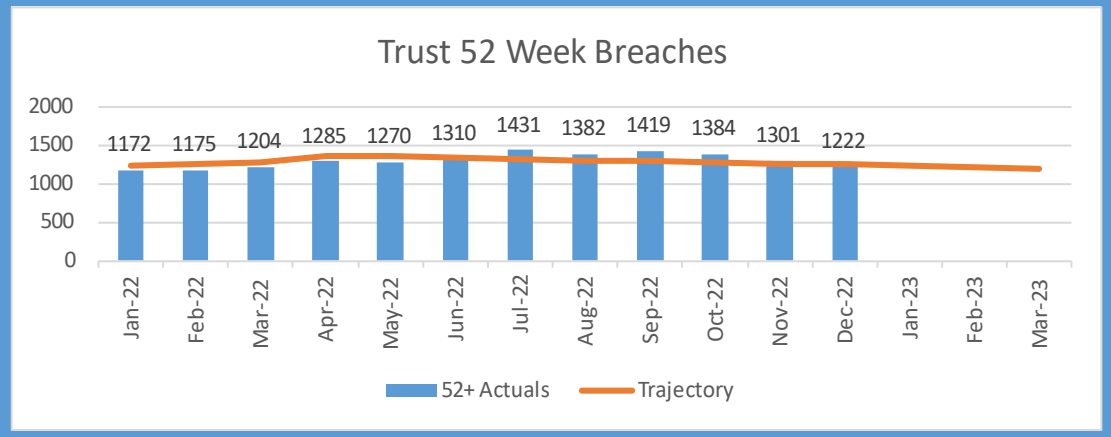
Key issues:

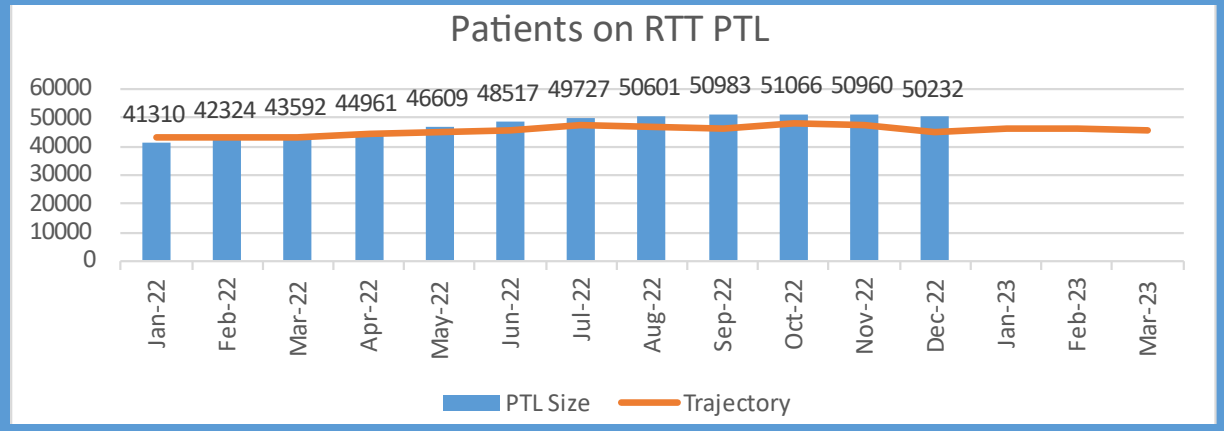
- Day case - Trust delivered 83.8% of plan (6.6 percentage points down from previous month) and 94.2% of 19/20 activity (10 percentage points up from previous month)
- Elective - Trust delivered 79.4% of plan (down 7.1 percentage points on previous month) and 97.3% of 19/20 activity (down 5.5 percentage points)
- All patients are listed on the basis of clinical prioritisation and longest waiting times
- Focused look on at theatre scheduling to ensure minimum of 85% utilisation of lists in line with GIRFT
- Daily clinical review continues to prioritise patients according to available capacity
- Loss of available operating capacity due to continued OPEL 4 winter pressures and theatre staffing issues.
- The majority of the surgical bed base was unavailable during December as this was re-purposed to manage winter pressures.

Key actions:

- Continue to list all patients, prioritising urgent, Cat 2's and the longest waiting Cat 3's & 4's
- All patients at risk of breaching 78 weeks will be offered a TCI date before the end of March 2023 where capacity allows. Any residual long waiters will be offered up for mutual aid.
- Outsourcing continues to improve with the exception of Parkhill.
- Conversion of inpatients to day case wherever possible
- Reviewing theatre project outcomes from another organisation (Bradford) to share best practice as recommended by GIRFT

6. Elective: Patient Tracking List and Long-Waiters





Key issues:

- At the end of December 2022 there are 1222 Incomplete Pathways to be reported as 52+ weeks which is a reduction from 1301 in November
- The total number of Incomplete pathways has decreased to 50232 from 50960 in November.
- There were no 104 week breaches in December
- The Trust Level month end 18 week performance for December 2022 is 62.7%, which is notably lower than November 2022 however is in line with previous December drops over the past few years.
- Elective programme was reduced in December due to winter pressures.
- In December there were only 20 working days as opposed to 22 in November, therefore less clock stop activity is expected.

Key actions:

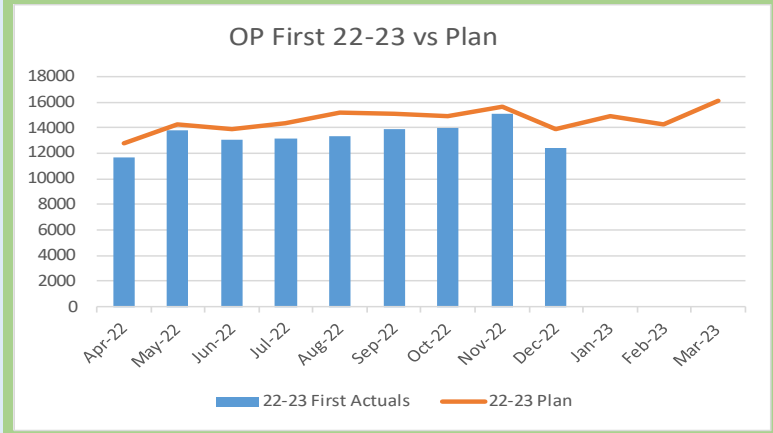
- Weekly PTL meetings maintained to ensure consistent approach across Trust to managing long waiters, both for outpatient and inpatient activity
- RTT Audits across all clinical service areas to identify opportunities for improvement/training
- Maintained focus on 104 week waiters and all 78ww patient pathways man-marked and tracked
- All patients at risk of being 78 weeks by the end of March are currently being allocated OPA / TCI where capacity allows, all others will be offered up for mutual aid.
- Currently out to procurement for a digital patient tracking system
- All patients over 52 weeks who have not been previously validated in the past 12 weeks are currently being validated.

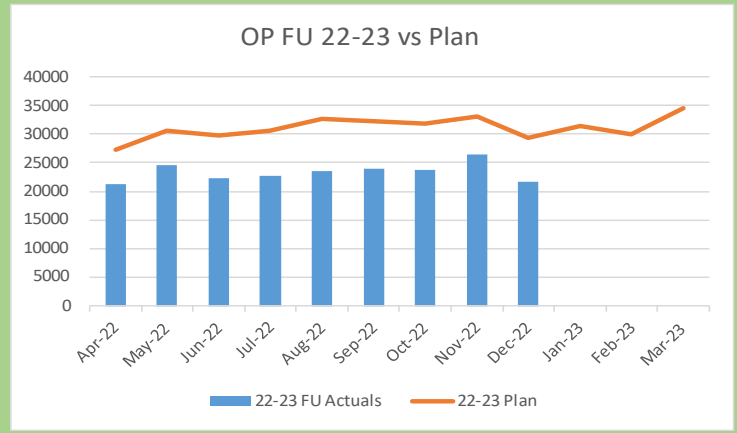
CCG	Values	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
NHS Bassetlaw CCG	Total Waiters	8848	9014	9334	9601	9922	10234	10507	10597	10757	10726	10732	10635
	% Under 18 Weeks	66.2%	66.3%	67.0%	67.3%	69.8%	68.1%	66.0%	65.5%	64.4%	65.5%	65.5%	64.0%
NHS Doncaster CCG	Total Waiters	25967	26589	27380	28196	29327	30620	31420	32060	32350	32295	32166	31533
	% Under 18 Weeks	67.0%	67.1%	68.3%	67.7%	70.7%	69.4%	67.2%	66.9%	65.5%	65.3%	65.4%	63.1%
Trust	Total Waiters	41310	42324	43592	44961	46609	48517	49727	50601	50983	51066	50960	50232
	% Under 18 Weeks	66.8%	67.3%	68.3%	68.1%	70.7%	69.1%	66.7%	66.2%	64.7%	65.1%	64.9%	62.7%

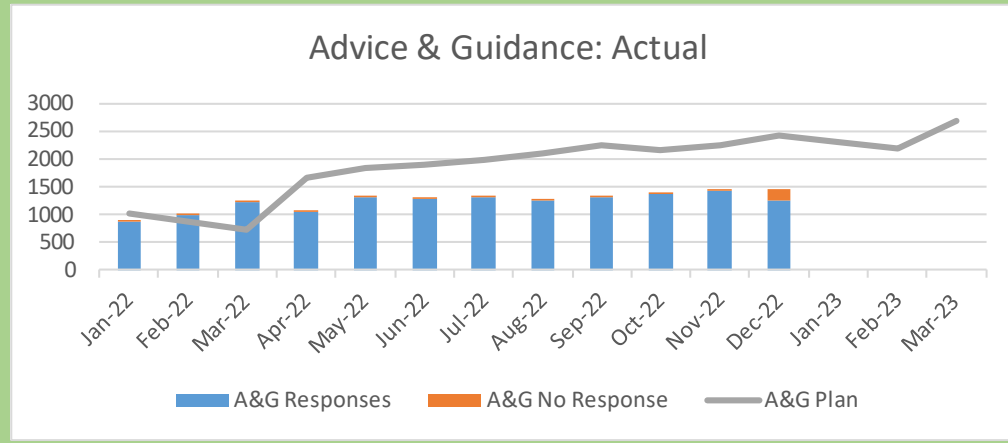
Reported 52+ Weeks: Top 5 Specialties

Speciality	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
TRAUMA & ORTHOPAEDICS	564	555	540	532	616	670	740	794	809	850	847	819	783
ENT	108	119	112	96	91	103	112	114	127	128	133	132	130
GYNAECOLOGY	29	38	45	77	103	127	139	153	167	161	161	128	115
UROLOGY	92	91	92	103	88	76	88	125	95	111	85	86	75
OPHTHALMOLOGY	275	279	287	321	317	224	150	154	110	85	70	62	75
PODIATRY	1	2	1	1	2	1	3	10	15	19	16	14	18

7. Elective: Outpatients A&G





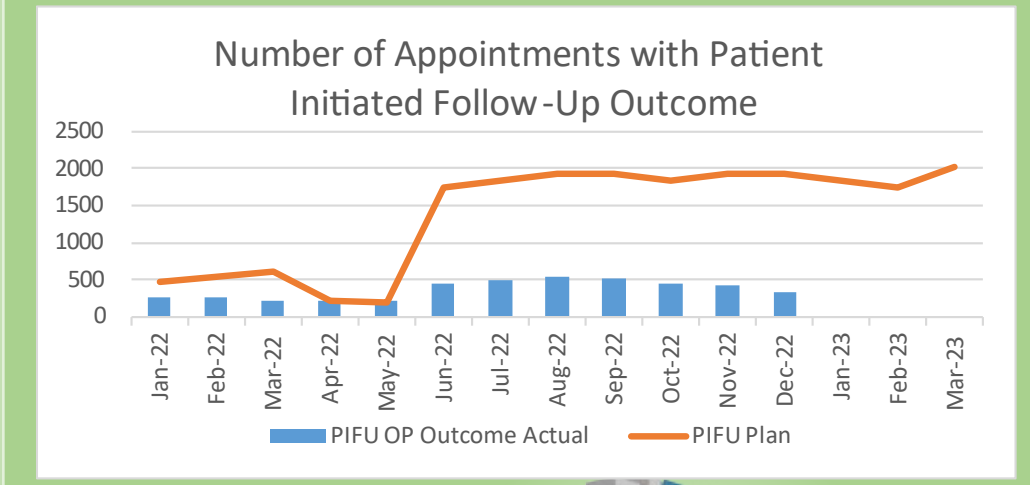


Key issues:

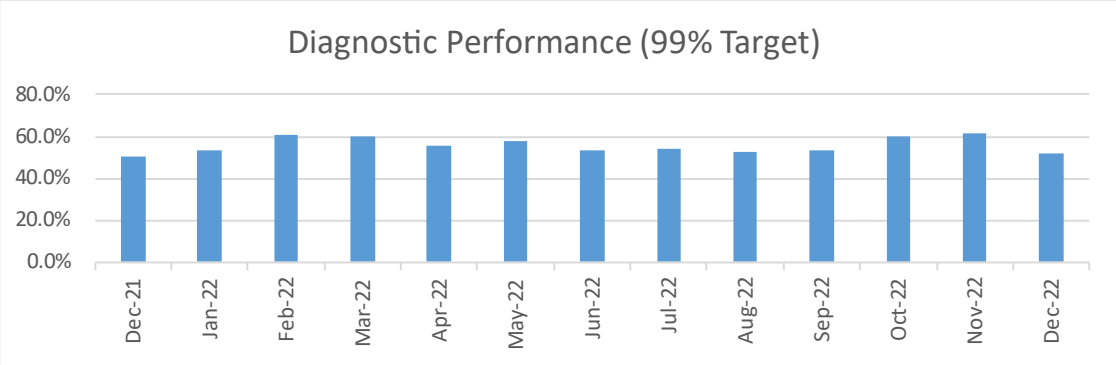
- First outpatient appointments the Trust delivered 89.5% of plan and 91.5% of 19/20 activity in December. A 7 percentage point decrease on November's activity vs plan
- Follow-up outpatient appointments the Trust delivered 74.0% of plan and 88.7% of 19/20 activity in December. A 5.9 percentage points decrease on November's activity vs plan
- PIFU plans progressing paper to TEG for approval to close a proportion of patients.
- A&G national reporting also includes Consultant Connect which is commissioned by PLACE therefore Trust is achieving the target of 16 per 100.

Key actions:

- Continue to look for opportunities to increase capacity, deal with the backlog and reduce waiting times for patients
- Piloting patients self scheduling follow up appointments in Dermatology.
- Discussion required around the continuation of e-reconciliation due to lost clinic capacity.
- Discussions continue regarding updated Covid guidance for AGPs in clinic areas
- Continued focus on validating patient pathways and business case in development for additional validation support
- Consultant RTT training to ensure sound understanding of RTT rules and guidelines
- Using patient engagement portal to undertake 12 weekly validation of all waiting lists in line with NHSE requirements.



8. Diagnostic waits



	Waiters <6W	Waiters >=6W	Total	Performance
Trust	8674	8080	16754	51.77%
NHS Doncaster	5577	5260	10837	51.46%
NHS Bassetlaw	2309	2154	4463	51.74%

Exam Type	<6W	>=6W	Total	Performance	Longest Waits
MRI	1757	1544	3301	53.23%	64
CT	1625	480	2105	77.20%	50
Non-Obstetric Ultrasound	3056	3467	6523	46.85%	54
Barium Enema	0	0	0		N/A
DEXA	330	781	1111	29.70%	34
Audiology	263	1254	1517	17.34%	64
Echo	369	89	458	80.57%	18
Nerve Conduction	172	23	195	88.21%	25
Sleep Study	22	0	22	100.00%	N/A
Urodynamic	56	13	69	81.16%	24
Colonoscopy	242	145	387	62.53%	13
Flexible Sigmoidoscopy	95	59	154	61.69%	13
Cystoscopy	334	4	338	98.82%	9
Gastroscopy	353	221	574	61.50%	13
Total	**8674**	**8080**	**16754**	**51.77%**	**64**

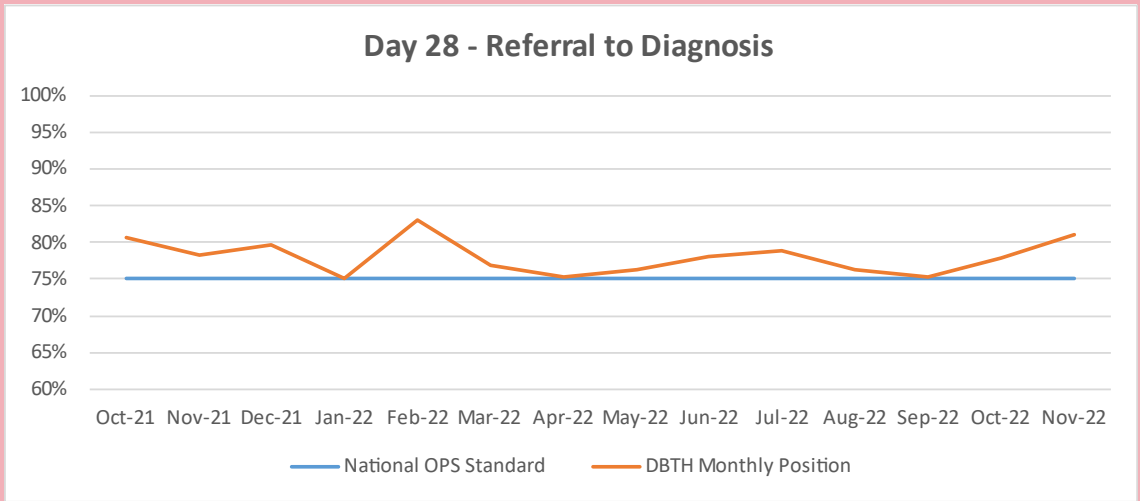
Key issues:

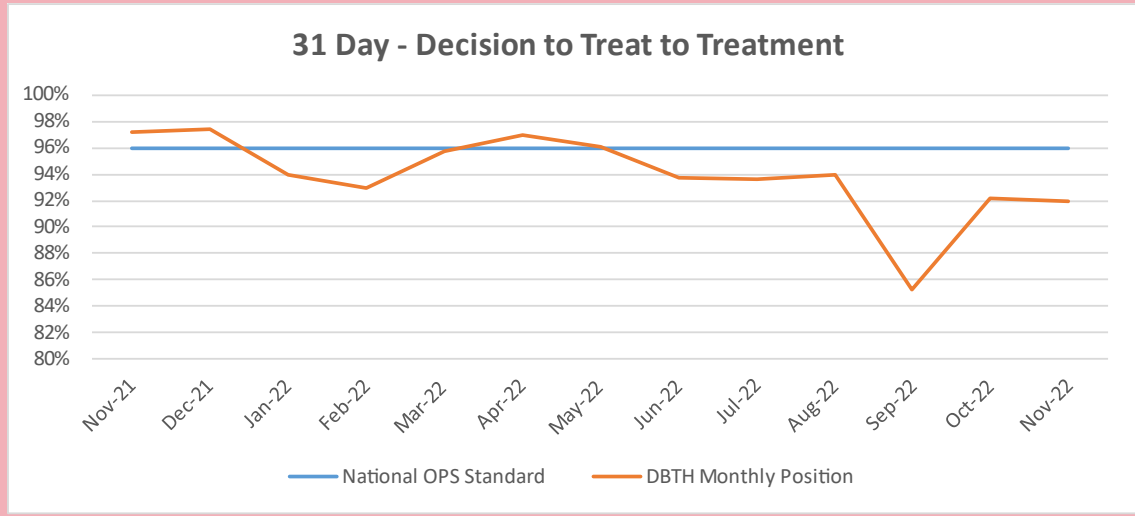
- Performance against the 6-week target deteriorated from 61.5% in November to 51.77% in December.
- Reduction in activity over the Christmas holiday period and increased sickness absence were key factors affecting performance. These was compounded by a delay in the re-commissioning of the second MRI scanner at Bassetlaw Hospital and by the MRI scanners at both DRI and Bassetlaw Hospital breaking during December.
- The only modality to achieve improvement from November to December was urodynamics.
- The greatest reductions in performance were in gastroscopy (-23%) and MRI (-15%).
- The greatest increases in the number of 6-week plus waiters were in MRI (+583), Non-obstetric Ultrasound (+383), and Gastroscopy (+136).

Key actions:

- Delivery of additional CT, MRI, and Non-Obstetric Ultrasound activity in Quarter 4 per the agreed recovery plans.
- Reforecasting of the MRI recovery trajectory to take accounts of the delay in re-commissioning the second scanner at Bassetlaw and the breakdowns of two scanners in December.
- An in-depth analysis of Audiology capacity and demand has demonstrated a significant capacity shortfall. An action plan is being developed.
- The business case for static CT and MRI scanners as part of the Community Diagnostics Centre is being considered by the South Yorkshire ICB..

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





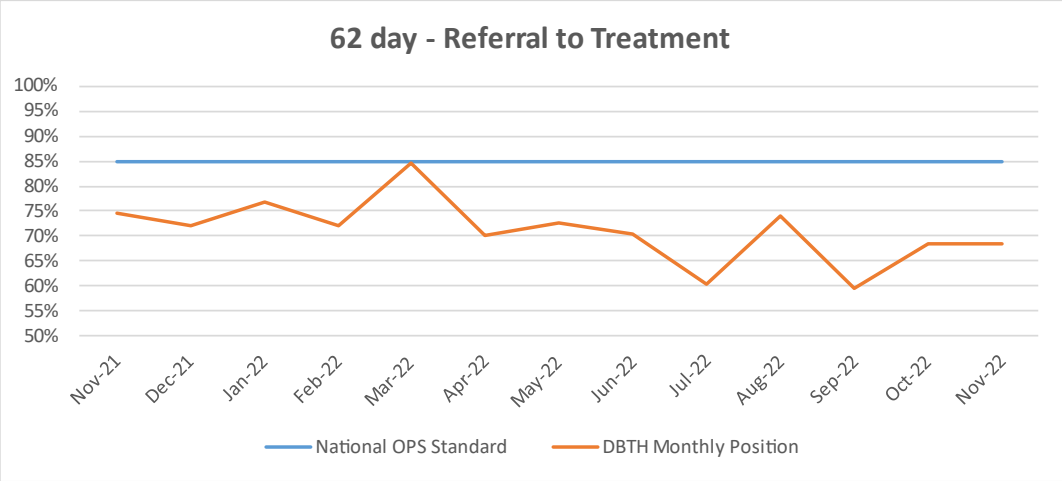
Key issues:

- Trust FDS standard compliant November 81% – 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



Nov-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	91.9%	100.0%	100.0%	68.4%	83.9%	48.3%

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:

Current priority and actions are focused around Awareness, education and embedding Health Inequalities into policies and procedures.

Significant work is underway to ensure all staff will have a basic understanding of Health Inequalities and that all new work streams consider HI.

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 ongoing to audit current good practice, share learning and identify areas of improvement.
- Data is not focussed on Health Inequalities as a priority, leading to inadequate datasets to allow informed identification of areas of concern or areas requiring target support.

Ethnic Category	Doncaster Population %	Bassetlaw Population %	Doncaster and Bassetlaw Combined %	Waiting List Ethnicity Breakdown: Jan-23
Asian/Asian British	2.5%	1.1%	**2.1%**	1.4%
Black/African/Caribbean/Black Br	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: Jan-23
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 19/01/2023 Data

Milestones	
SET training (HI inclusion in EDI section)	February 2023
QI training (HI inclusion in level 1 and 2 training)	January 2023
QPIA – HI included in new version	January 2023

Work streams	
Initial comm's via Buzz	complete
Intranet area development	created, content in progress
Questionnaire to staff	ready
Introduction video	in development
Inclusion in Business planning process	Complete
Literature Search	Underway
Assessment tool (HEAT)	To be trialled
Audit of current project areas	On going
University HI delivery	Initial contact made
Monday.com inclusion	In development

12. Performance – The Forward Look – 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

- Continue to embed SDEC criteria led referral model for ESA and YAS patients
- Overnight observations and education with clinical teams to identify issues with overnight performance
- Significant focus on patients with no right to reside (approx. 2 wards worth of beds)
- FCMS working on direct admission pathways due to number of ambulance arrivals that are referred from ED to FCMS

Elective

- Implementation of plan to digitally validate all waiting lists every 12 weeks
- Implementation of plan to continue agreed levels of outsourcing in T&O
- Present the business case for additional resource in the validation team
- Complete the procurement exercise for a digital patient tracking system and progress to implementation
- Maintain grip and focus on all long-waiting patients; IP challenges in ENT and ophthalmology due to sub-specialisation/orthopaedics due to demand and backlog

Cancer

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

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	31 January 2023	**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:	Appendix 1 – NHS Nation Objectives 2023/24				
Executive Summary					
Purpose of report:	To provide an update on the changes in the Recovery, Innovation and Transformation Directorate.				
Summary of key issues:	The report updates the board on progress with the approval of the MEOC and CDC business case both of which are expected to be reviewed and signed off nationally on 26th January 2023. CIP is targeted to deliver £19m against a plan of £19.25m.				
Recommendation:	To note the continued progress and in particular the funding approach taken by the ICS to the CDC case and the progress with national approvals.				
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		

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:

- The current status of the CDC programme
- an update on the MEOC business case
- next steps towards the development of a site strategy for DBTH
- an update on progress for the development of a business case for trauma services at DBTH.

2. CDC PROGRAMME

The Montagu CDC Imaging Business Case has been developed by DBTH and approved by DBTH Finance and Performance Committee and Board of Directors at the end of November 2022. Doncaster Place have approved the case and their Chief Officer presented the proposal to the SY ICB Operational Executive Group in December where it was approved that the case could be ratified and approved outside of the committee following discussion with South Yorkshire partners.

The cost of the case is greater than the original business case submission due to increased costs for electrical infrastructure required to support the development and the increasing costs of materials and labour due to inflation following tendering.

Expediting this business case in year was a condition set out by the National CDC Panel of approval. The Montagu CDC Phase 2 business case to refurbish estate enabling delivery of Non-Obstetric Ultrasound (NOUS) and an endoscopy suite/multifunctional clinic room/training facilities will make the Montagu CDC the only 'Large CDC' in South Yorkshire and Bassetlaw if this imaging case is approved.

During the preparation of this case the economic environment we find ourselves operating in has meant an increase in costs for the equipment to be secured. Ongoing clinical engagement with the SY Cardiac Clinical Network, has also advocated that we secure a Cardiac CT, alongside Cardiac software for MRI to enable the delivery of Cardiac Diagnostic pathways at the Montagu CDC. All these elements are now included in the case.

The capital cost of the case in total is £16.2M and over years equates to the following:

	22/23	23/24	24/25
South Yorkshire CDC Allocation	£4.54M Predominantly for equipment to be purchased in year, including the Cardiac CT and MRI and the endoscopy equipment for a second room	£5.354m Montagu Imaging Unit BC	Year 3 – 5 Planning underway with Business Cases to be submitted to SY&B ICB Q1 2023
National CDC underspend £350m (Nov 22 figure)		£6.3m For remainder of Montagu Imaging Unit BC to mobilise Q1 2024	
Total ask for Montagu Imaging Unit Business Case		£16.2M	

The SY ICB system is in support of the Montagu CDC development particularly seeking funding as set out above and are keen to understand if the national CDC programme will support in accessing the centrally held CDC capital reserve in 23/24 to allow us to expedite delivery of our large CDC. In order to secure and spend the capital in 22/23 we would need decision making to take place in January 2023. The case was

received by regional colleagues who started their review in the w/c 16th January 2023 with the expectation of submission to the national CDC panel 26th January 2023.

3. MONTAGU ELECTIVE ORTHOPAEDIC CENTRE (MEOC) PROJECT

The MEOC programme continues to move at pace. All partner organisations, place and ICS are reviewing the business case. The Rotherham Trust Board and the DBTH board have approved the case with Barnsley due to sign off in the first week of February.

In the last week two meetings have been held with the regional team to review the case. This has resulted in a number of issues being raised with the team however NEY region has submitted the case to the national team, with a recommendation for approval, the issues raised will be taken back through the project once we have final official notification along with any points coming from the central team. The national approvals committee will review on the case on the 26th January 2023. This means the case could have approval nationally and the money made available to DBTH before having local approval.

Work has continued with the partner Trusts clinicians and three clinical workshops have been held since the last F&P.

4. NEW HOSPITAL UPDATE

The project team is producing an outline proposal to commence work on the OBC, work on this has been delayed as resources have been focused on the MEOC project. The Director of Recovery, Innovation and Transformation has met with the CFO of the ICS to discuss moving forward and drafted a suggested letter for them to send to the DHSC.

5. SUSTAINABLE TRAUMA

The completion of the business case was targeted for the end of January 2023 but this date is again under pressure due to the unavailability of some clinical staff while they managed emergency pressures and non-operational meetings were cancelled during December to alleviate these pressures. Additionally, the MEOC (Montagu Elective Orthopaedic Centre) was prioritised and draws on largely the same stakeholder and project delivery resource as the trauma project. The work required to complete the business case needs to be replanned and a new target date set, this will be reviewed and taken to the Finance and Performance Committee.

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

Progress to date

Progress in December was slow however, the Trauma Management Meeting did take place on the 9th December 2022 and papers were circulated by Ranjit Pande, Clinical Lead, in advance of the meeting covering the options appraisal outcome and the measures (KPIs) for trauma services.

The work on completing the option appraisal is around 50% complete with stakeholders having assessed each option against critical success factors. Work is now underway on the economic evaluation of options, however as stated about this work is paused whilst the clinical meetings and next steps for MEOC are underway.

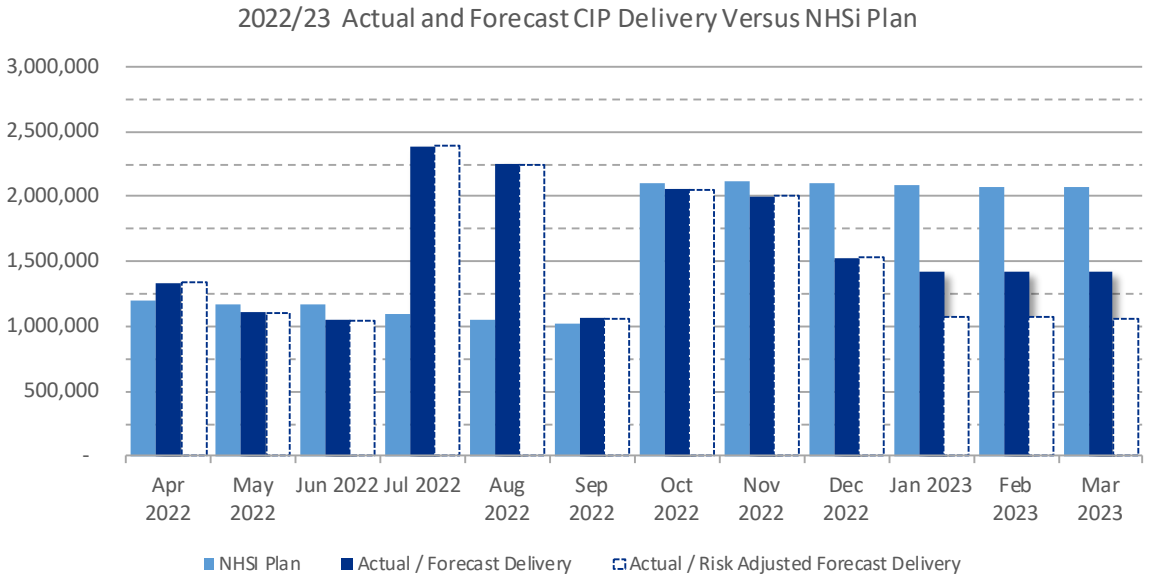
6. CIP PERFORMANCE

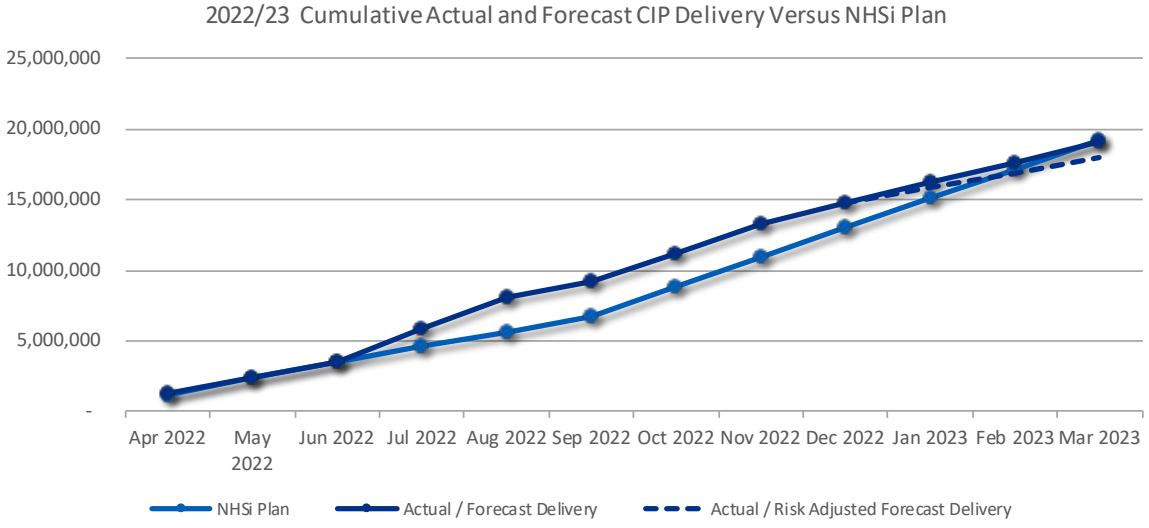
The Trust has an agreed plan to deliver a £19.25M savings in the current financial year. The overall target has been broken down into the following schemes.

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 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 £1.5m of savings in M9 versus the plan submitted to NHSI of £2.1m, an under-delivery of £0.8m.





	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	1,999,551	1,532,320	1,426,171	1,421,284	1,416,848	**19,043,459**
Delivery/Forecast v NHSI Plan	+142,802	-58,924	-120,924	+1,293,217	+1,190,274	+49,426	-47,865	-112,684	-573,462	-655,184	-656,837	-656,383	**-206,541**
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	13,246,835	14,779,156	16,205,327	17,626,611	19,043,459	
Cumulative Delivery/Forecast v NHSI Plan	+142,802	+83,878	-37,045	+1,256,172	+2,446,446	+2,495,872	+2,448,007	+2,335,324	+1,761,862	+1,106,678	+449,841	-206,541	

In month Performance

In December 2022 the Trust has delivered savings of £1.5m versus the NHSI plan of £2.1m. The following table details the key variances between forecast and actual delivery:

	Month 9				
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	401,615	401,615	401,615	0	0
ERF Productivity	458,333	458,334	458,333	0	-1
Temporary Staffing	0	100,000	0	0	-100,000
Procurement Savings	62,500	62,500	2,760	-59,740	-59,740
Unidentified	0	750,000		0	-750,000
Non Pay (Reserves Release)	333,333	333,333	333,333	0	0
C&F - Local	91,642	0	118,728	27,086	118,728
CSS - Local	68,301	0	54,742	-13,559	54,742
S&C - Local	20,489	0	20,489	0	20,489
Medicine - Local	70,027	0	70,027	0	70,027
E&F - Local	21,010	0	21,010	0	21,010
Other Corporate - Local	51,284	0	51,283	-1	51,283
Total	**1,578,534**	**2,105,782**	**1,532,320**	**-46,214**	**-573,462**

7. 2023/24 BUSINESS PLANNING

Guidance received

The *"2023/2024 Priorities and Operational Planning Guidance"* was published on the 23rd December 2022 and sets out the key targets for the NHS. The three key tasks identified for the coming financial year are:

1. Recover our core services and productivity
2. Make progress in delivering the key ambitions in the NHS Long Term Plan
3. Continue transforming the NHS for the future.

Further key points of note with specific targets are detailed below:

Improve ambulance **response** and A&E waiting **times**

- Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
- Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25).

Increase capacity in beds and reduce bed occupancy

- £1bn of funding through system allocations to increase capacity based on agreed system plans
- Increase utilisation of virtual wards towards 80% by the end of September 2023
- Reduce adult general and acute (G&A) bed occupancy to 92% or below.

Reduce elective long **waits** and cancer **backlogs**

- Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
- Meet system level activity targets (The contract default between ICBs and providers for most planned elective care (ordinary, day and outpatient procedures and first appointments but not follow-ups) will be to pay unit prices for activity delivered)
- Continue to reduce the number of patients waiting over 62 days
- Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
- Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028.

Recover and **increase productivity**

- Meet the 85% day case and 85% theatre utilisation expectations
- Reduce OPFU activity by 25% against the 2019/20 baseline by March 2024.

Improve performance against the core diagnostic standard

- Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
- Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition.

Deliver a balanced system financial position

- Meet the required efficiency target.

Continue to **improve maternity** services

- Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
- Increase fill rates against funded establishment for maternity staff.

Improve and reduce **health inequalities**.

Invest in our **workforce**

- Improved staff experience and retention through systematic focus on all elements of the NHS People Promise
- Support flexible working practices and flexible deployment of staff across organisational boundaries using digital solutions.

Continue to **progress digital** maturity.

Further details are included in the appendix and link referenced earlier.

Progress to date

A significant amount of work has already been completed on producing draft plans. The key deadlines were 6th January for divisional plans and 13th January for corporate department plans. A steering group has been established to govern the planning process and is meeting weekly with representatives nominated for each area. A number of workshops are now in diaries however some processes need to be further defined by their respective leads; this is proving challenging due to current Trust operational pressures.

8. RECOMMENDATION

The Board is asked to note the progress with the various projects outlined above, in particular the approvals process concerning the CDC and MEOC.

APPENDIX 1

Targets in planning guidance

National NHS objectives 2023/24

	Area	Objective
Recovering our core services and improving productivity	**Urgent and emergency care***	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
		Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
		Reduce adult general and acute (G&A) bed occupancy to 92% or below
	Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
		Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
	Primary care*	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
		Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
		Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
		Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
	Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
		Deliver the system- specific activity target (agreed through the operational planning process)
	Cancer	Continue to reduce the number of patients waiting over 62 days
		Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
		Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
	Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
		Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
	Maternity*	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
		Increase fill rates against funded establishment for maternity staff
	Use of resources	Deliver a balanced net system financial position for 2023/24
	Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
	Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
		Increase the number of adults and older adults accessing IAPT treatment
		Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
		Work towards eliminating inappropriate adult acute out of area placements
		Recover the dementia diagnosis rate to 66.7%
		Improve access to perinatal mental health services
	People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
		Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
	Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
		Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
		Continue to address health inequalities and deliver on the Core20PLUS5 approach

**ICBs and providers should review the UEC and general practice access recovery plans, and the single maternity delivery plan for further detail when published;*

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	31 January 2023	**Agenda Reference:**	**F1**
Report Title:	**Research and Innovation Strategy (2023-2028)**		
Sponsor:	Zoe Lintin, Chief People Officer		
Author:	Sam Debbage, Director of Education and Research Jane Fearnside, Head of Research		
Appendices:	Appendix 1: Research and Innovation Strategy (2023-2028) Appendix 2: Presentation to contextualise the strategy		
Report Summary			
Purpose of report:	To seek formal approval for the new Research and Innovation Strategy (2023 -2028) for DBTH.		
Summary of key issues/positive highlights:	**Overview** At DBTH, we have an overall ambition to be 'The safest hospital in England; Outstanding in all we do'. We believe that Research and Innovation are significant areas of activity to achieve this overall ambition. Appendix 1 is the final draft Research and Innovation Strategy 2023 – 2028. Appendix 2 is a presentation to contextualise the strategy. **Highlights** The R&I strategy has been developed over the past 12 months in partnership with our people, partners and the community we serve. There a four pillars to the strategy: 1. Grow Research Talent 2. Grow Innovation Expertise 3. Lead Research and Innovation 4. Grow Research investment There are five programmes of work: 1. Infrastructure 2. Research growth 3. Support and Management of Research and Development 4. Innovation 5. Patient and Public Involvement This is a five year strategy and will be grown on an annual stepped basis. **Next steps** A full business case with clear Key Performance Metrics will be developed in the next 2 months (submission to CIG) outlining the support required to deliver on the strategy. A communication and engagement plan will be developed with the intent to launch across DBTH in March, followed by a wider partner launch in May 2023.		

Recommendation:	The Board is asked to review and approve the new R&I strategy 2023 – 2028.				
Action Require:	**Approve**	~~Information~~	~~Discussion~~	~~Assurance~~	**Review**

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

Implications	
Board assurance framework:	SA1, SA2, SA3
Corporate risk register:	N/A
Regulation:	N/A
Legal:	N/A
Resources:	N/A

Assurance Route			
Previously considered by:		Trust Executive Group (TEG) Teaching Hospital Board (THB)	
Date:	12 December 2023	**Decision:**	TEG members supportive of the overall strategy and will prepare for engagement and support with developing the specific details of the business case including key performance measures. THB members supportive of the strategy. This is of significance as the memberships includes strategic senior partners from across Doncaster place including RDaSH, Public Health Doncaster and from across the wider South Yorkshire Integrated Care Board including the major Higher and Further education institutes
Next Steps:		Development of a business case with key performance measures, complemented by a communication and engagement plan.	
Previously circulated reports to supplement this paper:		N/A	

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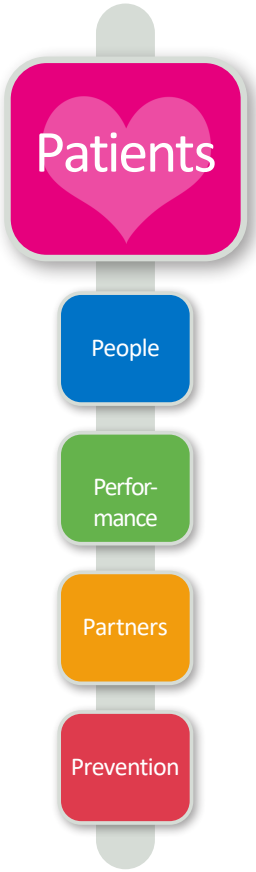
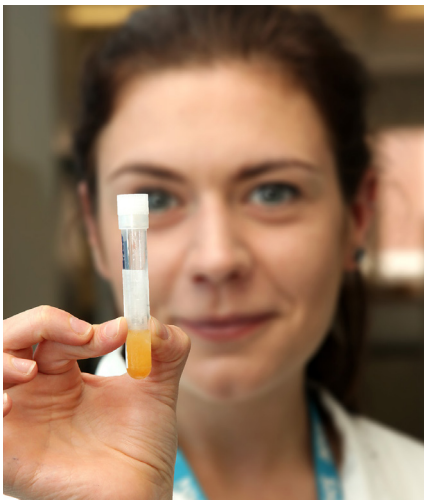
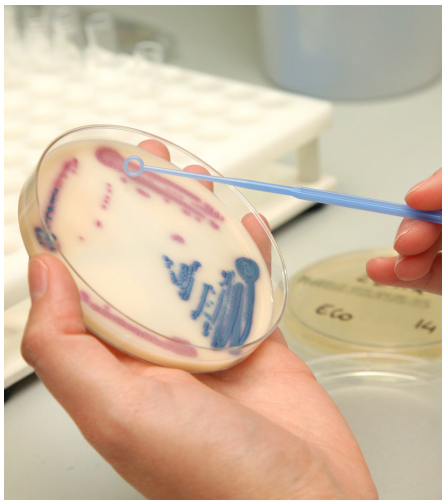


Research and Innovation Strategy

2023 – 2028





Research has been defined as:

The term research means different things to different people, but is essentially about finding out new knowledge that could lead to changes to treatments, policies or care. The definition used by the Department of Health is: "The attempt to derive generalisable new knowledge by addressing clearly defined questions with systematic and rigorous methods."

National Institute for Health and Care Research (2022)

Contents

Executive summary

DBTH recognises that research is integral to providing evidence-based treatment and care options for patients and is fundamental to meeting the Trust's ambition to be the 'Safest Hospital in England; Outstanding in all we do'.

The COVID-19 pandemic accelerated engagement and the importance of research, not only enabling an understanding of the disease but also providing the basis for therapeutic development through high quality clinical studies.

Furthermore, the pandemic was a catalyst for the development and implementation of innovative ways of working and delivery of clinical care. As public awareness of the benefits of research has increased as a result of COVID-19, so has the acceptability, willingness and capabilities to evolve clinical services and corporate departments in innovative ways of working to achieve the best patient and people outcomes whilst alleviating some of the pinch points in the system.

Research active hospitals have been shown to deliver better care, have better CQC ratings and better patient outcomes. The benefits are not just for those who participate in research but translate into all areas of Trust wide and individual performance.

Aligned to the wider Doncaster and Bassetlaw Teaching Hospitals (DBTH) Trust strategy, we will work closely with Quality Improvement (QI), Health Inequality (HI), Recovery, Innovation and Transformation directorate to increase performance through Research and Innovation. Proactive engagement and effective knowledge exchange with these teams will ensure that our commitment to deliver the best and safest clinical care is embedded within our strategic objectives for growing Research and Innovation over the next five years.

Our vision for Doncaster and Bassetlaw Teaching Hospitals is simple: To establish ourselves as a leading centre of research excellence for the benefit of our patients and our Trust.

To do this we will:

- Grow research talent: Identify and implement opportunities for all our people to either support, lead or promote research as well as identifying and implementing opportunities to attract talent into the Trust.
- Grow innovation expertise: More clearly define what innovation is (and isn't) and establish a process and framework to enable us to identify and develop innovation opportunities that might ultimately benefit the Trust and the people we serve.
- Lead Research and Innovation: Grow capacity and capability to expand our current research portfolio so we are leading as well as partnering in Research and Innovation studies.
- Grow research investment: Develop and implement a sustainable finance model that supports growth in Research and Innovation and maximises return on investment.

Stand with us today to improve care tomorrow

Research for you

Where we are now

Current strengths as the building blocks for achieving our vision

There are many strengths and achievements over recent years that will be optimised and built on as we implement our strategy for Research and Innovation over the next five years. These include:

Key strengths

- DBTH has an experienced and enthusiastic corporate research team with a reputation for efficient delivery and turnaround of research activity.
- DBTH has many active researchers in the Trust, many of whom have had some experience of conducting their own research in the past and who have an interest in doing so again.
- DBTH works with and hosts experienced academic colleagues, with an established track record of successful research grant applications.
- DBTH has a long established and trusted reputation for delivering outstanding education and a growing reputation for delivering research.
- DBTH has established links with academic institutes and industry partners at system, team and individual level.

Key achievements

- Outstanding delivery of research during COVID and quick recovery phase to open studies again following this.
- Successful implementation of the Born and Bred in Doncaster (BaBi-D) research study which provides us an investment leverage for future activity and significant partnership working.
- Joint appointments of Professors of Nursing and Surgery.
- Investment in a dedicated research hub; Research, Education and Clinical Academic Hub (REaCH) to support expanding research activity.
- Improved the scope and efficacy of communications promoting our work, which has raised the research profile within DBTH and in the wider community.
- Development of a robust research governance framework to support our future growth and transition into a centre of excellence.

DBTH is incredibly successful in the delivery of portfolio research, and this has not only been recognised by the National Institute for Health and Care Research (NIHR) Clinical Research Network Yorkshire and Humber (CRN) but also by our external stakeholders.

As part of a recently conducted external strategic review, feedback included “the Research and Development team are amazing” with “exceptional knowledge and efficiency in study set up”. Whilst portfolio research brings significant investment into the Trust, to date this hasn’t been driven by our strategic priorities (although it may align) or with the specific needs and wants of our population. In order to fulfil our ambition of becoming a leading research centre of excellence, we need to grow the current R&I infrastructure to support the growth of research developed and led by DBTH. The benefits of growth beyond our current research portfolio include creating and sustaining a financial Research and Innovation model as well as tackling the most important health and care challenges of our Trust and the people we serve.

Ultimately, our ambition over the next five years is to raise the profile of the Trust in that it not only successfully supports delivery of portfolio research to one that is also regionally and nationally recognised as leading Research and Innovation that drives real improvements in the health and wellbeing of our population, and our workforce.

People at the heart of what we do:

We have developed our Research and Innovation Strategy with our patients, people, and partners very much at the heart of it, as we believe this is essential for tangible improvements in the health and wellbeing of the people we serve. In line with national and regional initiatives to improve healthy life expectancy, we believe that taking a whole life, whole system approach will ensure much needed synergy across acute to community care as well as more widely across the system.

Therefore, strategic priorities have been developed to support:

- "Starting well": Improving maternal and child health and wellbeing
- "Living well" : Improving patient outcomes in areas of greatest need
- "Ageing well": Improving the health and wellbeing of our ageing population

Our ambition

Our vision:

TO BE A LEADING CENTRE OF RESEARCH EXCELLENCE THROUGH A TALENTED AND DIVERSE WORKFORCE THAT DRIVES IMPROVEMENT IN THE HEALTH AND WELLBEING OF THE PEOPLE WE SERVE

Our mission:

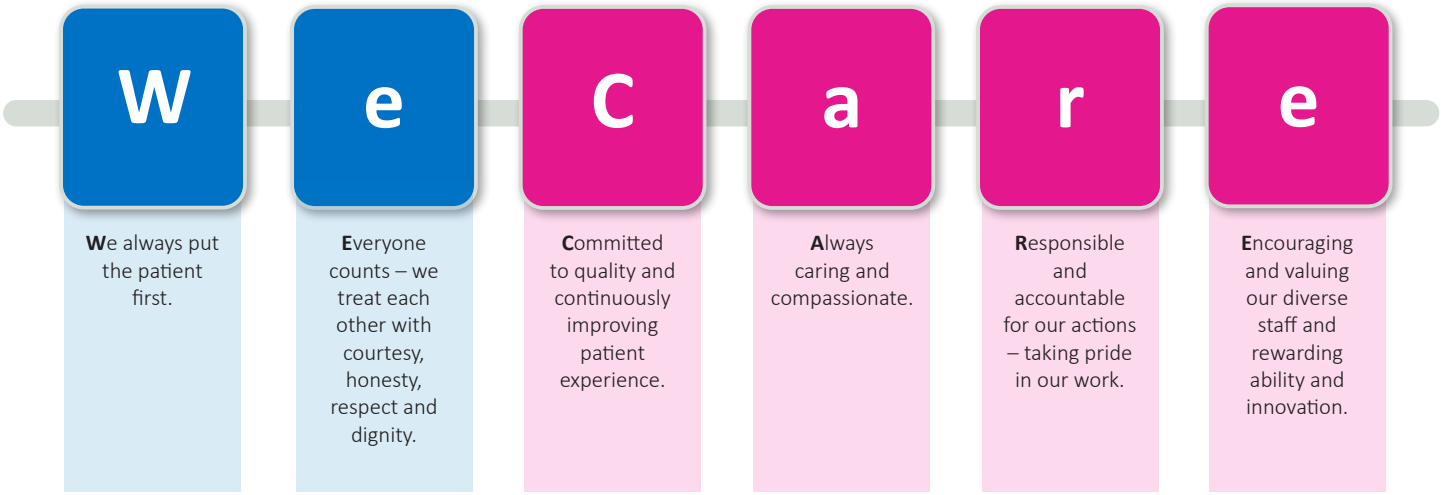
TO MAKE RESEARCH INTEGRAL TO EVERY ROLE ACROSS OUR WORKFORCE BY DEVELOPING THE NECESSARY RESOURCES, EDUCATION AND INFRASTRUCTURE IN COLLABORATION WITH ALL OUR PARTNERS

Our values:

The 'Research Rhino' is the mascot for all Research and Innovation activity within the Trust and is endorsed by the Doncaster Yorkshire Wildlife Park.

We have worked in partnership with our patients, people and partners to develop core values that will be embedded within the Research and Innovation we undertake and support.

We have developed some 'RHINO' values, underpinned byt the overarching Trust values 'We Care' that have patients at the centre of everything we do.



In achieving our research aspirations we remain committed to:

- **Respect:**
  We recognise the value of our patients, partners and workforce and express that value through our words and actions
- **Honest**:
  Our commitment to undertake honest and ethical research underpins how we develop, deliver and disseminate Research and Innovation
- **Inclusive:**
  We remain committed to "making research everyone's business" to ensure that research is accessible to ALL our patients AND workforce equally
- **Network:**
  Our unique appreciation of the value of partnerships, recognising that by working together we can more effectively achieve our goals and provide the foundation on which we will grow our network to support Research and Innovation
- **Opportunity:**
  Our innovative and dedicated approach to be and do better for the people we serve ensures we seize all opportunities for a lasting legacy

Current drivers for Research and Innovation at DBTH

Supporting our long-term ambitions:

- **Ability to sponsor all types of research:**

A long-term ambition is for DBTH to be able to provide sponsorship of all types of research studies including Clinical Trials of Investigational Medicinal Products (CTIMPs) as well as trials involving medical devices. We will spend the next five years growing research capability and capacity within the Trust, particularly building on our R&I infrastructure to ensure all necessary governance and regulatory requirements are in place. In growing our expertise to sponsor clinical trials, we have a number of additional challenges to address over the next five years.

These include; ensuring support services are adequately resourced to deliver DBTH led research including CTIMPs, particularly building capacity and capabilities in core support services including pharmacy and pathology.

As we grow our partnerships and support for Research and Innovation, we will need to consider building resources and capacity for imaging services. In addition to growing both R&I and service support infrastructure, we will need to extend Chief and Principal Investigator (CI & PI) coverage and will be working closely with our academic partners and the Research Education Lead to ensure that we are maximising opportunities, through regional and national schemes such as the Associate Principal Investigator scheme endorsed by the National Institute for Health and Care Research (NIHR) and Royal Colleges.

- **Paving the way to achieving University Teaching Hospital status:**

Another long term ambition to support our trajectory for achieving University Teaching Hospital status includes building and implementing the framework to develop Academic Directorates as we grow research activity. The creation of Academic Directorates within the Trust will form the foundation.

Academic Directorate status has the benefit of not only generating specialised research activity in areas of strategic priority for patients and our people but also generates additional research income that may be reinvested into building capacity and capability in that area. Furthermore, the metrics used to determine whether Academic Directorate is awarded will support the metrics and outputs required to achieve University Teaching Hospital status such as the number of high quality publications, Clinical Academics in addition to continuing to grow the high quality clinical education delivered at DBTH. We will spend the next five years building the metrics and governance as well as research activity to support Academic Directorates.

- **Growing research across all parts of the Trust:**

As we build on existing R&I infrastructure to grow Research and Innovation within Doncaster Royal Infirmary (DRI), we will also be looking to build capability and capacity for undertaking research at Bassetlaw (BH) and Montagu Hospitals (MH). Activities to grow Research and Innovation in these sites will involve working at a Trust wide level to identify challenges and programmes of work to address them. In addition, we will be working to embed a research inclusive culture at Bassetlaw and Montagu Hospitals complementing Doncaster Royal Infirmary.

- **Growing Research and Innovation talent**

Nursing and Midwifery:

At the end of 2021, the Chief Nursing Officer (CNO) for England released the strategic plan for Nurses, outlining the vision to "create a people-centred research environment that empowers nurses to lead, participate in and deliver research, where research is fully embedded in practice and professional decision-making, for public benefit". There are five themes underpinning the vision; Aligning nurse-led research with public need; releasing nurses' research potential; building the best research system; developing future nurse leaders of research and digitally-enabled nurse-led research. With the appointment of our Professor of Nursing in 2021, we are working to translate the CNO's vision into our own Trust ambition to grow and attract nursing leaders of research, active nurse research alongside embedding research into the core roles and responsibilities of our Nursing and Midwifery workforce.

Allied Health Professionals:

At the beginning of 2022, Health Education England published its Research and Innovation strategy for Allied Health Professionals (AHPs). The strategy outlines four central domains to achieve transformational impact and sustainable change. These are: Capacity and engagement of the AHP workforce community, to implement research into practice; Capability for individuals to undertake and achieve excellence in Research and Innovation activities, roles, careers and leadership; Context for AHPs to have equitable access to sustainable support, infrastructures and investment; Culture for AHP perceptions and expectations of professional identities and roles that "research is everybody's business".

"Making research everybody's business":

More recently, the National Institute for Health and Social Care (NIHR) and the Royal College of Physicians (RCP) issued a joint position statement of recommendations for how research should be made every day practice for all clinicians (including postgraduate doctors, medical students and other health care professionals). The joint statement also recognises the importance of clinical research in not just improving patient outcomes but also the potential of research to address some of the critical challenges the NHS is facing, such as waiting list backlogs and increasing pressures on the NHS. Our Senior Leadership Team will work with key stakeholders to embed all the above recommendations for trusts within our objectives for a research inclusive culture as well as everyday working practice.

- **The value of working in partnership:**

DBTH is recognised as an "exceptional partner" and this reputation has been forged on the honest, transparent and effective relationships at both place; with Doncaster Metropolitan Borough Council (DMBC), Rotherham Doncaster and South Humber (RDaSH) Trust and within the local Education sector; and externally with our local academic partners and NIHR infrastructure, such as the CRN, Research Design Service (RDS), Medical and In Vitro Diagnostic Cooperatives (MICs).

We have worked with our academic partners; The University of Sheffield (UoS) and Sheffield Hallam University (SHU) along with our place based partners such as RDaSH and the Public Health team within Doncaster Council to identify opportunities to align activity in complementary areas of strategic priority. Going forward we will translate these into tangible outputs through successful grant capture both as the lead and partner institution as well as developing joint programmes and initiatives that creates synergy across the system whilst supporting the delivery of activity in areas of strategic importance.

DBTH is one of the largest employers within Doncaster and Bassetlaw and we will be working closely with partners in the Education sector, such as Doncaster College, Hall Cross School and Retford Oaks to ensure that our Research and Innovation Strategy considers how to grow capacity and capability not only in Trust-wide career opportunities but also in clinical research through ensuring that it is embedded and considered right across the learning, teaching and training of our future workforce.

Areas of strategic priority

Working with our partners, patients, the public and other key stakeholders, we have identified a number of long-term challenges that our R&I Strategy aims to address. Whilst activity over the next five years will be prioritised to address the areas of strategic priority below, given the complexity and enormity of the challenges identified, activity in these areas will go beyond 2028. Over the next five years we will focus efforts to address:

Significantly worse health and wellbeing compared with the rest of the nation and the factors associated with poorer outcomes:

To improve our chances of success and achieve the greatest impact, tackling poor health and wellbeing of our patients and the people we serve, we will prioritise working in partnership and across the system. To do this, we will:

- Identify opportunities to grow Research and Innovation with our academic, commercial and healthcare partners to address the relevant factors contributing to poor health and wellbeing, for example; obesity, smoking cessation, alcohol and substance misuse
- Develop and evaluate processes for working in partnership across the care pathway to support effective collaborations, building on the specialist knowledge and expertise of our partners to ultimately grow Research and Innovation opportunities within DBTH and beyond
- Work closely with the South Yorkshire and North Nottinghamshire Integrated Care Boards (ICBs) and the Mayoral Combined Authorities (MCAs) as well as our wider partners and regional initiatives to prioritise Research and Innovation activities to answer the most pressing research questions

Improving maternal and child health:

Childhood mortality is significantly higher than the national average within our region whilst more babies are below average birth weights. In alignment with The National Maternity Safety Strategy ambition to ensure continuity of care to half the rate of stillbirths, neonatal mortality and reduce the rate of preterm births, our ambition is to grow Research and Innovation in this area. Furthermore, the launch of the Born and Bred in Doncaster (BaBi-D) cohort study that aims to improve the health and wellbeing of families across Doncaster with a focus on addressing health inequalities and inclusion, provides the springboard to identify the needs of our local families and gives us an opportunity to work across the Doncaster Borough using connected data. This better understanding of the wants and needs of the families we serve, will provide a robust platform on which to grow Research and Innovation in this area. We will:

- Ensure the ongoing successful delivery of the BaBi-D study

- Grow research expertise in maternal and child health by developing R&I infrastructure and provide development opportunities to support our workforce to expand our current research portfolio in this area
- Identify pertinent research questions, building on the findings of the BaBi-D study and existing partnerships, in addition to maximising opportunities for innovative approaches to using routinely collected data to improve maternal and child health outcomes
- Ensure that all learning from the BaBi-D study is effectively and appropriately disseminated to maximise benefit to both the patients and clinical services and the potential of future research studies

Tackling the health and wellbeing challenges facing our already significant and growing ageing population:

We know that the number of people aged 75 years and over will increase by 57 % by 2028 for our region. Therefore, it is essential that we support this rapidly growing population to live well during this stage of their lives. Whilst our approach to working across the life course aims to improve not just life expectancy but healthy life expectancy in the long term, we will need to identify short and medium research priorities to address the negative impact the pandemic in particular has had on the general health and wellbeing of the older population. We will:

- Identify opportunities to improve patient outcomes through Research and Innovation that focuses on prehabilitation and rehabilitation in collaboration with our partners with existing expertise in this area
- Engage with patients, clinical, academic and wider health and care stakeholders to support the prioritisation of research activity and develop research that addresses the greatest unmet need for this population
- Identify opportunities to use big data and routinely collected data to answer the evidence gap in health and wellbeing challenges and work in collaboration with our partners to identify, develop and evaluate appropriate and innovative solutions to these challenges
- Ensure that all Research and Innovation is designed and delivered to be inclusive and accessible to an older population.

Improving patient outcomes through prevention, early diagnosis and better management of cardiovascular and respiratory diseases and cancer:

Building on both the regional statistics for cancer, cardiovascular and respiratory diseases contributing to the higher than national average of premature deaths as well as five clinical priority areas identified as requiring accelerated improvement as part of the NHS England and NHS Improvement approach to reducing health inequalities (Core20PLUS5), we will:

- Work in collaboration with our partners, the Quality Improvement and Health Inequality teams to better understand the needs of our local population and clinical services to identify priority research questions
- Work closely with our local councils and ICBs to ensure alignment of research activity that provides synergy across acute and community care, as well as more generally across the system
- Support, promote and roll out prevention initiatives, in addition to maximising research opportunities to better understand the challenges to prevention of these diseases specific to our local population
- Grow research capacity and expertise through exploring opportunities for joint working and appointments with our academic and clinical partners with a view to growing and attracting talent to support our Research and Innovation agenda in these priority areas

Using data and digital transformation to drive areas of strategic priority that addresses the greatest areas of unmet health need:

The use of routinely collected data, big data and digital technologies has the potential to transform future healthcare and is a prominent strategic priority for funders of applied health and care research. The ability to support and deliver research studies that involve the use of data is a current strength of DBTH as well as a strategic priority. Over the next five years we will:

- Work with Information experts both within the Trust and with partners to develop and implement a programme of work to digitally support the

growth of Research and Innovation

- Work with partners to develop a research portfolio using real-world data, supported by strong governance and processes for de-identification to ensure studies fulfil requisite legal frameworks, including all data protection and state aid laws
- Work with experts in data, Computer Science and Artificial Intelligence to optimise innovative approaches for the use of real-world data in answering research questions in areas of strategic priority
- Work with patients, our people and the public to develop our strategy and processes for research involving real-world datasets, focussing on equality, diversity and inclusion particularly underrepresented groups

Embedding, growing and supporting a "research for all culture" within the Trust

Improving the care and outcomes for the patients we serve through clinical excellence is at the forefront of the Research and Innovation we undertake within the Trust. Furthermore, a "research for all" culture is one that is integral for growing and nurturing our ambition for becoming a leading research centre of excellence. As we grow Research and Innovation within the Trust, we will continue to embed and promote our research inclusive culture for everyone whether you are a patient who chooses to take part in research, a member of team DBTH wanting to either deliver or support a research project or develop a research career, or stakeholders wanting to partner with DBTH. Over the next five years we will:

- Increase the visibility of research to patients, the public and our people through a targeted communication and promotion strategy and increased awareness through physical signage and digital platforms.
- Raise the profile and awareness of research activity and strategic priorities through an enhanced communication and dissemination strategy across the Trust and with our wider stakeholders and partners.
- Reduce barriers to Research and Innovation through standardised language that is easily understood across all experience and access to research.
- Include Research and Innovation in the Trust workforce induction process to support our "research for all" culture.
- Delivery of a range of training opportunities to support the development of individuals interested in pursuing research, as well as to upskill the wider workforce

In addition to the strategic priorities identified above, there are a number of other areas of activity that are essential to the Trust achieving its Research and Innovation ambitions both in the short and long term. Areas to groware detailed in the next section.

Patient and Public Involvement and Engagement:

Involving patients and the public in the identification of key challenges and research priorities is essential to our commitment to having patients and the public at the heart of what we do. We will ensure that the Research and Innovation we undertake is developed and designed with those with lived experience of the unmet need we are trying to address, in addition to focus efforts for better inclusion of underrepresented groups. Over the next five years we will:

- Grow the membership of the current Public, Patient, Involvement and Engagement (PPIE) group to ensure that the voices of underrepresented communities are present
- Ensure equality, diversity and inclusion are embedded within any patient and public involvement and engagement activities
- Work with our partners to maximise opportunities to involve and engage with Community Connectors, and other essential public involvement groups
- Identify and implement a sustainable funding model for PPIE to ensure that participants are adequately reimbursed for their time and input

Building research capacity and capability

DBTH has a reputation for being a "great place to work". Feedback from a recent strategic review from those who already possess research expertise really valued the commitment from the Trust and line managers to ensure research time was prioritised, valued and supported by their team. Working with our recently appointed Professors of Surgery and Nursing, we will ensure that the framework and career progression is developed and implemented over the next five years for supporting our people into clinical academic roles. Working with our academic partners, we will explore opportunities for joint appointments, not only in clinical areas but also in data science to support our strategic focus to grow research in that area. We will explore opportunities to grow talent within the Trust such as a Clinical Research Academy in partnership with our local universities and identification of pump priming funding. Over the next five years, we will:

- Develop processes for identifying members of Team DBTH with innovative ideas that will improve the health and wellbeing of our patients as well as the services we provide
- Further refine and expand support through the "Ideas Clinic"
- Develop and implement research frameworks for all clinical and health care professional roles
- Encourage support for research to be recognised as part of direct clinical activity and reward involvement of such through local and national awards
- Ensure that multidisciplinary workforce planning encompasses those who support research
- Identify development opportunities with partner organisations for our people wanting to support and deliver research such as internships, mentoring, short placements or shadowing opportunities.

Growing research and development

Over the next five years we will continue to grow and transform our approach to supporting and managing research at the Trust whilst ensuring that our reputation for outstanding research set up and management is not compromised. Through streamlined processes for setting up research projects in the organisation, studies will be set up rapidly and with minimal bureaucracy. We will ensure that our systems and processes are optimised to maximise resource utilisation. We will:

- Provide ongoing review and improvement of processes and Standard Operating Procedures across the research team and key support services to streamline delivery
- Identification of working case studies to grow capacity and capability in leading Research and Innovation.
- Identify and develop the skills required to deliver different types of clinical studies in addition to emerging types of trials e.g. real-world data studies, Artificial Intelligence
- Identify and implement support for our workforce in developing high quality grant applications to ensure access to specialist knowledge through partnerships whilst optimising on existing support available through the NIHR
- Grow capacity within the R&I team to support more studies through recruitment of key personnel e.g. Quality Assurance, Data Management.

Innovation

NHS England states that innovation is critical for expediting "the pace and scale of change, and delivering better outcomes for patients across all five domains of the NHS Outcomes Framework". Innovation in health and care research involves turning new ideas into downstream benefits to patients, the public and the NHS through development, evaluation, implementation and finally adoption and spread. Innovation isn't exclusive to devices but includes new ways to deliver services or care, technology or to some, includes new ways to evaluate interventions such as adaptive clinical trial designs or using routinely collected data (innovative research methodologies).

NIHR and United Kingdom Research Innovation (UKRI) as global major funders of health and care research, remain committed to promoting partnerships with industry, growing clinical entrepreneurs as well as providing opportunities to attract international investment within the UK. In addition, the Life Sciences Industry Strategy promotes and supports innovation to be co-developed in collaboration with the NHS, further emphasising the importance of how the unmet need must drive innovation to improve the health and wellbeing of our nation i.e. technology pull versus market push. To establish DBTH as a leading Trust in innovation, over the next five years we will:

- Improve Trust-wide understanding of what innovation is and is not
- Develop and implement processes and the necessary governance to support research involving innovation
- Grow capacity and capability to support expanding our current portfolio of commercial studies
- Develop and implement a Clinical Innovation Gateway to support working partnerships between the Trust, industry and academia as well as supporting colleagues to develop their innovative ideas
- Design and implement an "Improvement through Innovation" programme to support team members with innovative ideas and approaches for new technologies or services
- Identify opportunities to contribute to a sustainable research funding model through developing processes and frameworks to support commercialisation of research involving innovation
- Further develop relationships and partnerships with organisations such as the Academic Health Science Network (AHSN), regional Integrated Care System Innovation Hubs and emerging accelerator programmes such as those running through our academic and industry partners

Supporting national and regional strategic priorities

Health Inequalities:

For our region, health inequalities (HIs) are increasing rather than improving despite preventable mortality falling. HI will be a cross-cutting theme for our R&I Strategy and we will ensure that the Research and Innovation we undertake considers this across the research/innovation pipeline, from design to delivery and through to adoption. We also believe that taking this approach will provide the best framework to tackle health inequalities and aligns to the recent framework for action designed to support the reduction of health inequalities at both national and system level, the Core20PLUS5. Core20PLUS5 defines a target population cohort, identified as the most deprived 20% of the population, PLUS population groups such as those that identify as ethnic minority, people with a learning disability and autistic people, people with protected characteristics and inclusion health groups such as people experiencing homelessness, vulnerable migrants, amongst others. 5 represents the five clinical areas of focus including; Maternity; Severe Mental Illness; chronic respiratory disease; early cancer diagnosis and hypertension.

To address health inequalities through Research and Innovation we will:

- Work with our HI programme leads to identify opportunities to address inequalities in access to and experience of health services through Research and Innovation
- Identify opportunities to work with our partners, our Integrated Care Systems and industry to support and lead Research and Innovation that addresses specific areas of inequality, for example:

    - Inequalities in life expectancy
    - Inequalities in healthy life expectancy
    - Inequalities in avoidable mortality
    - Inequalities long term health conditions
    - Inequalities prevalence of mental ill health

- Ensure health inequalities are appropriately considered in research applications and more generally in the development and implementation of Research and Innovation strategic priorities within the Trust

Sustainability:

The NHS has set itself the ambitious challenge of becoming the world's first net zero health service. The NHS and healthcare in general contributes to 5% of global CO2 emissions and not only do we have a moral and ethical duty to reduce carbon emissions for the benefit of the planet, we know that the drivers of climate change also contribute to poor health outcomes and increase health inequalities. To support the net zero agenda within Research and Innovation in the Trust, we will work with our teams who are wanting to develop and support research to consider what impact it might have with regard to sustainability. Over the next five years we will:

- Work with sustainability teams within the Trust, and our partners to identify opportunities to embed sustainability within Research and Innovation
- Work with key stakeholders to ensure the contribution of Research and Innovation undertaken within the Trust on the net zero agenda is appropriately disseminated and considered within pathways to impact

Key Performance Indicators

Evaluation and monitoring of performance against this strategy will be coordinated by the R&I Senior Leadership Team, working in close partnership with relevant clinical and corporate colleagues. A five year operational plan will be developed to accompany the strategy and will be the framework for which the monitoring process will occur. Annual delivery plans will be incorporated into the operational plan with clearly defined timescales against the actions to be taken to deliver the strategy objectives

Governance

Clearly defined reporting mechanisms will ensure the implementation and compliance with the strategy is effectively and efficiently assessed. Delivery of the R&I Strategy will be appropriately supported and monitored via the following reporting structure:

Quality and Effectiveness Committee (QEC)

With devolved responsibility from the Board, QEC will be provided with an annual assurance report against the R&I strategy work plan. This will be complemented by a Research and Innovation highlight report for every QEC meeting.

Teaching Hospital Board (THB)

Through the THB, partners will be regularly updated and engaged across the breadth of the R&I Strategy. This will also provide a forum to discuss developments, opportunities and ensure that we remain committed to our promise.

Research and Innovation Committee (RIC)

An update on the deliverables against the R&I work plan will be shared at each RIC meeting. This will ensure that key leaders in research and innovation across DBTH have a forum to discuss, engage and influence the activity.

Trust Executive Group (TEG)

TEG will be utilised as a forum to engage, update and provide constructive challenge with all the Executive, Clinical and Corporate Directors

Achieving Our Vision To Be A Leading Centre of Research Excellence: Research and Innovation Strategy (2023-2028)

Sam Debbage, Director of Education and Research
Jane Fearnside, Head of Research

January 2023

Outstanding delivery and recovery of research during C19

BORN & BRED IN Doncaster

Successful implementation of the Born and Bred in Doncaster study (BaBi-D)

Disce Doce

Joint appointments of Professors of Nursing and Surgery

Investment in a dedicated research hub

Improved scope and efficacy of research communications

Robust research governance framework to support future growth

Current recruitment of over 1000 patients to research

Current Research Capacity Funding of £41K

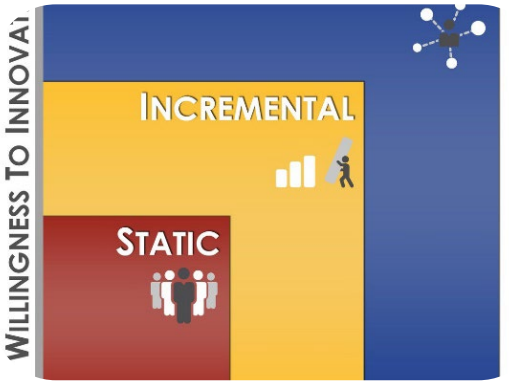
Where we are now:

www.dbth.nhs.uk

Leading research

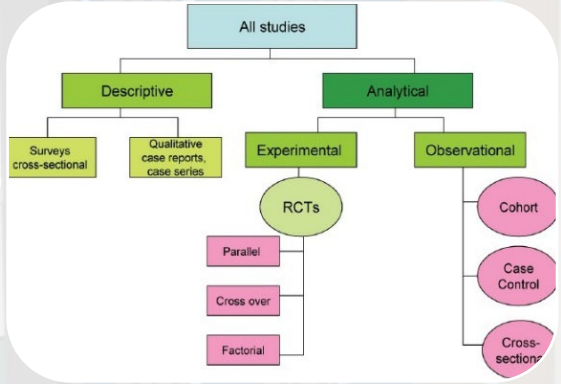
Research in partnership

Joint appointments



Leading Innovation

Raised profile of DBTH as leading research



Ability to sponsor all types of research

Grow patient recruitment to research

Grow research capacity funding and grant capture

Where we want to be:

www.dbth.nhs.uk

Leading Centre of Research Excellence

Grow Research Talent	Grow Innovation Expertise	Lead Research & Innovation	Grow Research Investment
- Identify opportunities for all our people - Identify & implement opportunities to attract talent	- Increase understanding of innovation across the Trust - Establish processes and frameworks to maximise innovation opportunities	- Grow capacity & capability to expand research - Develop and deliver research in partnership	- Develop & implement a sustainable finance model to: -support growth - secure return on investment

To be the safest Trust in England, outstanding in all that we do

The foundations of our strategy

www.dbth.nhs.uk

Core Programmes

www.dbth.nhs.uk

1.Infrastructure:	2.Research Growth:	3.Research & Development:	4.Innovation:	5.Patient & Public Involvement:
To grow research infrastructure to support our vision	Growing research across all parts of the Trust	To grow & transform our support & management of research	To improve patient outcomes & ensure benefits to patients & the NHS	To ensure that the voices of ALL our patients are present
Ability to sponsor all types of research	Research framework to achieve UTH status	Process &SOP review & implementation	Improve Trust wide understanding of what innovation is/is not	Grow PPIE membership
Supporting growth in resources	Growing & retaining talent	Identification of working case studies	Development & implementation of processes & governance	Development & Implementation of EDI framework
Academic Directorate Development	Develop & implement a research pipeline	Skills identification & development	Development & implementation of innovation initiatives	Sustainable funding model development

Strategic Priorities

1.Health & Wellbeing:	2.Child & Maternal Health:	3.Healthy Ageing:	4.Prevention, early diagnosis & better management:	5.Data & Digital Transformation:
Opportunities to grow R&I in areas of greatest need	Grow expertise in maternal & child health	Identify opportunities to improve patient outcomes	Collaborative working to understand the needs of our population & services	Develop & implement a work programme to digitally support R&I
Develop & evaluate partnership working across the care pathway	Maximise opportunities from BaBi-D	Engagement with all stakeholders for research prioritisation	Support, promote & roll out prevention initiatives	Development & Implementation of research governance and processes
Work closely with ICBs, MCAs, HEIs to prioritise R&I	Develop & implement DBTH led research	Ensure all research is inclusive and accessible to the older population	Grow research capacity & expertise	Expand partnerships in data, Computer Science & AI

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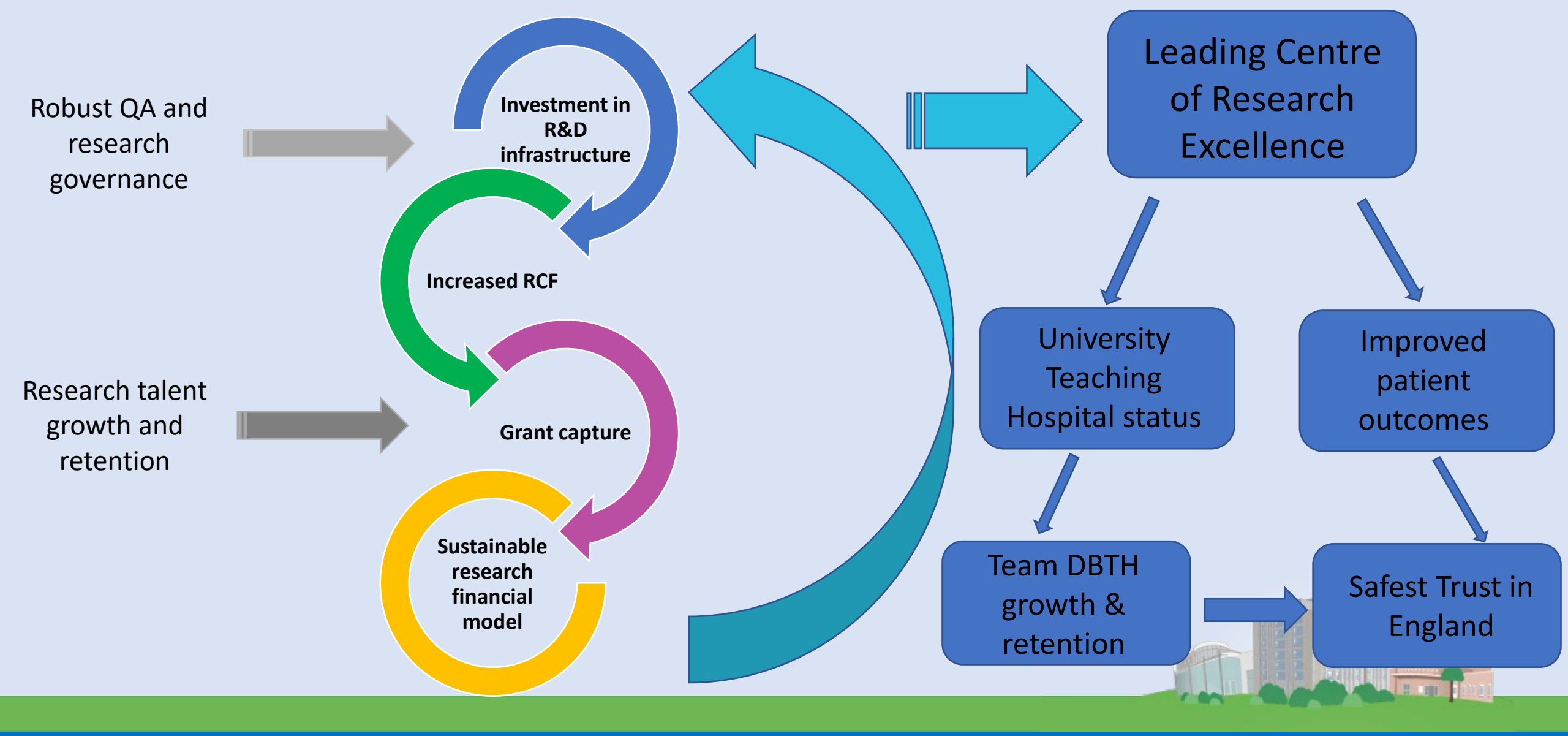

Funding the strategy

www.dbth.nhs.uk

The R&I Strategy Support and Approval

- TEG
- THB
- QEC
- Trust Board

Delivery plan Support and Approval

- Stakeholder engagement
- Development and implementation of the delivery plan
- TEG

New R&I Strategy Launch

- Implementation of Coms. strategy
- Internal launch – March 2023
- External launch – May 2023

Next steps

Thank you & Questions

www.dbth.nhs.uk

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	31 January 2023		**Agenda Reference:**	**F2**	
Report Title:	**Q3 2022/23 Update Corporate Director Objectives**				
Sponsor:	Richard Parker Chief Executive				
Author:	Richard Parker, Chief Executive				
Appendices:	Appendix 1 – spreadsheet of objectives detail				
Report Summary					
Purpose of report:	This report updates the Board of Directors on the progress made in Quarter 3 on the delivery of the Breakthrough and Corporate Objectives for 2022/23 through the work undertaken by Executive Directors and the Executive Team. Progress to date reflects the challenges of the continuing spikes in Covid activity, the early onset of winter pressures and influenza, the demands of the elective recovery programme and recruitment to the Executive Team.				
Summary of key issues/positive highlights	The updates identify that the challenge of accelerating the pace of recovery continue to be impacted by ongoing operational pressures but that the work towards the delivery of the Trusts Strategic Objectives and True North is being maintained. Following the reporting of the Q2 update at October 2022's Board meeting, the Chair and Non-executive Directors have met with individual executive directors to discuss specific objectives, recognise the achievements to date and develop their understanding of the challenges faced.				
Recommendation:	The Board of Directors is asked to note the contents of the updates and advise on any changes and amendments to the suggested objectives to ensure that actions through 2022/23 continue to mitigate risks to the delivery of the Strategic Vision.				
Action Required:	~~Approval~~	~~Information~~	**Discussion**	**Assurance**	~~Review~~

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

Implications	
Board assurance framework:	The Corporate objectives reflect the work needed to deliver the Board of Directors strategic direction and mitigate known and reasonably foreseeable risks.

Corporate risk register:	Delivery of the Corporate Objectives for 2022/23 will support the reduction in known and reasonably foreseeable risks.
Regulation:	The Corporate Objectives for 2022/23 identify actions which will be taken to maintain and ideally improve, the Trusts CQC Good rating at the next assessment. Demonstrating compliance with the standards expected to be achieved for a Good rating in the Safe Domain and an Outstanding rating in the Caring Domain.
Legal:	The Corporate Objectives for 2022/23 aim to maintain the Trusts progress and compliance with statutory responsibilities.
Resources:	The resources required to deliver the Corporate Objectives for 2021/22 are identified as part of the planning processes for 2022/23.

Assurance Route			
Previously considered by:			
Date:		**Decision:**	
Next Steps:	Specific objectives will be reviewed at Board Committees with overall progress reported to the Board of Directors in: • April 2023		
Previously circulated reports to supplement this paper:	2022/23 Corporate Objectives, True North and Breakthrough Objectives, Board of Directors Papers, and Performance Reports.		

1. INTRODUCTION

This paper updates the Board of Directors (BoD) on the progress which has been made by the Executive Team towards the delivery of the Corporate Objectives. The impact of the Covid pandemic continues to have an impact on the Trusts patients and staff with continuing pressure on emergency, elective, and diagnostic pathways. As a result, of the operational pressures and the recruitment to Executive Director vacancies the Trusts performance in Q3 is similar to that reported in Q2 with completion of the strategic aims and objectives has been slower than originally anticipated.

The previously reported progress following the creation of the Directorate of Recovery, Innovation and Transformation has been maintained and successful recruitment to the Chief People Officer, Chief Operating Officer and Chief Nurse posts have been completed in Q3.

2. BACKGROUND

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

During 2021/22 progress on the revitalisation of previous programmes of work and delivery continued to be affected by the sustained pressures within the South Yorkshire and Bassetlaw system related to the ongoing Covid pandemic. In 2022/23 the full impact of the pandemic on planned, urgent and emergency care and colleagues is visible and in Q3 continuing peaks of Covid, and the early onset of winter pressures has continued to create significant challenges in recovery.

3. CORPORATE OBJECTIVES

The contribution each Director has made towards the delivery of the agreed objectives at the end of Quarter 3 are identified in appendix 1.

Board committees have agreed the specific objectives and undertake assurance on the delivery of the specific elements to assure the delivery of the Trusts performance and following the update to Board in Q2 the Chair and Non-executive Directors have met with individual executive directors to recognise the achievements to date and develop their understanding of the challenges faced.

4. RECOMMENDATIONS

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

EXECUTIVE OBJECTIVES 2022/2023

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Deputy CEO / Director of RIT

Name	Deputy CEO / Director of RIT	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status	Q3 Update	Q3 Status	Q4 Update	Q4 Status
Take a lead role in working with Partners in Bassetlaw Place and the Nottingham Integrated Care System to achieve the Place and Systems Objectives and Outcomes objectives for 2022/ 23.		Jon Sargeant	RIT01	BOD	DBTH to be an active partner in Nottinghamshire Care System and for any elements of the Nottinghamshire ICS system plan to be delivered as necessary. Monitored through Board report updates and via regular report into Finance and Performance Committee (F&P).	2022-10-17	Attending meetings with the provider alliance, last report to board being the nominations paper re the Notts ICB. Taking part, with other Executive Directors, in a KPMG review on behalf of Notts Provider Alliance regarding direction of travel.	Working on it	Attending a number of N&N ICS Executive level meetings as well as Bassetlaw Place Partnership meetings or ensuring cover at these where needed. Regular contact with locality Director and planned Place visits in October and November. Partnership working linked in with RDaSH working and presented to September Board and October F&P.	Working on it	Embedded in meetings, Sitrep report to be completed work in progress. Verbal updates to F&P to date	Working on it		
Engage at Place and ICS to identify transformation and development opportunities which enhance the services for our communities and staff		Jon Sargeant	RIT02	BOD	Plans will be in place for services which reduce inequalities and improve outcomes.	2022-10-17	Work ongoing	Working on it	work ongoing. scheduled meeting with RDaSH to explore transformation joint working cancelled at short notice due to ill health. looking to reschedule.	Working on it	MEOC is an example, work on One Doncaster Plan and Bassetlaw Cabinet	Working on it		
Establish a Trust Wide plan to drive Recovery, Transformation and Improvement opportunities across the Trust to improve quality and safety, reduce inequality and improve efficiency and effectiveness.		Jon Sargeant	RIT03	F&P / A&R / PC / QEC	Plan for recovery of elective and emergency performance has been developed, and amended to reflect higher than expected Covid 19 and emergency activity. Wider plan to be produced by October 2022.	2022-10-17	Work ongoing	Working on it	A Trust transformation board has been established to drive progress across a number of key workstreams. Workstreams have also been set up with programmes of work focussing on the key Trust priorities across quality, elective recovery and workforce amongst others. These are all being managed through monday.com	Working on it	Infrastructure to do so in place, Business Case for additional resource at CIG, Ann Plan set this up for 2022/23. No clear plan for quality improvement with MD and CNO portfolio. Some operational improvement. Will produce an outline plan for 23/24	Working on it		
Complete the Service Line reporting work utilising the results to drive the Trusts Strategic Direction		Jon Sargeant	RIT04	F&P	Plan to be presented to TEG, F&P, Quality and Effectiveness Committee (QEC) and onto Board in October 2022	2022-10-17	Specialty reports largely completed, additional workshops held with Trust Executive Group(TEG) and Executive Team. Regular report made to F+P	Working on it	Clinical specialty strategies complete for all divisions except for children's and families. additional follow workshops being held with C&F specialties with final specialty clinical strategy document to be completed in November.	Working on it	Service Line work complete Site views on BDGH and DRI underway, board seminar postponed will rearrange	Done		
Support the delivery of a robust learning and development programme to maximise the capacity and capability for improvement		Jon Sargeant	RIT05	PC	Plan to be presented to TEG, F&P, QEC and onto Board in October 2022	2022-10-17	Work ongoing	Working on it	Work ongoing	Working on it	Infrastructure to do so in place, Business Case for additional resource at CIG (not approved)	Working on it		
Support the Board of Directors to champion Quality Improvement as the vehicle for transformation		Jon Sargeant	RIT06	BOD	Plan to be presented to TEG, F&P, QEC and onto Board in October 2022	2022-10-17	Work ongoing	Working on it	Communication plan being worked on with Communications to highlight the engagement & successes of Qi. Bi-monthly repot out sessions being set up (17th November 10-11 next one – for 3 Level 2 Graduations') – to invite NEDs and Executive team representative. Key Performance indicators for Qi being developed and trialled – ongoing. Annual update to QEC – completed October 2022. All improvement projects now being managed via Monday.com and reported into the transformation board – completed. Improvement regular updates into TEG – started September 2022	Working on it	Infrastructure to do so in place, Business Case for additional resource at CIG (not approved)	Working on it		
Lead the development of the New Hospital Business Case and once funding has been approved ensure the deliver of the Trust major capital programmes; Bassetlaw Emergency Care Village, Mexborough Surgical Care Hub, Mexborough Community Diagnostic Centre		Jon Sargeant	RIT07	BOD / F&P	Monitored through project plans, and agreed budgets into F&P and onwards to the BOD as required.	2022-10-17	BEV case to be presented to F&P and Trust Board in July, CDC case completed and submitted, work on going on other schemes	Working on it	There is an ICB/DMBC/DBTH meeting on 10/1 to discuss way forward for new build. BEV OBC - RFIs have been received and responded to. Awaiting further feedback. RAAC - project commenced, due to complete March 23. MEOC - short form BC being developed for Dec. Approval Feb 23. Open - Autumn/Winter 23.	Working on it	BEV case FBC at FP TB in Jan, MEOC Case with national team next week, CDC case with national team this week	Working on it		
Ensure the delivery of the Trust Information and Technology Strategy maximising the benefits of Information Technology to safety, efficiency and effectiveness		Jon Sargeant	RIT08	F&P / QEC / ARC	Monitored through project plans, and agreed budgets into F&P and onwards to the BOD as required.	2022-10-17	EPR case presented to the FP and Trust board and submitted to NHSE	Working on it	Currently awaiting central sign off of the OBC in advance of going out to procurement. We continue to deploy Nerve Centre modules e.g. Clinical Photography, and case notes.	Working on it	EPR approved to FBC and being finalised, Nerve Centre	Working on it		
Maximise the benefits and opportunities of the Wholly Owned Subsidiary (WOS)		Jon Sargeant	RIT09	F&P / A&R	The WOS is making an increasing contribution to the Trusts plans	2022-10-17	Good progress made with Quality Medical Education and Training (QMET), and the WOS is looking at feasibility of putting a small pharmacy on BDGH site	Working on it	Work ongoing with WOS opportunities	Working on it	Good progress made with QMET, and the WoS is looking at feasibility putting a small pharmacy on BDGH site	Working on it		
Ensure that the Board of Directors, Board Sub Committees and Trust Operational Management Groups have quality assured information by which to assess and assure that delivery of the Trusts Strategic and Operations Objectives.		Jon Sargeant	RIT10	ALL	Monitored against project plan for data improvement, and the introduction of data quality kitemarks. Reporting into F&P and other BOD sub-committees as required.	2022-10-17	Derrick Scorecard system now live and Project Management processes via Monday.com software being implemented	Working on it	Project management processes and reporting embedded and feeding into transformation board and programme steering groups	Working on it	Monday. com live planning for 2022/23, Derrick to be live fully in 2023/24. POSM meetings and governance update	Working on it		

Medical Director

Name	Medical Director	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status	Q3 Update	Q3 Status	Q4 Update	Q4 Status
Fully implement the job planning process. Ensuring that job plans support the delivery of safe, sustainable, efficient and effective services Ensure that the internal audit recommendations are completed		Tim Noble	MD01	F&P / QEC	100% of senior medical staff job plans reviewed, agreed and signed off on the Allocate system Ensure the job planning review process is established to have an annual job plan cycle Job Plan Audit Recommendations Action Progress Meeting established to progress and monitor actions against internal audit recommendations through to completion	2022-10-17	Job Plan Action Progress Meeting established. 14 out of 20 actions and sub-actions now complete and closed by internal auditors The first of a series of job planning workshops for clinical directors held 05/07/2022	Working on it	One remaining action open, update submitted to October's Audit and Risk Committee.	Working on it	One remaining action to complete and progress continues to be made to improve job planning activity: Continue to ensure all medical workforce information is accurate and kept up to date Group Job planning meetings Further discussion/support with individual specialties Awaiting the allocation of the new licences	Working on it		
Support specialties and Divisions to optimise recruitment and retention processes with a specific focus on smaller services and difficult to recruit to areas.		Tim Noble	MD02	QEC	Targeted workforce meetings with specialties/divisions to be established to optimise recruitment and retention processes, with Medical Director, Medical HR, Divisional Director, Divisional Director of Operations, Clinical Directors, Education Department Share good practice and learning across specialties	2022-10-17	MD with responsibility for workforce, working with Medical HR, Education Department and Divisional/Specialty leads to identify specialties with difficulty in recruitment	Working on it	Medical Director for workforce working with target specialties	Working on it	Medical Director for Workforce continues to work with target specialties, reviewing and supporting capacity needs and workforce plans as part of Divisional Annual Business Planning for 2023/34	Working on it		
Following the completion of the reviews of Corporate, Divisional and Directorate Governance arrangements embed the clinical governance and risk management process changes		Tim Noble	MD03	QEC	In line with the recommendations from the external review, ensure governance arrangements and risk management processes are revised and a change management plan developed Communication and engagement with divisional and corporate areas to embed recommended changes through the robust governance framework	2022-10-17	External review complete and report awaited.	Working on it	External peer review report now received. This has been analysed and in concert with PSIRF will help re-shape our governance review. There is a recommendation for an "implementation team" for PSIRF which will assist in producing the changes.	Working on it	The revised clinical governance framework, which has already been approved and ratified by the Board of Directors and its sub-committees, will be formalised and implemented alongside the wider Patient Safety Incident Response Framework and recommendations from the Mason-Higgins external peer review. PSIRF implementation business case discussed 23/01/23	Working on it		

Name	Deputy CEO / Director of RIT	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status	Q3 Update	Q3 Status	Q4 Update	Q4 Status
In conjunction with the Chief Nurse ensure that the Trust is able to demonstrate evidence of compliance with the standards required to achieve a CQC Good rating in the Safe Domain and an Outstanding rating in the Caring Domain.		Tim Noble	MD04	QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet and exceed the CQC standards.	2022-10-17	Working with Chief Nurse to complete the development and implementation of the Trust's Quality Strategy	Working on it	There are effective Clinical Governance processes in the Trust. Further work will continue with the Chief Nurse.	Working on it	Working in conjunction with the Chief Nurse who commenced in post January 2023, to ensure delivery of PSIRF and governance changes to optimise patient safety and learning	Working on it		
Jointly lead the maternity improvement plan in line with national recommendation from the Ockenden report, clinical Negligence Scheme for Trusts (CNST) year 3 and any further related reports		Tim Noble	MD05	BOD / QEC	Work closely with Chief Nurse and Director of Midwifery to deliver the action plans developed in line with national recommendation from the Ockenden report. Review of safety culture within maternity, work closely with Chief Nurse and Director of Midwifery to review findings, agree recommendations and develop action plans. The 2022/ 2023 Assurance Framework will ensure the Trusts plans are being delivered. Milestone outcomes to be jointly agreed with Chief Nurse and Director of Midwifery.	2022-10-17	Working closely with Chief Nurse and Director of Midwifery to jointly agree action plans in line with national recommendation from the Ockenden report.	Working on it	Having regular meetings with the Maternity team.	Working on it	Board level patient safety champion for maternity with conducting safety walk rounds at Bassetlaw and Doncaster. This role has now formally transferred to the Chief Nurse. Involved with Children and Families Board.	Working on it		
Ensure that learning from incidents, complaints, claims and the Learning from Death Reviews are used to improve the quality and sustainability of services; maintaining and improving outcomes and a reduction in HSMR & SHMI		Tim Noble	MD06	BOD / QEC	Medical Examiner Learning from Death Reviews and lessons learnt will be used to maintain and improve outcomes and reduce HSMR and SHMI Learning from incidents, complaints, claims demonstrated in the integrated quality and performance report, with targeted interventions as needed	2022-10-17	Medical Examiner Team scrutinising non-coronial deaths in acute Trust Board reports produced to provide assurance of recommendations and implemented actions. Trust Mortality Group reviewing HSMR performance and trends.	Working on it	The Medical Examiner service continues to assess all adult hospital deaths. the learning from deaths nurse is assisting in the delivery of change and has presented to the Senior medical staff at MAC. Mortality data is under regular review.	Working on it	Mortality analysis is reported to the Trust's Board of Directors meetings. Nationally, regionally and locally mortality is increasing and it is not clear why this is the case. Therefore, the Mortality Investigation Group has been established to: investigate increasing HSMR and SHMI numbers benchmark DBTH position against its peers examine local factors to understand their effect on DBTH mortality rates, such as clinical coding, pathway changes quality assure the scrutiny of deaths via the Medical Examiner process seek any learning or changes that would make a difference The first meeting of the Group was held on Friday 20 January, and a plan of action agreed.	Working on it		
Work with the Chief People Officer to maximise the benefit of the Senior Doctor Leadership Development Programme to develop senior leaders across the Trust.		Tim Noble	MD07	PC	Senior doctor leadership development programme in place Proactively encourage senior medical workforce to engage with the programme Encourage the use of study leave to allow protected time for leadership development	2022-10-17	Senior doctor leadership development programme planned for 2022/23	Working on it	The Medical Directors Directorate have collaborated with the leadership team and delivered workshops for senior medical leaders in the organisation.	Working on it	Working with the Chief People Officer, a series of leadership development sessions are planned for senior medical staff throughout 2023	Working on it		
Fully embed the Medical Advisory Committee (MAC) as the vehicle for engagement and communication with the wider senior medical workforce.		Tim Noble	MD08	PC	Establish bi-monthly Medical Advisory Committee meetings with agreed Terms of Reference Establish bi-monthly MAC planning meetings to cover a range of subject matter as requested by the senior medical workforce Invite Executive Directors and Non-Executive Directors to attend each meeting as a means of engaging and having two-way communication between the senior medical workforce and Trust Board members	2022-10-17	Medical Advisory Committee meetings established monthly Senior medical staff surveyed for input into topics and themes for discussion Process in place to forward plan agenda	Working on it	MAC is fully embedded and continues to have a wide mix of presentations and topics. Surveys have helped with topic selection with both internal and external speakers. Feedback is very good.	Done	MAC continues monthly and a schedule of topics, presentations and speakers has been planned to the end of March 2023	Done		
Support the delivery of the Trust Strategic Direction through the delivery of safe, resilient, efficient clinical pathways which are compliant with NICE guidance and evidence based practice and aligned to the Place, ICS and Acute Fed clinical networks		Tim Noble	MD09	ALL	Engage with divisions and specialties through Service Strategy Reviews, incorporating GIRFT recommendations, in line with Trust Strategy Oversight of priorities in terms of short, medium and longer term strategic plans Support pathway redesign to ensure services are delivering efficient clinical pathways that are evidence based and aligned to wider clinical networks	2022-10-17	GIRFT review in specialities to produce up-to-date position re: GIRFT recommendations.	Working on it	The Medical Director for Operational Stability and Optimisation has progressed this work, using GIRFT and Model hospital tools.	Working on it	The Medical Director for Operational Stability and Optimisation continues to progress this work. Full day GIRFT events are running during January 2023, with a series of specialty presentations. The regional GIRFT leads are in attendance and scrutinise plans and progress. They are also offering support and guidance, sharing benchmarking information and peer support	Working on it		

Director of Finance

Name	Director of Finance	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status	Q3 Update	Q3 Status	Q4 Update	Q4 Status
Work with the Corporate and Divisional Directors to ensure the delivery of the Trust revenue plan		Alex Crickmar	DOF01	F&P / A&R	Improved support to Divisions to support delivery of the Trust's financial plan. This will be reported monthly to F&P, with the year end accounts presented to ARC.	2022-10-17	Year end accounts signed off at the end of June with unqualified audit opinion for 21/22. Currently off track against financial plan by £1.1m. Financial assurance framework in place for 22/23 with escalation and support offer through POSM meetings with Divisions to improve financial position.	Working on it	The Trust is currently behind financial plan at the end of Q2 as reported to Trust Board. Budgets have been set and agreed with budget holders and financial framework put in place with Divisions with controls in place to support delivery of plan.	Working on it	Achievements Year end accounts signed off at the end of June with unqualified audit opinion for 21/22. 22/23 Budgets and Financial Plan set – improved triangulation of workforce, activity and finance plans, pressure on ICB to review allocations Rigour, grip and control reintroduced post COVID - Financial assurance framework in place for 22/23 with escalation and support offer through POSM meetings working with Divisions to improve financial position. Improvement in Procurement controls – tighter grip on number of STWs and Direct Awards, improved number of tenders. Challenges Finance often seen as less of a priority Temp staffing challenge linked to workforce and operational challenges Inflation and cost of living pressures Financial position/plan very challenging – currently off plan, forecast position challenging Staffing challenges – Finance and Procurement (workload to support increased tendering activity).	Working on it		
Work with the Corporate and Divisional Directors to ensure the delivery of the Trusts Capital Plan		Alex Crickmar	DOF02	F&P / A&R	Improved support to Divisions to support delivery of the Trust's financial plan. This will be reported monthly to F&P, with the year end accounts presented to ARC.	2022-10-17	Corporate Investment Group (CIG) re-introduced from beginning of financial year, with significant number of capital cases now approved, especially in Estates. Capital plan currently on track to be delivered by year end.	Working on it	Whilst the Trust is behind plan on capital, this is a phasing issue with the expectation that plans will be delivered by year end. The finance team has been fully involved in supporting the operational capital plan along with a number of significant capital developments including EPPR, BEV etc.	Working on it	Achievements Re-establishment of Corporate Investment Group (CIG) from beginning of financial year with increased rigour applied to the review of business cases. Team working more effectively with Divisions to deliver improved cases Development and update of LTFM to support modelling of large business cases/service developments The finance team has been fully involved in supporting the significant capital developments including ePR, BEV, CDC, MEOC etc. A number of the business cases has received Board and F&P approval, with CDC receiving national approval. Capital plan currently on track to deliver. Challenges Steep learning curve for team (some new members) and took significant capacity to support large cases. Quality of business cases has not always been to required standard causing rework and extra support.	Working on it		
Support the work on the large scale business cases; the New Hospital Strategic Outline Business Case, Bassetlaw Emergency Care Village, Community Diagnostic Centre and the Elective Surgical Hub.		Alex Crickmar	DOF03	F&P / A&R	Approval of business cases. The development of cases will be monitored through business cases to F&P and onwards to the BOD as required.	2022-10-17	Finance team continued to support all significant business cases. EPRR approved at Board in Q1. CDC Phase 2 now approved by national team. Currently working on BECV ahead of presentation to Board in July.	Working on it	The finance team has been fully involved in supporting the significant capital developments including ePR, BEV etc. with an updated LTFM being used to support financial modelling. A number of the business cases has received Board and F&P approval, with CDC receiving national approval.	Working on it	Achievements Re-establishment of Corporate Investment Group (CIG) from beginning of financial year with increased rigour applied to the review of business cases. Team working more effectively with Divisions to deliver improved cases Development and update of LTFM to support modelling of large business cases/service developments The finance team has been fully involved in supporting the significant capital developments including ePR, BEV, CDC, MEOC etc. A number of the business cases has received Board and F&P approval, with CDC receiving national approval. Capital plan currently on track to deliver. Challenges Steep learning curve for team (some new members) and took significant capacity to support large cases. Quality of business cases has not always been to required standard causing rework and extra support	Working on it		

Name	Deputy CEO / Director of RIT	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status	Q3 Update	Q3 Status	Q4 Update	Q4 Status
Ensure the delivery of the Estates Strategy and Plans		Alex Crickmar	DOF04	F&P / A&R	Annual objectives for Estates will be delivered in line with plan (e.g. Granger Report). This will be monitored through project plans and reported through to F&P and ARC.	2022-10-17	Estates plans and objectives are all currently on plan to be delivered including good progress on the Granger report actions which was reported on at the July F&P Committee.	Working on it	The Estates team are currently delivering against its annual plan, with some good progress made in a number of areas including actions relating to the Granger report as reported to F&P.	Working on it	Achievements Team working effectively with Divisions. E and F Appraisal rate 95% and Staff Survey rate result of 64% highest ever. Increased staff engagement and use of Trust Team Engagement and Development TED approach and TED surveys. Launch of first E & F Day providing recognition of the role E & F play in supporting patient care. Well received by wider organisation. Commencement of comprehensive maintenance review in accordance with the requirements of BS 8210 Facilities Maintenance Management (7 Point Plan) part of Granger Report recommendations. Due to risk presented by the condition of the Estate working with NHSE/I and local EPRR colleagues to develop contingency and business continuity plans to enhance emergency response for critical infrastructure failures. Completion of Space Utilisation Surveys and Space Audit move to staff working offsite and partnering with DMBC in the Doncaster CIVIC Quarter. Good progress with QI H & S project working with a number of divisions and corporate teams and successful procurement of H&S Cultural Climate Tool. Provision of Board H&S Responsible Person Training and development of Trust H&S Strategy. Implementation of the Trusts Green Plan including Climate Change Risk Assessments and development of a Decarbonisation Adaption Plan. Development of Trust Sustainable Travel and Transport Plan and review of transport fleet and options for the future of the Park and Ride and EV Charging. Safe Park Mark accreditation successfully achieved for Doncaster Racecourse Park and Ride car park. Launch of staff transport survey through social media, posters and QR codes. Achievements Work in progress to complete the BC for support to achieve the National Standards of Healthcare Cleanliness. Development of Action Plan to achieve the National Standards for Healthcare Food and Drink including Quality, Nutritional Value, Sustainability, Experience and Environment. Very good PLACE results across the Trust. Challenges Unprecedented rise in energy costs. The Trust aged estate equipment and systems are inefficient. The Trust has instructed an energy consultant to review opportunities to improve efficiency as part of the Decarbonisation Strategy and Adaptation plan. Resource and funding to achieve the Estates Maintenance Review (7 Point Plan). Resource and funding to achieve The National Standards of Healthcare Cleanliness. Estates and Facilities Recruitment and Retention of staff particularly low grade Service Assistant posts. Pressures to support staff with regard to the cost of living crisis example food costs. Lack of Accommodation to support the International Nurses recruitment programme.	Working on it		
Deliver an improved management accounts function including systems and training		Alex Crickmar	DOF05	F&P / A&R	Roll out of training programme to Divisions, development of systems (including finance dashboard as part of data warehouse project), development programme for the team and review of structure including roles and responsibilities. This will be monitored through project plans.	2022-10-17	Training Programme videos are in the last stages of completion, ledger information now linked into Datawarehouse and finance dashboards are developed in draft and are in the process of being signed off over the next month, FBP development programme being reviewed, and roles and responsibilities work has now started.	Working on it	The Finance and Procurement team have developed a suite of online training videos for use by Divisions. The team have also developed online financial dashboards through the datawarehouse and this is now being tested with Divisions for sign off. A full review of tasks undertaken within management accounts has been undertaken with improvements made in processes. This includes the month end timetable is now 2-3 days reported earlier than it was pre-COVID. Further work on reviewing roles and responsibilities is needed.	Working on it	Achievements The Finance and Procurement team have developed a suite of online training videos for use by Divisions. Development of systems - Online financial dashboards developed with Divisions are now live – linked to DERICK/Datawarehouse project A full review of tasks undertaken within management accounts with improvements made in processes. This includes the month end timetable is now 2-3 days reported earlier than it was pre-COVID. Review of structure and roles and responsibilities completed Recruitment to some of vacant positions (FBPs), team building (insights) with FBPs. Challenges Delivery of changes in roles and responsibilities/structure has been slower than hoped. Recruitment to some vacant posts been difficult and therefore staff having to cover gaps. Time for training and development of team impacted.	Working on it		

Chief People Officer

Name	Chief People Officer	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status	Q3 Update	Q3 Status	Q4 Update	Q4 Status
Develop and launch revised People Strategy aligned with national NHS People Plan, People Promise and priorities.		Zoe Lintin	CPO01	BOD / PC	Engagement with colleagues to author the revised People Strategy, which will demonstrate the DBTH interpretation and delivery against the national plan and priorities. Work to begin in Q2/Q3, to launch Q4.	2022-10-17	Planned for work to begin Q2	Working on it	Initial engagement started at committees, agreed to align with NHS People Plan with 4 pillars	Working on it	People Strategy 2023-27 drafted by CPO and shared with multiple stakeholders in January for feedback, including TEG, Board Committees and colleague networks. Intention to go through approval process at TEG and Board in February. Delivery plan to then be developed and People Committee to have oversight	Working on it		
Design and implement a Trust wide approach to engagement in the national staff survey, including developing plans to improve participation, feedback on the results and corporate/ local action planning to improve results.		Zoe Lintin	CPO02	BOD / PC	Approach defined for the 2022 staff survey defined and communicated in Q2 prior to survey launch. Engagement sessions booked ready for lifting of embargo in Q4, with consistent approach to action planning at Trust-wide and local level. 63% response rate or better in the survey (Q3).	2022-10-17	Tender for provider for 2022 survey underway and approach to engagement in the survey results being communicated. Update at July PC.	Working on it	Approach designed to cover the whole survey life cycle, supported at TEG, People Committee, Board & Partnership Forum. Implemented and communicated for 2 survey. Expectations set for engagement in survey results	Done	Highest ever response rate for staff survey at DBTH achieved & amongst leading acute trusts nationally. Preparations underway for teams engagement phase following lifting of national embargo on the results (date tbc).	Done		
Actively support and further develop the Trust Leadership and Organisational Development opportunities. Consolidate/strengthen links with Education and Research Team		Zoe Lintin	CPO03	PC	Leadership development prospectus in place and offer expanded throughout the year. Roll-out of the Team Engagement and Development (TED) tool to support teams, as part of the national pilot. Improvements in leadership questions in staff survey. Embed role as new Exec lead for Education and Research, maximising opportunities for working with the People and Organisational Development (P&OD) team.	2022-10-17	Leadership prospectus launched. TED tool workshop held in June with c80 participants, first teams using the tool. Exec lead for Education and Research confirmed in June.	Working on it	Closer working with Education & Research team, now with same Exec lead across People & OD and E&R. New Head of Leadership, OD, EDI & Wellbeing started on secondment Sept 22. Overall offer to be reviewed again once leadership behaviours framework developed	Working on it	Established as Exec lead for Education & Research directorate enabling closer working with People & OD directorate. Increased use of TED tool during two year pilot Key cultural change workstreams launched on Flexible Working and Just Culture Leadership development offer to be fully reviewed following development of Framework	Working on it		
Build on the Health and wellbeing offer to ensure a sustainable and holistic offer for our people making best use of system opportunities.		Zoe Lintin	CPO04	BOD / PC	Comprehensive, proactive and holistic health and wellbeing (H&W) offer in place which is well understood and accessible by our people. Improvements in H&W questions in staff survey. Increase in number of H&W Champions. Increase in preventative aspects of the overall offer. Positive impact on sickness absence (recognising impact of other factors). Review of Occupational Health capacity undertaken and decisions made on resource requirements.	2022-10-17	Wellbeing offer continues to be expanded e.g. smear clinics. OH business case previously submitted. H&W update at July PC.	Working on it	Health & Wellbeing offer continues to be embedded. Work underway on a proposal for more sustainable funding model (Oct)	Working on it	Comprehensive and growing offer in place and areas of focus identified e.g. menopause. More sustainable approach to funding approved by Charitable Funds Committee. Strategic review of Occupational Health service being commissioned, with reference to national OH strategy.	Done		
Working with the Executive Team and other colleagues, develop and implement a leadership behaviours framework building upon the Develop, Belong, Thrive Here at DBTH.		Zoe Lintin	CPO05	PC	Engagement with colleagues to develop the framework, linked to existing DBTH ethos and national resources (Q3). Plan in place for launch, implementation and future embedding of the framework linked to all aspects of the employee life cycle. Staff survey impact in future years.	2022-10-17	Plan for engagement to begin in Q3 after the summer period.	Working on it	Initial discussions held with colleagues, planning for wider engagement in Q3	Working on it	Multiple engagement sessions held during Nov/Dec 22 with good attendance and positive feedback. Next stage in Q4 – development of Framework based on local feedback and strategies as well as national resources. Launch in Mar/Apr 23, with plan for embedding into life at DBTH	Working on it		
Review recruitment and retention processes to maximise efficiencies, improve timescales and enhance applicants experience. Developing and strengthening the recruitment and retention team, and the use of technology.		Zoe Lintin	CPO06	PC	Completion of Quality and Improvement (QI) project on end to end recruitment process, from vacancy approval to 'first day ready'. Improvement action plan developed and delivered with PMO support. Improvements seen in length of process and candidate experience. Recruitment team capacity explored and decisions made on resource requirements. Automation options explored.	2022-10-17	QI project scoped and workshop arranged for 19 July with stakeholders. Recruitment business case previously submitted. Update on recruitment KPIs and plans at July PC.	Working on it	QI improvement project underway with launch and follow-up workshops. Actions identified and progress being monitored on Monday.com. Several changes made quickly to streamline the recruitment process. KPIs being reviewed	Working on it	Qi project completed and majority of actions completed (Monday.com). New KPIs introduced to be monitored by People Committee. Feedback surveys being completed as part of Qi project. Automation recently introduced to issue contracts. Business case on recruitment model being presented in January	Working on it		
Review the approach to casework including the implementation of technology to improve experiences.		Zoe Lintin	CPO07	PC	Casework database implemented. Improvement in length of time taken on individual casework. Further roll-out of 'just culture' approach to managing casework, working with Staff Side colleagues.	2022-10-17	Casework database implemented. Update at July PC.	Working on it	Allocate ER Tracker implemented, all cases from 01.04.22 on the system. KPIs on timescales being monitored. 99% positive feedback from managers to date. 'Just Culture' ethos being explored, starting with reviewing tone of all template letters	Working on it	Initial data on ER tracker shows improvement in timescales and experience of those managing cases Tone and language in letters and policies being reviewed Links to Just Culture workstream - launch with People & OD and Patient Safety teams in Jan 23	Working on it		

Chief Operating Officer

Name	Deputy CEO / Director of RIT	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status	Q3 Update	Q3 Status	Q4 Update	Q4 Status
Name	Chief Operating Officer	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status	Q3 Update	Q3 Status	Q4 Update	Q4 Status
Ensure that EPRR plans and assurances are in place to respond to all reasonably foreseeable incidents		Denise Smith	COO01	ARC	Plans being updated post Covid business continuity and emergency plans. Training offer has been updated and is being rolled out across on call teams.	2022-10-17	Training being booked. Monthly EPRR updates booked with COO	Working on it	The EPRR compliance plan was presented to BoD in September and the plan is going to Audit Committee on the 14th October	Done		Done		
Ensure the delivery of the National, ICS and Local standards for Urgent and Emergency Care, Elective Care and cancer care, and diagnostics ensuring that wherever possible reduce inequalities in access.		Denise Smith	COO02	F&P	Business as usual plans in place and emergency recovery board set up July 22 Elective recovery board set up August 22	2022-10-17	Monthly review and weekly updates agreed	Working on it	Daily operational review taking place performance has been stubbornly resistant to improvement the major changes to the AMDY ASU in October are on plan	Working on it	Performance against the diagnostic, cancer and elective recovery programmes is achieving slow progress and performance against Urgent and Emergency Care (UEC) standards in lower than planned with specific challenges remaining for ambulance handovers. The Trust remains focused on continued progress towards reducing the elective witing times to less than 78 weeks and achieving the diagnostic and cancer standards as soon as possible. The Trusts new substantive COO joins the Trust in January 2023 and will refresh the recovery plans. The Emergency Care Intensive Support Team to visit the Trust in January to bring a fresh eyes approach to the UEC recovery plan.	Working on it		
Ensure wherever possible that the delivery of the recovery and restoration plans reduce inequality		Denise Smith	COO03	QEC	Emergency recovery and Elective recovery boards setup with review monthly	2022-10-17	ICB monthly review	Working on it	Recovery plan for electives is in train with twice monthly updates	Done		Done		
Ensure arrangement are in place to maintain and improve patient flow to maximise efficiency and effectiveness		Denise Smith	COO04	F&P	Performance which related to patient flow will be at 2019/ 2020 levels.	2022-10-17	Plan to be updated	Working on it	As ICS and local standards we are performing below the national average the complex improvement and winter plans are in place but reliant on ICB and place #! #! #!	Working on it	A number of actions have been undertaken to maintain and improve flow. The Emergency Care Improvement Support Team will visit the Trust in January to bring a fresh eyes approach to the Trust and PLACE response and plan.	Working on it		
Ensure that services deliver the required levels of transformation to allow access to enhanced funding		Denise Smith	COO05	F&P	Services will be linked into QI program and transformation board. Transformation board will meet monthly with feed in from elective and emergency programs	2022-10-17	First boards to be held in Q2	Working on it	Transformation plans developed and reviewed during Q2	Working on it	In light of the challenges experienced in Q3 transformation plans will be reviewed with the new COO	Working on it		
Develop, agree and implement robust plans to manage winter pressures and enhanced IPC measures		Denise Smith	COO06	F&P / PC	Winter plans will be in place by Q3 to reflect divisional plans Winter plans linked to the Integrated Care System and PLACE plans.	2022-10-17	Initial plan shows bed reduction latest version to include ward 22 beds	Working on it	winter plan has been developed and costed the ICB and place are agreeing the overall plan and partial implementation gas commenced without further community support we will not be able to maintain performance at safe levels and care for staff and patients will suffer	Stuck	The Trusts winter plans were in place but the Trust experienced significant pressures from increased rates Covid , Influenza and paediatric winter viruses. The Christmas and New period were particularly difficult with a significant increase in the presentations to the Emergency Departments and the acuity, dependency and length of stay of admissions. A full review of the 22/23 PLACE plan will be undertaken to ensure that lessons are learnt to enhance planning for the 23/24 bank holiday and winter plans	Working on it		

Chief Nurse

Name	Chief Nurse	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status	Q3 Update	Q3 Status	Q4 Update	Q4 Status
Working with the Executive Medical Director to embed a 'Quality Framework' define the characteristics and evidence that will define and support the Trust to be 'Outstanding in all that we do		Karen Jessop	CN01	QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet and exceed the CQC standards	2022-10-17	Implementation now commenced, project team working question set on trial areas , this will feed into newly formed quality steering group then Transformation board. 'Perfect Ward' audit and accreditation tool across all in patient areas to ensure we have a robust mechanism to measure quality metrics including, patient falls, hospital acquired pressure ulcers, medication incidents.	Working on it	Work in progress. Accreditation audits now being transferred to the new Tendable Audit Solution. Just gone live, to be presented to Nov Board.	Working on it	The Board of Directors received a presentation on the development and implementation of Tendable in Q3 and work continues to maximise its effectiveness. The Trusts new Chief Nurse commences in post in January 2023 and further work will be undertaken with the Executive Medical Director to ensure that systems an processes are on place for 2023/ 2024.	Working on it		
In conjunction with the Executive Medical Director ensure that the Trust is able to demonstrate evidence of compliance with the standards required to achieve a CQC Good rating in the Safe Domain and an Outstanding rating in the Caring Domain		Karen Jessop	CN02	QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet and exceed the CQC standards	2022-10-17	Working with The Executive Medical Director to complete the development and implementation of the Trust's Quality Strategy Work underway to ensure the Trust and Division can demonstrate compliance with the CQC standards.	Working on it	Awaiting new CQC quality assessment framework which will replace current KLOEs and will link in with Trust Quality framework. Walk around maternity in place against current KLOEs as risk of inspection due for maternity.	Working on it	Working in conjunction with the Executive Medical Director to ensure delivery of PSIRF and governance changes to optimise patient safety and learning	Working on it		
Jointly lead the maternity improvement plan in line with national recommendation from the Ockenden report, clinical Negligence Scheme for Trusts (CNST) year 3 and any further related reports		Karen Jessop	CN03	BOD / QEC	Work closely with Medical Director and Director of Midwifery to deliver the action plans developed in line with national recommendation from the Ockenden report. Review of safety culture within maternity, work closely with Medical Director and Director of Midwifery to review findings, agree recommendations and develop action plan. The 2022/ 2023 Assurance Framework will ensure the Trusts plans are being delivered.	2022-10-17	Ockenden action plan in place and reported to the BOD Additional resources being put in place to proactively collect and catalogue CNST evidence Birth rate plus review completed. Report to be provided to QEC Work underway to strengthen the midwifery management structure	Working on it	Ockenden and CNST action plans in place. Project manager recruited to support CNST & Ockenden workload – date to start to be agreed. 2 x 8b posts recruited to support DoM (operational and strategic) start dates Dec 2022 & Jan 2023 Regular progress reports given to QEC and BOD	Working on it	Previously reported actions are now in place. Internal audit have undertaken a review of the evidence to support the Trusts CNST self assessment which will be presented to Board in due course. An Organisational Development programme has been agreed to further support a learning and team culture. The service is actively engaged in LMNS and National programmes related to key Ockenden actions	Working on it		
Ensure the patient/carer voice is listened to by delivering increasing evidence of co-produced outcomes		Karen Jessop	CN04	QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet and exceed the CQC standards	2022-10-17	Work is underway to implement a revised patient experience service.	Working on it	Work continuing to develop strategy.	Working on it	The previously reported actions will be reveiwed by the new CN when she commences in post in January 2023.	Working on it		
Ensure safe and benchmarked staffing levels through the Trust, Safer Nursing Care Tool (SNCT) undertaken n May 2022, full feedback will be presented at board in September 2022.		Karen Jessop	CN05	BOD / QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet and exceed the CQC standards	2022-10-17	Safe staffing assessments and recommendation will be presented to BOD in September	Working on it	Sept Board - latest data collection May 22 identified the need to refresh training for some colleagues as well as new starters. This work will be delivered by the Shelford Group in Oct. Next data collection land Nov 22.	Working on it	The previously reported actions will be reviewed by the new CN when she commences in post in January 2023.	Working on it		
Implementation of the Patient Safety Incident Response Framework (PSIRF) and development of patient safety specialist roles across the organisation. Awaiting further national guidance on next steps , patients safety champions identified and in place		Karen Jessop	CN06	F&P / QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet and exceed the CQC standards	2022-10-17	Work is underway and will be finalised once the external reviews of risk and governance are completed.	Working on it	External review of risk and governance completed. Report being reviewed to identify recommendations. Timeline for PSIRF implementation to be present to QEC in Oct, as guidance has now been received.	Working on it	Progress to implement the PSIRF actions has been slower than expected in Q3 and the Trust will need to accelerate implementation in Q4 to ensure delivery of the framework in 2023/ 2024	Working on it		
Celebrate, share and promote good practice		Karen Jessop	CN07	QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet and exceed the CQC standards	2022-10-17	Individual opportunities to celebrate good practice and patient care are reported through established communication channels and celebration events are being planned. Listening events with senior nurses are underway.	Working on it	Individual opportunities to celebrate good practice and patient care are reported through established communication channels and celebration events are being planned. Listening events with senior nurses are underway	Working on it	Individual opportunities to celebrate good practice and patient care are reported through established communication channels and celebration events are being planned. Listening events with senior nurses are underway	Working on it		

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	31 January 2023	**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 JAN 2023		

Executive Summary	
Purpose of report:	For assurance that the Trust risk management process is being followed; new risks identified and current risks reviewed and updated in a timely way.
Summary of key issues:	<u>Key changes to the CRR this period:</u> • No new corporate risks rated 15+have been added or escalated from Trust Executive Group • Currently there are 85 risks logged rated 15+ across the Trust, a small reduction from last month. • 15 of these risks are currently monitored via Corporate Risk register (CRR) • Risk ID2472 – (COVID1) - World-wide pandemic of Coronavirus-management. Risk rating decreased from 15 to 9 (3Cx3L). Rationale for decrease: visiting being reinstated as current infection rates reduced and "return to living with COVID" guidance being implemented. Reviewed IPC BAF assured by QEC <u>Action Status of risk management process</u> • 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. • New Risk Manager (Operational) now in post and process of risk validation of 15+ risks now reviewed via Risk management Board (RMB). • Risk Manager undertaking series of reviews of risks 15+ with operational leads directly within divisions. (see section below) • New thematic review added to agenda of RMB - review of frequent incidents across the Trust or in a specific area ascertaining if there is a risk on the register (add / amend), looking at themes in NHS • 360 Assurance attended RMB January 16th to observe processes. <u>15+ Risk activity status Dec/Jan since introduction of Risk Manager</u> • 15 + Risks on register in Dec 2022 - 94 • 15+ Risks Archived - 6 • 15 + Risks Downgraded - 15 • 15 + Risks discussed at Risk Mgt Board (Dec/Jan) 26 (12 Dec / 14 Jan) • 15+ Risks discussed with Risk Manager - 8 (documented)

	• NEW reported 15 + Risks to go to RMB - 12 (6 Dec/6 Jan) • Total 15 + Risks on register in Jan 2023 - 85				
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 & Risk Management Board– (15+ risks)	
Date:	Risk Mgment Board Jan 2023	**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+	

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**	20/02/2023	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	**6/1/23 There is evidence that current demand peaks have outstripped supply - Strep A . Mutual aid, via NHSE across country. Alternative medicines and preparations sourced** **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)	Jan-23	⟺
2664	**PEO3**	03/07/2023	Clinical Specialist Services	Critical Care	**Inability to recruit and retain adequate numbers - causing staff shortage for 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)	Jan-23	⟺
2472	**COVID1**	16/06/2023	Directorate of Nursing, Midwifery and Allied Health Professionals	Not Applicable (Non-clinical Directorate)	**COVID 19 Pandemic - 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.**	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	Karen Jessop	**16/12/2022 IPC baf submitted to QEC. Mitigating actions in place for covid outbreaks. Covid numbers managed in line with current process. ITU equipment in place. Staffing meetings and daily ops meeting in place to support with outbreaks. 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	**High Risk**	**9**	High Risk (6)	Dec-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	Denise Smith	**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	⟺

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)**	07/04/2023	Chief People Officer	Not Applicable (Non-clinical Directorate)	**Inability to engage with and involve colleagues, learners and representatives to improve experiences at work**	Failure to engage and communicate with staff and representatives in relation to immediate challenges and strategic development	Zoe Lintin	**with TEG, People Committee and other networks in Jan 23. Engagement sessions held in Nov and Dec 22 to inform design and development of new DBTH Leadership Behaviours Framework. Plan to launch Mar/Apr 23 [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)	**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	**07/12/2022 BDGH Asset capture in progress. Projected completion Q3/Q4 for all three Trust sites.** **Business case in progress for submission Q4. 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)	Dec-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	**Extreme Risk**	**15**	Moderate Risk (4)	Sep-22	⟷
16	**PEO2 (F&P8)**	07/04/2023	Chief People Officer	Not Applicable (Non-clinical Directorate)	**IInability to recruit a sufficient workforce and to ensure colleagues have the right skills to meet operational needs**	Inability to recruit a sufficient workforce and have a workforce 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	**[03/01/2023 11:42:07 Zoe Lintin] Workforce planning and Learning Needs Analysis built into business planning processes for 23/24** **Schedule of deep dive workforce planning workshops to be arranged with specialties from Feb/Mar 2023** [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	**Extreme Risk**	**16**	High Risk (12)	Jan-23	⟷

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
1807	**F&P20 / Q&E12**	28/02/2023	Estates and Facilities	Not Applicable (Non-clinical Directorate)	**Risk of Critical Lift Failure in a Number of Passenger Lifts Trust Wide**	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	**[07/12/2022] Work on Lift 7 complete.** **Work commencing Jan 23 on Women's theatre lift and South Block Theatre lift[09/10/2022** Howard Tim**ms]** 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	Extreme Risk	**20**	High Risk (8)	Dec-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**	28/04/2023	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	Denise Smith	**[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**	17/04/2023	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	**03/01/2023 11:32:33 Zoe Lintin] System co-ordination on impact of industrial action 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)	Jan-23	⟺
3112	**QEC-PSIRF**	28/02/2023	Exec Med Dir	Not Applicable (Non-clinical Directorate)	**Patient Safety Incident Response Framework- compliance with meeting deadline for completing implementation of PSIRF**	The PSIRF is a contractual requirement under the NHS Standard Contract and as such is mandatory for services. Organisations are expected to transition to PSIRF within 12 months, completing by Autumn 2023. The lack of a PSIRF Implementation team risk non-compliance with the NHS contract therefore a financial penalty and reputational risk.	Tim Noble / Simon Brown	**[30/11/2022] business case in train for PSIRF implementation team. Continue to attend webinars from NHSE to ensure keeping up to date with current learning and updates. Some staff started HSIB PSIRF modules with further staff due to attend. Exec Lead for PSIRF now identified.** **Regular updates give at CGC,and QEC. Project monitored via MONDAY.COM and the Quality Steering gp Chaired by Deputy Chief Nurse** **Paper created to execs** **PSIRF guidance / project steps now on Monday.com5/10/22-** Paper created to execs PSIRF guidance / project steps now on Monday.com	High Risk	**12**	Low Risk (1	Nov-22	⟺

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Audit and Risk Committee - Chair's Highlight Report to Trust Board

Subject:	Audit & Risk Committee Meeting	**Board Date: 31 January 2023**
Prepared By:	Kath Smart	
Approved By:	ARC Members	
Presented By:	Kath Smart	
Purpose	The paper summaries the key highlights from the Audit and Risk Committee meeting held on 27 January 2023	

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
1. Stage 2 Head of Internal Audit Opinion – Moderate outcome due to 2 factors:- a. Audit Recommendations closure rate 68% (timeliness); 88% overall closure rate. Needs to be 75% or above b. Risk Management arrangements – in particular addressing 3 recommendations relating to; escalation of risks; 15+ risks; Board/ Committee oversight of mitigating actions 2. Maternity Standards CNST Review - requires additional work to improve compliance. Actions all agreed and underway. Referred into Quality & Effectiveness Committee (QEC). 3. Patient Safety (Datix review) – requires additional work to improve the Datix system and reporting of Near misses/ No harms – Actions agreed and underway. Referred into QEC <u>Key risks to escalate</u> None	• Risk Management - Presentation on process to address 3 recommendations relating to improving risk management arrangements and addressing the recommendations outstanding. Anticipated date for completion is by the end of March 2023. • Declaration of Interest, Gifts, & Hospitality - new system (Civica) has been launched and has made a good start. Work underway to monitor compliance to bring up to the required standard of compliance with declarations, particularly secondary employment.
Positive Assurances to Provide	**Decisions Made**
• Counter Fraud work progressing as planned • Financial Sustainability Audit (national piece of work) shows good performance on the whole • Health & Safety Bi-annual report – demonstrated ongoing improvements and assurance of management of risk across key H&S areas • ISA 260 (External Audit Recommendations) – showing positive progress • ARC Effectiveness Report concluded, and satisfactorily signed off along with workplan for 23/24 • Single Tender Waivers/ Losses and compensation show compliance with SO/SFI's • Full Board Assurance Framework – positive progress being made • Third party assurances received on Trust major systems - Payroll (VPS) and Finance (SBS)	

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Finance & Performance Committee - Chair's Highlight Report to Trust Board		
Subject:	Finance & Performance Committee Meeting	**Board Date: 31 January 2023**
Prepared By:	Kath Smart	
Approved By:	F & P Committee Members	
Presented By:	Kath Smart	
Purpose	The paper summaries the key highlights from the Finance & Performance Committee meeting held on 26 January 2023	

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
Matters of concern Committee considered the risks to the year end revenue position. The Committee were satisfied with the plans in place to mitigate risks and felt to be appropriate, however, there is still risk of year end not achieving target. Full report in the Board pack. Achievement of Elective and Non-Elective performance targets and activity remains a challenge for the Trust. New COO in role from Jan 2023 and is reviewing actions, information and data to provide assurances. Additional key risks to escalate None	• Planning for 23/24 activity and finance requirements is underway following publication of national planning guidance; • Awaiting feedback from Qi Work (Ambulance Handovers) and ECIST (Emergency Care Improvement Support Team) to identify further opportunities for improvement.
Positive Assurances to Provide	**Decisions Made**
• Capital Infrastructure update provided positive assurance on progress: some concern of delay over capital spend by 22/23 year end, but being managed appropriately; • 22/23 CIP broadly on track to deliver; • Cash position is currently healthy, challenges are foreseen by the ADoF and close monitoring & forecasting is in place • Ongoing work as reported before in Elective and Non-Elective areas including Ambulance Handovers, particularly Transfer of Care hub work • Board Assurance Framework – SA4 reviewed and viewed as relevant, fully detailed and up to date.	• SYB Pathology Laboratory Information Management System Business Case – Full Business Case was recommended to Board for approval; • Bassetlaw Emergency Village – Full Business case was recommended to Board for approval • Patient Pathway Business Case – Business case was recommended to Board for approval

Doncaster and Bassetlaw Teaching Hospitals
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Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	31 January 2023	**Agenda Reference:**	**G3**
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 renewal relating to Sunshine Day Nursey BDGH with tenant Luans Little People Ltd.	Signed Richard Parker OBE Chief Executive Alex Crickmar Interim Director of Finance	Date of sealing 15 December 2022

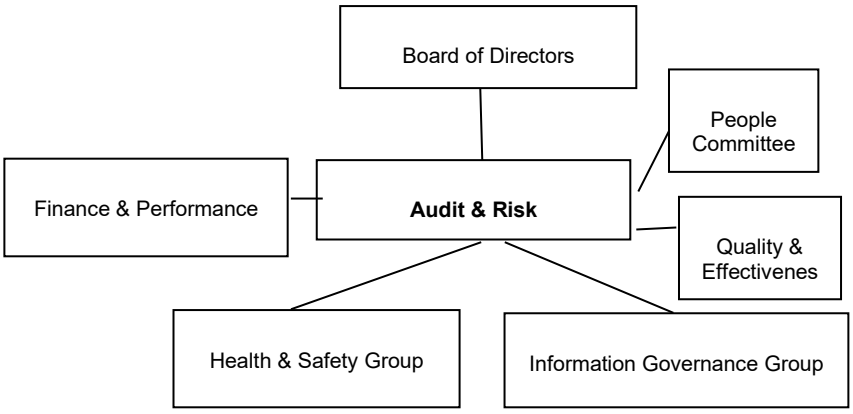
Recommendation:	The Board is requested to approve the use of the Trust Seal				
Action Require:	**Approval**	**Information**	~~Discussion~~	~~Assurance~~	~~Review~~

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:	14/12/2022	**Decision:**	Approved
Next Steps:	none		
Previously circulated reports to supplement this paper:			

Audit and Risk Committee (ARC)
Terms of Reference

Name	Audit and Risk Committee ("the Committee").
Purpose	To provide the Board of Directors ("the Board") with a means of independent and objective review of internal controls and risk management arrangements relating to: • Financial systems; • The financial information used by the Trust; • Controls and assurance systems; • Risk management; • Health and Safety, Fire and Security; • EPRR; • Compliance with law, guidance and codes of conduct; and • Counter fraud activity.
Responsible to	The Committee reports to the Board. The Chair of the Committee is responsible for reporting assurance to the Board on those assurance matters covered by these Terms of Reference through review and update of the Board Assurance framework. The minutes of the Committee shall be submitted to the Board of Directors. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the Council of Governors, or require executive action. The Committee will present a written annual report to the Board summarising the work carried out during the financial year and outlining its work plan for the future year.
Delegated authority	The Committee is a Non-Executive Committee and holds no executive powers other than those specifically delegated in these Terms of Reference.
	 The Committee is authorised to investigate any activity within its Terms of

	Reference. It is further authorised to seek any information it requires from any employee of the Trust and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to secure legal or independent professional advice, or to request the attendance of external advisers with relevant experience and expertise if it considers this necessary.
Duties and work programme	1 <u>Integrated Governance, Risk Management and Control</u> 1.1 The Committee shall review the effectiveness of the system of integrated governance, risk management and internal controls, to satisfy the Board that its approach to integrated governance remains effective. 1.2 Determine the actions, controls and audits/reviews required to provide Non-Executives and the Board with robust assurance regarding the reported financial position going forward; and to maintain the confidence of governors, regulators and the public. Undertake ongoing review of the implementation and effectiveness of these. 1.3 The Committee will review the adequacy of: i. all risk and control related disclosure statements (in particular the Annual Governance Statement and Declarations of Compliance made to NHSI) together with any accompanying Head of Internal Audit statement, external audit opinions or other appropriate independent assurance, prior to endorsement by the Board; ii. the underlying assurance processes that include the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of related disclosure statements; iii. the policies and procedures for ensuring compliance with relevant regulatory, legal and code of conduct requirements; and iv. the arrangements, policies and procedures for all work related to fraud and corruption (but shall not be responsible for the conduct of individual investigations); and v. The operating of, and proposed changes to, the Board of Directors standing orders, standing financial instructions, the constitution, codes of conduct, scheme of delegation and standards of business conduct. 1.4 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurance from executive directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. 2 <u>Internal Audit</u>

2.1 The Committee shall monitor the effectiveness of the internal audit function established by management that meets mandatory *Public Sector Internal Audit Standards* and provides appropriate independent assurance to the Committee, Chief Executive and Board. This will be achieved by:

i. consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;
ii. review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;
iii. consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources;
iv. oversee the effective implementation of internal and external audit recommendations;
v. ensuring that the Internal Audit function is adequately resourced and have appropriate standing within the organisation; and
vi. annual review of the effectiveness of Internal Audit.

3 <u>External Audit</u>

3.1 The Committee shall review the work and findings of the External Auditor whom are appointed by the Council of Governors and consider the implications of and management's responses to their work. This will be achieved by:

i. consideration of the appointment and performance of the External Auditor in accordance with the Trust specification for an External Audit Service, informed by NHSI's Audit Code for NHS Foundation Trusts;
ii. discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan ensuring co-ordination, as appropriate, with other External Auditors in the local health economy;
iii. discussion with the External Auditors of their local evaluation of audit risk and assessment of the Trust and associated impact on the audit fee;
iv. review of all External Audit reports, including agreement of the annual audit letter, before submission to the Board and review of any work carried outside the annual audit plan, together with the appropriateness of management responses; and
v. review of the annual audit letter and the audit representation letter before consideration by the Board.

4 <u>Other Assurance Functions</u>

4.1 The Committee shall review the findings of other significant assurance

functions, both internal and external to the organisation, and consider their implications to the governance of the organisation. These may include, but will not be limited to: any reviews by Department of Health Arms' Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Resolution, Health and Safety, Shared Business Services etc.); professional bodies with responsibility for the performance of staff; or functions (e.g. accreditation bodies, etc.) relevant to the Terms of Reference of this Committee.

4.2 In addition, the Committee will review the work of the other Committees within the organisation whose work can provide relevant assurance to the Committee's own scope of work.

5 Management

5.1 The Committee shall request and review reports and assurance from directors and managers on the overall arrangements for governance, risk management and internal control.

5.2 They may also request reports from individual functions from within the organisation as appropriate.

6 Financial Reporting

6.1 The Committee shall review the Annual Report and Financial Statements before recommendation to the Board, focusing particularly on:

i. the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
ii. compliance with accounting policies and practices;
iii. unadjusted mis-statements in the financial statements;
iv. major judgemental areas;
v. significant adjustments resulting from the audit;
vi. the clarity of disclosures; and
vii. the going concern assumption.

6.2 The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

7 Counter Fraud Arrangements

7.1 The Committee shall ensure that there is an effective counter fraud function established by management that meets the NHS Counter Fraud standards and provides independent assurance to the Committee, Chief

Executive and Board. This will be achieved by:

i. review the adequacy of the policies, procedures and plans for all work related to fraud, bribery and corruption;
ii. ensuring effective co-operation with the Counter Fraud function and that it has appropriate standing within the Trust;
iii. receipt of quarterly reports and an annual report from the Local Counter Fraud Specialist (LCFS) on counter fraud activity and investigations;
iv. ensuring compliance with Section 24 of the NHS National Contract regarding fraud and NHS Standards for Providers as required by the NHS Counter Fraud Authority.

8 Other areas of work

8.1 Information Governance:- The Committee shall receive reports and review assurance from directors and managers on the overall arrangement for compliance with Information Governance Standards.

8.2 Health and Safety, Fire and Security:- The Committee shall receive reports from relevant directors and officers, including the Local Security Management Specialist, on the arrangements for compliance with relevant health and safety, fire and security standards.

8.3 EPRR:- The Committee shall receive reports from the Trust's Emergency Planning Officer on Emergency Preparedness, Resilience and Response, including the proposed statement of compliance arising from the annual self-assessment against NHS England's Core Standards return.

9 Special Assignments

9.3 The Committee shall commission and review the findings of any special assignments required by the Board.

10 Performance

10.3 The Committee shall request and review reports and assurance from directors and managers on the overall arrangements for reporting compliance with:
i. the Trust's corporate objectives;
ii. NHSI's governance standards and declarations, including the review of areas of non-compliance in the context of NHSI's "comply or explain" philosophy; and
iii. key performance objectives as appropriate but not to duplicate the work of QEC or F&P

11 Risk Management

11.3 The Committee will provide assurance to the Board that the Risk

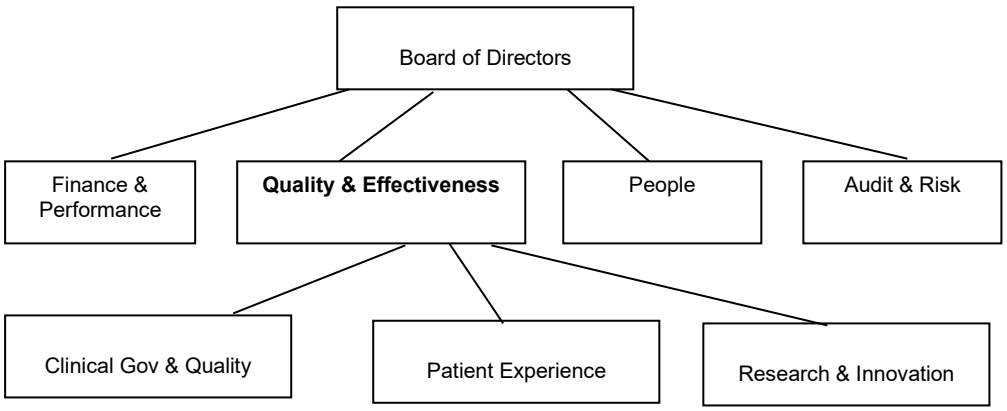
	Management Strategy is being complied with, including, but not limited to, reviewing Risk Registers. The Committee shall request and review reports and assurance from directors and managers on effects of arrangements to identify and monitor risk. The Board will retain the responsibility for routinely reviewing specific risks. 12 <u>Workplan</u> 12.3 The Committee's annual work plan is an appendix to these Terms of Reference and is subject to annual review by the Committee.
Policy approval	The Committee has responsibility for approving the following policies: • Fraud, Bribery & Corruption Policy and Response Plan; • Standards of Business Conduct and Employees Declarations of Interest Policy.
Chair	A Non-Executive Director, appointed by the Board of Directors, will chair the Committee.
Membership	Four Non-Executive Directors. Time served needs to be removed agreed by the committee and needs to be 2 out of the 4 NEDs for quoracy. • One of the Non-Executives shall have recent and relevant financial experience. • Each Non-Executive shall normally not serve more than three years as a Committee member, unless the requirement for one of the members to have recent and relevant financial experience is compromised. • The Trust Chair of the Trust shall not be a member of the Committee.
In attendance	• Director of Finance • Company Secretary/Director Corporate Affairs • Local Counter Fraud Specialist • Appropriate internal and external audit representatives • Security Management Specialist • Corporate Governance Officer (Minutes) • Other trust staff as appropriate / requested The Chief Executive, executive directors or other officers will be required to attend at the request of the Committee, for issues relevant to their areas of responsibilities. Two public governors, nominated by the Council of Governors, will be invited to attend the Committee, as observers. The Chair and Chief Executive of DBTH will be invited to attend at least annually.
Secretary	Corporate Governance Officer

Voting	Matters will generally be decided by way of consensus. Where it is necessary to decide matters by a vote then each member will have one vote. The Chair will have a casting vote.
Quorum	Two members.
Attendance requirements	Committee members must attend at least 50% of meetings.
Frequency of meetings	No less than quarterly and more frequently as required. At least once per year, the Committee should meet with the external and internal auditors, without management being present, to discuss matters relating to its responsibilities and issues arising from the audit. The External Auditor and Head of Internal Audit may request a private meeting if they consider that one is necessary. They will also have direct access to the Chair of the Committee.
Papers	Papers will be distributed a minimum of five clear working days in advance of the meeting.
Permanency	The Committee is a permanent Committee.
Reporting Committees	Health and Safety Committee Information Governance Steering Group
Circulation of minutes and other reporting requirements	The Governor observers shall report to the Council of Governors on a quarterly basis regarding the work of the Committee, any matters needing action or improvement and the corrective actions to be taken. Following the Council of Governors appointment of the External Auditors, the Committee shall report to the Council of Governors regarding the reappointment, termination of appointment and fees of the External Auditors.

Date approved by the Committee:	19/4/2022
Date approved by the Board of Directors:	TBC
Review date:	19/4/2023

Quality and Effectiveness Committee

Terms of Reference

Name	Quality and Effectiveness Committee ("the Committee")
Purpose	The Committee will carry out its duties as an assurance Committee of the Board of Directors (''the Board") in reviewing systems of control and governance specifically in relation to clinical quality and governance and in delivery of high quality patient care. It is supported by the Audit and Risk Committee which provides the oversight arm of the Board, reviewing adequacy and effectiveness of controls. The work of the Committee is aligned to the Trust's Strategic Objectives and is organised to provide assurance on the progress towards the True North Objectives: - To provide outstanding care and improve patient experience; - Everybody knows their role in achieving the vision; - Feedback from staff and learners in top 10% in UK; - In recurrent surplus to invest in improving patient care.
Responsible to	The Board. The Chair of the Committee is responsible for reporting assurance to the Board on those matters covered by these terms of reference through review and update of the Board Assurance framework. The minutes of the Committee shall also be submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the Board of Governors, or may require executive action. The Committee will present a written annual report to the Board summarising the work carried out during the financial year and outlining its work plan for the future year.
Relationship to other Committees	The Committee will receive information and assurances from the Trust's internal management and operational Committees as required. This includes Clinical Governance and Quality Committee and Patient Experience Committee below. 

Delegated authority	The Committee is a Committee of the Board and holds those powers specifically delegated to it by the Board and set out in these terms of reference. The Committee is authorised to investigate any activity within its terms of reference. It is further authorised to seek any information it requires from any employee of the Trust and all employees are directed to co-operate with any request made by the Committee. The Committee may make a request to the executive for legal or independent professional advice and request the attendance of external advisers with relevant experience and expertise if it considers this necessary. The Committee will operate at a strategic level as the executive is responsible for the day to day delivery of Trust services and management of its workforce.
Duties and work programme	(1) To review reports relevant to the Committee that relate to the following matters: - the Trust wide quality objectives as part of the Quality Strategy, - the clinical risk management framework and any controls and assurances against relevant clinical risks on the Board Assurance Framework, - the effectiveness of clinical governance, clinical risk management, clinical audit and effectiveness and clinical control, - maternity safety accountabilities, - promoting an honest and open reporting culture, - disclosure statements (in particular the Quality Report and Declarations of Compliance made to NHSE), prior to endorsement by the Board, - the CQC Essential Standards of Quality and Safety as part of the internal assurance process, - compliance with licensing standards of the Care Quality Commission, - any improvement reviews/notices from the Care Quality Commission and other external assessors, - clinical data and patient identifiable information to ensure that it is in accordance with the Caldicott Guidelines and relevant legislation and guidance, - adverse clinical incidents, complaints and litigation and examples of good practice and learning, and trend analysis - the QPIA process for Efficiency and Effectiveness Improvement Plans, - infection control, - mortality, - comments, compliments and complaints, - safer staffing for delivery of high quality patient care

	(2) Through the Teaching Hospital Board the committee will ensure that Research and Innovation and external links with Universities and Colleges are driving forward our ambition to become a University Teaching Hospital (3) Through the Clinical Governance & Quality Committee, the Committee will obtain assurance that clinical governance strategies and plans are embedded and that the clinical governance function is adequately resourced and has appropriate staffing. (4) To undertake thematic reviews and deep dives into quality, governance and safer staffing related issues. (5) To ensure that the Trust has reliable, up-to-date information about what it is like being a patient experiencing care administered by the Trust. (6) To approve terms of reference and membership of reporting sub-Committees and oversee the work of those sub-Committees. (7) To hold the Divisional Directors to account for clinical quality and governance in their areas.
Chairing arrangements	The chair will be nominated from among the non-executive members of the Committee. The vice-chair will nominated from the other two NEDs on the committee.
Membership	• Three members, appointed by the Board from amongst the Non-executive Directors (other than the Chairman of the Trust). • Executive Medical Director • Chief Nurse
In attendance	• Director Corporate Affairs /Company Secretary • Director of Education & Research (or Deputy) • Deputy Chief Nurse • Deputy Director Nursing – Patient Experience • Clinical Governance and Professional Standards Co-ordinator • Corporate Governance Officer (Minutes) • Other Trust staff as appropriate / requested • Two governor observers
Secretary	Corporate Governance Officer.
Voting	Matters will generally be decided by way of consensus. Where it is necessary to decide matters by a vote then each member will have one vote. The Chair will have a casting vote.

Quorum	Three members, including the chair or vice-chair.
Frequency of meetings	Once every two months.
Papers	Papers will be distributed a minimum of three clear working days in advance of the meeting, but ideally a week before.
Permanency	The Committee is a permanent Committee.
Sub-Committees	Clinical Governance & Quality Committee Patient Experience Committee Research & Innovation Committee
Date agreed by the Committee:	October 2022
Date approved by the Board of Directors:	
Review date:	October 2023

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	31 January 2023	**Agenda Reference:**	**G5**
Report Title:	**Approval of Trust Policy - Reviews Visits Inspections and Accreditations**		
Sponsor:	Richard Parker OBE, Chief Executive Officer		
Author:	Fiona Dunn, Director Corporate Affairs/Company Secretary		
Appendices:	G5 - Reviews Visits Inspections and Accreditations CORP/COMM 11v5		

Executive Summary	
Purpose of report:	To update the relevant document in line with current/best practice.

Summary of key issues:	As Board is aware, there are a number of agencies that may undertake reviews to assess the Trust's performance or use the result of internal reviews to benchmark the Trust against its comparators.
	Therefore the principal purposes of this policy are as follows:
	• To ensure that preparation for reviews includes a prospective gap analysis against standards or requirements in order to ensure that:
	  ○ Review outcomes are as positive and compliant as possible, within available resources.
	  ○ Wherever possible, there are no surprises from reviews and that financial planning can take place with maximum notice, enabling resources to be identified efficiently.
	• To ensure that data and other information required for reviews is accurate, of the highest possible quality, has been validated prior to submission, and is shared with the relevant agencies in a timely manner.
	• To ensure that there is a centrally held and internally audited record of all reviews together with their associated reports and action plans. These are to be maintained, updated and monitored in accordance with this policy.
	• To ensure that recommendations and action plans arising from reviews are appropriately managed by the Clinical Governance Quality Committee, Performance, Overview & Support Meetings (POSM) or Trust Executive group (TEG) and escalated to the Board of Directors as required.
	
	The policy has been reviewed, with the following adjustments made following consultation with Executives, and approval at the Trust Executive Group on 9/1/2023:
	• Minor changes and updates to reflect Divisional structure and committee governance structures
	• Also now to includes visits/reviews that are undertaken virtually
	• Reinforcement of message that compliance of the policy is required

Recommendation:	• The Board is asked to ratify the changes made in Trust policy for Management of Reviews, Visits, Inspections and Accreditations as approved at Trust Executive Group 9/1/2023

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
Corporate risk register:	Risk ID7 (F&P6)
Regulation:	All NHS Foundation Trust are required to have a system in place to identify and 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

Assurance Route			
Previously considered by:		Circulation Executive Directors 30/12/22 and TEG 9/1/23	
Date:	9/1/2023	**Decision:**	Approved with Comments incorporated into documents & recommendations actioned
Next Steps: For Board Ratification		Approve to go to Board 31st January 2023	
Previously circulated reports to supplement this paper:		Draft documents of the above	

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Management of Reviews, Visits, Inspections and Accreditations Policy

This procedural document supersedes: CORP/COMM 11 v.4 - Management of Reviews, Visits, Inspections and Accreditations Policy.

Did you print this document yourself?

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

Name and title of author/reviewer:	Fiona Dunn – Director Corporate Affairs
Date revised:	December 2022
Approved by:	Board of Directors
Date approved:	
Date issued:	
Next review date:	January 2025
Target audience:	Trust-wide

Management of Reviews, Visits, Inspections and Accreditations Policy

Amendment Form

To be completed when reviewing an existing APD

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

Version	Date Issued	Brief Summary of Changes	Author
Version 5	30 December 2022	• Minor changes and updates to reflect Divisional structure and committee governance structures • Also now Includes visits/reviews undertaken virtually	Fiona Dunn
Version 4	29 January 2015	• Title change • Updates to reflect new Care Group structure, and changes to committee structure • Reporting of external assurance register added	Maria Dixon
Version 3	February 2013	• This policy has been re-written, please read in full. • New style format as per CORP/COMM 1.	Maria Dixon
Version 2	October 2009	• Title change • This policy has been re-written, please read in full	Maria Dixon

Management of Reviews, Visits, Inspections and Accreditations Policy

Contents

Management of Reviews, Visits,

Inspections and Accreditations Policy

1. INTRODUCTION

NHS organisations are required to participate in reviews by external agencies, some of which may be undertaken at short notice. Some review bodies such as the Health & Safety Executive and the Care Quality Commission (CQC) may also undertake unannounced visits.

This policy and process is for the effective coordination and evaluation of the work of such reviews. It will help to reduce overlap and allow potential gaps in assurance to be identified and addressed.

This is part of the organisation's internal control system and provides assurance to the board in order that it may benefit from the work undertaken by reviewers and ensure that the process is efficient and meaningful to the Trust.

2. SCOPE

The scope of this policy is limited to routine or risk-based visits, inspections, or reviews for assessment, accreditation or benchmarking purposes, or has the potential to impact upon the reputation of the Trust. Such reviews may be conducted internally or by an external agency, but the scope of this policy is restricted to those reviews which are either externally mandated or externally reported. For the purposes of this policy and procedure, the term "reviews" will be used to reflect all of these methods of enquiry. (Visits or reviews can also be virtual)

National Institute of Clinical Excellence Guidance (NICE) is outside the scope of this policy and is managed using the NICE Guidance Policy (CORP/COMM 10).

National Confidential Enquiries are outside the scope of this policy and are managed using the National Confidential Enquiry (NCE) Policy (CORP/COMM 20).

The scope of this policy does not include all external data collection exercises that take place within the Trust. The Trust's Information Team routinely participate in and manage data submissions which are overseen through the existing management arrangements. The scope also does not include routine internal assessments that are not reported or mandated externally, such as Tendable assessments.

In addition, some training programmes and initiatives within the organisation may seek accreditation from local universities with the accreditation process managed solely by the training provider. Such exercises do not fall within the scope of this policy, which primarily focuses on nationally led, external visits and inspections that have the potential to impact significantly on the Trust's performance assessments and reputation.

3. PURPOSE

There are a number of agencies that may undertake reviews to assess the Trust's performance or use the result of internal reviews to benchmark the Trust against its comparators. The principal purposes of this policy are as follows:

- To ensure that preparation for reviews includes a prospective gap analysis against standards or requirements in order to ensure that:
    - Review outcomes are as positive and compliant as possible, within available resources.
    - Wherever possible, there are no surprises from reviews and that financial planning can take place with maximum notice, enabling resources to be identified efficiently.
- To ensure that data and other information required for reviews is accurate, of the highest possible quality, has been validated prior to submission, and is shared with the relevant agencies in a timely manner.
- To ensure that there is a centrally held and internally audited record of all reviews together with their associated reports and action plans. These are to be maintained, updated and monitored in accordance with this policy.
- To ensure that recommendations and action plans arising from reviews are appropriately managed by the Clinical Governance Quality Committee, Performance, Overview & Support Meetings (POSM) or Trust Executive group (TEG) and escalated to the Board of Directors as required. This will be achieved through clear lines of accountability and responsibility in relation to each of the reviews as detailed in this section.

4. DUTIES AND ACCOUNTABILITIES

4.1 Chief Executive

As Accountable Officer, the Chief Executive is ultimately responsible for the process of managing and responding to reviews effectively and the delegation of these responsibilities.

Where no Accountable Director is named in this policy, the Chief Executive will be notified and is responsible for nominating an Accountable Director.

4.2 Executive Directors and Divisional Directors

All directors are responsible for supporting the Accountable Director and Operational Review Lead in conducting a gap analysis and risk assessments against any recommendations resulting from the review and implementing any resulting action plans.

All directors are responsible for ensuring that their Divisional risk register reflects any gaps identified in this gap analysis and are allocated an appropriate risk rating.

4.3 Accountable Director

The Accountable Director is the nominated lead, usually an Executive or Divisional Director. The Accountable Director will oversee preparation for reviews, nominate the Operational Review Lead and inform the Operational Review Lead, Trust Executive Group and Review Operational Working Group (where required) of their nomination.

The Accountable Director will inform the Director of Corporate Affairs of the forthcoming review. The Accountable Director will also inform the Director of Communications and Engagement and Head of Information if appropriate.

The Accountable Director will report progress, final results and implementation of recommendations to the Review Operational Working Group, Trust Executive Group, Chief Executive and Board of Directors as appropriate.

The Accountable Director will ensure that the Board Assurance Framework is updated to reflect assurance arising from reviews.

4.4 Board of Directors

This policy and procedure will ensure that the Board of Directors is assured regarding the management of reviews and of an appropriate organisational response to the outcome of the reviews where required. An 'External Assurance Register' will be maintained by the Trust Board Office.

4.5 Operational Review Lead

The Operational Review Lead will generally be a Divisional General Manager or a Divisional Director of Nursing, or a head of department or appropriate manager in a corporate directorate.

The Operational Review Lead will be nominated by the Accountable Director and is responsible to the Accountable Director for the effective management of the review until all actions resulting from the process are fully implemented.

The Operational Review Lead will:

(a) Inform the relevant staff and managers of the forthcoming review, detailing the scope of the review and agreed timescales;

(b) Decide whether to instigate a Review Operational Working Group to help with the whole planning of the visit which may include agreeing the logistics of onsite visits etc.

(c) Conduct a prospective gap analysis against standards or requirements in order to ensure that review outcomes are as positive and compliant as possible and that any necessary financial planning in relation to resourcing required actions can be undertaken in advance of the review;

(d) Complete the checklist at appendix E and return this to the Director Corporate Affairs confirming that the relevant preparation for the review has been undertaken;

(e) With the support of the Head of Information and/or other staff as appropriate, oversee the collation of relevant information for the review;

(f) Agree arrangements for validating data prior to submission with the Accountable Director;

(g) On receipt of the review report, ensure that all the information included in the report is accurate;

(h) Conduct a gap analysis and risk assessments against any recommendations made; develop an action plan if appropriate and agree this action plan with the Accountable Director. The action plan and risk assessment will, if appropriate, be reported to the Review Operational Working Group and Trust Executive Group;

(i) Review the report and actions plans regularly, in accordance with agreed timescales, and report the reviews to the Accountable Director, who will report to the Trust Executive Group if required.

4.6 Director Corporate Affairs

The Director Corporate Affairs (via Trust Board Office) will maintain an external assurance register, containing information relating to current, forthcoming and previous reviews. A summary form of this register, showing forthcoming and recent reviews, will be reported on a bi-monthly basis to the Trust Executive Group.

The Director Corporate Affairs will receive a copy of the post-review report for inclusion in the external assurance register.

4.7 Trust Executive Group (TEG)

A summary form of the external assurance register, showing forthcoming and recent reviews, will be reported on a bi-monthly basis to the Trust Executive Group. More detailed information regarding preparation for reviews will also be reported as appropriate.

Review reports will be reported to the Performance, Overview & Support Meetings, and the Trust Executive Group will approve the resulting action plan, if applicable. Action plans will be monitored through the Review Operational Working Group, unless otherwise determined by the Trust Executive Group.

4.8 Executive team

The executive team will determine whether post-review reports, action plans or any other information arising from a review should be escalated and reported in detail to the Board of Directors in addition to the arrangements outlined in paragraph 4.7 above.

4.9 All staff

All staff are responsible for notifying their Divisional Director or Executive Director if they receive information regarding a prospective review.

5. PROCESSES

The processes followed are as outlined in the process maps – see Appendix A and Appendix B.

5.1 Notification of planned reviews

Notifications of reviews are received by the Trust in a variety of different ways. All notifications of this kind must be forwarded to the Accountable Director, who will proceed in accordance with the process on Appendix A.

5.2 Notification of unannounced reviews

Notification of an unannounced review will occur when an external review body presents at a Trust site. In the case of the Care Quality Commission, it is likely that this will occur at the Chief Executive's Office. The member of staff who is first notified of the visit must contact the Chief Executive (in hours) or Director on Call (out of hours), who will proceed in accordance with the process on Appendix B.

5.3 Failure to provide notification

Where notification of a review does not take place, and therefore appropriate preparatory actions have not been undertaken in accordance with this policy, the Accountable Director should report to Trust Executive Group on the circumstances. The Executive Team shall determine whether the matter is to be escalated to the Board of Directors.

5.4 Maintenance of the external assurance register

The Director of Corporate Affairs (via Trust Board Office) will maintain a register of all reviews, both past and future. The database will contain the reports resulting from the reviews.

The Trust Executive Group will review the External Assurance Register bi-monthly.

The Director Corporate Affairs will review the External Assurance Register annually to identify any items for inclusion in the annual report, quality account or other reporting mechanism as appropriate.

5.5 Development, maintenance and review of action plans

Following receipt of the report, the Operational Review Lead will:

(a) ensure that the report has been received by the Accountable Director and Director Corporate Affairs;

(b) review the report to ensure its accuracy;

(c) conduct a gap analysis and risk assessments against any recommendations resulting from the review;

(d) once the accuracy of the report has been confirmed, and where appropriate, develop a report and action plan in response to any recommendations. The report and action plan must detail the following:

- a summary of the main review findings
- recommendations made
- compliance with recommendations
- action required
- lead for each action
- timescales for the completion of actions
- review frequency for each action
- date actions completed

This report and action plan is to be agreed with the Accountable Director before being provided to the Director Corporate Affairs and formally submitted to the Trust Executive Group (TEG). The action plan will be approved by Trust Executive Group, provided the Trust Executive Group is satisfied that it is adequate.

The Operational Review Lead will oversee implementation of the agreed action plan on behalf of the Accountable Director. Monitoring of action plans will be through the Review Operational Working Group (if applicable) unless determined otherwise by the trust Executive Group.

Once an action plan has been fully implemented, the Operational Review Lead will notify the Director Corporate Affairs of this, for recording on the external assurance register and reporting to the Trust Executive Group.

Many reviews use bespoke action plan formats, and these should be used where they exist. Where there is no set action plan format, leads should use the standardised Trust action plan headings as indicated in section (d) above.

5.6 Post review reports

Post review reports will be provided to the Director Corporate Affairs for inclusion in the External Assurance Register. They will also be formally submitted to the Trust Executive Group, along with a report from the Accountable Director and an action plan if appropriate (see para 5.5).

The executive team will determine whether post review reports should be escalated and reported in detail to the Board of Directors in addition to the arrangements above.

5.7 Risk register and assurance framework

Following gap analysis and risk assessment of both forthcoming reviews and recommendations and action plans resulting from past reviews, the Operational Review Lead will escalate details of any risks assessed as ‘high’ or ‘extreme’ to their Divisional/

directorate risk register or to the corporate risk register (via Risk Management Board) as appropriate.

The Accountable Director will ensure that the Board Assurance Framework is updated to reflect assurance arising from reviews. Any risks added to the corporate risk register will be reviewed using the established mechanisms for doing so.

All directors are responsible for ensuring that their local risk registers reflect any outstanding gaps identified from this gap analysis and are allocated an appropriate risk rating.

6. MONITORING COMPLIANCE

What is being monitored	Who will carry out the monitoring	How often	How reviewed/Where reported to
Monitoring of compliance with the policy	Divisional Director	Monthly	Monthly monitoring at SMT meetings
Monitoring of post-review action plans	Divisional Director	Monthly	Monthly monitoring at SMT meetings

APPENDIX A - PROCESS MAP - PLANNED REVIEWS

REVIEWER (External or Internal) – (NB also includes virtual reviews)
Provides notification of forthcoming review.

↓

MEMBER OF TRUST STAFF
Notifies Accountable Director. In the absence of a named Accountable Director, the Chief Executive is notified and will nominate an Accountable Director.

↓

ACCOUNTABLE DIRECTOR
Notifies Operational Review Lead and Director Corporate Affairs (via Trust Board Office).
Notifies Head of Information / Director of Communications & Engagement if appropriate.

↓

DIRECTOR CORPORATE AFFAIRS
Adds review to external assurance register.
Ensures Trust Executive Group is notified of review.

↓

OPERATIONAL REVIEW LEAD

- Agrees key review contact within clinical / corporate service (where appropriate)
- Undertakes prospective gap analysis & develops action plan where appropriate
- Undertakes prospective risk assessment & escalates risk assessments where appropriate
- Makes arrangements for management of the review (possible Review Operational Working Group)
- Clarifies practical arrangements for on-site visits (where appropriate)
- Alerts & liaises with Divisional Directors / General Managers where appropriate
- Oversees collation of information, ensures information is quality assured prior to submission
- Ensures information is submitted within specified timescales

↓

REVIEWER
Provides post-review report

↓

OPERATIONAL REVIEW LEAD

- Shares report with:
  - Accountable Director and other key contacts in the relevant Division/directorate
  - Trust Executive Group, which will review the report and approve action plan if applicable
  - Director of Communications and Engagement
  - Director Corporate Affairs for inclusion in external assurance register
- Conducts gap analysis and risk assessment in response to recommendations
- Ensures action plan is developed in response to recommendations
- Reports progress against action plan in line with agreed review timescales to Review Operational Working Group (or other group as determined by Trust Executive group)
- Escalates risk assessments to Divisional risk register and corporate risk register as appropriate

↓

ACCOUNTABLE DIRECTOR
Reports back to reviewer regarding action taken.

APPENDIX B - PROCESS MAP - UNANNOUNCED REVIEWS

EXTERNAL REVIEW BODY
Presents at Trust site / Chief Executive's office unannounced

↓

STAFF INFORMED OF REVIEW
- Immediately notify Chief Executive (in hours) or Director on call (out of hours)
- CE or Director on call nominates and notifies Accountable Director and other Executive Directors as appropriate.

(if CQC, follow CQC Alert Action Cards found on the HIVE)

↓

ACCOUNTABLE DIRECTOR
Notifies Operational Review Lead, Director Corporate Affairs and any other appropriate members of staff If
(if CQC, follow CQC Alert Action Cards found on the HIVE)

↓

OPERATIONAL REVIEW LEAD
- Management of the visit / review
- Alerts Divisional Directors / General Managers where appropriate
- Ensures information is quality assured prior to submission
- Ensures information is submitted to external body within specified timescales
- Notifies Trust Executive Group at first opportunity

DIRECTOR CORPORATE AFFAIRS
Adds review to external assurance register

↓

EXTERNAL REVIEW BODY
Provides post-review report

↓

OPERATIONAL REVIEW LEAD
- Shares report with:
  - Accountable Director and other key contacts in the relevant Division/directorate
  - Trust Executive Group, which will review the report and approve action plan if applicable
  - Director of Communications and Engagement
    - Director Corporate Affairs for inclusion in external assurance register
- Conducts gap analysis and risk assessment in response to recommendations
- Ensures action plan is developed in response to recommendations
- Reports progress against action plan in line with agreed review timescales to Operational Working Group (or other group as determined by Trust Executive Group)
- Escalates risk assessments to Divisional risk register and corporate risk register as appropriate

↓

ACCOUNTABLE DIRECTOR
Reports back to external review body regarding action taken.

APPENDIX C – REVIEW OPERATIONAL WORKING GROUP AND TRUST EXECUTIVE GROUP REPORT TEMPLATE

Forthcoming reviews

Division/Directorate management teams are asked to:

- Notify the Director Corporate Affairs and relevant Executive Director of any forthcoming reviews that are not listed below.
- Notify the Director Corporate Affairs of any changes to the information shown below.
- Ensure the checklist (shown overleaf) for forthcoming reviews has been returned.

FORTHCOMING REVIEWS					
Review date	**Description**	**Operational Review Lead**	**Checklist returned** (date)	**Risk assessment**	**Outcome expected** (date)

Past reviews resulting in action plans

Division/Directorate management teams are asked to:

- Update the Director Corporate Affairs regarding completion on the action plans for the reviews shown below.
- Notify the Director Corporate Affairs of any changes to the information shown below.

PAST REVIEWS RESULTING IN ACTION PLANS					
Review date	**Description**	**Operational Review Lead**	**Action plan approved by TEG** (date)	**Risk assessment**	**Expected completion of action plan** (date)

APPENDIX D – SCHEDULE OF AGENCIES AND REVIEWS

This policy applies to all reviews which are mandated or reported externally, or which have PR implications for the Trust. The list below gives examples of the agencies and reviews to which this policy applies but is not exhaustive.

Agencies with statutory enforcement powers
Care Quality Commission (CQC)
Charities Commission
Environmental Agency
Environmental Health
Fire Service
Health & Safety Executive
Human Fertilisation and Embryology Authority
Human Tissue Authority
Information Commissioner office
Police
Regulators of health professionals, including: • GMC • Nursing and Midwifery Council • General Pharmaceutical Council • Health and Care Professions Council • and others
The Equality and Human Rights Commission

Other agencies or reviews (but not limited to those listed)
United Kingdom Accreditation Services (UKAS)
Commissioners
Confidential enquiries
Coroner
Health and Wellbeing Boards
Health Education England
Home Office – Controlled Drugs licence
Healthwatch England
IR(ME)R Regulations (Radiology)
JAG Accreditation (endoscopy)
Medicines & Healthcare products Regulatory Agency (MHRA)

MHRA Blood Bank Inspections (– Blood Safety and Quality Regulations 2005)
National Audit Office
National Cancer Action Team (peer reviews)
National Institute for Health and Care Research (NIHR)
NHS England
National Specialised Commissioning Group
NHS Blood and Transplant
NHS Counter Fraud and Security Management Service
NHS Resolution
OFSTED (safeguarding)
Overview and Scrutiny Committees of local authorities
Parliamentary and Health Service Ombudsman
Peer Reviews eg Trauma Peer Review
Patient Led Assessments of the Care Environment (PLACE)
National Staff Survey
UK Health Security Agency (UKHSA)
Universities and Local Training and Education Boards

APPENDIX E – PRE-REVIEW CHECKLIST

Review:	
Review body:	
Review date:	
Accountable Director:	
Operational Review Lead:	
Overall risk assessment:	

Action	Date Completed	Completed by
Director Corporate Affairs informed of review.		
Other relevant staff and managers informed.		
Identify aim of review, and desired outcome.		
Gap analysis - identify expected outcome and gaps.		
Action plan to address identified gaps developed and agreed by Accountable Director.		
Risk assess gaps and escalate risk assessments in line with policy if appropriate.		
Risk assess the overall review based on expected outcome, and escalate risk assessments in line with policy if appropriate.		
Agree arrangements for the collation of any information required, and for validating data prior to submission.		
Agree arrangements for practical management of the review.		

APPENDIX F - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	CSU/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Management of Reviews, Visits, Inspections & Accreditations Policy	CEO	Fiona Dunn	Existing Policy	December 2022

1) Who is responsible for this policy? Name of Directorate Director Corporate Affairs (Chief Executive Directorate)

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes? To improve preparation for and outcomes of reviews of the Trust (i.e. improve compliance and improve assurance regarding compliance)

3) Are there any associated objectives? Legislation, targets national expectation, standards No

4) What factors contribute or detract from achieving intended outcomes? – Compliance with the process maps in the policy.

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] - No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] – N/A

6) Is there any scope for new measures which would promote equality? [any actions to be taken] N/A

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1✓	Outcome 2	Outcome 3	Outcome 4

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 4

Date for next review: December 2025

Checked by: CEO Date: December 2022

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	31 January 2023	**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 November 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 a Chair and Chief Executive Network session, which included NHS Providers' Annual General Meeting. The remainder of the session provided an insight into strategic policy, an opportunity to reflect on maternity services, following the recent maternity reviews and the implications on workforce, regulation and funding. To close, the group heard from Patricia Hewitt, who had been commissioned by the Department of Health & Social Care to undertake an independent review of integrated care systems.

This month I have attended a full board meeting, which included a midterm view of NHS Providers' strategy, feedback from the executive team and an insight into influencing activities and publicity relating to industrial action, winter pressures and engagement in respect of the Hewitt Review.

January's Governor Advisory Committee included a presentation from the Care Quality Commission on its revised strategy and the impacts on governors, a policy update and an overview of Q3 activity of GovernWell, the governor support programme. A review of the governor support programme is underway to ensure it remains relevant and effective and I will participate in this process.

Governors

Just prior to Christmas I hosted a governor coffee morning, as the majority of meetings are held virtually, newly elected governors haven't had the opportunity to meet face to face, so it was a great way to meet fellow governors, non-executives and colleagues from the Trust Board Office. Governors have also been able to participate in briefing and development sessions, covering system/partnership working, delivered by the Chief Executive and sessions on workforce and the leadership behaviour framework, presented by the Chief People Officer.

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 Dr Sam Debbage, following her appointment as Director of Education & Research, Ken Anderson, Chief Information Officer and introductory meetings with Cathy Hassell, Managing Director of South Yorkshire Acute Federation and Andria Birch, Partner Governor. As a group of non-executives, we also meet on a monthly basis and over recent weeks have met with executive directors to understand progress with director's corporate objectives.

Celebratory Events

During December I attended Doncaster Chamber's Business Awards, where the achievements of individuals and organisations from across the city were recognised. I also joined colleagues at the annual League of Friends Carol Service at Bassetlaw Hospital's chapel, where I gave a reading.

Recruitment

The Nominations & Remunerations Committee have considered recruitment options for non-executive directors. Mark Bailey's first term of office comes to an end on 31 January 2023 and Neil Rhodes has taken the decision to stand down at the end of the month. As reported at the Council of Governors meeting, I am delighted to confirm that a second term of office was agreed for Mark Bailey which provided stability to the Board and retains organisational memory. Interviews for the remaining post took place on 23 January and more details will be shared in due course.

Other meetings and events

Since my last report I have chaired December's Board meeting, attended the Charitable Funds Committee and a Chair and Chief Executive virtual regional roadshow.

I continue to be actively involved in the South Yorkshire Acute Federation Board meetings and a development event for all Trust Board members across South Yorkshire took place in early December, with clinical representatives in attendance. The session considered the journey to date of the Acute Federation, development of a clinical strategy, collaboration and efficient and effective use of resources. I also joined my South Yorkshire Chairs at a monthly meeting with Integrated Care Board Chair, Pearse Butler.

I joined the Nottingham & Nottinghamshire Integrated Care Board Chair and Chief Executive, on a tour of the planned Bassetlaw Emergency Care Village site, had a regular meeting with them and Richard Parker and prior to Christmas attended a system partner meeting.

As a Board, we have attended development sessions on the Leading to Outstanding Programme, the Leadership Behaviour Framework and a session on governance and controls process, led by the Interim Director of Recovery, Innovation & Transformation.

As part of Doncaster Chamber's extensive membership programme, I attended a Women in Business network event at the Yorkshire Wildlife Park, where I was able to hear inspirational stories from four local businesswomen who have achieved success in male dominated roles.

I have attended a number of the Wellbeing Wednesday sessions, including energy saving, breast care, love your liver and the menopause live event, with Dr Dawn Harper. They are a great source of information and I would encourage you all to join a session when you can.

To close my report, I would like to take the opportunity to share my personal thanks and those of the Board with my deputy, Neil Rhodes, for his support and commitment over the past six years at the Trust and we wish Neil a bright, happy and healthy future!

NED Reports

Mark Bailey

Since the last Board report, Mark has assumed the role of chair for the People Committee and held the first meeting for 2023 in January. Mark also chaired the Charitable Funds Committee and the Teaching Hospital Board and participated in the Board Committees for Finance & Performance and Audit & Risk.

Board strategy and development participation in the period included our leadership behaviours

framework, programme governance and performance assurance structures. In December, Mark attended the 'all Board' off-site event held by the South Yorkshire Acute Federation which concentrated on key collaboration initiatives to aid sustainable recovery of patient services.

Preparations to assume the chair role for our Wholly Owned Subsidiary are well advanced ahead of the forthcoming retirement of Neil Rhodes and have included attendance at the subsidiary's January Board meeting. Similarly, Mark has completed handover of the Charitable Funds role to fellow Non-Executive Hazel Brand and as part of this held a joint courtesy call with the Executors of the Fred & Ann Green Legacy.

As part of the programme of Board visits, along with the Chief Executive and Executive Medical Director, Mark was pleased to meet and listen to the experiences of Pharmacy and Simulation Centre teams at Doncaster Royal Infirmary and Montagu Hospital.

Kath Smart

Kath has attended her regular committee meetings including Board, Finance & Performance, Quality & Effectiveness and Charitable Funds. Alongside other non-executive colleagues she presented to the November Council of Governors' meeting and attended the December coffee morning with governor colleagues.

She has had 1:1 meetings with the Trust Chair, Interim Director of Recovery, Innovation & Transformation and joined meetings with her fellow non-executives to review a Chairs Log, the quality of Board papers and the review of directors' objectives progress meetings.

As part of the Board to Ward programme, Kath visited the Gresley Unit (Kestrel, Kingfisher and Mallard Wards) with Denise Smith, Chief Operating Officer and heard about patient care, discharge challenges, pathways and staffing. She also attended the Wednesday walk rounds over Christmas with Anu Agrawal, Divisional Director of Medicine and the Transfer of Care Hub Team who are working to try and improve the discharge process.

Along with other Board colleagues she attended the Acute Federation board development event, the leadership behaviours framework and leading to outstanding workshop sessions.

Finally, she chaired the recruitment panel for 2 specialties: Consultant in Infectious Diseases & General Medicine; and Trauma & Orthopaedics lower limb Consultant and is delighted the Trust were able to make suitable appointments to join team DBTH.

Hazel Brand

Hazel has continued to develop relationships with colleagues in Nottingham & Nottinghamshire ICS (N&N ICS) and Bassetlaw Place. She has attended meetings of Chairs and Elected Members, ICS Reference Group, and Acute Providers Collaborative Group. It is important that DBTH is 'at the table' with an opportunity to remind colleagues elsewhere in the county of Bassetlaw Hospital's existence, services to patients, and current and planned developments.

In preparing to take over the role of Chair of the Charitable Funds Committee from Mark Bailey in March, she has met, with Mark and Jon Sargeant and the executor of the late Fred and Ann Green. The agenda was to facilitate the formal handover, and to discuss plans for developments at Montagu Hospital. There may be initiatives, over and above mainstream NHS funding, that the Fred & Ann Green Legacy can support.

As part of the programme of board visits to wards and departments, Hazel was given a briefing on developments at Bassetlaw Hospital, removal of reinforced autoclaved aerated concrete and the planned Bassetlaw Emergency Village. A second visit in January will be to the Children's Ward at Doncaster Royal Infirmary.

Jo Gander

Since the last Board report Jo has chaired the Quality & Effectiveness Committee and attended the Charitable Funds and People Committee meetings. She has joined the Acute Federation Trust Board development session and the Trust's Leadership Behaviour Framework workshop. She attended the governor briefing and development sessions on partnership/system working and the Chief People Officer's briefing on workforce.

She has met on a 1:1 basis with the Chief Nurse and Executive Medical Director and joined her fellow non-executive directors to hear of progress made in delivery of Dr Noble's corporate objectives. She attended a report out from the Trust's Quality Improvement programme, South Yorkshire Integrated Care System Allied Health Professionals Strategy event and supported discussions in preparation for the Core20PLUS5 board development session.

Finally, as part of her induction Jo attended the two-day non-executive director induction programme provided by NHS Providers.

Chief Executive's Report
January 2022

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

An update on the Trust's response to COVID-19 and associated activity

Throughout December and into January, the Trust saw a significant increase in the number of patients attending our urgent and emergency services.

Much of this activity was driven by the triple challenge of COVID, influenza and the winter viruses and illness common at this time of year. A spike in any one of these is difficult but to face all three at once is unprecedented and has made for a very difficult period.

Despite this, the efforts of Team DBTH, as usual, has been extraordinary and I want to underline my thanks to every member of the team who has supported us in responding to the challenges.

During this time, we have worked closely with partners to try and alleviate pressures, and this has included trying to provide more inpatient and community capacity and innovations such as virtual wards which aim to ensure patients can be safely cared for at home wherever possible. Th situation has also required the South Yorkshire Acute Trust to work collaboratively and offer mutual aid wherever needed.

As one of the challenges we have faced is significant rises in COVID and flu, I would encourage those within at-risk groups to consider vaccination, and to encourage friends and families get vaccinated and continue to follow good infection prevention and control measures; hands, face, space, and ventilation. The more we can reduce transmission the more our services will be able to operate at more normal levels.

At the time of writing, the rates of Covid and influenza have begun to reduce, however we continue to closely watch our position and ready to take necessary action to manage any spikes in attendance.

Reinforced autoclaved aerated concrete (RAAC) replacement programme at Bassetlaw Hospital

The main hospital building at Bassetlaw dates to 1976, with the Mental Health Building Block 47 and part of the Theatres building Block 43 built using reinforced autoclaved aerated concrete (RAAC).

Although considered a revolutionary new building material at the time, RAAC is now outdated and newer construction materials offer more longevity and durability, as well as having lower maintenance cost. Whilst there is no immediate risk to the buildings, our Trust is taking proactive action to remove the material before any potential issues arise.

A RAAC replacement programme has been launched by NHS England/Improvement and the Trust has funding to remove all (RAAC) panels from Bassetlaw hospital and replace with a new modern roof.

Work on the RAAC roof will be completed in March 2023, following which once the final business case for the Bassetlaw Emergency Village project is approved work will commence on this major development.

An update on works to our Central Delivery Suite

The Central Delivery Suite and Triage at Doncaster Royal Infirmary (DRI) is currently undergoing a £2.5 million refurbishment as the area is updated and modernised.

The works, which began in May 2022, includes a full refurbishment of the suite's birthing rooms, as well as the creation of a new welcoming reception and waiting area, and the opening of our first Midwifery Led Birth Centre. The delivery suite will include a fully equipped Obstetric Observation Area to support women who need additional observations and a large well equipped Triage department to support all our women and families.

Whilst Midwifery-led Maternity services have been provided across the NHS, this will mark the first time this has been possible at Doncaster Royal Infirmary.

If mums-to-be are fit and healthy and are expected to deliver without complication, the new area provides a more comfortable and home-like environment, with the option of a birthing pool. If mum and baby encounter any issues, they can be swiftly transferred to the Obstetric service, which is in a neighbouring area.

The refurbishment is expected to be complete in February/March 2022. In the meantime, the temporary Central Delivery Suite is currently situated on level 3 of the Women's and Children's Hospital at Doncaster Royal Infirmary.

In addition to the new facilities, the team has taken the opportunity to upgrade the area's general infrastructure, including the placement of new windows, ceilings, flooring, ventilation, heating, fire precautions and much more.

The project is being overseen by the Capital Planning Unit, which is part of the Recovery, Innovation and Transformation directorate.

In addition to the upcoming refurbishments, Doncaster and Bassetlaw Teaching Hospitals' Charity is currently fundraising to create a specialist bereavement suite which is also sited within the Women's and Children's Hospital at Doncaster Royal Infirmary. Known as the 'Serenity Appeal', individuals can find out more, and how to donate, by heading to https://dbthcharity.co.uk/serenity-appeal

New device introduced at local hospitals to improve accuracy of breast cancer surgery

With support of Doncaster and Bassetlaw Teaching Hospitals' Charity, colleagues have introduced Magseed and Magtrace to help improve the accuracy and timeliness of breast tumour surgery.

Cancers picked up through breast screening are usually small and impossible to feel. To help clinicians find tumours. Traditionally colleagues have used a wire which is placed within the tumour by the radiologist on the day of surgery, or the day before.

Unfortunately, wires can sometimes displace making it difficult to find the tumour, extending the time taken during surgery, with a knock-on effect for other planned procedures. The patient may even need a second surgery if the tumour cannot be located.

Looking for better ways of working, colleagues at DBTH are now working with a new system called Magseed. Using this process, healthcare professionals can deploy a tiny metal marker, about the size of an apple pip, which can be placed in the tumour any time before surgery.

Radiologists and surgeons alike prefer to use seeds because they are easier to put in than a wire, and do not displace, making it easier to find the tumour. Additionally, the whole procedure becomes much more accurate and results in minimal removal of breast tissue and it's not a problem if the procedure is delayed as the seed does not displace, stays completely still and is painless.

From a patient perspective, having a seed placed within the tumour is more convenient than having a wire placement, with patients not having to worry about it coming out or hurting when in place.

Colleagues at the Trust have also introduced Magtrace. Like Magseed, this makes use of magnetic particles for sentinel node biopsy – a procedure in which the sentinel lymph node is identified, removed, and examined to determine whether cancer cells are present. Traditionally, a dye is injected on the side of the cancer. The dye then travels through lymphatics to the armpit lymph nodes and concentrates in the most important sentinel nodes.

Previously, clinicians were using radiocolloid injected by the Gamma Camera team which must be injected less than 24 hours before surgery, and Bassetlaw patients had to travel to Doncaster for the procedure.

Using Magtrace, patients can be injected safely within their clinical appointment up to 30 days before surgery at DRI or BDGH. This also negates the need for radiocolloid, which is currently in short supply due to manufacturing problems and has helped to maintain the service and avoid any delays to cancer surgeries.

Born and Bred in Doncaster (BaBi-D) research programme signs up 500 participants in just six months

A new research study to improve health outcomes for local children and families has just recruited its 500th participant in Doncaster.

Led by the Trust, and delivered in partnership between local health organisations, the Born and Bred in Doncaster (BaBi-D) research programme is a birth cohort data collection study. The project links information from both the participant's patient records and their child's patient record, to build up a much clearer picture of people's lives and answer questions that aim to improve healthcare services.

The Research Team at DBTH expected to recruit approximately 10 percent of the expectant mothers to the study within the first year. This target was set against 2021 birth rate figures and was equivalent to 308 participants. However, the number of participants consenting to take part in the study have exceeded this target, reaching 500 recruits in the first six months of the project.

Prospective participants are asked to join when they see their midwife, who are asked for their consent to become part of the study. If consent is given, health researchers join lots of data about the participant and their child so that health organisations can look at ways to improve healthcare services through research and planning in the local area and beyond.

Data obtained through the study can help local health organisations explore topics around health inequalities and determine measures to address these areas of concern, such as whether there are relationships between things that happen in pregnancy and children's future health.

The BaBi-D project is a partnership with health and social care providers and wider partners in the area; Doncaster and Bassetlaw Teaching Hospitals (DBTH), Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH), Doncaster Council, Primary Care Doncaster, and supported by the research departments at The University of Sheffield and Sheffield Hallam University.

The Born and Bred In (BaBi) network is part of the Born in Bradford family and is supported by the National Institute for Health Research Yorkshire and Humber ARC (NIHR YHARC). As of 5 December 2022, the BaBi network has successfully recruited 14,439 participants.

To find out more please visit: https://www.babinetwork.co.uk/babi-sites/babi-bradford

Appointments and departures at the Trust

Other appointments and departures:

- **Karen Jessop** has been taken up post as Chief Nurse.
- **Denise Smith** has been taken up post as Chief Operating Officer.
- **Suzanne Stubbs** has taken up post as Interim Deputy Chief Operating Officer.
- **Danielle Bhanvra** has taken up post as Head of Midwifery.

DBTH Digital Transformation

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Integrated Quality & Performance Report

Reporting Period - December 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	28/12/2022	19/01/2023	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

Dec 22

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

DBTH Health

15 %

(Last Month 15%)

(44 + 15 / 400 = 15 %)

Finance

NOT AVAILABLE

Coming Soon

People

Unvalidated

0 %

0 out of 6 KPI's

SET Training	81.70 %
Completed Appraisals	78.55 %
Employee Turnover	0.87 %
Sickness Absence	6.52 %
Workforce Vacancies	10.00 %
Consultants with Signed Off Job Plans in EJP	39.40 %
Time to Fill Vacancies	81 Days

Health Inequalities

0 %

0 out of 1 KPI's

Health Inequalities	0/1

Patients

44 %

11 out of 25 KPI's

IPC	5/6
Patient Safety	1/4
Patient Experience	1/3
HSMR	1/3
Falls	0/1
Friends and Family Test	0/2
Medical Examiner	1/1
Audit & Effectiveness	0/2
Skin Integrity	2/2
VTE	0/1

Performance

15 %

9 out of 61 KPI's

Urgent and Emergency Care	0/11
Waiting List	1/6
Cancer	3/8
Activity Against Plan	1/9
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 (Not Available)
Elective Outpatients	Elective Outpatients Trends
Elective Theatres	Elective Theatres Trends

All Performance KPIS Trends

Urgent & Emergency Care Dec 22

ED Attendances
16996

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
30.30 % !
Goal: 65.00 %

Ambulance Handovers Within 30 Mins
51.08 % !
Goal: 95.00 %

Ambulance Handovers More Than 60 Mins
33.25 % !
Goal: 0.00 %

EM Wait Times

A&E: Max wait 4 hours from arrival/admission/transfer/discharge
60.58 % !
Goal: 95.00 %

% Patients with Total Length of Stay in Emergency Department More Than 12 hours
8.77 % !
Goal: 2.00 %

Self Arrivals - Initial Assessment Within 15 Mins
50.70 % !
Goal: 95.00 %

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
18.61 % !
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	229	58.82 %
OTHER	433	27.40 %
GYNAECOLOGY	105	18.18 %
GENERAL SURGERY	277	16.90 %
TRAUMA AND ORTHO SURGERY	164	13.33 %
GENERAL MEDICINE	1335	12.91 %
Total	**2543**	**18.61 %**

Non Admission Wait Times

(For Monitoring Only)

TOTAL - % patients leaving A&E from clinically ready to proceed to Departure within 60 Mins
62.52 % !
Goal: 95.00 %

Attendance Disposal Item	A&E Attendances Count	Patients leaving A&E from clinically ready to proceed to departure within 60Mins
ANP Discharge	22	66.67 %
Dead on Arrival	1	
Died in department	33	25.00 %
Discharged	9376	63.45 %
Discharged home with COVID-19 advice to self-isolate	3	50.00 %
ESA - Direct to Orthopaedics	47	
ESA - Referred to Ambulatory Care	91	100.00 %
ESA - Referred to FCMSUCC	21	
ESA - Referred to	93	80.00 %
Total	**14453**	**62.52 %**

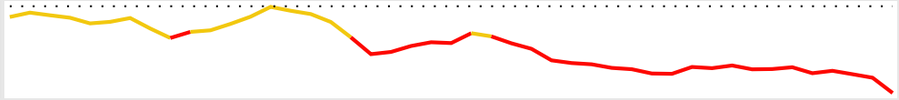
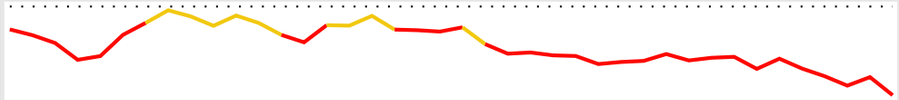
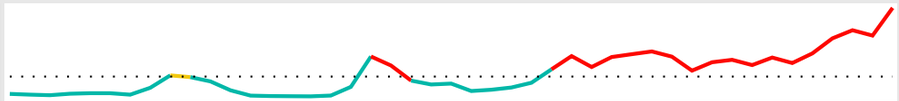
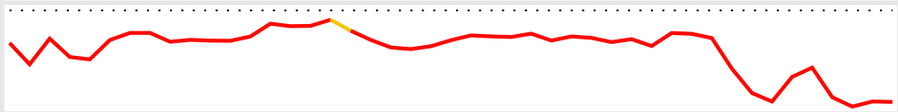
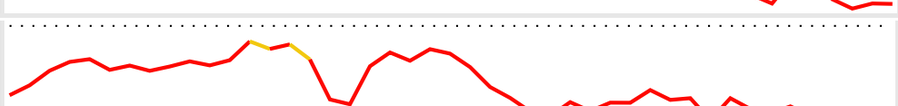
Hospital

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	60.58 %	95.00 %	!	
Ambulance Handovers Within 15 Minutes	30.30 %	65.00 %	!	
Ambulance Handovers Within 30 Minutes	51.08 %	95.00 %	!	
Ambulance Handovers More Than 60 Minutes	33.25 %	0%	!	
% Patients with Total Length of Stay in Emergency Department >12 hours	8.77 %	2.00 %	!	
TOTAL -% patients leaving ED from clinically ready to proceed to admission within 60 mins	18.61 %	95.00 %	!	
Self Arrivals - Initial Assessment Within 15 Mins	50.70 %	95.00 %	!	

Waiting List

Dec 22

Active RTT waiters (Total Incomplete Pathways)

50232

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

1222

RTT Number of 78 Weeks Waiters

98

Target 0

RTT Number of 104 Weeks Waiters

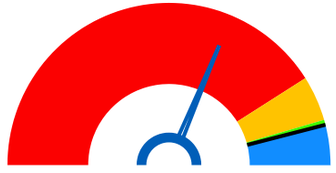
0

Target 0

% of patients waiting less than 18 weeks from referral to treatment

62.71 % !

Goal: 92.00 %

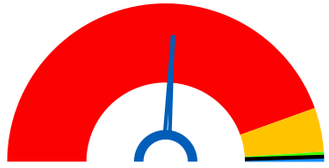


Waiters - Diagnostic Activity

% of patients waiting less than 6 weeks from referral for a diagnosti...

51.84 % !

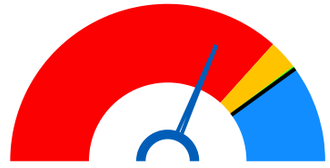
Goal: 99.00 %



Trust - % DM01 Diagnostic Activity vs 19/20 levels

93.92 % !

Goal: 120.00 %

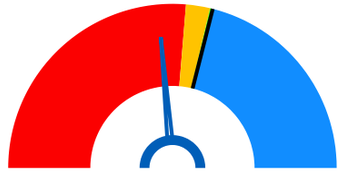


RTT Clock Stop Activity

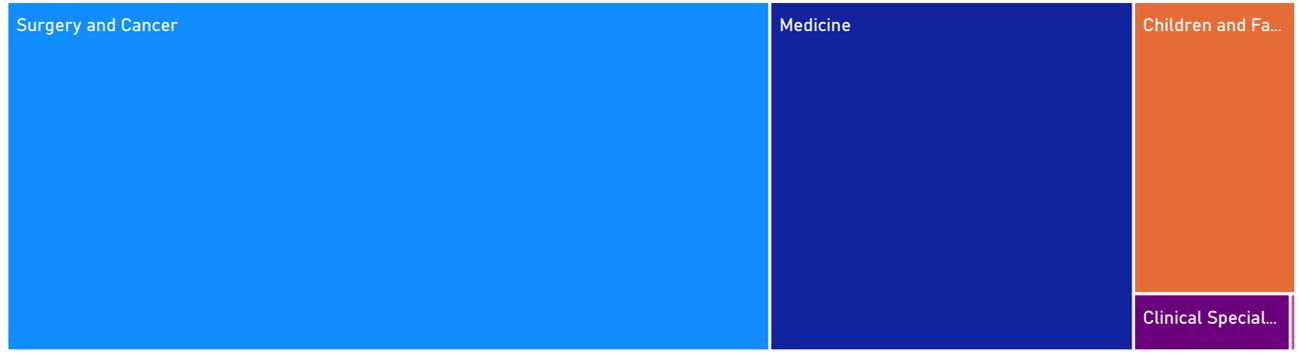
Clock Stop Activity (% against 19/20)

89.64 % !

Goal: 110.00 %



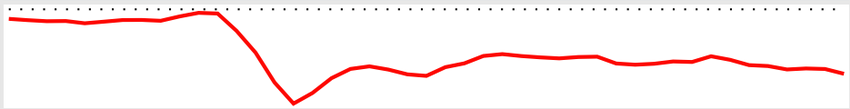
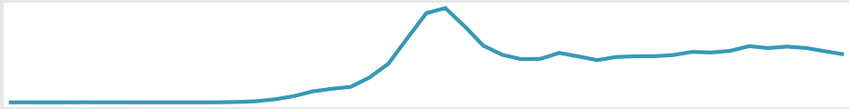
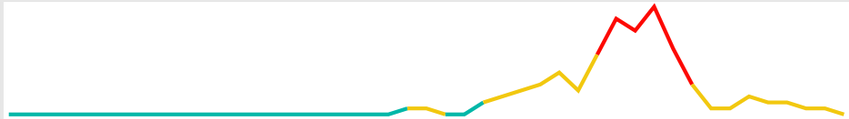
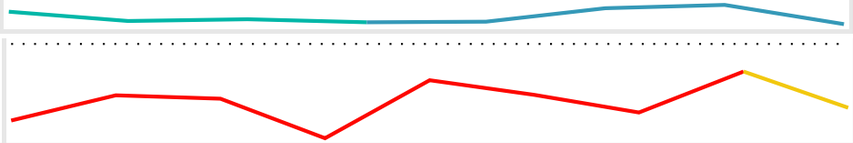
Division (Drill Down For Speciality)



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	62.71 %	92.00 %	!	
RTT Number of 52 Weeks Waiters	1222			
RTT Number of 78 Weeks Waiters	98	0		
RTT Number of 104 Weeks Waiters	0	0	✓	
% of patients waiting less than 6 weeks from referral for a diagnostics test (DM01)	51.84 %	99.00 %		
Clock Stop Activity (% against 19/20)	89.64 %	110.00 %	!	

Cancer

Nov 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...

81.00 %✓

Goal: 75.00 %

Maximum 31 day wait from decision to treat to first definitive treatment for all cancers

91.90 % !

Goal: 96.00 %

Maximum 31 day wait for subsequent treatment - Surgery

100.00 %✓

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

68.40 % !

Goal: 85.00 %

Maximum 62 wait from referral from NHS cancer screening service to first definitive treatm...

83.90 % !

Goal: 90.00 %

Cancer Waiting Times Open Suspected Cancer Pathways 63 - 104 Days

44.00 !

Goal: 22.00

Cancer Waiting Times Open Suspected Cancer Pathways 104 Days +

18.00 !

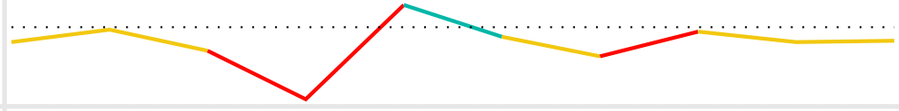
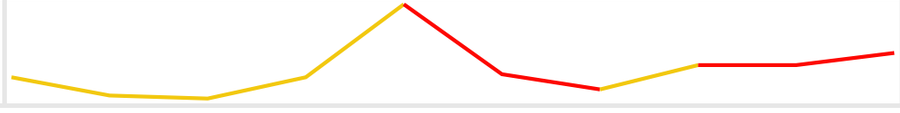
Goal: 0.00

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)	81.00 %	75.00 %	✓	
Maximum 31 day wait from decision to treat to first definitive treatment for all cancers	91.90 %	96.00 %	▲	
Maximum 31 day wait for subsequent treatment - Surgery	100.00 %	94.00 %	✓	
Maximum 62 wait from referral from NHS cancer screening service to first definitive treatment	83.90 %	90.00 %	▲	
Maximum 62 day wait for patients on 2ww pathway to first definitive treatment	68.40 %	85.00 %	!	
Cancer Waiting Times Open Suspected Cancer Pathways 63 - 104 Days	44.00	22.00	!	
Cancer Waiting Times Open Suspected Cancer Pathways 104 Days +	18.00	0.00	!	

Activity Against Plan

Dec 22

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh	Daily Refresh (D)	Monthly Refresh (M)

Inpatients

TOTAL Activity against plan

41559 !

Plan: 48255 (-6696)

M

Non Elective Activity - Discharges (for monitoring)

4615

D

Endoscopy Activity against plan

1275 !

Plan: 1537 (-262)

M

Day Case Theatre Activity against plan

760 !

Plan: 980 (-220)

D

Non-Theatre Elective Activity - excluding Endoscopy against plan

201 ✓

Plan: 184.133 (+17)

M

In Patient Elective Theatre Activity against plan

348 !

Plan: 436 (-88)

D

Outpatients

Outpatient Procedures (For Monitoring Only)

6,357

D

Outpatient New Activity - face to face Including Procedures against plan

10,029 !

Plan: 11,721 (-1,692)

D

Outpatient Follow Up Activity - face to face Including Procedures against plan

18,047 !

Plan: 24,604 (-6,557)

D

Outpatient New Activity - Virtual against plan

1,701 !

Plan: 2,170 (-469)

D

Outpatient Follow Up Activity - Virtual against plan

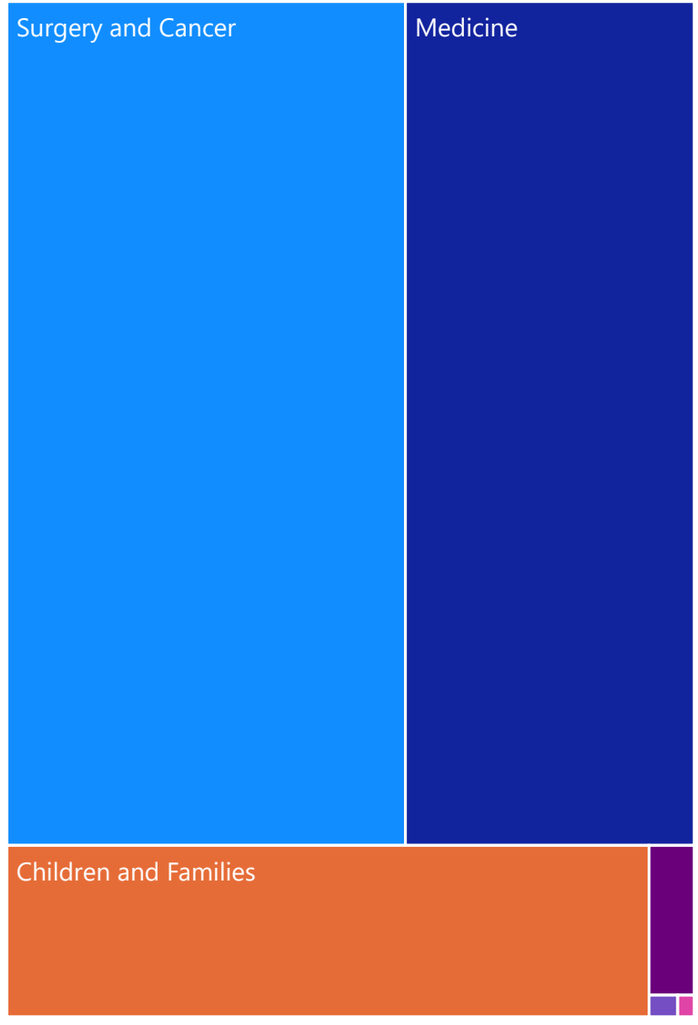
3,647 !

Plan: 4,653 (-1,006)

D

Click here for Activity Against Plan Trends →

Division (Drill Down Currently Not Available for Inpatients Section)

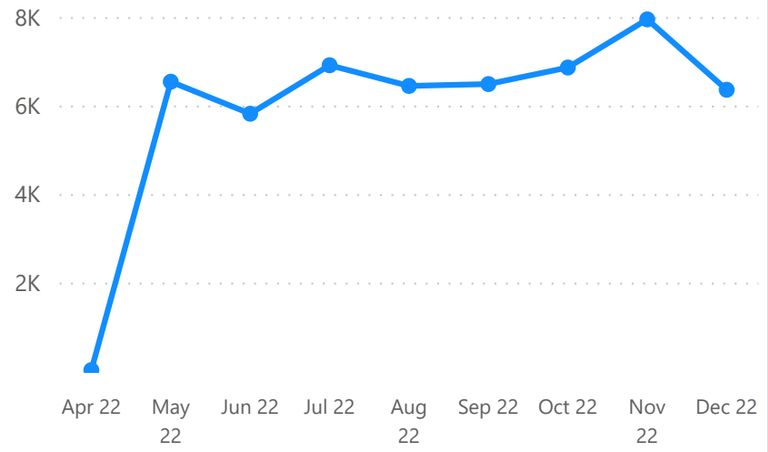


Activity Against Plan Trends - Outpatients

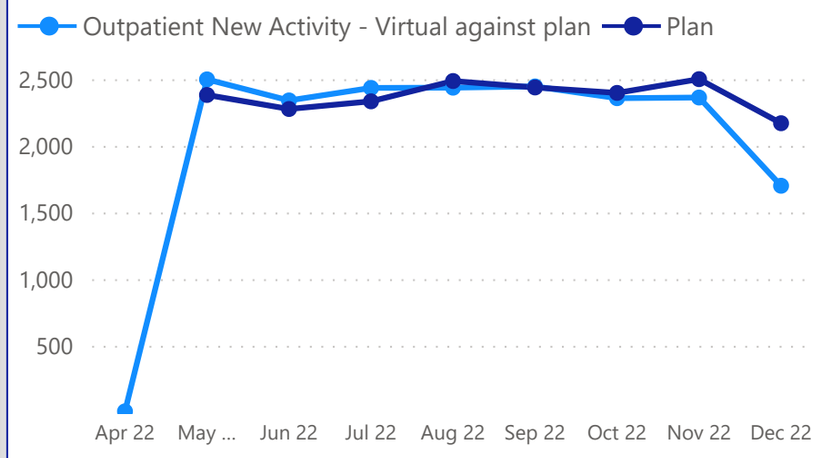
Data refresh	D All KPIs on this page are refreshed on daily basis.

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

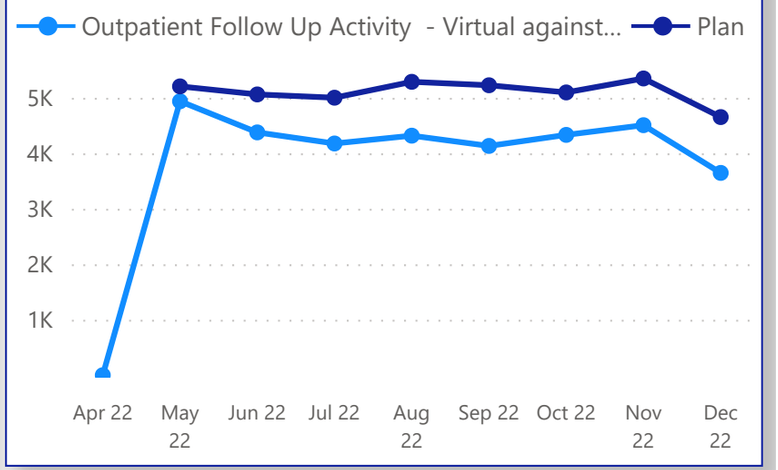
Outpatient Procedures (For Monitoring Only)



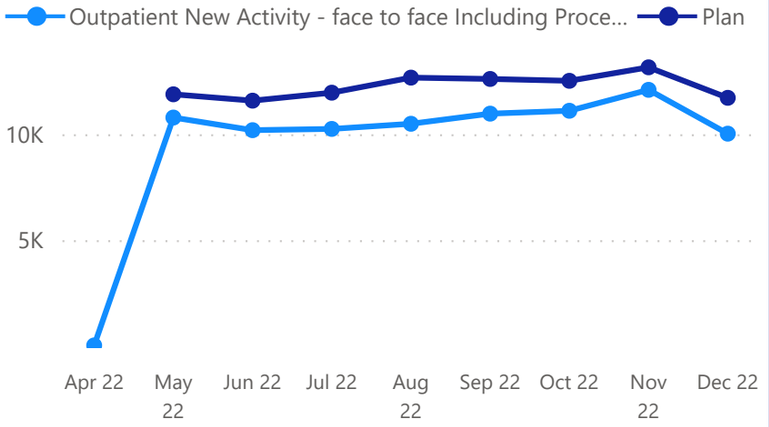
Outpatient New Activity - Virtual against plan



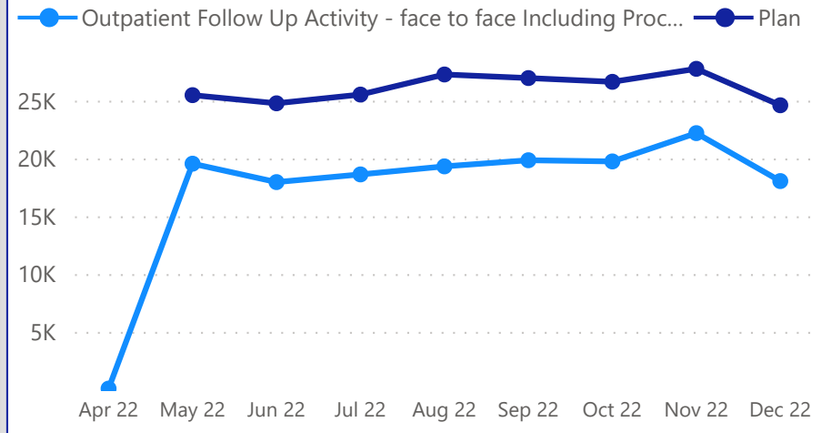
Outpatient Follow Up Activity - Virtual against plan



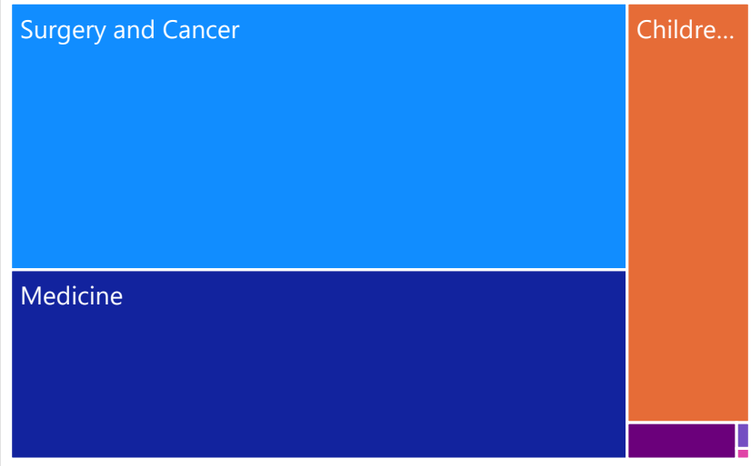
Outpatient New Activity - face to face Including Procedures against plan



Outpatient Follow Up Activity - face to face Including Procedures against plan



Division (Drill Down For Speciality)



30/04/2022 31/12/2022

Click here for Intpatients Trends

Activity Against Plan Trends - Inpatients

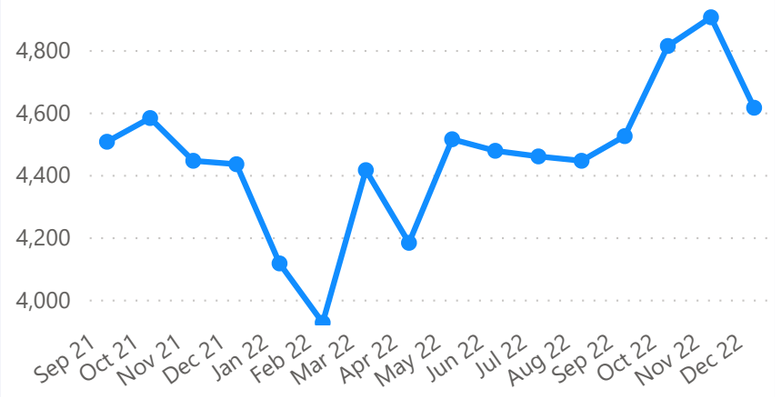
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (D) All KPIs on this page are refreshed on daily basis.

TOTAL Activity against plan

Not Available

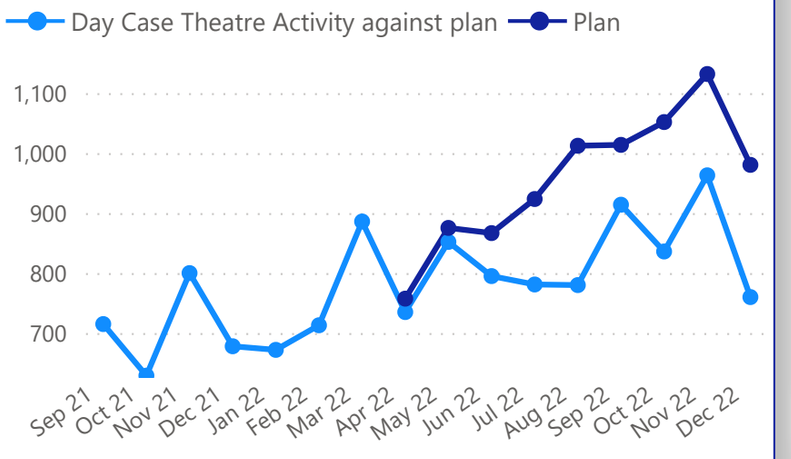
Non Elective Activity - Discharges (for monitoring)



Endoscopy Activity against plan

Not Available

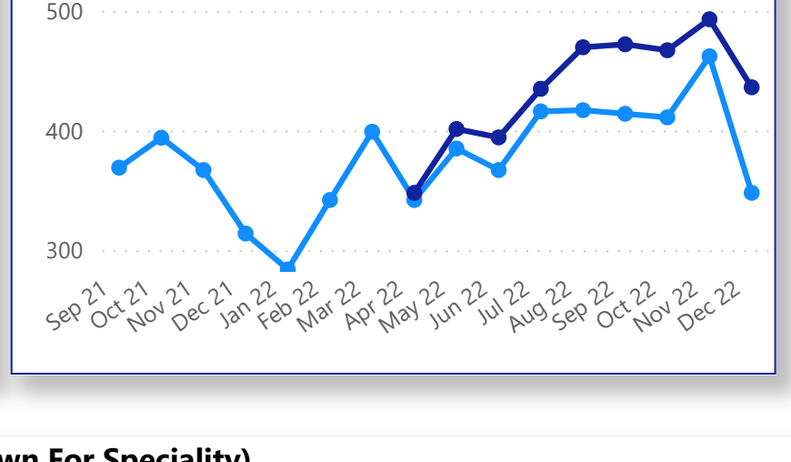
Day Case Theatre Activity against plan



Non-Theatre Elective Activity - excluding Endoscopy against plan

Not Available

In Patient Elective Theatre Activity against plan



01/09/2021 31/12/2022

Division (Drill Down For Speciality)

Elective Recovery Fund

Dec 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)

84.77 % !

Goal: 104.00 %

Outpatient New Core Activity Value (% against 19/20)

82.18 % !

Goal: 104.00 %

Day Case Core Activity Value (% against 19/20)

96.80 % !

Goal: 104.00 %

Outpatient Follow Up Core Activity Value (% against 19/20)

78.54 % !

Goal: 75.00 %

Outpatient Procedures Core Value (% against 19/20)

80.18 % !

Goal: 104.00 %

In Patient Elective Core Activity Value (% against 19/20)

80.43 % !

Goal: 104.00 %

TOTAL Independent Sector Activity Value (Sum of Price Actual)

£382,195.94

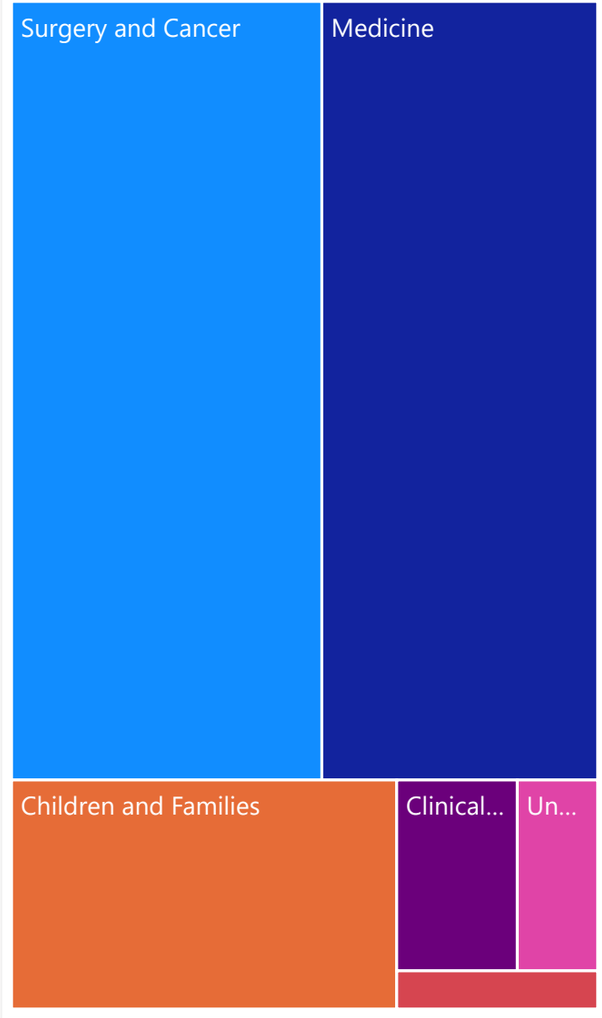
TOTAL Independent Sector Activity Value (Sum of Total Income)

£372,705.86

Attendances Outside Clinic (AOC) (Sum of Price Actual)

£166,306.61

Division (Drill Down For Speciality)

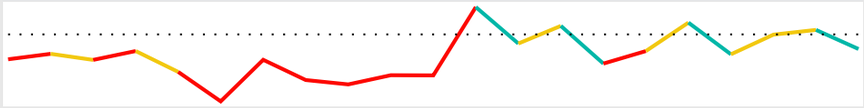
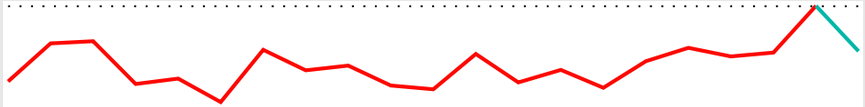
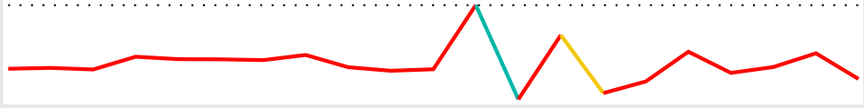


Click here for Elective Recovery Fund Trends →

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)	96.80 %	104.00 %	▲	
In Patient Elective Core Activity Value (% against 19/20)	80.43 %	104.00 %	!	
Outpatient Follow Up Core Activity Value (% against 19/20)	78.54 %	75.00 %	!	
Outpatient New Core Activity Value (% against 19/20)	82.18 %	104.00 %	!	
Outpatient Procedures Core Value (% against 19/20)	80.18 %	104.00 %	!	
TOTAL Activity Core Value (% against 19/20)	84.77 %	104.00 %	!	

Stroke

Oct 22

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

62.32 % ✓

Goal: 24.00 %

Overall SSNAP Rating

B ✓

Goal: B

Proportion directly admitted to a stroke unit within 4 hours of clock start

33.33 % !

Goal: 75.00 %

Proportion of patients scanned within 1 hour of clock start (Trust)

46.38 % !

Goal: 48.00 %

Percentage discharged given a named person to contact after discharge

66.67 % !

Goal: 80.00 %

Percentage of eligible patients given thrombolysis

100.00 % ✓

Goal: 90.00 %

Click here for Stroke Discharges Trends (Not Available) →

Elective Outpatients

Dec 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
76.30 % !
Goal: 95.00 % (D)
Unvalidated

Divisional - Out Patient Booking % Appointments Booked 2 weeks Prior
67.27 % !
Goal: 95.00 % (D)
Unvalidated

Utilisation - % Booked Out Patient Clinic Slots Attended
32.66 % !
Goal: 90.00 % (D)
Unvalidated

Number of Registered Referrals not Appointed
29,745 (M)

Attended Appointments

New to Follow Up Ratio 19/20 Comparison
-0.09 !
Goal: -25.00 % (D)

TRUST - % of OP appointments delivered virtually (video or telephone)
16.00 % !
Goal: 25.00 % (D)

% of First Out Patient Appointment via ERS Advice & Guidance Activity
5.11 % !
Goal: 16.00 % (M)
Unvalidated

Not Attended Appointments

Out Patients: % Provider Cancellation Rate (less than 6 weeks notice)
69.01 % !
Goal: 5.00 % (D)

Out Patients DNA Rate 19/20 Comparison
1.16 % ! (D)

Out Patients: DNA Rate (First Appointment)
12.28 %
(for monitoring only) (D)

Out Patients: DNA Rate (Follow Up Appointment)
11.69 %
(for monitoring only) (D)

Typing Turnaround

Typing Turnaround Time (dictation to letter sent) (Trust Contract) within 2 WD
In Development

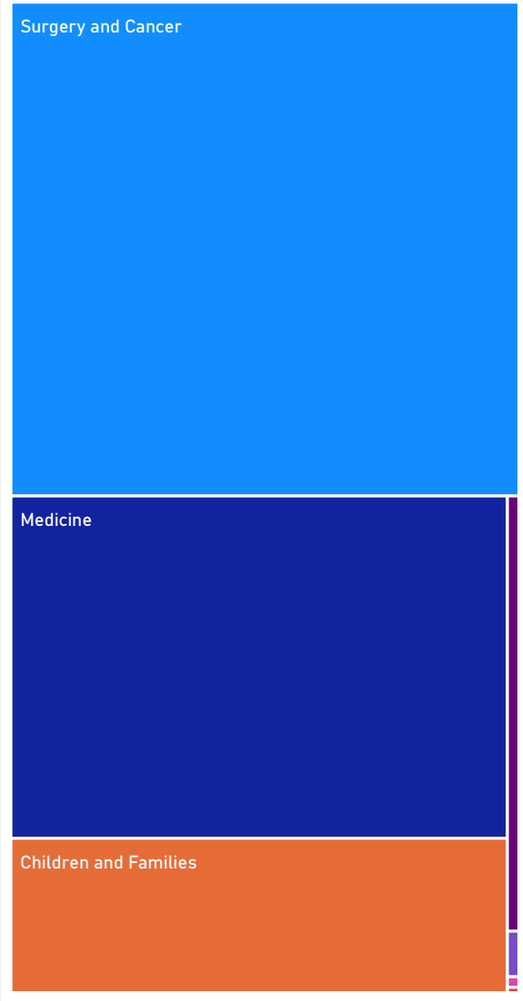
Patient Initiated Follow Up Pathway

TRUST - % patients dicharged onto Patient Initiated Follow Up Pathway in Month
1.12 % !
Goal: 5.00 % (D)

Data Quality

Number of Unreconciled Appointments 14 days +
1859 !
Goal: 0 (D)
Unvalidated

Division (Drill Down For Speciality)

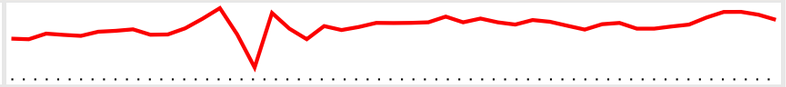
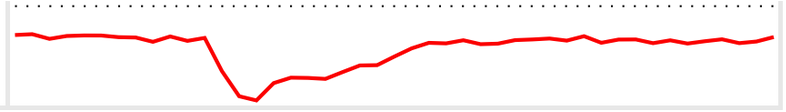
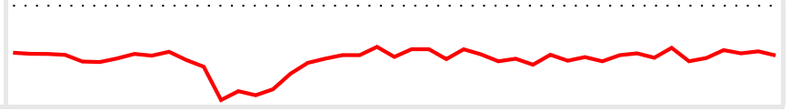
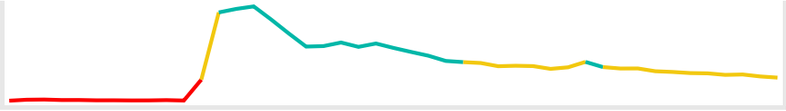
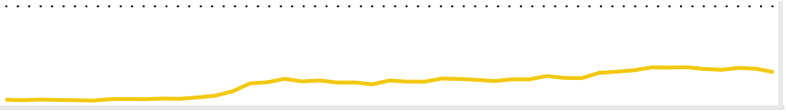
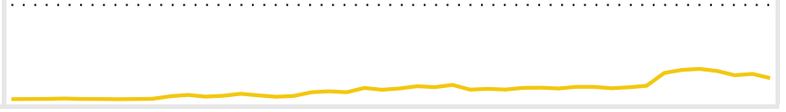


Click here for Elective Outpatients Trends →

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)	69.01 %	5.00 %	!	
Central - Out Patient Booking % Appointments Booked 2 weeks Prior (D)	76.30 %	95.00 %	!	
Divisional - Out Patient Booking % Appointments Booked 2 weeks Prior (D)	67.27 %	95.00 %	!	
TRUST - % of OP appointments delivered virtually (video or telephone) (D)	16.00 %	25.00 %	▲	
% of First Out Patient Appointment via ERS Advice & Guidance Activity (M)	5.11 %	16.00 %	▲	
Number of Registered Referrals not Appointed (M)	29,745	0		
Typing Turnaround Time (dictation to letter sent) (Trust Contract) within 2 WD (D)	In Development			
Number of Unreconciled Appointments 14 days + (D)	1859	0	!	
TRUST - % patients dicharged onto Patient Initiated Follow Up Pathway in Month (D)	1.12 %	5.00 %	▲	
Utilisation - % Booked Out Patient Clinic Slots Attended (D)	32.66 %	90.00 %	!	

Elective Theatres | Dec 22

NHS
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

86.36 % !
Goal: 95.00 %
D

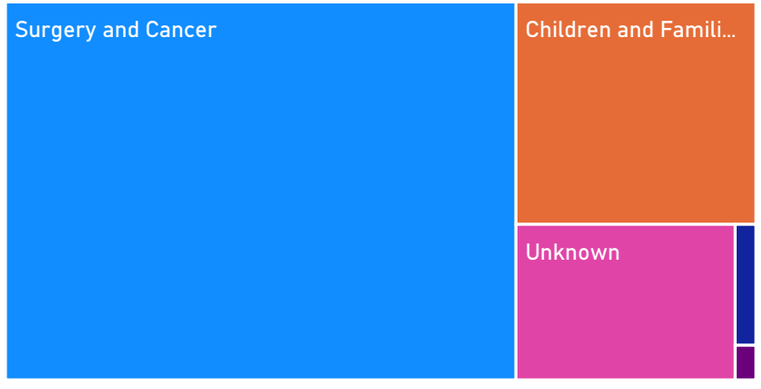
Trust: Operating Theatre Booking - % of available time booked 2 weeks prior

71.15 % !
Goal: 75.00 %
D

Trust: Operating Theatre Booking - % of available time booked 4 weeks prior

37.94 % !
Goal: 50.00 %
D

Division (Drill Down For Speciality)



% Cancelled Operations on the day (non-clinical reasons) (M)

Trust View
0.70 % ✓
Goal: 1.00 %

Surgery & Cancer
1.00 % ✓
Goal: 1.00 %

Children & Families
2.50 % !
Goal: 1.00 %

Medicine
0.20 % ✓
Goal: 1.00 %

Cancelled Operations Not Rebooked within 28 Days (M)

Trust View
15 !
Goal: 0

Surgery & Cancer
14 !
Goal: 0

Children & Families
1 !
Goal: 0

Medicine
0 ✓
Goal: 0

Number of Priority 2 Patients waiting 28 days + for surgery from date of listing or P2 Categorisation (M)

Trust View
819 !
Goal: 0

Surgery & Cancer
799 !
Goal: 0

Children & Families
20 !
Goal: 0

Medicine
0 ✓
Goal: 0

% of available Operating Theatre Time Utilised

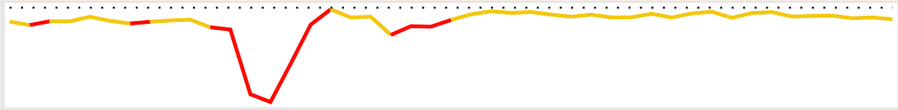
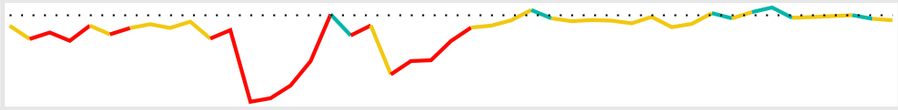
78.78 % !
Goal: 85.00 %
D

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	86.36 %	95.00 %	▲	
Operating Theatre Booking - % of available time booked 2 weeks prior	71.15 %	75.00 %	▲	
Operating Theatre Booking - % of available time booked 4 weeks prior	37.94 %	50.00 %	!	
% of available Operating Theatre Time Utilised	78.78 %	85.00 %	▲	

Patients: IPC

Dec 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

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

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

Dec 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
4 ✓	22 !
Goal: 2	Goal: 18

Medicine Division

In Month	YTD
2 ✓	15 ✓

Surgery & Cancer Division

In Month	YTD
2 ✓	5 ✓

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
0 ✓	5 ✓
Goal: 2	Goal: 18

Medicine Division

In Month	YTD
0 ✓	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

Oct 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 Nov 21 - Oct 22)

113.60 !

Goal: 100.00

Hospital Services Mortality Rate (HSMR): Elective (rolling 12 Months- Nov 21 - Oct 22)

50.83 ✓

Goal: 100.00

Hospital Services Mortality Rate (HSMR): Non-Elective (rolling 12 Months- Nov 21 - Oct 22)

114.39 !

Goal: 100.00

Patients: Patient Safety | Dec 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
26 !	3 !	14 !	0 ✓	9 !
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
50 !	19 !	17 !	0 ✓	14 !
Goal: 0	Goal: 0	Goal: 0	Goal: 0	Goal: 0

Patients: Patient Safety

Dec 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
4	2	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
1,086 !	905 !	29 !	22 !	130 !
Goal: 0	Goal: 0	Goal: 0	Goal: 0	Goal: 0





Patients: Patient Safety

Dec 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 | Dec 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
47 ✓	377 ✓
Goal: 56	Goal: 504

Medicine Division

In Month	YTD
35 ✓	227 ✓

Clinical Specialities Division

In Month	YTD
2 ✓	30 ✓

Surgery & Cancer Division

In Month	YTD
2 ✓	78 ✓

Children & Families Division

In Month	YTD
0 ✓	4 ✓

Non Inpatient Areas

In Month	YTD
8 ✓	38 ✓

Patients: Falls

Dec 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

35
(33 Last Year)
-6.06 % !
Goal: -10%

Medicine

25
(27 Last Year)
-7.40 % ✓
Goal: -10%

Surgery & Cancer

9
(6 Last Year)
+50 % !
Goal: -10%

Children & Families

1
(0 Last Year)
% !
Goal: -10%

Clinical Specialties

0
(0 Last Year)
0 % !
Goal: -10%

Patients: Patient Experience | Dec 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
44	16	22	1	5
(54 Last Year)	(29 Last Year)	(14 Last Year)	(4 Last Year)	(7 Last Year)
-18.51 ✓	-44.82 ✓	+57.14 % !	-75 ✓	-28.57 ✓
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
22.00 % !	23.00 % !	1.00 % !	0.00 % !	25.00 % !
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
45 !	22 !	19 !	2 ✓	2 ✓
Goal: 4	Goal: 4	Goal: 4	Goal: 4	Goal: 4





Patients: Claims

Dec 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	2	2	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

Dec 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

0.24 % !

Goal: 10.00 %

Friends & Family Response Rates (Inpatients) Increase response by year end

8.30 % !

Goal: 15.00 %

Patients: Audit and Effectiveness | Dec 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
92.40 % !	95.70 % !	99.60 % !	94.90 % !	86.20 % !
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
16.00 %	4.10 %	6.25 %	12.90 %	45.50 %

Patients: Medical Examiner

Dec 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

100.00 %✓

Goal: 100.00 %

Patients: VTE

Dec 22

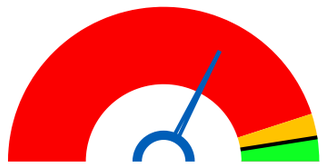
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

VTE - % of patients having a VTE Risk Assessment

64.84 % !

Goal: 95.00 %



Patients: Reducing Length Stay | Dec 22

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Data refresh (D) All KPIs on this page are refreshed on daily basis.

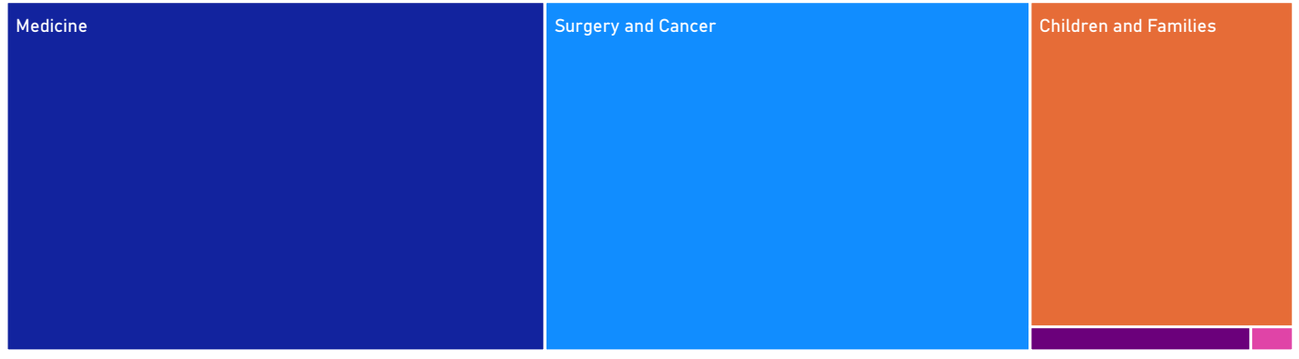
Days - Reducing length of stay for patients in hospital for 21 days +

4.69 % !

Discharges - Reducing length of stay for patients in hospital for 21 days +

2.50 % !

Division (Drill Down For Speciality)



People

Dec 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

0.87 % !
Goal: 0.83 %

Completed SET Training

81.70 % !
Goal: 90.00 %

Completed Appraisals

78.55 % !
Goal: 90.00 %

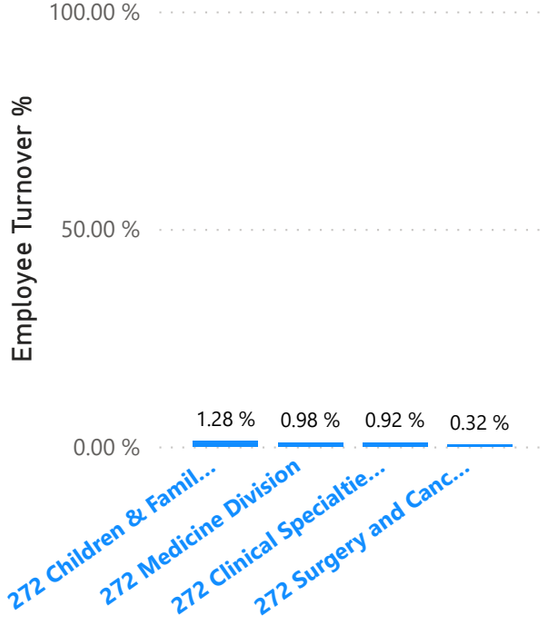
Open Cases

282

Cases Closed in Month

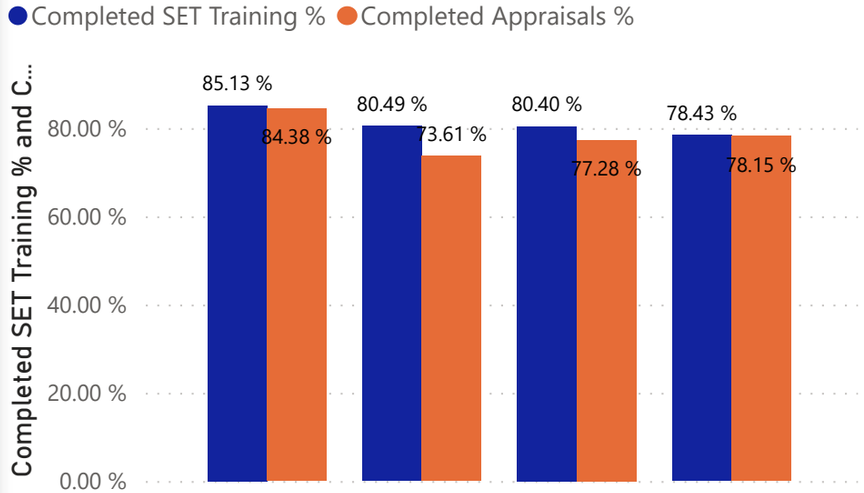
25

Division - Employee Turnover



click on a division to filter the ...

Division - Completed SET Training and Completed Appraisals



click on a division to filter the other visuals

Type Of Case	Open Cases	Cases Closed In The Month
Capability UHR	115	13
Capability No UHR	96	9
Disciplinary	44	2
Flexible Working	11	0
Grievance	9	1
Further Stages Appeal	3	0
Harassment	3	0
Further Stages Tribunal	1	0
Total	**282**	**25**

People Forms Data | Dec 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
6.52 % !
Goal: 3.50 %

Overall Staff Vacancies
10.00 % !
Goal: 5.00 %

Consultants with Signed Off Job Plans in EJP
39.40 % !
Goal: 90.00 %

Medicine Division Sickness Absence
7.52 % !
Goal: 3.50 %

Children & Families Sickness Absence
7.13 % !
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
52.50 % !
Goal: 90.00 %

Children & Families Consultants with Signed Off Job Plans in EJP
18.75 % !
Goal: 90.00 %

Surgery & Cancer Sickness Absence
5.92 % !
Goal: 3.50 %

Clinical Specialties Sickness Absence
6.20 % !
Goal: 3.50 %

Surgery & Cancer Workforce Vacancies
8.00 % !
Goal: 5.00 %

Clinical Specialties Workforce Vacancies
10.00 % !
Goal: 5.00 %

Surgery & Cancer Consultants with Signed Off Job Plans in EJP
20.27 % !
Goal: 90.00 %

Clinical Specialties Consultants with Signed Off Job Plans in EJP
52.50 % !
Goal: 90.00 %

People Forms Data | Dec 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

81 !
Goal: 47 Days

Medicine Division - Time to Fill Vacancies (Days)

86 !
Goal: 47 Days

Children & Families - Time to Fill Vacancies (Days)

51 !
Goal: 47 Days

Surgery & Cancer - Time to Fill Vacancies (Days)

45 ✓
Goal: 47 Days

Clinical Specialties - Time to Fill Vacancies (Days)

75 !
Goal: 47 Days

Health Inequalities

Dec 22

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

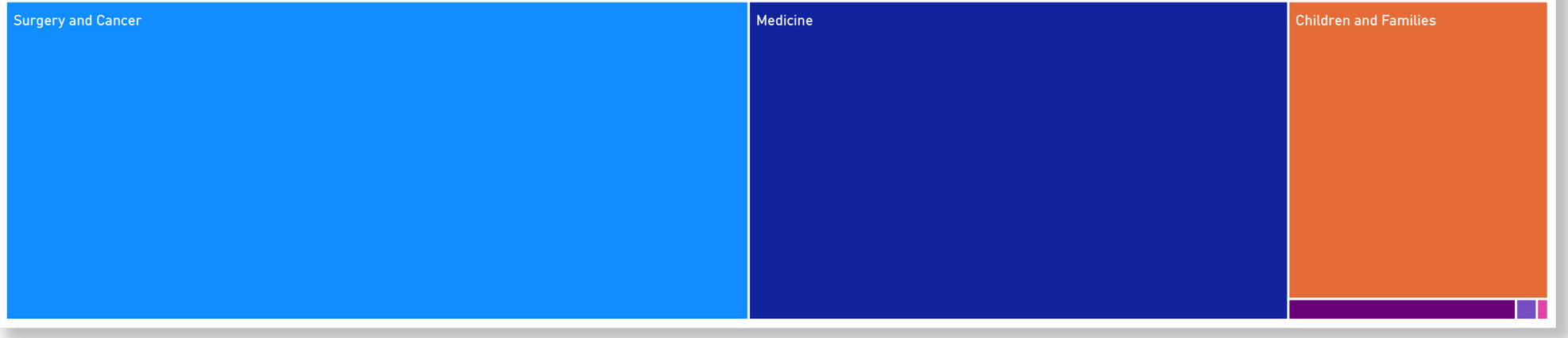
Data refresh (D) All KPIs on this page are refreshed on daily basis.

% Patients on CAMIS with Ethnicity Recorded

94.74 % !

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

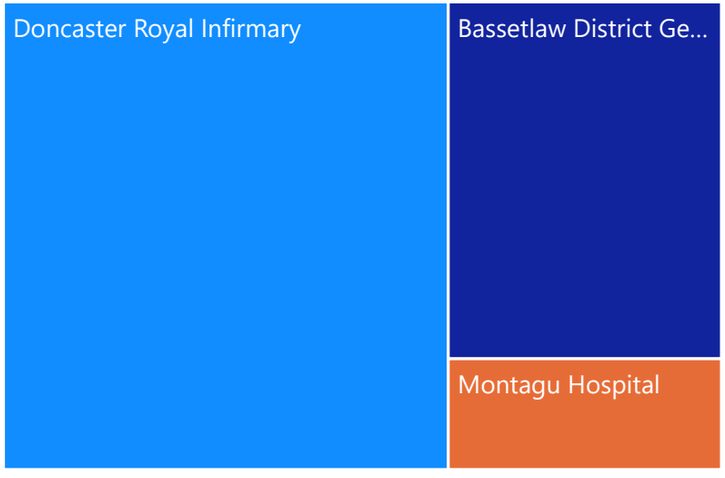
Ambulance Handovers More Than 60 Minutes

TOTAL -% patients leaving Emergency Department from clinically ready to proceed to admission within 60 mins

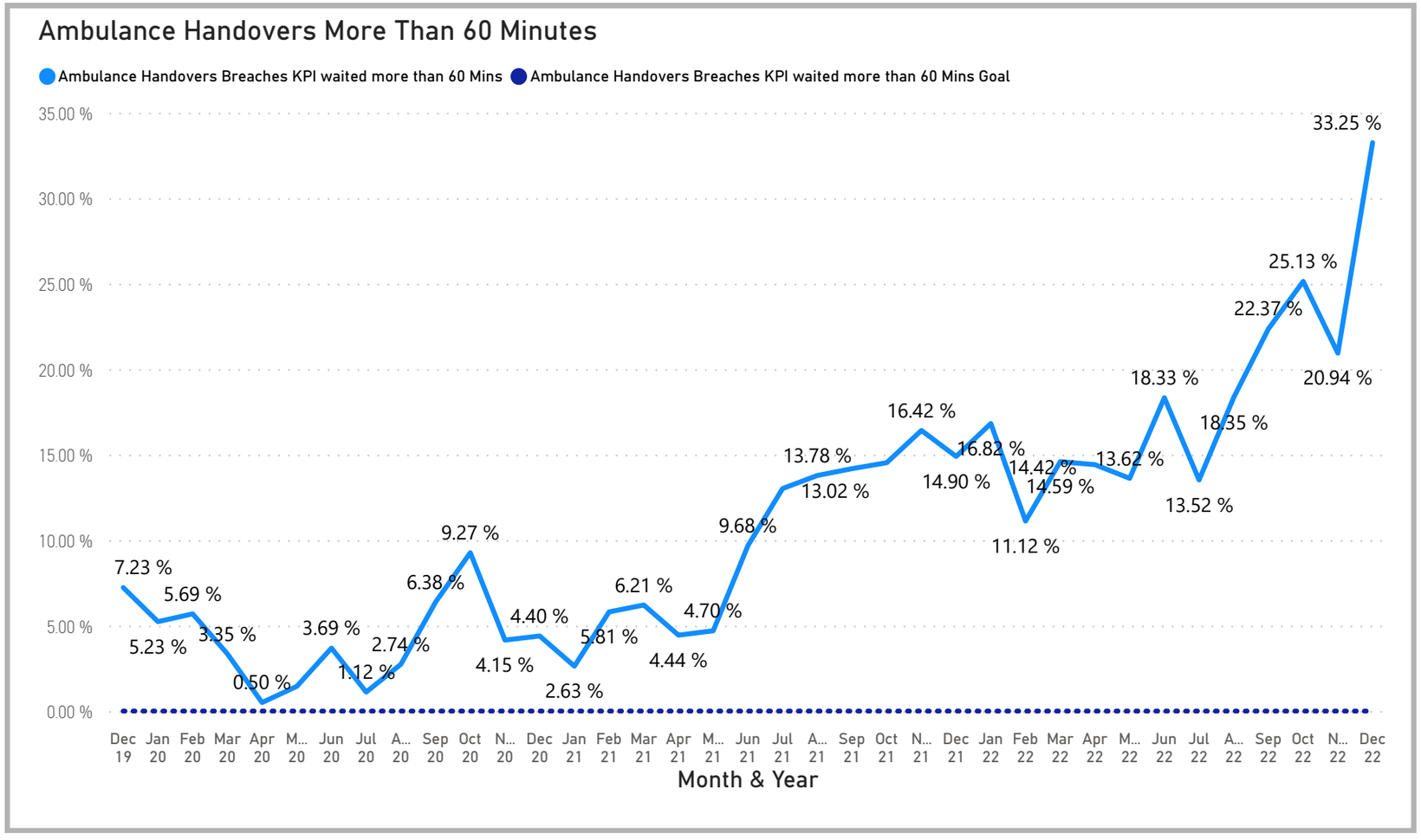
A&E: Max wait four hours from arrival/admission/transfer/discharge

% 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 27 October 2022 at 09:00 via Microsoft Teams

Present:	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:	Mandy Espey, Health Inequalities Lead Doncaster Place (Item C2) Claudia Gammon, Corporate Governance Officer (Minutes) Joseph John, Medical Director for Operational Stability and Optimisation Paul Mapley, Efficiency Director (Item D2) Karen McAlpline, Interim Deputy Chief Operating Officer Elective Suzanne Stubbs, Interim Deputy Chief Operating Officer Emergency	
To Observe:	Andrew Middleton, Deputy Lead Governor	
Apologies	Mark Bailey, Non-executive Director George Briggs, Interim Chief Operating Officer Fiona Dunn, Director Corporate Affairs /Company Secretary Angela O'Mara, Deputy Company Secretary Lynne Schuller, Lead Governor	
		ACTION
FP22/10/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.	
FP22/10/A2	**Requests for any other business (Verbal)**	
	No items of other business were declared.	
FP22/10/A3	**Action Notes from Previous Meeting (Enclosure A3)**	
	Action 1 - FP22/05/C1 – Urgent & Emergency Care Recovery Programme Interim Deputy Chief Operating Officer Emergency explained the recovery programme updates were added to Monday.com. This included SDEC, EAU, acute flow, site operations and winter plan. This action could be closed.	

	<u>Action 2 - FP22/07/B1 - Ambulance Attendances @ ED where primary care solution was appropriate</u> This was included within the report – action to be closed. **<u>Action 3 - FP22/07/B1 - Red to Green Roll-out – Progress Update</u>** This was included within the report – action to be closed. **<u>Action 4 - FP22/07/B2 - Elective Recovery Plan</u>** This was included on the agenda – action to be closed. **<u>Action 5 - FP22/07/C1 - Trust-wide Themes from the Performance, Overview & Support Meeting</u>** Interim Director of Recovery, Innovation and Transformation would send meeting invitations to the NED's for the POS meetings **<u>Action 6 - FP22/09/B2 - Emergency Department</u>** This action was tracked via Monday.com and could now be closed. **<u>Action 7 - FP22/09/C1 - Nottinghamshire and South Yorkshire ICB</u>** This action wasn't due until November.	
	The Committee: - ***Noted the above updates***	
FP22/10/B1	**<u>Emergency Department Performance</u>**	
	The Interim Deputy Chief Operating Officer for Emergency provided key highlights were, 4-hour waits were at 69.38% this had slightly increased since August 2022. There had been 250 12-hour trolley breaches in September 2022, an increase from 207 in August 2022. The Emergency Assessment Unit (EAU) had reopened on 3 October, was situated next to the Emergency Department. Ambulance delays continued to be challenging with the long waits at DRI. Length stays and the red to green programme had been incorporated into daily ward rounds. Issues with the discharge of patients continued with 90 patients across DRI and Bassetlaw awaiting discharge. Following a question from the Chair about the 90 patients and where they would be cared for. The focus was on the outward flow. This was an issue that was being investigated by the Trust. Kath Smart asked about the continuous flow model that was being trialled in other Trusts, was it something that DBTH were investigating. Discussions were taking place internally, particularly around the clinical risks, continuous flow would require the boarding of patients on wards, Nottingham ICB were hoping to trial at Bassetlaw. The Medical Director for Operational Stability and Optimisation commented that to enable the continuous flow model to work, the clinicians would need to support it.	
	The Committee: - ***Noted and took assurance from Emergency Department Performance Update***	

FP22/10/B2	**<u>Elective Performance Update</u>**	
	The Interim Deputy Chief Operating Officer for Elective provided the key highlights; further work on the patient treatment list was required, 52-week breaches remained high at 1419 and two patients had been waiting over 104 weeks. The diagnostic improvement plan work was in progress, supported by the Interim Deputy Chief Operating Officer for Emergency. Ward 19 was now fully staffed to support emergency surgery. The elective recovery plan was to be finalised shortly. The modular theatres at Doncaster were scheduled to be opened on 31 October 2022. There were continued issues with surgical patient flow, pathways, and direct admission on to wards that don't require a surgeon to access them. The Interim Deputy Chief Operating Officer for Emergency added that this was due to bed space. Winter capacity was fully open with extra beds across all three sites. Other options were being investigated with Tickhill road being one of them. The ICB had been contacted for additional beds. Kath Smart commented that the Patient Tracking Listing (PTL) had grown along with the waits since the beginning of Covid-19. The aim was to try to get more work into the independent sector. It was confirmed that in October the independent sector activity had increased. With patients wating 78 weeks options to work with Claremont and Thornbury Hospitals was being explored. The elective plan would be shared with system partners and the Board. Assistance from NHSE 2 days a week to assist with the cleansing of the PTL workload. Several products had been investigated into risk stratification and a patient tracking system. The underspend had increased over the first five months of the year by £300,000. A meeting at Place and the Integrated Care Board had been arranged regarding the higher bed occupancy. Supporting the community and help with the pressures over winter. The request for funding had been made for £800,000 due to being over committed against the Winter plan. Ballots were being held with the nursing staff and junior doctors regarding rates of pay, this would have an impact on elective recovery.	
	<u>Action:</u> - ***Update from the elective recovery action plan and a briefing to be presented at the next F&P.*** - ***Partnership plan to be presented providing an update on the right to reside issues following the place meeting.***	**JS/ GB** **JS/ GB**
	<u>The Committee:</u> - ***Noted and took assurance from the Elective Performance Update***	
FP22/10/C1	**<u>Recovery, Innovation & Transformation Directorate Update</u>**	
	The Interim Director of Recovery, Innovation and Transformation provided the key points on the appendices within the update. <u>Service Line Review/Strategy Update</u>	

	The service line review was going to plan with DRI being the second emergency centre and that Bassetlaw would be a cold site, this was agreed at the Executive Directors meeting and via the Trust Executive Group. <u>Update on Progress of Capital Infrastructure</u> The Reinforced Autoclaved Aerated Concrete (RAAC) work had started with the opening of three theatres. The Bassetlaw Emergency Village (BEV) planning documents had been signed off and submitted. The Electronic Patient Record (EPR) case would be approved shortly by the NHSE board. The Community Diagnostic Centre (CDC) phase 1 was complete with phase 2 funding being agreed. <u>MEOC Update</u> A business case was being produced on behalf of the ICS together with its partners Rotherham Hospital and Barnsley Hospital. Most of the trauma work required a radiologist to carry out the work. Kath Smart commented on the large projects and what the capacity was. Continued work was being carried out, looking at the interface, same day emergency care and the pathway. Work was being carried out with the Deputy Chief Operating Officers and the new hospital build team. It wasn't a concern for the Bassetlaw Emergency Village (BEV) money that was required to be spent by the 24th of March 2023. The Single site trauma unit collaboration with Barnsley and Rotherham was progressing.	
	<u>The Committee:</u> - ***Noted and took assurance from the Recovery, Innovation & Transformation Directorate Update***	
FP22/10/C2	**<u>Health Inequalities</u>**	
	The Health Inequalities Lead for Doncaster Place provided a detailed overview of the paper that was included within the pack. The Chair praised that the report mentions the issues in Doncaster and some patients not having digital knowledge to book appointments and that it was being investigated. It was confirmed that the Trust couldn't discriminate with those on waiting lists. Covid-19 had highlighted the impact on people from more deprived areas. The access policy was followed in the best way possible. The prioritisation was dependent on clinical needs. Patient engagement providers were ensuing that patients weren't disadvantaged and were seen within the policy, the policy was to be reviewed. Health Inequalities had also been raised at the Quality and Effectiveness meetings and required investigating as to where it sat best.	
	<u>Action:</u> - ***The Chair to agree whether Health Inequalities best sits with Quality and Effectiveness Committee or Finance and Performance***	**NR**

	T*he Committee:* - ***Noted and took assurance from the Health Inequalities Update***	
FP22/10/D1	**Financial Performance – Month 6**	
	The Acting Director of Finance outlined the key points within the paper for month 6: The Trust's year to date financial position was a deficit of £9.2m, £1.0m adverse to plan. The year to date overspends was £5.2m, mainly due to high agency usage in maternity services. The divisions were continuing to look at the amount spent on locums. The number of vacancies, high levels of Covid-19 absence and operational pressures all contributed to the overspends. The Trust had seen added pressures due to changes in the National Institute for Health and Care Excellence (NICE) guidance on insulin pumps. The Elective Recovery Funds (ERF) were at £6m, as the rules for q3 & q4 ERF were not known £4.7m was at risk. Expenditure appeared to be the same as other trusts. Capital spends in month 6 was £1.7m against plan of £3.2m. Year to date this was £5.3m against a plan of £10.5m. The cash balance was £22.8m, which had reduced by £4.3m compared to the previous month. This was expected to decrease throughout the rest of the year because of the impact from the backloaded capital plan. The Chair asked if the Trust was confident, they could deliver the capital programme. The Acting Director of Finance confirmed that the Trust would be able to deliver the capital programme. Although there were larger risks around this, they were monitored via capital monitoring. Following a question from Kath Smart regarding the forecast and the discussions in place around sickness absence, moving forward what it would look like in a breakeven position. There was over £1m risk and covid/sickness levels were high which was out of the Trusts control. Issues around the plan and the ERF levels were also a risk therefore it was difficult to forecast what the plan was including the winter plan.	
	T*he Committee:* - ***Noted and took assurance from the Financial Performance Update***	
FP22/10/D2	**CIP Update**	
	The Efficiency Director provided an overview of the overall CIP position. Year to date the Trust had delivered £9.2m of savings against a plan of £6.7m, an over delivery of £2.5m. Recurrent schemes would lower the gap. Temporary staffing forecast was reduced to £80,000, with a focus on agency spends through substantive recruitment. Further work was taking place with procurement and the operational pressures with a focus on major contracts and regular meetings to identify issues. The unidentified plan included the biggest gap around medicine. The next steps were to provide additional support to divisions and focus on how to maximise elective recovery. Mark Day observed that it was useful seeing the CIP plan and the shortfall with targets, this would be discussed further offline. Next year's plan would be presented at the November F&P meeting.	

	The Committee: - ***Noted and took assurance from the CIP Update***	
FP22/10/E1	**Board Assurance Framework SA4**	
	The Acting Director of Finance confirmed that all risks and corrective actions were up to date. Kath Smart asked about the estate risk issue and how much of it was included within the Board Assurance Framework (BAF).	
	Action: - ***Update required on the Estates issue to improve the hospital and whether this was reviewed via the BAF.***	**FD**
	The Committee: - ***Noted and took assurance from the Board Assurance Framework SA1 and SA4 CIP Update***	
FP22/10/E2	**Corporate Risk Register**	
	The Chair commented on the current economic issues, including the use of food banks by lower paid employees across other Trusts. The Chief People Officer confirmed the matter would be discussed at the Executive Directors meeting. Kath Smart raised that risk ID19 F&P4 regarding estates infrastructure and that no updates had been made since March 2022.	
	Action: - ***Update required for risk ID 3104 - Impact on the Trusts workforce and the economic context/cost of living.*** **JS** - ***ID19 F&P4 – Last review date was March 2022 this risk requires an update*** **AC**	
	The Committee: - ***Noted and took assurance from the Corporate Risk Register***	
FP22/10/E3	**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?	
FP22/10/F1	**Governor Observations**	
	Andrew Middleton praised the committee meeting observing that the Health Inequalities update was beneficial. Andrew Middleton added that it was positive that the financial position was broadly on plan and that he was confident with this.	

	Andrew Middleton requested that the governors receive a strategy workshop within Board, this would be discussed with the Company Secretary outside of the meeting.	
FP22/10/G1	**<u>Any Other Business</u>**	
	No items of other business were raised.	
FP22/10/G2	**<u>Performance Report Appendixes</u>**	
	The performance report appendices were noted.	
FP22/10/G3	**<u>Minutes of the Sub – Committee Meetings (Enclosure G3)</u>** - Cash Committee – 2 September 2022 - Capital Committee – 25 August 2022	
	<u>The Committee:</u> - Noted the Cash Committee minutes from the 2 September and the Capital Committee minutes from 25 August 2022	
FP22/10/G4	**<u>Minutes of the meeting held on 26 September 2022</u>**	
	- The Committee approved the minutes of the meeting held on 26 September 2022	
FP22/10/G5	Date and time of next meeting (Verbal)	
	Date: Thursday 24 November 2022 Time: 09:00 Venue: Microsoft Teams	
FP22/10/H	Meeting closed at: 11:45am	

DRAFT

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

PEOPLE COMMITTEE

Minutes of the meeting of the People Committee
Held on Tuesday 8th November 2022 at 09:00am via Microsoft Teams

Present:	Mark Day, Non-Executive Director (Chair) Mark Bailey, Non-Executive Director Zoe Lintin, Chief People Officer Tim Noble, Executive Medical Director Hazel Brand, Non-Executive Director Jo Gander, Non-Executive Director	
In attendance:	Mark Brookes, Associate Director of People and Organisational Development Kirsty Clarke, Acting Deputy Chief Nurse Sam Debbage, Director of Education and Research Kelly Fairhurst, Head of Recruitment and Medical HR (Item D4) Sudipto Ghosh, Associate Medical Director for Professional Standards and Revalidation (Item C5) Kirby Hussain, Equality, Diversity, and Inclusion Lead Claudia Gammon, Corporate Governance Officer (Minutes) Anthony Jones, Deputy Director of People and Organisational Development Nick Mallaband, Medical Director for Workforce and Speciality Development Angela O'Mara, Deputy Company Secretary Gavin Portier, Head of Organisational Development, EDI, and Wellbeing Beccy Valance, Head of Quality Improvement Academy and Clinical Lead Qi	
To Observe:	Mark Bright, Public Governor – Doncaster Kay Brown, Staff Governor	
Apologies:	Fiona Dunn, Director Corporate Affairs/Company Secretary	
		ACTION
PC22/11/A1	**Welcome, apologies for absence and declarations of interest (Verbal)**	
	The Chair welcomed the members and attendees. Apologies for absence were provided. No conflicts of interest were declared.	
PC22/11/A2	**Requests for Any Other Business (Verbal)**	
	The Chief People Officer was asked to provide an update on the industrial action	
PC22/11/A3	**Actions from previous meeting (Enclosure A3)**	

	Action 1 – PC22/07/D1 – Workforce Assurance and Education Report It was agreed by the committee that this action could be closed **Action 2 – PC22/07/K1 – Annual Governance Report – ISA 260** It was agreed by the committee that this action could be closed **Action 3 – PC22/09/B1 – Job Planning Audit** It was agreed by the committee that this action could be closed **Action 4 – PC22/09/C2 – Teaching Hospital Board** It was agreed by the committee that this action could be closed **Action 5 – PC22/09/C5 – EDI** It was agreed by the committee that this action could be closed	
	The Committee: - ***Noted the updates and agreed, as above, which actions would be closed.***	
PC22/11/ B1	**Board Assurance Framework (BAF) True North SA2 & 3** The Chief People Officer confirmed that the industrial action corporate risk had been added to the BAF, as part of a combined risk also incorporating the cost of living. Further attention would be paid for future iterations of the BAF, to look at the educational actions and further support for colleagues and learners. The BAF would be refreshed every financial year. Mark Bailey asked about leadership development and where was the succession planning process for senior roles discussed as this had been previously referred to by the auditors. The Chief People Officer explained that this wasn't currently included within the BAF and would be considered further as an action. The role of REMCO would also be investigated further for succession planning at Executive level. The Executive Medical Director explained that the divisional structure was being considered into how it could be strengthened to allow colleagues to develop further. Jo Gander commented about business continuity and a plan in the future for recruiting especially within senior roles as this was a lengthier process which resulted in a gap in workforce.	
	Action – - ***Address succession planning within the BAF***	**ZL**
	The Committee: - ***Noted and took assurance from the Board Assurance Framework – True North SA2 & 3***	
PC22/11/ C1	**Staff Engagement** The People Officer provided key points on staff engagement; the staff survey completion rate was at 56% currently which was high performing amongst acute hospitals nationally. The Chief People Officer described the approach being taken to develop the new DBTH Leadership Behaviours Framework. Sessions would be held in November or December to engage with leaders	

	and colleagues. This would include a Leadership Assembly session and a session with Trust Executive Group and Board. The Team Engagement and Development (TED) tool had embarked on a 2-year pilot scheme. Hazel Brand asked about the leadership behaviours planning and the middle management tiers, how would they be included in the framework. It was confirmed that the framework would be embedded over a period of time, including linking with the recruitment processes aligning with appraisals and reviewing leadership development offer. The Star awards had taken place and had a positive influence of colleagues, tables were sponsored by partners. As the ticket prices were low it enabled more people to attend.	
	The Committee: - ***Noted and took assurance from the Staff Engagement Report***	
PC22/11/ C2	**<u>Education Report</u>** **The SET Framework** The Director of Education and Research confirmed that there had been an improvement in the SET compliance and there was continued work with the medical and dental staff group as this was the area with the lowest compliance. Risk assessments took place to ensure the Trust were complaint and had enough sufficently trained colleagues on shift. The Director of Education and Research presented the new training framework Following a question from Jo Gander regarding the Trusts engagement with the faculty at University of Sheffield and plans for the future. The Director of Education and Research advised that work was continuing closely with Sheffield across the ICB and Place. Work was also taking place with the Chief People Officer and a further update would be presented to the committee in the future for assurance. The Medical Director for Workforce and Speciality Development asked if there were enough people available to enable training to be completed. How do the Trust invest in additional people and how the headroom was predicted. Further work was in progress with the finance department to discuss this at Trust Executive Group. The development of colleagues was key and would be fully supported and built into the framework. The Acting Deputy Chief Nurse observed recruitment and retention was important and that the Trust needed to make more time for people requiring training. The Committee confirmed to the Chair that they supported the framework and the Director of Education and Research would provide updates in future reports. **GMC Survey** The Director of Education and Research confirmed that all colleges had engaged with the Trust and had a more positive outcome in the past two years. Since working with the college tutors' significant improvements in specialties had been made.	

	The Chair mentioned that there had been good progress with SET training, however, could the Trust do more with the resus training. The Director of Education and Research assured the Committee that there were enough spaces on the various levels of resus training. Staff release was one of the biggest issues due to clinical workload coming first. Work would continue to support colleagues on shift that required training. The Medical Director for Workforce and Speciality Development commented that people needed to be competent with their resus training until the resuscitation teams were able to attend. Ensuring that there were enough basic life support trained colleagues on shift prior to the fully trained resus team being on scene was key. Following a question from the Head of Organisational Development, EDI, and Wellbeing about mitigating the risk and looking at where the areas were struggling with resus training, it was clarified that this was discussed at clinical governance within divisions.	
	The Committee: - ***Noted and took assurance from the*** **Education Report, supporting the framework**	
PC22/11/ C3	**<u>Health & Wellbeing Update</u>** The Chief People Officer explained that a proposal for the future health and wellbeing offer bid had been proposed to go to Charitable Funds Committee at the last People Committee. The paper presented an updated proposal to request a 3-year allocation from Charitable Funds Committee and support Health and Wellbeing. This approach had been supported by the Executive team to go forward to Charitable Funds Committee and People Committee was being sought. The Committee supported the proposal Charitable Funds bid.	
	Action: - ***Finalise the proposal and present to Charitable Funds Committee***	**ZL**
	The Committee: - ***Noted the Health and Wellbeing Update and Supported this being presented to the Charitable Funds Committee.***	
PC22/11/ C4	**<u>Appraisal Season</u>** The Chief People Officer confirmed that the appraisal season had recently ended with a completion rate of 83.43%. Reviews were being undertaken via feedback and focus groups to plan for 2023. Further work was taking place to look at a more streamlined approach to the paperwork and encourage more focus on the conversation and recording/reporting issues. Feedback around leadership and culture was shared amongst the senior teams. The target was at 90% due to any challenges that the appraisals may bring. It was noted that this years completion was higher than previously, with an ambition to achieve at least 90% in future years.	
	The Committee: - ***Noted and took assurance from the Appraisal Season***	
PC22/11/ C5	**<u>Revalidation for Doctors Annual Report</u>** The Associate Medical Director for Professional Standards and Revalidation provided a brief background, all clinicians must have their license to practice revalidated by the general medical	

	council (GNC) every 5 years. The annual report runs between the 1st April and the 31st March 398 clinicians were connected to the Trust. Every year the report was then provided to NHS England along with the appraisals at this time. The appointment of the lead appraisers was a highlight of 2021 as they would ensure quality assurance was maintained. The compliance rate had increased to 79% for the completion of the appraisals in March 2022. There were currently IT issues with the appraisal form. Therefore, alternative software was being investigated to provide the data and improve compliance. A business case bid was in the process for this. The Executive Medical Director added that as training had been provided to more appraisers, they were each given 6 or 7 colleagues to appraise per year. During Covid-19 the Trust could miss 2 appraisals and still revalidate and we chose to continue. The report was signed off by NHS EI and at present the 70-page medical appraisal interactive guide form was difficult to use. Other software would connect with the GMC and ESR to allow more efficient completion. Following a question from Hazel Brand regarding the process if the completion rate wasn't at 100%, it was answered that although the compliance rate was at 79% due to Covid-19 this percentage was adequate. Previously if the normal target rate of 85% wasn't achieved the Trust would have a visit from NHS England to look at processes and make recommendations. All appraisals must be completed by 31st March and alerts were received by the clinicians to ensure this was completed. All revalidation data can be accessed via the GMC website and there was the function to defer colleagues for 12-18 months if required. The report was agreed by the People Committee and would now be presented to NHS EI.	
	The Committee: - ***Noted and took assurance from the*** **Revalidation for Doctors Annual Report and to be submitted to NHS England**	
PC22/11/ C6	**<u>Violence Prevention Standards Biannual Report</u>** The Local Security Management Specialist explained that this was the first bi-annual report that had been presented at People Committee. The Committee were asked for a non-executive director to lead the standard. The overall standard with NHS England meant that the trust was non-compliant and therefore the violence and prevention standards were added to the Estates and Facilities risk register. This was not an unusual position compared to other Trusts. Collaborative work was being carried out with stakeholders. The information within the report was from Datix. The Chair praised the amount of information within the standards and asked if the Trust could do more to improve the results. Violence would never be able to be eliminated however, it was also about educating and supporting our teams and patients. Jo Gander volunteered as the lead non-executive director for the standards, which would be discussed outside of the meeting. This would be part of the Health and Wellbeing Guardian role.	

	Throughout the 6-month period of April to September 273 incidents were reported this didn't include any incidents between colleagues as these were reported differently. Administrative teams were encouraged to report any verbal abuse they receive over the phone and for warning letters to be sent if required. Mark Bailey asked about the difficult issues that colleagues face every day and how the trust can support more. By promoting and encouraging staff to report issues. It was also included within the staff survey with details around the prevention against violence and if people were affected by violence or verbal abuse. The Violence and Prevention standards also linked in with the Audit and Risk Committee and security management. It had been agreed previously that People Committee would have oversight. The guidance from December 2021 didn't include a designated Non-Executive Director lead however, it was now required. The requirement was for the Non-Executive Director to assist with violence and prevention from a health and wellbeing point of view, which gave the suggestion of including within the Health and Wellbeing guardian remit.	
	The Committee: - ***Noted and took assurance from the Violence Prevention Standards Biannual Report***	
PC22/11/ C7	**EDI Update** The Head of Organisational Development, EDI, and Wellbeing explained that the Equality, Diversity, and Inclusion action plan had been updated to make the actions more specific and measurable to remove duplications. Duplications were linked to the recommendations in the race code. A new action plan was to be implemented and would be received at the Trust Executive Group meeting on 14th November 2022. The reciprocal mentoring programme was to be open a new cohort to senior leaders for after the 12 months. Work with the recruitment team was being carried out around shortlisting and protected characteristics. The team was also working within the community and with different groups of people and networks. The Executive Medical Director asked about how the reciprocal mentoring feedback was publicised. There was a feedback form that included what could be carried out better including knowledge and experience. The Chair commented on the wording of some actions and this would be considered in the next iteration of the action plan.	
	The Committee: - ***Noted and approved the EDI Action Plan.***	
PC22/11/ C8	**Internal Audit Report – Recruitment** The Deputy Director of People and Organisational Development explained that this audit report had been previously presented to Audit and Risk Committee with two key medium risk recommendations being highlighted. The first was the revised key performance indicators and monitoring these and recording of pre-employment checks. The recruitment process currently consisted of 80 individual steps. Three engagement sessions had taken place and identified short-	

	, medium- and long-term objectives to make improvements. Recruitment activity had increased especially within international recruitment which had been a success. The Trust continue to hold events and recruitment fairs to promote various roles within the Trust. The Deputy Director of People and Organisational Development advised that the actions were on track to be completed by the deadline.	
	The Committee: - ***Noted the Internal Audit Report on Recruitment***	
PC22/11/ D1	**Workforce Supply and Demand** The Deputy Director of People and Organisational Development informed the Committee that this was the first workforce supply and demand report and asked for feedback on its content. The report had links with aspects of the reports including education and international recruitment. The report focuses on some of the more difficult areas to recruit including the risks and the actions being taken. It was noted that bank and agency levels remained high. Discussions had been held across place and the ICB to assist with the mitigating of some of the workforce challenges. Further work was being carried out to investigate the data and if the Trust was fully staffed within all areas. The Acting Deputy Chief Nurse referred to learners that had carried out work experience to ensure they were fully supported. To look at vacancies across positions as the data wasn't always a true reflection. The Deputy Director of People and Organisational Development advised that the reports could focus on other areas or particular staff groups.	
	The Committee: - ***Noted and took assurance from the Workforce Supply and Demand Update***	
PC22/11/ D2	**Widening Participation Q2** Feedback was requested from the committee on this item as this wasn't discussed as part of the meeting at the time.	
PC22/11/ D3	**Job Planning plan and targets** The Executive Medical Director advised that there were two actions that were in review however, they were both improving and this was helped by admin support. Although job planning wasn't at 100% it was progressing. Over 100 job plans were signed off every year with some specialty sessions being booked in with teams.	
	The Committee: - ***Noted and took assurance from the Job Planning plan and targets***	
PC22/11/ D4	**Overview of Improvement Projects** Feedback was requested from the committee on this item as this wasn't discussed as part of the meeting at the time.	
PC22/11/ F1	**Equality and Diversity Committee Terms of Reference**	

	It was confirmed that the terms of reference were to be ratified at the People Committee. Members were asked to provide feedback to the Company Secretary and add this to the January 2023 agenda.	
	The Committee: - ***Noted and approved the Equality and Diversity Committee Terms of Reference***	
PC22/11/ F2	**People Committee Terms of Reference** Feedback was requested from the committee on this item as this wasn't discussed as part of the meeting.	
PC22/11/ G1	**Governor Observations (Verbal)** Mark Bright referenced the figure of 273 violence and aggression incidents and praised the discussions around this. Mark Bright also commented on the appraisal evaluation survey and the doctors in training. Mentioning that medical students that train abroad, some do come back to the UK to work.	
	The Committee: - ***Thanked the Governor for their observations.***	
PC22/11/ H1	**Minutes of the Sub-Committee Meeting (Enclosure J1)**	
	The Committee noted: i. Health & Wellbeing – August 2022 ii. Training and Education Committee – August 2022 iii. Freedom to Speak up Forum – July 2022 iv. Teaching Hospital Board – March & June 2022	
PC22/11/ I2	**Any Other Business (Verbal)** The Chief People Officer provided an update on the industrial action that the unions were out to ballot and Trusts would shortly receive further information. Working with the ICB was important to ensure a consistent approach when preparing for any industrial action. The period of notice for strike action was at least 14 days before the start of the strike. The workforce was divided in opinion on whether to vote for industrial action. Further support for colleagues was required along with more communications as it was acknowledged this wasn't personal against the Trust and was a national dispute.	
	The Committee: - ***Noted the update on Industrial Action Ballots.***	
PC22/11/ I3	**Minutes of the Meeting held on 6th September 2022**	
	The Committee: - ***Approved the minutes of the meeting held on 6th September 2022.***	

PC22/11/ I4	**Items of escalation to the Board of Directors (Verbal)**	
	There were no items of escalation to/from: i. People Sub-Committees ii. Board Sub-committees iii. Board of Directors	
PC22/11/ I5	**Assurance Summary (Verbal)**	
	The Committee was asked by the Chair if it was assured, on behalf of the Board of Directors on the following matters. Any matters where assurance was not received, would be escalated to the Board of Directors: - **Matters discussed at this meeting,** - **Progress against committee associated Executive's objectives,** - **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?**	
PC22/11/ I6	**Date and time of next meeting (Verbal)**	
	Date: Tuesday 17th January 2022 **Time: 9.00am** **Venue: Microsoft Teams**	
	Meeting closed at: 12:33pm	

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

QUALITY AND EFFECTIVENESS COMMITTEE

Minutes of the meeting of the Quality and Effectiveness Committee
Held on Tuesday 4th October 2022 at 13.00 via Microsoft Teams Videoconferencing

Members:	Mark Bailey, Non-Executive Director Hazel Brand, Non-Executive Director Jo Gander, Non-Executive Director (Chair) Lois Mellor, Director of Midwifery Dr Tim J Noble, Executive Medical Director Kath Smart, Non-Executive Director	
In attendance:	Fiona Dunn, Deputy Director Corporate Governance/Company Secretary Kirsty Edmondson-Jones, Director of Innovation and Infrastructure (Item B1) Claudia Gammon – Corporate Governance Officer (Minutes) (CG) Heather Jackson, Director of Allied Health Professionals Rob Mason, Head of Quality Improvement (Item B1) Angela O'Mara, Deputy Company Secretary Jane Smith, Business Manager for Education and Research	
To Observe:	Peter Abell, Public Governor Bassetlaw Lynne Logan, Public Governor	
Apologies:	Simon Brown, Acting Deputy Chief Nurse Kirsty Clarke, Acting Deputy Chief Nurse Sam Debbage, Deputy Director of Education and Research Marie Hardacre, Head of Nursing for Corporate Services Abigail Trainer, Acting Chief Nurse	
		ACTION
QEC22/10/A1	**Welcome, apologies for absence and declarations of interest**	
	The Chair welcomed the members, attendees, and governor observers and introduced herself as it was her first meeting It was noted that it would be a shorter QEC meeting due to clinical staff required to help with the dramatic increase in urgent and emergency hospital attendances at the DRI.	
QEC22/10/A2	**Conflicts of Interest (Verbal)**	
	No conflicts of interest were declared.	
QEC22/10/A3	**Actions from previous meeting (Enclosure A3)** **Action 1 – QEC21/12/C2 – Quality Framework** Update for this item was due at the December 2022 meeting	

Action 2 – QEC21/12/C2 – Quality Strategy
Update was due at the December 2022 meeting

Action 3 – QEC22/02/D4 – Respect Audit
Audit to be completed and returned via Clinical Governance Committee – This action could be closed

Action 4 – QEC22/04/C1 – Board Assurance Framework
This was included within the agenda and could be closed.

Action 5 – QEC22/06/C7 – Tendable Implementation Update
This had been raised as a new action on the log (15) and was closed

Action 6 – QEC22/06/C6 – Mental Health Strategy
No update as this would be added to the December 2022 agenda

Action 7 – QEC22/06/D6 – Patient Experience Report
Update was due at the December 2022 meeting

Action 8 – QEC22/06/D1 - Patient Experience KPMG Report
No update as this would be added to the December agenda

Action 9 – QEC22/06/J1 – AOB: Violence and Aggression
Update was due at the December 2022 meeting

Action 10 – QEC22/09/C1 – Patient Safety Incident Response Framework Update
No update as this would be added to the December agenda

Action 11 – QEC22/09/C1 – PSIRF
No update as this would be added to the December agenda

Action 12 – QEC22/09/C1 - BAF
The review of this action was ongoing with 360 Assurance and could be closed

Action 13 – QEC22/09/C3 – Patient Safety Report – Open Cases
This item was on the agenda and could be closed

Action 14 – QEC22/09/C7 – Tendable
Update was due at the December 2022 meeting

Action 15 – QEC22/09/C9 – Learning from Deaths Hydration and Nutrition Update
Update was due at the December 2022 meeting

Action 16 – QEC22/09/D3 – Health Inequalities
Update was due at the December 2022 meeting

Action 17 – QEC22/09/F2 – Central Alerting System (CAS)
TN confirmed that outstanding CAS alerts had been identified and closed where appropriate. System implemented to ensure all outstanding alerts were escalated and managed. This action could be closed.

	Action 18 – QEC22/09/F2 – CQC Insight Reports No update as this would be added to the December agenda	
	The Committee: - ***Noted the updates and agreed, as above, which actions would be closed.***	
	Action: Claudia Gammon would update the Action Log.	**CG**
QEC22/10/B 1	**Quality Improvement Annual Update** The Director of Innovation and Infrastructure provided an overview of the quality improvement annual update report. Explaining that it covered the performance metrics, quality improvement points and how this impacted on the organisation and the patients. The original plan was to engage with 628 people across 23 teams however, the improvement team engaged with 879 people across 35 teams on improvement projects. Currently there were 48 live quality improvement projects on the quality improvement database. The Head of Quality Improvement provided examples of achievements from teams that had used quality improvement process between October 2021 and September 2022. Examples included: • Audiology had received a lot of complaints due to unanswered calls; this had reduced by 86% due to the introduction of a new data system in 2021. • The productive medicine management team had released 30 mins a day for caring for patients by reducing time for chasing keys. • Increasing the filling out of the food charts within the frailty ward had enabled better conversations with loved ones and patients. Kath Smart commented about the balance within the teams, the improvement, and the major pieces of work, as to ensure this was in line with the true north objectives. It was confirmed that this was within the Recovery, Innovation and Transformation directorate plans and would be monitored via Monday.com to ensure all projects were captured in one place. Hazel Brand asked about the 48 live quality improvement projects and the aligning of them. The Head of Quality Improvement answered that there were 3 levels of engagement, to ensure that the divisional support, governance structure and the quality improvement business partners were all aligned. This was a new way of working and embedding quality improvement alongside the true north objectives.	
	Action: - ***Hazel Brand and Jo Gander to walk around the QI department and attend the meetings***	**RM**
	The Committee: - ***Noted and took assurance from the Quality Improvement Annual Update***	
QEC22/10/C 1	**Board Assurance Framework (BAF) SA1** The Company Secretary explained that the BAF had previously been presented at Board on the 27th of September with no updates since. The feedback from 360 Assurance regarding the changes to the BAF and explaining the strategic risks in detail then connecting them to	

	the strategic breakthrough and aims was in progress. It was important to explain the risks and show the impacts of them on the BAF, ensuring the Trust were providing patient care. The Executive Medical Director provided information that once the Emergency Assessment Unit was reopened it would increase trolley capacity for ambulance handovers and reduce the risk to patients. There was also an external patient safety governance review, with changes being investigated. Further project management work would be implemented into this. It was confirmed that the patient safety review would be presented at the Trust Executive Group meeting and then return to Quality and Effectiveness Committee with the next steps being implemented. Following a question from Kath Smart about the target risk rating for the Patient Safety Incident Response Framework (PSIRF) and if it was achievable within the next 12months. It was confirmed that this would be reviewed regularly with the oversight of the Risk Management Board. Mark Bailey asked about the levels of risks and what the higher risks were. The strategic aim impacted on scoring the risks along with the risk appetite. The Company Secretary explained that it was essential the risks with high ratings were reviewed in line with the risk appropriate and then to ensure that appropriate controls and mitigating actions are in place and highlighted on the BAF.	
	Action: - ***TN/KC/SB/GB to work with FD to ensure all strategic risks were defined and input on DATIX and BAF before then reviewing target risk score***	**TN/KC/ SB/**
	The Committee: - ***Noted and took assurance from the Board Assurance Framework.***	
QEC22/10/C 2	**<u>Clinical Governance & Quality Assurance Update</u>** The Executive Medical Director provided highlights from his report: • One of the key concerns within Infection Prevention and Control was blood culture contamination rate and the volume of patients been seen via the Emergency Department. • Mortality data was rising but wasn't causing any significant issues. • The national shortage of bowel preparation supplies was improving. All divisions were reviewing their open incidents and that no harms were identified. Kath Smart asked if there was a timescale on when the overdue open incidents would be closed, it was confirmed that further work would be undertaken to ensure there was justification as to why they couldn't be closed. There was currently no timescale as a result. The Clinical Governance Committee provides assurance information that was then presented to QEC. The Chair added that receiving information on the key issues in departments, the organisation, patients, mitigating actions and articulating risks further via the Clinical Governance committee would be useful for QEC. All open incidents were reported within a central system (DATIX) and feedback provided to the divisions to review and support.	

	The Committee: - ***Noted the Clinical Governance & Quality Assurance Report***	
QEC22/10/C 3	**Organisational Learning (Verbal)** The Chair asked about the risks and lessons learnt from incidents and actions from the Care Quality Commission (CQC) and how this was shared. It was confirmed that this had been previously shared via a 'Sharing How We Care newsletter' that would be reintroduced if feasible once a new Chief Nurse was in post.	
	Action – - ***Receive an update on the Sharing How We Care newsletter and was it was feasible to reinstate***	**TN/KC/ SB/FD**
	The Committee: - ***Noted the Organisational Learning Update***	
QEC22/10/C 4	**Learning from Deaths Q1** The Executive Medical Director confirmed that the number of deaths had decreased with all being scrutinised. It was also raised about the format of the report received by QEC and that any feedback on this was to be received outside of the meeting	
	Action: - ***Feedback regarding the report and the changing of the format***	**TN**
	The Committee: - ***Noted and took assurance from the Learning from Deaths Q1 Report***	
QEC22/10/C 5	**Safer Staffing** This item wasn't discussed due to no nursing staff present for operational pressures	
QEC22/10/C 6	**Maternity Quality Overview** The Director of Midwifery provided a maternity update: • The central delivery suite was to move upstairs within the modular build. • Bassetlaw had been assisting with the number of patients at Doncaster and given the option to move. • Medical staffing issues were challenging due to absence and vacancies on the rota that were then covered by locums. • There was still a shortage of midwives however, there were more senior midwives in the team. • The Health and Wellbeing had increased its offer with the use of; counselling, reiki, therapy dog visits and freedom to speak up within the team. • Current midwifery vacancy rates were at 28.53 whole time equivalents. • Birthrate+ report was required to be analysed and a workforce paper would be presented to the Trust Board in October 2022. • Digital transformation service was on going with all maternity notes being accessible online. • The Ockenden initial report was progressing. The final report had been benchmarked with actions in place. • The Clinical Negligence Scheme for Trusts had safety actions that were at risk including midwifery staffing and training.	

	• The maternity service was under scrutiny and external assurance from NHSE, regional teams, LMS and the CQC. Kath Smart commented about the risks surrounding the vacancy position and whether the newly qualified staff receive enough support. A recruitment and retention team lead is allocated in these areas to work together and assist the newly qualified staff whilst completing the preceptorship programme for the 1st year which should then help with the retention. Mark Bailey asked about the international nurses and learning with stay and thrive. The Director of Midwifery added that working in the UK was different to abroad. Allowing the nurses time to practice over here was key along with the recruitment working with them in small cohorts.	
	The Committee: - ***Noted and took assurance from the Maternity Quality Overview***	
QEC22/10/C 7	**Quality Framework & Quality Strategy (Verbal)** This item was deferred to December due to no nursing staff being present	
QEC22/10/D 1	**Patient Experience Update** This item wasn't discussed due to no nursing staff present for operational pressures	
QEC22/10/F 1	**Corporate Risk Register** The Company Secretary confirmed that no new risks rated 15 and above were added.	
	The Committee: - ***Noted the Corporate Risk Register***	
QEC22/10/F 2	**CQC and Regulatory Compliance Update** The Executive Medical Director confirmed that there were no medical updates regarding the CQC. The Trust had received a visit from the Dr David Crichton, Medical Director for SYBICS , Richard Jenkins CEO and Alison Knowles from the SYBICB to observe the Emergency Department and pathways but had received no formal feedback. Kath Smart enquired about preparedness for CQC inspections and where the Trust was at this moment in time? The Medical Director answered by saying that there was no formal programme in place at the moment but will feedback. The Director of Midwifery outlined that Midwifery services were beginning to look at reports for the service and the staffing and how to continue with this and clarified checks on the "Shoulds" and "Musts" from last action reports and were planning spot checks to recent updated KLOEs for maternity. Hazel Brand asked if an overview of the action plan of the future CQC visit would be presented to Quality and Effectiveness Committee. The Company Secretary explained that as the CQC were changing their reporting style and format then would suggest that this not be escalated at present until the new framework for inspection is published, but just focus on the key areas eg Maternity and ED for now. The committee agreed not to escalate at present.	

	The environmental Place assessments for governance would be presented to the Patient Experience Committee, then Clinical Governance and then Quality and Effectiveness Committee.	
	Action: - 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**
QEC22/10/F 3	**Corporate Objectives – to update (Verbal)** This item wasn't discussed due to no nursing staff present for operational pressures	
QEC22/10/F 4	**Quality and Effectiveness ToR** Heath and Inequalities was required to be added to the duties along with adding items into the various sections to be in accordance with the work plan.	
	The Committee: - ***Noted and approved the* Quality and Effectiveness ToR once changes had been made**	
QEC22/10/H 1	***Governor Observations*** Peter Abell praised the quality improvement discussion and how it linked with transformation. Also, impressed with the continued care, work, and movement of patients within maternity. Lynne Logan praised the reports and asked about the improvements within Datix and the timescale. It was confirmed that the improvements were in progress, but no timescale had been set.	
QEC22/10/I1	**Sub-Committee Meetings (Enclosure I1):** - Clinical Governance Committee Minutes –August 2022	
	The Committee: - ***Noted the Clinical Governance Committee minutes from August 2022***	
QEC22/10/J1	**Any Other Business** The Clinical Audit Annual report raised by Kath Smart to be presented at December meeting	
QEC22/10/J2	**Minutes of the meeting held on 5th September 2022**	
	The Committee: - ***Noted and approved the minutes from the meeting held on 5th September 2022.***	
QEC22/10/J3	***Issues escalated from/to:*** i) QEC Sub-Committees ii) Board Sub-Committees iii) Audit & Risk Committee	

QEC22/10/J4	**<u>Assurance Summary</u>** The Committee was asked if it was assured, on behalf of the Board of Directors on the following matters. Any matters where assurance was not received, would be escalated to the Board of Directors: - Matters discussed at this meeting, - Progress against committee associated Executive's objectives, - Are there any emerging new risks identified?		
	<u>The Committee were assured on behalf of the Board of Directors on:</u> - ***Matters discussed at this meeting.*** - ***Progress against committee associated Executive's objectives,*** - ***No new emerging risks identified***		
QEC22/10/J5	**<u>Date and time of next meeting (Verbal)</u>**		
	Date: **Time:** **Venue:**	**Tuesday 6th December 2022** **13:00** **Microsoft Teams**	
	Meeting End time	15:01	

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

CHARITABLE FUNDS COMMITTEE

Minutes of the Meeting of the Charitable Funds Committee
Held on Thursday 15th September 2022 at 1.30 pm via Microsoft Teams

Trustees: Mark Bailey – Non-Executive Director (Chair)
Suzy Brain England – Chair of the Board
Richard Parker – Chief Executive
Alex Crickmar – Acting Director of Finance
Kath Smart – Non-Executive Director
Jo Gander - Non Executive Director
Hazel Brand – Non Executive Director
Abigail Trainer – Acting Chief Nurse
Zoe Linton – Chief People Officer

Attendees: Peter Brindley and Norma Brindley - Executors and Representatives of the Fred & Ann Green Legacy
Sarah Dunning – Corporate Fundraiser
Matthew Bancroft – Head of Financial Control
Fiona Dunn – Company Secretary

Apologies: Jon Sargeant – Director of Recovery, Innovation and Transformation
Emma Shaheen – Head of Communications and Engagement
Dr T J Noble – Medical Director

CFC22/09/A1 **Welcome and Apologies for Absence (Verbal)**

The Chair welcomed the members and attendees.

CFC22/09/A2 **Conflicts of Interest (Verbal)**
No conflicts of interest were declared.

CFC22/09/A3 **Actions from Previous Meetings**

Action 1 - CFC/2/03/B4 – Presentation from Fund Holder on Funded Scheme - CLOSED
Due to operational pressures it has not been possible to undertake a video for the Butterfield Suite. Trustees will be able to see the suite on site visits and there will also be photos on the website.

Action 2 CF22/03/D1 – Annual review of Charitable Funds Policy (including Committee Terms of Reference) - CLOSED
The Head of Communications and Engagement has constructed suitable wording for inclusion within the policy around the interaction between DBTH Charity and external charities.

Action 3 - CFC22/06/B1 – Review of Fund Balances - CLOSED

Review of fund balances is included within the Fund Balance Report, Item B1.

Action 4 - CFC22/06/B2 – International Nurses - CLOSED
International Nurses are included within the Fund Balance Report, Item B2.

Action 5 - CFC22/06/B2 – Medical Equipment
The Medical Equipment is outstanding, Dr Noble has been encouraged to complete the review before Christmas.

Action 6 - CFC22/06/B2 – Corporate Teambuilding - CLOSED
Corporate Teambuilding is included within the Fund Balance Report, Item B1.

Action 7 - CFC22/06/C1 – Overview of Current and Planned Fundraising Activities Serenity-Suite – CLOSED
To note. Communication circulated to CFC Members in July 2022 regarding the expenditure of the Serenity Suite.

Action 8 - CFC22/06/C1 – Bassetlaw & Mexborough – CLOSED
Bassetlaw and Mexborough appeals is included within Item C1.

Action 9 - CFC22/06/C1 – Recommendations
Consultation work going on around the future of the charity and its structure. Final report due in December.

Action 10 - CFC22/06/D1 – Committee Workplan
The Committee Workplan has been updated and will review with an end of year position in December.

Action 11 - CFC22/06/E1 – Governor's Observations - CLOSED
The question raised by Mick Muddiman will be put onto the governor portal.

Action: Matthew Bancroft would update the Action Log. **MB**

The Committee:

- ***Noted the updates and agreed as above, which actions would be closed.***

Expenditure

CFC/22/09/B1 **Review of Fund Balances**

Matthew Bancroft presented the paper and reported that at the end of August 2022 there is an operating surplus of £85,000 in year to date, mainly as a result in increase in donations through fundraising efforts. Charitable expenditure for patient benefits is in line with the previous year but a little bit behind in terms of staff benefit. There is quite a lot of spend to come out of items that have been approved but not actually been actioned in terms of expenditure. The Team building events have had 24 applicants come through to present.

To note: there has been a loss on investments in the five months to August, this may be due to inflation levels and the potential risk on the economy, particularly around energy

prices. Although in the last two years there has been gains of £2m. A General Investment Review paper will be brought to the next meeting.

Kath Smart asked if the investment advisors would be coming to a future meeting to understand what the forecast looks like. Alex Crickmar replied he would ask the investors to attend a future meeting.

Kath Smart commented that she was pleased to see the benefits to staff taking off and it was very positive that staff health and wellbeing is at the forefront alongside patient welfare.

Neil Rhodes stated that it was important to manage expectations in relation to return on investments. Neil Rhodes also requested a tracker be produced to show the average returns, a view of the income profile from the investments, coupled with an expenditure profile over recent years.

Suzy Brain-England said to bear in mind the changing times in relation to donations and fundraising.

Action: ***The Investors to be contacted regarding their views and advice.*** **AC/ MB**

A summary to be produced regarding the return on investments over the last few years and an expenditure plan.

The Committee:

- ***Noted the approved update for Fund Balances.***

CFC22/09/B2 **Approval of Expenditure**

a) International Nurses

Abigail Trainer advised that the funding for international nurses relates to the accommodation costs. Part of the offer for international nurses is that the Trust supports them with the first three months of accommodation costs while they settle into the country. The request is for funding for the next twenty international nurses that will be arriving into the country as part of the ongoing recruitment process, which is in line with what has happened in the past and also in line with other Trusts.

Suzy Brain-England said that she was supportive of the request in principle but would like support for other nurses relocating from around the UK as well as international nurses as it would benefit a broader nursing cohort.

Abigail Trainer said that she would take this forward with Zoe Linton regarding relocation packages for nurses within the UK. **AT**

Jo Gander asked if the funding was necessary as the Trust is already providing cost effective accommodation. Jo Gander also asked if the funding should be coming from charitable funds. Jo Gander said that the Trust could support international nurses coming into the organisation in other ways and was concerned that the funding is inequitable.

Neil Rhodes was supportive of nurses receiving funding in relation to accommodation costs. Neil Rhodes said that the Trustees had seen first-hand the benefits the international nurses provide and is a positive way of driving down the costs of bank and agency staff. Though feels that the funding should not come from charitable funds.

Alex Crickmar stated that in terms of the Charitable Funds, the funding is above and beyond what the Trust would normally do, as nurses would normally be charged for accommodation under the NHS rules.

Richard Parker stated that recruiting nurses from England does not create additionality in terms of costs as after a month's induction period they would contribute to the Trust, as opposed to international nurses who would not contribute for three to six months, therefore would not see a reduction in bank and agency expenditure. We would probably see a protracted period of induction for overseas recruits which is above and beyond. Richard Parker is supportive of the funding as we were going above and beyond to make transition to the UK easier for international nurses and not something that we could give to every employee

Zoe Linton was fully supportive of the funding and stated that the nurses would go to other Trusts if not supported. Zoe Linton agreed to look into the relocation policy for wider staff groups. **ZL**

Hazel Brand asked if there was any evidence of the benefit of recruiting international nurses.

Abigail Trainer replied that work had been undertaken with both NHS Professionals and the ICB regarding international recruitment and all Trusts had made the same offer. The Trust has also provided pastoral care and a Stay and Thrive Matron has been recruited which is not exclusive to international nurses but to all newly qualified staff that come in as registered nurses and the response has been positive. Abigail Trainer said that it was in the Trust's interest to look after the workforce and part of that is supporting them with initial cultural change when they come into the country.

Mark Day asked if the funding was in the remit of the charity. Mark Day asked as a general question how decisions are made regarding funding and how they fit around the objects of the charity.

Mark Bailey replied that a pre-meeting is held and the requests are scrutinised regarding how they fit into the charitable funds remit regarding what is over and above what the health service would pay for.

Neil Rhodes asked if it is so above and beyond that if not approved, would it not be funded from other sources.

Richard Parker replied that the Trust has a list of priorities and the above and beyond requests would be competing against other services that are under pressure including clinical services, therefore could not guarantee that funding for international nurses would be a priority area. In light of Richard Parker's response Neil Rhodes was supportive of the paper.

The Committee:

Approved funding for International Nurses

b) Shuttle Bus (funded via Fred and Ann Green Fund)

Matthew Bancroft presented the case to seek approval for the Shuttle Bus funded via the Fred and Ann Green Fund to Montagu. The current supplier, CT Plus went into administration at the beginning of August. A new provider has been found but the costs have increased due to the increase in energy prices to £240,000 per annum. Therefore, requesting the committee to support the funding for the additional expenditure of £70,000. Due to short timescale an alternative supplier was found for 12 months whilst we went out to tender for a new service and look at the future around shuttle bus services.

Hazel Brand raised the question of nominal charging. Richard Parker replied that this has been looked into, but it was decided due to the increase in the cost of living this was not an option at this point in time.

Norma Brindley advised the committee that the shuttle bus, which was one of the first schemes paid for from the Fred and Ann Green Legacy was appreciated by the people of Mexborough and believes that the service should not be charged for at present. Also due to the present climate with the increase in fuel Norma Brindley advised that the increase should be paid, but research should be undertaken into the usage of the service.

The Committee:

Approved funding for the Shuttle Bus (funded via Fred and Ann Green Fund)

c) Serenity Suite

Alex Crickmar advised the committee to note that a review had taken place regarding the increasing costs of the Serenity Suite. The review had been circulated to the Trustees outside of the meeting and had now been approved.

Richard Parker advised that work on the Serenity Suite was underway and was due to be completed in line with the CDS refurbishment in December.

Mark Bailey and Alex Crickmar confirmed that the control of costs would be with the Executive Team and the Facilities Team going forward.

Richard Parker assured Hazel Brand that a process to control the costs was undertaken, but due to extraordinary changes and price rises, costs are an issue at the present time.

The Committee:

Noted funding for the Serenity Suite had been approved outside of the meeting.

CFC22/09/B3 **Charitable Funds Development Committee (Above and Beyond Committee)**

The Charitable Funds Development Committee paper was provided and noted. Mark Bailey asked if there were any questions to be raised post meeting.

CFC22/09/C1 **Fundraising**

Overview of Current and Planned Activities

i) Fundraising Events (Including Serenity Suite, Bassetlaw)

Adam Tingle advised the Committee that a fundraising campaign is going to be developed around the Emergency Village and a fundraising campaign will be developed in Montagu around the Community Diagnostic Centre, both are still in development at the moment, but will have some updates in the near future.

Serenity Appeal

The Serenity appeal for maternity bereavement has raised £77,854 to date. A kitchen has also been kindly donated by Howden's. The appeal has also received £15,000 from the National Lions Grant Scheme and the International Lions are going to match the funding of £15,000 and with the exchange rate, it is expected that an additional £33,000 be added to the appeal, which will significantly help against the target of £150,000. The Three Peaks Challenge took place in June and some skydiving, which raised £10,000. A further skydive has been arranged for the Baby Loss Awareness week. £2,824 was also raised from a raffle.

The Serenity Appeal Ball due to take place on the 14th October at the Ye Olde Belle has been cancelled due to the economic crisis and the national mourning period and will be rearranged for May 2023.

Mark Bailey asked what the external communications have been regarding rescheduling the ball. Adam Tingle stated that a press release has gone out and also adverts on the website. Adam Tingle said with more time to advertise and receive auction prizes that he was confident that the event in May would go ahead.

Hearts for Doncaster Appeal

The Hearts for Doncaster Appeal sculpture is now in place on Chequer Road, in the centre of Doncaster. To present £12,876 has been raised, which equates to approximately 600 hearts. Photos will be shared after the national period of mourning ends.

Shining Stars

The illuminated stars that are put on all three sites at Christmas has raised over £60,000 in the last two years and are hoping for a similar response this year. To date we have received sponsorship from four stores.

Award of Recognition

The NHS Big Tea went to every service and ward within the Trust and have received good feedback and engagement from staff.

The six weeks of summer give away has just come to an end, which gave away ten prizes ranging from £25 to £50 vouchers every Friday and announced by Richard Parker, again was very well received by staff.

Annual Star Awards
£11,500 has been raised in sponsorship and currently working with a tenth business for sponsorship.

Team Building Activities
The team building activities are for teams to get together for an away day to talk about their objectives but in a fun setting at a cost of £400 maximum. To date 24 applications have been accepted at a cost of £5,318 and a further seven have been received this week.

Working Environment Improvement Scheme
This is a £1,000 pot to improve the office environment and make it a nicer place to work in. We have received 86 applications to date.

ii) Fundraising External Consultancy
Currently working with More Partnership to advise how to develop the charity in the future. At the moment conducting insight gathering, reviewing policies and documents, working with Sarah Dunning, Fundraising Manager and also conducting in depth interviews, with Trustees, staff and the general public. The recommendations will be completed in November and will bring back to the December committee meeting.

iii) NHS Charities Together
NHS Charities Together is a grant that was launched in 2020 for monies up to £30,000. The Trust will put a bid in based on the recommendations of the More Partnership and also the toolkit from NHS Charities and will bring to the December meeting what we will be bidding for.

Hazel Brand questioned the consistency of the Trust's green plan regarding the shining stars and what the energy implications are for the Trust's electricity bill. Adam Tingle said that this had not been factored in but would work with Matt Gleadall in Estates and will factor in going forward.

Suzy Brain-England and Zoe Linton said to think about how to get the message across to people regarding accessing funds

Abigail Trainer and Adam Tingle are meeting next week to discuss communications around funds.

Mark Bailey asked for an update at the December meeting on how we promote and encourage communications. **AT**

Richard Parker said we need to think about how we market appeals to maximise the benefits.

Mark Bailey stated that a report would be issued regarding the charity and then a discussion would take place around the structure and ambition. Going forward to

look into the governance of major activities and the implications for the charity and the Trust.

The Committee:

Noted the overview of current and planned activities.

Governance

CFC22/09/D1 Review of ISA 260 Workplans

Alex Crickmar asked the Committee to note the Review of the ISA 260 workplans which are undertaken by the external auditors and sets out any issues around the external audit.

The Committee:

Noted the review of the ISA 260 Workplans

CFC22/09/D2 Draft Annual Accounts and Annual Report 2021/22

Alex Crickmar stated that the draft annual accounts were due an external audit on the 10th October 2022. The accounts are near completion, Matthew Bancroft will be doing a further audit to review cut off dates to ensure the income and expenditure is recognised in the correct period.

Alex Crickmar requested the Trustees and Committee Members provide comments on the annual report by the end of September to Matthew Bancroft and to copy Alex Crickmar into the responses. **All**

Mark Day asked whether the auditors review whether the expenditure complies with the objectives of the charity. Matthew Bancroft reassured the Committee that part of the auditor's role was to ensure that expenditure is appropriate to the charity. Alex Crickmar stated that the auditors check the consistency between the annual reports regarding the objectives of the charity and the accounts.

Kath Smart stated that it was good governance for the Trustees to challenge whether criteria meets the charities objectives even though it is checked by the auditors.

The Committee:

Noted the Draft Annual Accounts and Annual Report 2021/22 and will provide comments

CFC22/09/D3 Updated Charitable Funds Development Committee (Above and Beyond Committee) Terms of Reference

Abigail Trainer provided the updated terms of reference for the Charitable Funds Development Committee for approval and stated that there were minor changes around timing and admin.

Mark Day said that delegation in the terms of reference need to be clarified. Mark Day also commented that the amount should be agreed on an annual basis.

Alex Crickmar provided assurance that each year a budget is set in terms of expected spend on charitable funds and the target is reviewed annually.

Alex Crickmar agreed that the wording around the delegated limits needs tidying up around the Director of Finance role. At present the Director of Finance signs off all expenditure relating to charitable funds.

Matthew Bancroft will update the Terms of Reference and bring back to the December meeting. **MB**

Fiona Dunn asked for clarification regarding decisions on bids if the Chief Nurse was not present at the meeting. Fiona Dunn also thought the name of the committee should be amended. Alex Crickmar agreed that the name of the committee should be changed.

The Committee:

Agreed that a review of the wording of the Terms of Reference and a change of name of the committee would be undertaken and to be brought back to the December committee meeting.

CFC22/09/E1 **Governor Observations** `

Norma Brindley asked for an update on the developments of the Mexborough Site.

Richard Parker said that due to challenging times due to inflationary costs and the economy that the Trust would not get the model planned for a centre of excellence for Orthopaedics from the £15m TIFF money. The plan was for two operating theatres and 24 beds. A meeting took place today to review the position and whether the TIFF funding was the correct approach.

Norm Brindley also commented that the roof on the Aurora Centre at Montagu had now been completed.

Information Items to Note and Any Other Business

CFC22/09/F1 The minutes of the sub-committee meeting of the Charitable Funds Development Committee (Above and Beyond Committee) were provide and noted.

CFC22/09/F2 Minutes of the Charitable Funds Committee Meeting held on the 20th June 2022
The minutes of the Charitable Funds Committee Meeting held on the 20th June 2022 were approved.

The attendees to be amended to read Trustees are 'attendees' and 'not in attendance'

CFC22/09/F3 Any Other Business
Hazel Brand requested the Memorandum and Articles of Association and other governance and charity documents to be provided to new members.

CFC22/09/F4 **Assurance Summary**

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:

Approved the assurance summary

CFC22/09/F5 Date and Time of Next Meeting

Date: Thursday 8th December 2022
Time: 1.30 pm
Venue: Microsoft Teams

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

CHARITABLE FUNDS COMMITTEE ANNUAL REPORT 2021/2022

DATE:	**December 2022**
PREPARED BY:	**Mark Bailey, Chair of the Charitable Funds Committee**

1 INTRODUCTION

1.1 Doncaster & Bassetlaw Teaching Hospitals NHS FT is the sole corporate Trustee of the Charitable Fund.

The Board of Directors act as this Trustee and is the body responsible for running the operation of the Charitable Funds and ensuring a good governance structure is maintained.

The Charitable Funds Committee (CFC), a sub-committee of the Board, is constituted to

- provide assurance to the Board of Directors on the provision of charitable funds for the purpose of improved welfare and amenities for patients and staff.

- ensuring that there is adequate and appropriate governance in the authorisation of expenditure from the Charitable Funds.

The purpose of this report is to provide the Board of Directors with a summary of the work of the Charitable Funds Committee ("the committee") for the year 2021/22.

1.2 This report summarises the key information required against the following four elements namely:

a) The role and the main responsibilities of the Committee;

b) Membership of the Committee;

c) Number of meetings and attendance.

2	STRATEGIC CONTEXT
2.1	DBTH Charitable Funds ***must*** satisfy the following criteria to meet the requirements of charity law: • the expenditure is consistent with DBTH Charitable Funds' objects; and • the expenditure is for a charitable purpose; and • the expenditure will result in public benefit; and • in the case of restricted funds, it must be consistent with the objects recorded for that fund. In addition, the expenditure should follow Charity Commission advice, which is that the funds of NHS Charities should be used to: • provide a new **additional** service or facility where DBTH has no obligation to provide the service or facility and no exchequer resource to do so; or • **enhance** an existing service or facility (where exchequer funds provide a certain level of service but additional funding could improve the level and quality of the provision); or • **maintain** an existing service or facility on a time limited basis, normally of no more than one year. This might be to 'bridge' a gap in research or service programme or for a 'pilot project' where there is a reasonable prospect of securing long-term exchequer funding.
3	**THE ROLES AND MAIN RESPONSIBILITIES OF THE COMMITTEE**
3.1	The main purpose of the Committee is to: a) To oversee and manage the Trust's Charitable Funds, including the Fred and Ann Green charitable funds, and to provide assurance and raise concerns to the Board of Directors. b) Make recommendations, as appropriate, on charitable fund matters to the Board of Directors.
4	**MAIN ACTIVITIES**
4.1	During 2021/22 the Committee has delivered its key responsibilities and duties as outlined in its Terms of Reference. Five Committee meetings were originally planned for the year, however, due to operational pressures, associated with Covid, it was necessary to cancel one of the meetings.

4.2	All issues for escalation have been continuously reported upwards to the Board of Directors with relevant information being shared with the Finance and Performance Committee.
4.3	Through review and scrutiny of the Trust's charitable fund balance, the Committee has been able to provide the Board of Directors with the assurance against approval of expenditure. Throughout the year the Committee has promoted the further development of the Charity and the positive use of funds in line with Trust priorities. The Committee has continued to incorporate the assurance protocols with respect to the Fred & Ann Green Legacy and has welcomed the attendance and observations of the Executors as part of the decision making on the use of the funds.
4.4	The main areas covered during 2021/22 on behalf of the Board were: a) Financial - fund balances, investment performance and risk, income, and expenditure projections b) Fundraising strategy – including specific major fund-raising campaigns c) Implementation of Charitable Funds Policy with respect to priority areas for expenditure – including the use of Fred & Ann Green Legacy d) Listening to feedback on the positive impact on patients and staff from the use of funds and receiving ideas for future beneficiaries e) Committee Terms of Reference, Reserves Investment Policy; Risk management and internal controls.
5	**REPORTING**
5.1	Minutes of each of the meetings were formally presented to a subsequent meeting of the Board of Directors, with the Committee Chair drawing any key issues to the attention of the Board.
5.2	The Chair of the Charitable Funds Committee attended Council of Governors to answer questions and provide assurance to Governors. A short news summary of fund-raising activities and charitable expenditure has been

	provided to Trustees and Governors on a regular basis by the Director of Communications & Engagement.
6	**MEETINGS AND MEMBERSHIP**
6.1	The Committee met on 4 occasions during 2021/22 and the Committee's membership and attendance has been as follows:

Name	Role	Meeting attendance
Mark Bailey - Chair	Non-executive Director	4 of 4
Suzy Brain England	Chair of the Board of Directors and Council of Governors	4 of 4
Pat Drake	Non-executive Director	1 of 3
Neil Rhodes	Non-executive Director	4 of 4
Kath Smart	Non-executive Director	4 of 4
Sheena McDonnell	Non-executive Director	2 of 4
Richard Parker	Chief Executive	3 of 4
Jon Sargeant	Director of Finance/Director of Recovery, Innovation & Transformation	4 of 4
Alex Crickmar	Acting Director of Finance	2 of 2
Dr. Tim Noble	Executive Medical Director	2 of 4
David Purdue	Deputy Chief Executive and Chief Nurse	1 of 4

7	**SUB COMMITTEES**
7.1	The committee has the following sub-committee: • Above and Beyond Committee (previously Charitable Funds Development Committee) Minutes of the sub-committees are presented to each meeting of the Committee for information.
8	**WORK PLAN**
8.1	The Committee work plan was refreshed in June 2022 and used as a point of reference to prepare draft agendas for discussion at pre-meets, which took place approximately three to four weeks before the Committee meeting.

9	**COMMITTEE EFFECTIVENESS**
9.1	A committee effectiveness review had not been completed during 2021/22; the Director of Corporate Affairs had provided a commitment to undertake this review prior to 31 March 2023.
10	**CONCLUSION AND RECOMMENDATIONS**
10.1	In conclusion, the Committee delivered well against its key objectives during 2021/22.
11	**WORK FOR 2023/24**
11.1	Work to progress in 2023/24 includes: a) A Committee Effectiveness Review b) Continued development of the Committee work plan c) Support of the Corporate Fundraiser d) Continued review of the fund balances e) Continue to consider business case requests for charitable funds f) Continue the monitoring of the investment of the charitable fund

Final

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

TRUST EXECUTIVE GROUP

Minutes of the Meeting of the Trust Executive Group
Held on Monday 14th November 2022 @ 2pm via Microsoft Teams

Present:	Anurag Agrawal - Divisional Director – Medicine Ken Anderson - Chief Information Officer George Briggs - Interim Chief Operating Officer Alex Crickmar - Acting Director of Finance Sam Debbage - Director of Education & Research Fiona Dunn - Director of Corporate Affairs / Company Secretary Antonia Durham-Hall - Divisional Director – Surgery and Cancer Kirsty Edmondson-Jones - Director of Innovation & Infrastructure Eki Emovon - Divisional Director - Children and Families Zoe Lintin - Chief People Officer Richard Parker – Chief Executive (Chair) Dr Tim Noble - Executive Medical Director Kathryn Rigby – Breast, Vascular, Urology and Gastrointestinal Clinical Director Jochen Seidel – Divisional Director for Clinical Specialties	
In attendance:	Laura Brookshaw - 360 Assurance Kirsty Clarke – Deputy Chief Nurse Katie Michel – PA to the Chief Executive (Minutes) Adam Tingle - Acting Director of Communications and Engagement Ruth Vernon - 360 Assurance	
Apologies:	Nick Mallaband - Medical Director for Workforce and Specialty Development Jon Sargeant - Interim Director of Recovery, Innovation & Transformation Howard Timms - Acting Operational Director of Estates and Facilities	
		ACTION
TEG22/11/A0	**Internal Audit Action Log Update** Ruth Vernon, 360 Assurance, highlighted the main points included within the papers sent out prior to the meeting. Ruth Vernon informed the group of the follow up position as moderate assurance and explained that this could be increased during the remainder of the year by completion of the actions within Appendix C. Ruth Vernon referred to the three actions open from previous years and explained that two actions were in relation to risk management and the third was in relation to the BAF and it was expected for these to be closed at the year end. Ruth Vernon provided an overview to the reports within the pack - Head of internal audit opinion – Actions were agreed with FD and AC to develop the BAF - Recruitment – For information - Patient Safety Incidents – Actions were agreed to help develop Datix to support the framework during the next 12 months	

	The Acting Director of Finance emphasised the importance of being on track with the internal audit actions. Ruth Vernon and Laura Brookshaw left the meeting	
	The Committee: - ***Noted and discussed the Internal Audit Action Log Update***	
TEG22/11/A1	**Welcome and Apologies for Absence (Verbal)**	
	The Chief Executive welcomed members and those in attendance; the above apologies for absence were noted.	
TEG22/11/A2	**Matters Arising / Action Log**	
	There were no actions outstanding.	
TEG22/11/A3	**Conflict of Interest (Verbal)** No conflicts of interest were declared.	
TEG22/11/A4	**Requests for any other business (Verbal)** No items of other business raised.	
TEG22/11/A5	**CEO Update** The Chief Executive informed the group that since the last meeting the Integrated Care Board (ICB) had been formally established and held three meetings in public. The Board was focused on initiating the formal systems, procedures and setting up the ICB's subcommittees which included the Integrated Care Partnership Board, chaired by Oliver Coppard (South Yorkshire Mayor). The Chief Executive highlighted that the ICB was moving towards the implementation of the national strategies, which included the management of winter and looking at next year's plans in regard to finance and delivery of services. The Chief Executive referred to the Acute Federation (Federation of the Acute Trust in South Yorkshire) and pointed out that a lot of work was being done to try and achieve consistency. The Chief Executive gave the example of terms and conditions of service for staff and explained that reports were to be produced to reflect the systems and performance in each organisation for comparability. The Divisional Director for Clinical Specialties asked whether the collaboration work within the Acute Federation was voluntary. The Chief Executive explained that since July 2022, there was a statutory responsibility to collaborate, and organisations will be judged upon their efforts and work to do so. The Divisional Director for Children and Families raised the question of whether the ICB would be involved with emergency care provision.	

	The Chief Executive confirmed this and explained that the ICB are the commissioners for urgent care.	
	The Committee: - ***Noted the CEO Update***	
TEG22/11/B1	**<u>Risk Management Board Update</u>**	
	The Executive Medical Director explained that the KPMG internal audit identified concerns around the Trust's approach to the corporate risk register which led to some recommendations including a Risk Management Board to be established. The Executive Medical Director confirmed that the first Risk Management Board meeting had taken place on the 17th October 2022. The Executive Medical Director highlighted that the Board would be supported by working groups to work through the risk register. The Executive Medical Director added that the Risk Manager post had been appointed to with an expected start date of early December. The Chief Executive updated the group on the Chief Nurse post which was referred to within the papers. The Chief Executive confirmed that Karen Jessop would formally join the Trust as Chief Nurse on 9th January 2023 but until that date, Karen would be spending a few days over at the Trust to start her induction. The Chief Executive also remaindered the group that the new Chief Operating Officer, Denise Smith, would be formally joining the Trust on 2nd January 2023.	
	The Committee - ***Noted the*** **Risk Management Board Update**	
TEG22/11/C1	**<u>Clinical Update</u>**	
	The Executive Medical Director outlined the main points from the report sent out prior to the meeting and added that Alan Fletcher (National Medical Examiner) and Graham Cooper (Regional Medical Examiner) had visited the previous Friday and gave complementary feedback about the team. The Executive Medical Director also expressed thanks to the team. The Chief Executive suggested for the Hospital Standardised Mortality Ratio (HSMR) to be kept under review due to its importance towards performance. The Director of Corporate Affairs asked the Executive Medical Director whether figures from the HSMR are detailed further in any other meetings. The Executive Medical Director confirmed that this was included in the Mortality Governance Meeting. The Executive Medical Director explained he would check the terms of reference to ensure the meeting looked at the processes in detail.	
	The Committee - ***Noted the Clinical Update***	
TEG22/11/C2	**TENDABLE**	

	The Deputy Chief Nurse provided a brief explanation to TENDABLE following the presentation included within the pack. The Deputy Chief Nurse summarised by informing the group that results were starting to come through and the next step would be to embed this across Paediatrics and Midwifery to provide more evidence in terms of an internal and external perspective. The Director of Innovation & Infrastructure expressed her support for TENDABLE and explained the benefits for quality improvement within the organisation. The group showed support for TENDABLE.	
	The Committee - ***Noted the TENDABLE presentation***	
TEG22/11/C3	**<u>Finance Update</u>**	
	The Acting Director of Finance updated the group on the month 7 position and explained that we had a deficit in month of C.£900k which leads to a year-to-date deficit of C.£10.1million and added that we had already hit the planned deficit for this financial year. The Acting Director of Finance pointed out that the main pressure continued to be pay, which included the significant amount of temporary staffing and agency costs. The point was raised by the Acting Director of Finance that the treasury is looking into the NHS workforce increasing but there is an 8% reduction in activity taking place compared to pre-covid 2019-20. He added that this would be looked at internally as well as externally. The Acting Director of Finance ran through the ICB financial position and highlighted that the Mental Health Trusts are struggling, including RDaSH and Sheffield Health and Social Care. A part of their reasoning for the deficit was due to the pay award impact. The Acting Director of Finance raised the national issue of the deficit and explained the renewed focus to look at this year's financial position for the end of this financial year. The Acting Director of Finance raised that locally we were under significant scrutiny from the ICB and NHS England and informed the group that at a recent meeting Doncaster Place had been asked to put together a financial recovery plan. The Acting Director of Finance highlighted the importance of working towards this year's financial position due to a case being put forward for extra allocation of funding to DBTH. The case was with the ICB however we needed to have evidence of control and productivity. The Divisional Director for Children and Families raised the point of looking into SPA's for consultants as we could have more consultants on the ground, but their time is being spent doing other things rather than clinical work. The Chief Executive confirmed that issues like this one would be looked into around productivity and efficiency.	
	The Committee - ***Noted the Finance Update***	

TEG22/11/C4	**<u>Operational Update</u>**	
	The Chief Operating Officer raised the key messages from the presentation shared prior to the meeting. The Chief Executive highlighted the data on page 102 which showed the majority of patients being discharged after 4pm which leads to ambulances building up around the 6pm handover period. The Chief Executive outlined the issue of not discharging patients in the morning and suggested for a piece of work to be done around this to improve the process. The Divisional Director of Medicine showed support for this work and requested more capacity and support as a division in order to be able to address this thoroughly. The Chief Information Officer provided an update to the group on the patient tracking system and explained that the specification had been drafted and we would be going out to market towards the end of the week which would give us greater insight in terms of where our patients are, at any given time. The Chief Executive raised the issue around the BMA rate card and additional sessions. He confirmed that the Executive Medical Director had sent out a letter on behalf of the Trust Board confirming the discussions that had taken place. The Chief Executive raised the point that we do not have permission from NHS employers to enact the rate card issue which is subject to national negotiations. He added that we want to achieve consistency across the Trust, and we raised the amount we paid this year, by a factor the Board of Directors felt was reasonable. The Chief Executive summarised by expressing thanks to colleagues for their efforts and help with the activity.	
	The Committee: - ***Noted the Operational Update***	
TEG22/11/C5	**<u>People Update</u>**	
	The Chief People Officer provided the following updates: - As of 14 November, the staff survey response rate was at 60% - Appraisal season was complete with a completion rate of 83.43% - The new Equality, Diversity and Inclusion plan was in place following an action flagged by an audit - Flexible working – launched first conversation as part of this agenda - Leadership behaviours framework – Engagement with leaders and colleagues had begun The Director of Innovation & Infrastructure highlighted the efforts of the Estates and Facilities team on their appraisal and staff survey completion rate. The Chief Executive and Chief People Officer congratulated the team.	
	The Committee:	

	- ***Noted the People Update***	
TEG22/11/D1	**CIG Update**	
	The Acting Director of Finance took the paper as read and explained that the Clinical site case would be discussed at agenda point E5.	
	The Committee: - ***Noted the CIG Update.***	
TEG22/11/E1	**Strategy Update**	
	- MEOC The Director of Innovation & Infrastructure ran through the main points highlighted within the report and explained that useful workshops had taken place across the three organisations with a third meeting in the pipeline for when the Deputy Chief Executive returns from a period of annual leave. The Director of Innovation & Infrastructure informed the group that we were on track to complete the business case for the 30th November. - Sustainable trauma services The Director of Innovation & Infrastructure informed the group that since the previous update there had been a questionnaire circulated for feedback on the options appraisals and KPI measures being developed however the response rate was low. Therefore, further meetings took place to encourage a few more responses but there was still a lot of work to do. The Chief Executive suggested for the next steps to include the detailed work around what we think of the practical options and asked for the Director of Innovation & Infrastructure to confirm with James Nicholls the ask of today's meeting and what the next steps would be. - New DRI The Director of Innovation & Infrastructure informed the meeting that high level feedback had been received on the strategic outline case which was submitted in January. She added that there was yet to be a funding announcement however members from the original project team are to start working with DMBC who were given £6million of levelling up funding to begin to remediate the Basin site. - Service strategy and site strategy The Director of Innovation & Infrastructure explained there were no further updates on the service strategy. In regard to site strategy, the Director of Innovation & Infrastructure confirmed that the working group membership had been agreed and informed the group of the three phases to develop: - Securing our second emergency site for South Yorkshire - To set the direction for the core emergency services at Bassetlaw	

	- Optimising the distribution of elective services	
	The Committee: - ***Noted the Strategy Update***	
TEG22/11/E2	**<u>Innovation Update</u>**	
	The Director of Innovation & Infrastructure summarised the points from within the report and explained that the business case was due for the wider directorate to go to CIG in December which will include a request for four Qi business partners to enable Qi on a regular and daily basis.	
	The Committee: - ***Noted the Innovation Update***	
TEG22/11/E3	**<u>Capital Update</u>**	
	The Director of Innovation & Infrastructure highlighted the RAAC programme on-going at Bassetlaw and provided an update. She informed the group of the risk due to Notts Mental Health experiencing difficulty in relocating two of their mental health wards that were due to vacate mid-November. The Director of Innovation & Infrastructure flagged issues relating to the Vanguard theatres and explained a further meeting was taking place that evening to speak to colleagues about the changes to the temporary modular theatre. The Breast, Vascular, Urology and Gastrointestinal Clinical Director expressed the issue of lack of communication and teamwork to what was going to happen. The Chief Executive summarised by highlighting a meeting which was taking place later that day with the Chief Operating Officer and other colleagues to discuss and resolves the issues. The Chief Information Officer referred to the contingency plans in place for the digital projects and added that he would be attending the National EPR Investment Board the following week. The Chief Executive noted that business cases approved as part of this year's plan would be taken forward but cases that needed approving and funding for next year would go onto the list for cost pressure funding as we do not know what funding we have for next year.	
	The Committee: - ***Noted the Capital Update***	
TEG22/11/E4	**<u>Clinical Site Management Team model</u>**	
	The Chief Operating Officer explained that this was the second time the case had come to this group following an update to the case with more affordable levels. He confirmed that CIG had approved the case and it was asked for the case to be brought to TEG for	

	overall approval. The Chief Operating Officer highlighted the team and himself recommended and support Option 3. The Chief Executive and Chief People Officer pointed out that the circulated paper hadn't been updated from a previous version. The Acting Director of Finance suggested the benefits also need to be quantified and tracked and expressed concern around the cost pressure. The Chief Executive summarised by explaining the case needed further work on the key points that had been raised previously so that the case could be demonstrated as a key priority. The group agreed for a robust plan for winter to go ahead and for more work to be done on the expected outcomes and resolving issues before approving the case.	
	The Committee: - ***Noted the Clinical Site Management Team model and agreed for further work to be done on developing the case.***	
TEG22/11/F1	**<u>Education and Research Update</u>**	
	The Director of Education and Research asked for TEG members volunteer to become Health Career Ambassadors to help with growing out workforce and engage with the local citizens and explained this would be launched on 2nd and 9th December. The Director of Education and Research explained that she was working with the communications team following learners coming into the organisation that weren't known about and reinforced the message that all learners must go through the Education team. The Director of Education and Research put forward the new Research and Innovation Strategy and asked for the groups approval on the strategy which would be followed by a detailed work plan and full business case. The group approved the strategy.	
	The Committee: - ***Noted the Education and Research Update and approved the Research and innovation Strategy***	
TEG22/11/G1	**<u>ICS Update</u>**	
	Th Chief Executive provided an update on development of technology within the Executive Steering Board (ESB) which oversees the provision of South Yorkshire and Bassetlaw Pathology Services. The Chief Executive explained that the issue of the LIMS had been considered and the ESB supported for a final business case to be developed to determine and demonstrate that Cerner LIMS would produce value for money.	
TEG22/11/H1	**<u>Place Update</u>**	

	Update provided within agenda item A5.	
TEG22/11/I1	**Any other Business (Verbal)**	
	None.	
TEG22/11/I2	**Digital Maternity Strategy**	
	The Chief Executive referred to the strategy for the group to note as the strategy had been approved.	
	The Committee: - ***Noted the Digital Maternity Strategy***	
TEG22/11/I3	**Staff Side Budget**	
	The Chief People Officer explained that the recommendation from the paper had been approved.	
	The Committee: - ***Noted the Staff Side Budget***	
TEG22/11/I4	**Minutes of the Trust Executive Group meeting dated Monday 12th September 2022**	
	The Committee: - ***Noted and approved the minutes of the meeting dated Monday 12th September 2022.***	
TEG22/11/I5	**Date and time of next meeting (Verbal)**	
	Date: Monday 12th December 2022 Time: 14:00 – 17:00 Venue: Via Microsoft Teams	
	The meeting closed at: 16:56	

Final

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

TRUST EXECUTIVE GROUP

Minutes of the Meeting of the Trust Executive Group
Held on Monday 12th December 2022 @ 2pm via Microsoft Teams

Present:	Anurag Agrawal - Divisional Director – Medicine Ken Anderson - Chief Information Officer Alex Crickmar - Acting Director of Finance Sam Debbage - Director of Education & Research Fiona Dunn - Director of Corporate Affairs / Company Secretary Antonia Durham-Hall - Divisional Director – Surgery and Cancer Kirsty Edmondson-Jones - Director of Innovation & Infrastructure Eki Emovon - Divisional Director - Children and Families Zoe Lintin - Chief People Officer Richard Parker – Chief Executive (Chair) Dr Tim Noble - Executive Medical Director Jon Sargeant - Interim Director of Recovery, Innovation & Transformation Jochen Seidel – Divisional Director for Clinical Specialties	
In attendance:	Laura Brookshaw - 360 Assurance Simon Brown – Deputy Chief Nurse Karen McAlpine – Deputy Chief Operating Officer Katie Michel – PA to the Chief Executive (Minutes) Adam Tingle - Acting Director of Communications and Engagement	
Apologies:	Kirsty Clarke – Deputy Chief Nurse George Briggs - Interim Chief Operating Officer Nick Mallaband - Medical Director for Workforce and Specialty Development Howard Timms - Acting Operational Director of Estates and Facilities	
		ACTION
TEG22/12/A0	**Internal Audit Acton Log Update** Laura Brookshaw, 360 Assurance, outlined the main points within the report sent out prior to the meeting and highlighted the outstanding actions to be completed.	
	The Committee: - ***Noted the Internal Audit Action Log Update***	
TEG22/12/A1	**Welcome and Apologies for Absence (Verbal)**	
	The Chief Executive welcomed members and those in attendance; the above apologies for absence were noted. He also explained that due to the operational demand in the Trust the meeting would be for urgent business only.	
TEG22/12/A2	**Matters Arising / Action Log**	

	There were no actions outstanding.	
TEG22/12/A3	**<u>Conflict of Interest (Verbal)</u>** No conflicts of interest were declared.	
TEG22/12/A4	**<u>Requests for any other business (Verbal)</u>** No items of other business raised.	
TEG22/12/A5	**<u>CEO Update</u>** The Chief Executive explained that the development work continued with the Integrated Care Board (ICB) following a positive federation event the previous week which included and involved senior clinical leaders in discussions around next steps.	
	The Committee: - ***Noted the CEO Update***	
TEG22/12/B1	**<u>Risk Management Board Update</u>**	
	The Chief Executive highlighted to the group that the Risk Management Board had been established and emphasised the importance the continuing Board. The Director of Corporate Affairs added that Tracy Evans-Phillips had started in the Risk Management role.	
	The Committee - ***Noted the*** **Risk Management Board Update**	
TEG22/12/B2	**<u>Civica Declare</u>**	
TEG22/12/B2	The Director of Corporate Affairs informed the group that Civica Declare for declarations of interest, hospitalities, gifts, sponsorships etc. had gone live on 1st December 2022 and decision makers had received direct emails to enable access. She also requested that the information was cascaded to all divisions.	
	The Committee - ***Noted the Civica Declare Update***	
TEG22/12/C1	**<u>Clinical Update</u>**	
	The Chief Executive made reference to a clinical engagement visit with the CQC relationship partners that was taking place the next day. He highlighted the issues of concerns raised in respect of whistleblowing activity related to ED pressures and the serious incidents that had been declared.	
	The Committee - ***Noted the Clinical Update***	

TEG22/12/C2	**<u>Finance Update</u>**	
	The Acting Director of Finance provided a brief overview of the financial position and explained the Trust was £1million off plan, Year to Date. The Acting Director of Finance also emphasised the challenges for the next financial year. The Acting Director of Finance explained that he would run through the forecast at the next meeting.	
	The Committee - ***Noted the Finance Update***	
TEG22/12/C3	**<u>Operational Update</u>**	
	The Chief Executive made reference to the continued slow progress within the performance areas and highlighted that we weren't where we wanted to be.	
	The Committee: - ***Noted the Operational Update***	
TEG22/12/C4	**<u>People Update</u>**	
	The Chief People Officer thanked the group for encouraging staff to compete the staff survey and explained that 65% of staff had done so which was a positive achievement. The Chief Executive referred to the paper on NHSP incentives sent out to the group for information. The Chief People Officer took the paper as read and explained that the recommendation was option 2 and asked the group for their approval The group approved option 2.	
	The Committee: - ***Noted the People Update and gave approval for option 2 on the NHSP Incentives paper***	
TEG22/12/D1	**<u>CIG Update</u>**	
	The Acting Director of Finance explained there were no items escalated to the group. The Chief Executive updated the group on the EPRR programme and the Chief Information Officer explained that the outline business case put forward by the Trust had been approved by the EPR investment board and work was continuing on the full business case.	
	The Committee: - ***Noted the CIG Update.***	

TEG22/12/E1	**<u>Strategy Update</u>**	
	The Interim Director of Recovery, Innovation & Transformation informed the meeting that the Montagu Elective Orthopaedic Centre case had finished and was due at the next Capital Investment Group meeting. He added that the aim was for the case to be approved and signed off within this financial year.	
	The Committee: - ***Noted the Strategy Update***	
TEG22/12/E2	**<u>Innovation Update</u>**	
	No further update.	
	The Committee: - ***Noted the Innovation Update***	
TEG22/12/E3	**<u>Capital Update</u>**	
	No further update.	
	The Committee: - ***Noted the Capital Update***	
TEG22/12/E4	**<u>Leader Toolkit</u>**	
	The Interim Director of Recovery, Innovation & Transformation explained that due to time pressures, information would be sent around on the Leader Toolkit in the new year.	
	The Committee: - ***Noted the Leader Toolkit Update***	
TEG22/12/F1	**<u>Education and Research Update</u>**	
	The Director of Education and Research requested approval from the group for the following papers: - Acuity SOP for Education and Research staff - New Education Framework - Reduction in SET awareness topics The group approved the three recommendations.	
	The Committee: - ***Noted the Education and Research Update and approved the recommendations***	

TEG22/12/G1	**ICS Update**	
	The Chief Executive informed the group that the first Integrated Care System quality review meeting the previous week which was an ask of the ICS Chief Executive, Medical Director and Chief Nurse to discuss the ED pressures and also challenges within maternity. The Chief Executive reminded the group that he was Chair of the Local Maternity and Neonatal System and explained that a one-topic meeting was being arranged to discuss diverts in maternity services.	
TEG22/12/H1	**Place Update**	
	No further update.	
TEG22/12/I1	**Any other Business (Verbal)**	
	The Divisional Director for Clinical Specialties asked the group which forum he should direct questions to regarding longer term reconfiguration of services across sites as currently this sat within the Annual Planning Cycle. The Interim Director of Recovery, Innovation & Transformation explained that a piece of work was being done on site strategies which would be brought to the Trust Executive Group in the new year. The Chief Executive made reference to a meeting hold that had been sent out for 8th February 2023 and explained that the time was to be used to looking at the challenges and priorities going forward.	
TEG22/12/I2	**Minutes of the Trust Executive Group meeting dated Monday 14th November 2022**	
	The Committee: - ***Noted and approved the minutes of the meeting dated Monday 14th November 2022.***	
TEG22/12/I3	**Date and time of next meeting (Verbal)**	
	Date: Monday 9th January 2022 Time: 14:00 – 17:00 Venue: Via Microsoft Teams	
	The meeting closed at: 14:43	

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 20 December 2022 at 09:30 via MS Teams

Present:
Mark Bailey - Non-executive Director
Suzy Brain England OBE - Chair of the Board (Chair)
Hazel Brand - Non-executive Director
George Briggs - Interim Chief Operating Officer
Alex Crickmar, Acting Director of Finance
Zoe Lintin - Chief People Officer
Dr Tim Noble - Executive Medical Director
Richard Parker OBE - Chief Executive
Neil Rhodes - Non-executive Director
Jon Sargeant - Interim Director of Recovery, Innovation & Transformation
Kath Smart - Non-executive Director

In attendance:
Fiona Dunn - Director of Corporate Affairs / Company Secretary
Angela O'Mara - Deputy Company Secretary (Minutes)
Lois Mellor - Director of Midwifery
Amy Lee - Senior Communications & Engagement Officer

Public in attendance:
Peter Abell - Public Governor Bassetlaw
Rob Allen - Staff Side
Andria Birch – Partner Governor
George Kirk – Public Governor Doncaster
Andrew Middleton - Public Governor Bassetlaw
Lynne Schuller - Public Governor Bassetlaw
Mandy Tyrrell – Staff Governor
Sheila Walsh - Public Governor Bassetlaw

Apologies:
Mark Day - Non-executive Director
Jo Gander - Non-executive Director

P22/12/A1 **Welcome, apologies for absence and declaration of interest (Verbal)**

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

P22/12/A2 **Actions from Previous Meetings (Enclosure A2)**

All actions were closed, received for completeness.

The Board:

- ***Noted the action log.***

P22/12/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) 10.

The Director of Midwifery shared learning from the recently received HSIB reports, which included the use of aspirin in early pregnancy and availability and access to interpreter services.

Hazel Brand highlighted the lack of reference to Bassetlaw Hospital on the Nottingham & Nottinghamshire Maternity Voices website, in view of the complexity of the Trust spanning two integrated care systems the Director of Midwifery agreed to feed into the Local Maternity and Neonatal System (LMNS) to establish clear and appropriate signposting of the service.

In response to a question from Mark Bailey, the Director of Midwifery confirmed that work on the Serenity Suite was expected to commence in January 2023, and had been delayed due to contractor availability.

As part of a recent walkabout with the non-executive maternity champion, the Executive Medical Director reported his observations of an enthusiastic and committed team, who, despite challenges, had made significant quality improvements to patient care.

The Board

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

P22/12/B2 **Mortality Measures (Enclosure B2)**

The Executive Medical Director confirmed that the Trusts monitoring of Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) metrics had highlighted an elevated mortality rates which had triggered the need for a more detailed investigation. Whilst an increase in mortality rates had been seen nationally it was important that the Trusts position was analysed robustly.

The Executive Medical Director confirmed that the planned approach would also include a review of the Medical Examiner processes, including the selection process for Structured Judgement Reviews (SJR), a peer review of mortality rates, clinical coding, and data analysis. The review would be undertaken as soon as possible, and the conclusions were expected to be presented to the March Board at the latest.

In response to a question from Hazel Brand, the Executive Medical Director confirmed that the terms of reference for the working group would be completed and would support completion of the investigation by the end of Q4 2022/23.

The Chief Executive informed the Board that the data analysis would be externally reviewed to provide additional assurance. Kath Smart welcomed the proactive approach and reinforced the importance of independent oversight.

The outcome of the investigation would be reported via Mortality Governance, the Quality & Effectiveness Committee and Board.

The Board:

- ***Noted the Mortality Measures***

P22/12/C1 **Winter Plan Update including Ambulance Handovers (Enclosure C1)**

The Interim Chief Operating Officer reported a slightly improved ambulance handover position, with continued weekly improvements seen over the last six to eight weeks. This has been positively impacted by a threefold increase in the number of patients seen in the Early Assessment Unit. Whilst this improvement was encouraging there was a need to deliver continued and significant improvements to the overall wait times.

Kath Smart confirmed the scrutiny of operational performance at the Finance & Performance Committee and welcomed the current quality improvement work and planned wider support from NHSE's Emergency Care Improvement Support Team.

Neil Rhodes supported the multi-faceted approach to improve provision, and in response to his question regarding the previously reported increase attendance in minors, the Interim Chief Operating Officer confirmed 90% of patients in the minor streams were now being discharged within the 4-hour standard.

The Chief Executive highlighted the direct correlation between ambulance handover delays and bed occupancy and with reduced flow out of the organisation the Trust continued to operate at up to 98% bed occupancy. Additional winter beds had already been opened and the importance of taking all opportunities to optimise internal efficiencies and to work collaboratively with partners at Place and across the system was reinforced.

The Board:

- ***Noted and took assurance from Winter Plan Update including Ambulance Handovers***

P22/12/C2 **Industrial Action Update (Enclosure C2)**

The Interim Chief Operating Officer confirmed ambulance service industrial action would take place on 21 December 2022. Planning meetings at a local, regional and national level were taking place and the situation was being managed via Gold Command. A potential second day of strike action had been declared on 28 December and whilst lessons could be learnt from day one, the timing between the Christmas and New Year period was expected to be more challenging. Both Yorkshire and the East Midlands Ambulance Services had declared industrial action and confirmed service provision by category. Internal plans to support reduced service provision and the need to facilitate handovers within 15 minutes had been agreed. Plans with partners had been made and the support of the operational team and the Board made available.

The Chief People Officer confirmed that whilst the Trust had not met the threshold for strike action by members of the Royal College of Nursing, the impact of neighbouring trust's action could not be ruled out in the future. Open relationships had been maintained with Staff side throughout this period.

The Chief Executive brought the Board's attention to the upcoming ballot of medical staff, including junior doctors and noted the potential for a different outcome.

Hazel Brand informed the Board of an article in today's press which indicated the likelihood of extensive strike action in 2023, the Interim Chief Operating Officer acknowledged this but was hopeful that a resolution between the government and unions would be reached. Should that not be the case, the impact on emergency and elective services was recognised.

The Chief Executive shared with Board the increased prevalence of Covid and Influenza A and promoted increased infection prevention and control measures, including hands, face, space, and ventilation, and sought public support in adhering to these preventative steps alongside of community support for the preventative vaccination programmes. Operational challenges were expected over the Christmas period and the Chief Executive formally recorded his thanks for colleagues' hard work and commitment in ensuring the system worked as efficiently and effectively as possible.

As this was the Interim Chief Operating Officer's last meeting, the Chair of the Board expressed her appreciation and that of fellow Board members and wished him well for the future.

The Board:

- ***Noted and took assurance from the Industrial Action Update.***

P22/12/C3 **Mexborough Elective Orthopaedic Centre (MEOC) Outline Business Case (Enclosure D1)**

The Interim Director of Recovery, Innovation & Transformation shared with Board the Mexborough Elective Orthopaedic Centre Outline Business Case.

The case was an example of collaborative working between the Trust, The Rotherham NHS Foundation Trust and Barnsley Hospital NHS Foundation Trust to deliver an orthopaedic elective service, unaffected by winter and emergency pressures, at the Trust's Montagu site and in line with the Elective Recovery Plan.

The model had been agreed by all three organisations, in accordance with Getting It Right First Time standards and best practice from existing successful surgical hubs.

The key risks to delivery were highlighted, which included the inability to recruit the required workforce and the potential for this to impact on delivery and subsequent income.

The case had been considered at Place, by the Integrated Care Board and the Finance and Performance Committee, with Board approval being sought by all three organisations. In order to secure the fixed price quotation, the order had to be placed by the end of February 2023, with a view to construction commencing in April and completion and a go live date in late October 2023.

The Chief Executive confirmed his support, the case had been discussed by the Acute Federation Chairs and Chief Executives and presented an excellent collaborative opportunity to develop a centre of excellence to support activity on a "cold site", where emergency and operational pressures would not impact delivery.

The Chair of the Finance & Performance Committee shared his appreciation of the well-developed case which had been constructed over a number of months and scrutinised by the Committee. He acknowledged the unique opportunity to develop the site, a valuable addition to service provision and a good news story for Mexborough. The ambitious programme received his full support.

In response to a question from the Chair of the Board, the Interim Director of Recovery, Innovation & Transformation confirmed more work was required on the workforce strategy which would consider a range of options, including a dedicated workforce, staff rotation or a hybrid model. The Chief People Officer confirmed the development of plans would be progressed across all three organisations and was expected to evolve as the clinical model developed. The Centre provided a positive recruitment opportunity and would support the Trust's development as an employer of choice.

In respect of the expected level of productivity and in response to a question from the Chair of the Board, the Director of Recovery, Innovation & Transformation confirmed that the model achieved an increased level of productivity, in line with GIRFT standards and had been subject to clinical engagement. Whilst the business case had been prepared on that basis, the potential for further future efficiencies was recognised.

The Board confirmed its unanimous support and approval of the business case; approval would now be sought from The Rotherham NHS Foundation and Barnsley Hospital NHS Foundation Trust's Board of Directors.

The Board:

- ***Approved the Mexborough Elective Orthopaedic Centre Outline Business Case***

P22/12/D1 **Any other business (to be agreed with the Chair prior to the meeting)**

No items of other business were raised.

P22/12/D2 **Governor Questions regarding the business of the meeting (10 minutes) ***

The Lead Governor welcomed the Mexborough Elective Orthopaedic Centre Business Case and shared her appreciation of the extensive preparatory work.

The following questions had been received from governors:

"Accepting that abnormal circumstances continue to impact services, nevertheless training completion rates are an ongoing concern. A particular example is the Practical Obstetrics Multi-Professional Training (PROMPT) data, especially for some clinical leadership groups. What further steps can be taken to improve completion rates?"

A full explanation of actions had been provided previously by the Director of Midwifery at the Quality & Effectiveness Committee and at Board and completion of training continued to be a priority, with all steps taken to facilitate training opportunities.

"The Executive Medical Director reports high mortality rates, and appropriately, the establishment of a working group for deeper understanding. Is there merit in inviting an external expert to join this group?"

The Chief Executive had reported external assurance of the review would take place and terms of reference for the working group would be developed imminently by the Executive Medical Director.

On behalf of the Council of Governors, the Lead Governors shared governors' appreciation for colleagues' hard work and commitment throughout the year.

The Board:

- ***Noted the governor questions.***

P22/12/D3 Minutes of the meeting held on 29 November 2022 (Enclosure D3)

The Board:

- Approved the minutes of the meeting held on 29 November 2022.

P22/12/D4 Date and time of next meeting (Verbal)

Date: Tuesday 31 January 2023
Time: 09:30am
Venue: MS Teams

P22/12/D5 Withdrawal of Press and Public (Verbal)

The Board:

- ***Resolved that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.***

P22/12/E Close of meeting (Verbal)

The meeting closed at 10.51