Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD MEETING - PUBLIC (REDUCED AGENDA)

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31 October 2023

09:30 GMT Europe/London

Virtual -TEAMS

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AGENDA

- 2310 - A Meeting Business 1
  - 00 Public Board Agenda - 31 October 2023 v5.pdf 2
  - 2310 - A1 Welcome, apologies for absence and declarations of interest (09:30) 5
    - A1 - Register of Interests & FPP (17.10.23).pdf 6
  - 2306 - A2 Actions from previous meeting 9
- 2310 - B True North SA1 - QUALITY AND EFFECTIVENESS 10
  - 2310 - B1 Chair's Assurance Log - Quality & Effectiveness Committee (09:35) 11
    - B1 - Chair's Assurance Log - Quality & Effectiveness Committee.pdf 12
  - 2310 - B2 Midwifery & Neonatal Update (09:40) 13
    - B2 - Maternity & Neonatal Update.pdf 14
    - B2 - Perinatal Surveillance Dashboard.pdf 25
    - B2 - Glossary of Terms - Maternity.pdf 30
  - 2310 - B3 Midwifery Workforce (09:50) 32
    - B3 - Midwifery Workforce.pdf 33
- 2310 - C True North SA4 - FINANCE AND PERFORMANCE 42
  - 2310 - C1 Chair's Assurance Log - Finance & Performance Committee (10:00) 43
  - 2310 - C2 Finance Update (10:05) 44
    - C2 - Finance Update - Month 6.pdf 45
- 2306 - D GOVERNANCE, ASSURANCE & STRATEGY 51
  - 2310 - D1 True North, Breakthrough & Corporate Objectives Q2 2023/24 (10:15) 52
    - D1 - True North, Breakthrough & Corporate Objectives Q2 2023-24.pdf 53
    - D1 - Appendix 1 Q2 Executive Objectives.pdf 58
  - 2310 - D2 Board Assurance Framework (Risks 1-7) & Trust Risk Register 15+ (10:25) 64
    - D2 - Board Assurance Framework.pdf 65
    - D2 - Appendix 1 BAF (Risks 1-7).pdf 68
    - D2 - Appendix 2 Trust Risk Report 15+.pdf 82
  - BREAK - 10:50 - 11:00 96
  - 2310 - D3 Chair's Assurance Log - Audit & Risk Committee (11:00) 97
    - D3 - Chair's Assurance Log - Audit & Risk Committee.pdf 98
  - 2310 - D4 Chair's Assurance Log - Charitable Funds Committee (11:05) 100
    - D4 - Chair's Assurance Log - Charitable Funds Committee.pdf 101
  - 2310 - D5 Charitable Funds Policy & Committee Terms of Reference (11:10) 102

D5 - Charitable Funds Policy & Terms of Reference.pdf 103
D5 - Draft Charitable Funds Policy V5..pdf 105
D5 - Draft Charitable Funds TOR October 2023.pdf 129
- 2310 - D6 Review of Risk Identification, Assessment and Management Policy (11:15) 133
D6 - Review of Risk Identification, Assessment & Management Policy.pdf 134
D6 - Risk Policy v5 DRAFT v3 - final.pdf 136
- 2310 - D7 Use of Trust Seal (11:40) 166
D7 - Use of Trust Seal.pdf 167
• 23010 - E OTHER ITEMS 169
- 2310 - E1 - Any other business (to be agreed with the Chair prior to the meeting) (11:45) 170
- 2310 - E2 Governor Questions regarding the business of the meeting * (11:50) 171
- 2310 - E3 Minutes of the Meeting held on 26 September 2023 (12:00) 172
E3 - Draft Public Board Minutes - 26 September 2023.pdf 173
- 2310 - E4 DBTH Self-certification - Protecting & Expanding Elective Activity 187
E4 - DBTH Protecting and Expanding Elective Capacity.pdf 188
E4 - Appendix DBTH Self Certification Protecting and Expanding Elective Capacity FINAL SBE-RP signed.pdf 191
- 2310 - E5 Date and Time of Next Meeting (11:10) 194
• MEETING CLOSE (11:10) 195

2310 - A MEETING BUSINESS

Suzy Brain England OBE, Chair

REFERENCES

Only PDFs are attached

00 Public Board Agenda - 31 October 2023 v5.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting Held in Public
To be held on Tuesday 31 October 2023 at 09:30
Via MS Teams

Enc		Purpose	Time
A	**MEETING BUSINESS**		**09:30**
A1	Welcome, apologies for absence and declarations of interest *Suzy Brain England OBE, Chair* *Members of the Board and others present are reminded that they are required to declare any pecuniary or other interests which they have in relation to any business under consideration at the meeting and to withdraw at the appropriate time. Such a declaration may be made under this item or at such time when the interest becomes known* *Members of the public and governor observers will have both their camera and microphone disabled for the duration of the meeting*		5
A2	Actions from previous meeting (no active actions) *Suzy Brain England OBE, Chair*	*Review*	
B	**True North SA1 - QUALITY AND EFFECTIVENESS**		**09:35**
B1	Chair's Assurance Log – Quality & Effectiveness Committee *Jo Gander, Non-executive Director*	*Assurance*	5
B2	Maternity & Neonatal Update *Lois Mellor, Director of Midwifery*	*Assurance*	10
B3	Midwifery Workforce *Lois Mellor, Director of Midwifery*	*Assurance*	10
C	**True North SA4 – FINANCE & PERFORMANCE**		**10:00**
C1	Chair's Assurance Log – Finance & Performance Committee *Mark Day, Non-executive Director*	*Assurance*	5
C2	Finance Update *Jon Sargeant, Chief Financial Officer*	*Assurance*	10
D	**GOVERNANCE, ASSURANCE & STRATEGY**		**10:15**
D1	True North, Breakthrough and Corporate Objectives Q2 2023/2024 *Richard Parker OBE, Chief Executive*	*Discuss*	10

D2	Board Assurance Framework (Risks 1 – 7) Trust Risk Register 15+ (as reference for the above item) *Zara Jones, Deputy Chief Executive* *Executive Directors*	*Assurance*	25
BREAK 10:50 – 11:00			
D3	Chair's Assurance Log – Audit & Risk Committee *Kath Smart, Non-executive Director*	*Assurance*	5
D4	Chair's Assurance Log – Charitable Funds Committee *Hazel Brand, Non-executive Director*	*Assurance*	5
D5	Charitable Funds Committee Policy & Terms of Reference *Angela O'Mara, Deputy Company Secretary*	*Approve*	5
D6	Review of Risk Identification, Assessment and Management Policy *Angela O'Mara, Deputy Company Secretary*	*Approve*	5
D7	Use of Trust Seal *Angela O'Mara, Deputy Company Secretary*	*Assurance*	5
E	**OTHER ITEMS**		**11:25**
E1	Any other business (to be agreed with the Chair prior to the meeting) *Suzy Brain England OBE, Chair*	*Discussion*	5
E2	Governor questions regarding the business of the meeting (10 minutes)* *Suzy Brain England OBE, Chair*	*Discussion*	10
E3	Minutes of the meeting held on 26 September 2023 *Suzy Brain England OBE, Chair*	*Approval*	5
E4	DBTH Self-certification Protecting & Expanding Elective Activity *Denise Smith, Chief Operating Officer*	*Information*	
E5	**Date and time of next meeting:** **Date:** Tuesday 23 November 2023 **Time:** 09:30 **Venue:** MS Teams	*Information*	
F	**MEETING CLOSE**		**11:45**

*Governor Questions

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

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

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

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

Suzy Brain England OBE
Chair of the Board

2310 - A1 WELCOME, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST

Suzy Brain England OBE, Chair 09:30

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

REFERENCES

Only PDFs are attached

A1 - Register of Interests & FPP (17.10.23).pdf

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
Register of Directors' Interests

Register of Interests

Suzy Brain England OBE, Chair of the Board

Chair at Keep Britain Tidy
Lead Examiner for Chartered Director by the Institute of Directors
Founder and Chair of Cloud Talking, Aspirational Mentoring
Co-opted Board member Doncaster Chamber of Commerce
Trustee of NHS Retirement Fund (until October 2023)
Advisory Committee on Clinical Impact Awards (ACCIA)
Facilitate/Chair NHS Providers training & development session as required

Kath Smart, Non-Executive Director

Chair – Acis Group, Gainsborough (Housing provider)
Court Secretary – Foresters Friendly Society, Sheffield (Mutual Society)
Senior Trust Associate Manager (TAM – or 'Hospital Manager' under the Mental Health Act) – Rotherham, Doncaster & South Humber NHS FT

Mark Bailey, Non-Executive Director

Non-Executive Chair, Doncaster and Bassetlaw Healthcare Services Ltd
Non-Executive Director – Derbyshire Community Health Services Foundation Trust
Executive Coach – NHS Leadership Academy (voluntary)
Non-Executive Director for MEDQP Ltd (Voluntary)

Jo Gander, Non-Executive Director

Managing Director Gander Healthcare Solutions (Dormant business)
Membership of Advisory Committee on Clinical Impact Awards (ACCIA) Yorkshire and Humber Sub-Committee

Mark Day , Non-Executive Director

Health Development Director, Equity Solutions Group - (Investment and development organisation that specialises in partnerships with the public sector and the Design, Build, Finance and Operation (DBFO) of bespoke buildings)
Non-Executive Chair, Summerhill Service Limited (SSL)- SSL is a wholly owned subsidiary of Birmingham and Solihull Mental Health NHS Foundation Trust providing a range of support services to the Trust and other customers

Hazel Brand , Non-Executive Director

Councillor, Bassetlaw District Council (independent) In this role, member of the Council's Appointments and Planning Committees
Parish Councillor, Misterton

Lucy Nickson , Non-Executive Director

Chief Executive for Day One Trauma Support, national charity

(as at 17th October 2023)

Richard Parker OBE, Chief Executive Officer
Member of the South Yorkshire Integrated Care Board
Spouse is a senior Nurse at Sheffield Health and Social Care Trust

Dr Tim Noble, Executive Medical Director
Spouse is a Consultant Physician at DBTH

Jon Sargeant, Interim Director of Recovery, Innovation & Transformation
Director, Doncaster and Bassetlaw Healthcare Services Ltd

Zoe Lintin, Chief People Officer
Trustee on the Board of Sheffied Academy Trust
Spouse works in NHS (STH)

Denise Smith, Chief Operating Officer
Various family members work in NHS. None working in SYB network

Emma Shaheen, Director Communication & Engagement
Sister is Deputy Director of Involvement, South Yorkshire ICB

Fiona Dunn, Director Corporate Affairs/Company Secretary
Animal Ranger, Yorkshire Wildlife Park

The following have no relevant interests to declare:

Karen Jessop	Chief Nurse
Emyr Jones	Non-Executive Director
Zara Jones	Deputy Chief Executive
Nick Mallaband	Acting Executive Medical Director

(as at 17th October 2023)

Fit and Proper Person Declarations

The Trust can confirm that every director currently in post has declared that they:

(i) am not an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged;

(ii) am not the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;

(iii) am not a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986;

(iv) have not made a composition or arrangement with, or granted a trust deed for, my creditors and not been discharged in respect of it;

(v) have not within the preceding five years been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on me;

(vi) am not subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986;

(vii) have the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which I am employed;

(viii) am able by reason of my health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which I am appointed or to the work for which I am employed;

(ix) have not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity;

(x) am not included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland; and

(xi) am not prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

Directors are requested to note the above and to declare any changes to their position as appropriate in order to keep their declaration up to date.

(as at 17th October 2023)

2306 - A2 ACTIONS FROM PREVIOUS MEETING

Decision Item

Suzy Brain England OBE, Chair

5 minutes

2310 - B TRUE NORTH SA1 - QUALITY AND EFFECTIVENESS

2310 - B1 CHAIR'S ASSURANCE LOG - QUALITY & EFFECTIVENESS COMMITTEE

Discussion Item | Jo Gander, Non-Executive Director | 09:35

5 minutes

REFERENCES

Only PDFs are attached

B1 - Chair's Assurance Log - Quality & Effectiveness Committee.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Quality & Effectiveness Committee - Chair's Highlight Report to Trust Board

Subject:	**Quality & Effectiveness Committee Meeting**	**Board Date:** October 2023
Prepared By:	Jo Gander, Committee Chair & Non-executive Director	
Approved By:	Quality & Effectiveness Committee Members	
Presented By:	Jo Gander, , Committee Chair & Non-executive Director	
Purpose	The paper summaries the key highlights from the Quality & Effectiveness Committee meeting held on 3rd October 2023	

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Ongoing concerns regarding the status of clinical audit and governance structure. Deep dive requires rescheduling due to MD absence. This is being arranged asap following QEC. • The Audit & Effectiveness Annual report update, along with Mortality Data assurance group report and action plan - currently 'work in progress' due to MD absence. • Concerns are escalating around the ability of DBTH to be fully compliant with CNST standards by December '23 - quality and safety implications as well as financial and reputational impact of non-compliance.	• Formal reporting on 'lessons learned' across clinical portfolios to be agreed along with examples of how these have been integrated into service delivery/policy as appropriate. • Three-year delivery plan for Maternity and Neonatal services progress noted through Maternity & Neonatal Transformation report. • Quality Accounts & Quality Measures to be confirmed across the organisation as reporting currently implies this is limited to the Chief Nurse portfolio, for review once guidance received from NHSE on recommended approach. • Agreement on how Quality measure will be referred between other Sub Committees of the Board and QEC to be confirmed e.g., GIRFT/Virtual Wards
Positive Assurances to Provide	**Decisions Made**
• Presentation on Equality and Equity in Midwifery received which outlined insights gained to date and next steps in developing plans to address identified health inequalities along with improving access to services for this cohort of patients. • Assurance gained from Chief Nurse report for Quality & Patient Safety. • QEC received and noted: Patient Experience and Involvement annual report, Safeguarding annual report and Infection Prevention and Control annual report. • QEC noted good progress on closure of complaints to agreed timescales.	• Deep Dive to be rescheduled urgently between Executives and NEDs relating to Clinical Audit delivery in response to the limited assurance received from 360 Assurance report. Agenda to cover delivery plan to deliver recommendations outlined in 360 Assurance report, Clinical Quality Governance structure, TOR for CGC and Audit & Effectiveness Forum, process for ensuring reliability and validity of audit results and any risks associated with current non-compliance. • Audit & Effectiveness Annual Report and Mortality action plan deferred until December's QEC. • Recommendation from Chief Nurse in relation to overdue serious incident actions being defined at agreed deadline date rather than 3 months post deadline approved by the committee. Acknowledging the risk that in the short term this will increase the overdue numbers. • Patient Safety Incident Response Plan approved.

2310 - B2 MIDWIFERY & NEONATAL UPDATE

Discussion Item | Lois Mellor, Director of Midwifery | 09:40

10 minutes

REFERENCES

Only PDFs are attached

- B2 - Maternity & Neonatal Update.pdf
- B2 - Perinatal Surveillance Dashboard.pdf
- B2 - Glossary of Terms - Maternity.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	31 October 2023	**Agenda Reference:**	**B2**
Report Title:	**Maternity & Neonatal Update**		
Sponsor:	Karen Jessop, Chief Nurse		
Author:	Lois Mellor, Director of Midwifery Laura Churm, Divisional Nurse, Paediatrics		
Appendices:	Perinatal Surveillance Dashboard		

Report Summary

Executive Summary

This report gives an overview on the progress within the maternity and neonatal services against the national standards. The report details the outcomes for mothers and babies in the service together with a number of initiatives to improve quality and safety.

Work against the current year 5 clinical negligence scheme for trusts (CNST) is ongoing, and progress is encouraging in all safety actions except the training requirement (safety action 8). Training compliance remains the biggest risk and continues to be managed at the CNST oversight committee.

Brief details regarding ongoing communication in relation to Year 2 submission and the Early Notification Scheme are included in the report, work is ongoing and further updates will be provided at November's meeting.

The maternity and neonatal service continue working together to improve the provision of transitional care within the organisation, this enables more babies to remain with their mother's in the transitional care area.

Awaiting resuts from the Score Culture Survey with planned engagement sessions with the leadership team.

Recommendation:	For the Trust Board of Directors to take assurance from the detail provided within this Maternity and neonatal report.			
Action Require:	~~Approval~~	~~Discussion~~	**Take assurance**	~~Information only~~
Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**
	To provide outstanding care and improve patient experience	*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*
We believe this paper is aligned to the strategic direction of:	**South Yorkshire ICS**		**NHS Nottingham & Nottinghamshire ICS**	
	Yes		**Yes**	

Implications	
Board assurance framework:	BAF risk 1 - No Changes
Risk register:	ID 16 - Inability to recruit a sufficient workforce and to ensure colleagues have the right skills to meet operational needs
Regulation:	CQC - Regulation 12 Potential high impact
Legal:	Clinical Negligence Scheme for Trusts - High impact
Resources:	

Assurance Route		
Previously considered by:		Governance Meeting in Children's & Families Division Children & Families Board
Date:	12 July 2023	
Any outcomes/next steps		Support to continue improvements in maternity & neonatal service, and achieve year 5 CNST standards
Previously circulated reports to supplement this paper:		

Monthly Board Report

October 2023

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

There was one case in September.

1.2 Neonatal Deaths

There was one late neonatal death due to genetic abnormality which was incompatible with life.

1.3 Actions/ Learning from Perinatal Mortality Review Tool (PMRT)

Further work is required on the pre-conceptional advice and care for those women experiencing miscarriage.

2. Neonatal Services

Neonatal staffing is 87% recruited with 81% of establishment at work, with 6% maternity leave. The Qualified in Speciality ratio remains at 70% averaged across both units but Neonatal Unit (NNU) is 64% standalone over the last 12 months. During June we had 98% of shifts resourced within British Association of Perinatal Medicine (BAPM) standards compared to 55% over the last few months, of these all shifts had the number of Registered nurses for clinical care but were missing a co-ordinator. A workforce review and 3 year plan to meet BAPM and CNST standards was discussed in the Trust Executive Group in September 2023, the GAPs were recogised and it was agreed they would support the development of a phased response to business splanning to be submitted to Trust Capital Investment group and included in the Divisions Business planning requirements for 2024/25.

No new serious incidents or Health Services Investigation Bureau (HSIB) eligible cases.

The Getting It Right First Time (GIRFT) action plan for Neonatal service remains open while we establish transitional care, a joint Quality Improvement (QI) programme commenced in June to develop a transitional care plan for both sites. Work to review neonatal consultant cover including planned absences is ongoing in relation to a historic Serious Incident (SI).

2.1 Avoiding Term Admissions into Neonatal Units (ATAIN)

Term admissions to the neonatal unit remain below both the national (6%) and Regional (5%) targets. An overarching action plan in progress and implementation of the neontatal transitional care unit will further reduce admissions to the neonatal unit.

Month	Live Births All Gestations	Term babies Inborn (>37/40)	Inborn admissions: (all gestations) excl transfers	Inborn TERM admissions (>37/40) excl transfers	Term Admissions as % of Live Births
Apr-23	331	309	32	9	2.7%
May-23	391	362	30	11	2.8%
Jun-23	381	333	38	15	3.9%
Jul-23	404	366	46	15	3.7%
Aug-23	397	370	34	13	3.3%
Sep-23	384	351	TBC	13	3.4%

Data quality checks now in progress highlighting previous omissions of 37+0 gestation reviews. Retrospective audits now completed.

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

Cases to date	
Total referrals	23
Referrals / cases rejected (1 declined by parents)	5
Total investigations to date	18
Total investigations completed	18
Current active cases	1
Exception reporting	0

3.1 Reports Received since last report

The service has received one report for factual accuracy checking.

3.2 Current investigations

No further cases identified

3.3 Health service Investigation branch (HSIB) / NHS resolutions (NHSR) / Care quality Commission (CQC) or other investigation with a concern or request for action made directly to the Trust

None.

4. Serious Incident Investigations (Internal)

No new cases.

5. Training Compliance

The service is proactively managing training, with staff allocated to training sessions and follow up for anyone who does not attend training. This is monitored by the CNST and Ockenden oversight committee. The most recent meeting assessed the risk of being non-compliant with Safety action 8 to have increased. This has been added to the risk register and is currently rated at 20.

The new doctors commenced in the organisation in August 2023, and this has had an effect on the monthly percentages. All the new doctors are booked onto training sessions with a trajectory to be >90% by 1 December 2023. Evidence of recent attendance of study days at other trusts from rotating doctors cannot be accepted. All doctors who have rotated to DBTH in September 2023 have to attend all face to face study days by 1 December 2023.

K2 E learning package and Cardiotocograph (CTG) Study Day

The training position on 30 September 2023 was:

Staff Group	K2 CTG Compliance	Study Day Compliance
90% of Obstetric Consultants	**60 % ↓**	**80% ↓**
90% of All other Obstetric Doctors including trainees	**57.1 % ↓**	**28.5%↓**
90% of Midwives	**84.1% ↑**	**72.5% ↓**
90% of NHSP Midwives	**87.2% ↑**	**53.5% ↓**

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

Staff Group	Prompt Compliance
90% of Obstetric Consultants	**73.7% ↓**
90% of All other Obstetric Doctors including trainees	**54.0% ↓**
90% of Midwives	**77.9% ↑**
90% of NHSP Midwives	**88.9% ↑**
90% of Maternity Support Workers	**73.2% ↑**
90% of Obstetric Anaesthetic Consultants	**100% ↑**

Newborn Life Support Training

Staff Group	NLS Compliance
90% of Midwives	**89.6 % ↓**
90% of NHSP Midwives	**100% →**

6. Service User Feedback

The Maternity and Neonatal Voice Partnership (MNVP) meeting on 21 September 2023 was well attended by service users, staff and other stakeholders.

The neonatal team shared the changes that had been made in the neonatal unit after a 15 steps visit from the MNVP including the signage, improving the parent rooms and the graduation board / photos when babies leave the unit to go home.

Service users shared their experiences of the service, and the way information is shared in the service in the written and verbal forms. This is a key piece of work on the MNVP workplan. There is ongoing work with the induction and triage services.

The MNVP chair regularly attends the maternity governance meeting, and now attends the board safety champion clinical visits and meeting bi monthly.

Ongoing targeted feedback sought from Changing Lives Doncaster (refugees and ethnic minorities) and Deaf Community.

7. Coroner Prevention of Future deaths (Reg 28) made directly to Trust

None.

8. Progress in achievement of Clinical Negligence Scheme for Trusts (CNST)

We are currently in the process of finalising our compliance position for CNST Year 5. We have identified a number of areas which require more work by the deadline of 5 December 2023, and a plan is in place to achieve each one. Standards won't be highlighted as completed until the evidence is collected and attached to the standard, for example where minutes of a Board meeting may be required to meet the standard.

The LMNS are holding regular "confirm and challenge" meetings with Trusts in relation to progress against achieving CNST year 5 and DBTHs meeting was held during October 2023, there were no concerns raised by the LMNS in relation to the approach the Trust were describing, although the meeting outcome documentation is awaited.

Safety Action 8 (training) is the standard at highest risk of non-achievement. There has been a decline in the number of staff compliant with training, this is mainly due to the commencement of the trainee doctors in August 2023. All staff have allocated dates for attendance and this is proactively monitored session by session with follow up and overseen by the Ockenden and CNST Oversight Committee.

For safety action 2 (maternity dataset submission) the Trust continues to demonstrate compliance by meeting 10/11 clinical quality improvement metrics (CIQMS) in the maternity services monthly statistics publication series, and continues to have sustained engagement with NHS England using the Data Quality Submission Tool supplied by NHS England monthly.

The Trust's Year 2 CNST submission (2019) has been reviewed by NHS Resolution (NHSR) and we have recently received correspondence suggesting that compliance was not achieved as

per the submitted self assessment. The Chief Nurse has written to the NHSR team for further clarity as there are anomalies in the letter sent to the Trust. A meeting to discuss this with NHSR is in the process of being arranged. As a result of the Year 2 scheme review an automatic review of the Early Notification Scheme was triggered, the feedback on this was received into the Trust in late October, with 14 cases reviewed by the scheme (over a 6 year period, dating back to 2017) and some recommendations have been made. On initial review many of the recommendations are in place or progress already, however further details will be presented to Trust Board in November once a complete review has been carried out.

9. Board Level Safety Champion

The safety champion visit was undertaken on 28 September 2023 on the Doncaster site. The MNVP attended this visit and meeting. Issues raised included:

- Lack of computers on the ward to access the electronic patient records. Plan: For the digital midwife to undertake a review
- Concerns about midwifery staffing and the support required in the clinical areas for the newly qualified midwives. Plan: The Director of Midwifery to offer a meeting to discuss the concerns and provide support
- Lack of visibility of the senior midwifery team working clinically. Plan: for the team to share their experiences working with the clinical team.

Positive feedback was received from the doctors in training, and about the K2 electronic patient record. The staff also shared their work on reducing the use of lithotomy, and how this had reduced perineal tears. The serenity suite also received positive feedback.

The following was discussed at the safety champion meeting:

- The single delivery plan template has been agreed by the Local Maternity and Neonatal System (LMNS) and an initial gap analysis is being undertaken. This document has been cross referenced with all the reports including Ockenden part 2 (the 15 immediate and essential actions).

The NHS Futures Platform is not well developed for maternity as yet however the Operational Delivery Network action plans for Neonates are on it, and the safety champions will sign up to the neonatal work stream.

Culture, Leadership & SCORE survey

Eight members of the senior team have completed the leadership course from midwifery, obstetrics, business and neonates.

The SCORE culture survey is in progress and completed on 30 September 2023, wrap around support will be provided by NHSE to review the results, and work on the culture within the unit.

The organisation has also invested in additional support with a bespoke package from Paul Furey for senior midwives and medical staff. This is running alongside the NHSE programme.

10. Perinatal Surveillance dashboard

For this month we have seen a decline in:

- Improvement in datix incidents open > 30 days

However all other metrics have remain relatively stable.

Ongoing work continues to learning from incidents and complaints.

11. Midwifery staffing

The service is expecting 29.2 WTE newly qualified midwives to commence by January 2024, the vast majority will commence on 16 October 2023. There are also 3.6 WTE more experienced midwives commencing in various roles in the service.

One to one care in labour remains stable, and for the month of September is:

Doncaster - 100%
Bassetlaw - 100 %

On the live birthrate+® app midwives can record any red flag incidents. The data is inputted every four hours and the following episodes of red flags were recorded in September 2023.

Doncaster

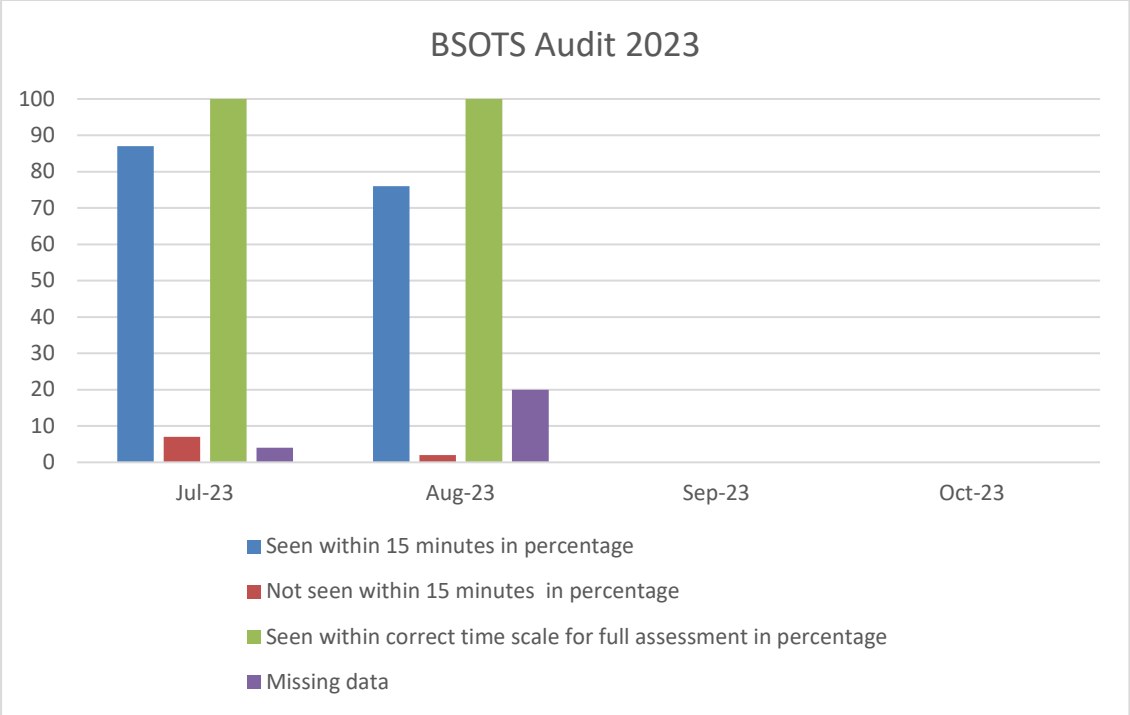
Red Flag	**Number of times**
Delayed or cancelled critical time activity	3
Delay between admission and commencing induction	1
Management Actions taken	
Redeploy staff internally	19
Utilise on call midwife	1
Staff unable to take allocated breaks	1
Unit on divert	7
Escalate to Manager on call	4

Bassetlaw

Red Flag	**Number of times**
Coordinator and unable to be supernumerary - providing 1:1 care	4
Management Actions taken	
Redeploy staff internally	11
Staff unable to take allocated breaks	2
Unit of divert	8
Escalate to Manager on call	3

The Triage Service

The triage service at DBTH utilises the Birmingham Symptom Specific Triage System (BSOTS), and this sets standards for the assessment of women attending the service according to clinical risk assessment. The service audits their performance against these standards on a monthly basis, and puts plans in place to improve the service.



The service has identified that staffing levels directly impact the ability to meet the gold standard of all women being assessed within 15 minutes of arrival. To improve this position the following actions have been undertaken:

- All vacant shifts advertised on NHSP
- Escalation of staffing challenges to the manager of the day for risk assessment and redeployment of staff if safe
- An advertisement for more core triage midwives to support the service

12. Medical Workforce

The divisional director and clinical director have been working together to ensure that the guidance related to the Royal College of Obstetricians and Gynaecologist guidance on the roles and responsibilities of Consultant obstetricians and gynaecologists is continuing to be implemented.

The standard operating procedure for compensatory rest has been completed and will be ratified on the next guidelines group. The service is currently non-compliant with this and below is the action plan to address this.

Standards	Action	Responsible Individual	Completion date
1. RCOG guidance on compensatory rest where Consultants and Senior (SAS) Doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day	All clinicians to undertake a job diary exercise to demonstrate the level of compliance/ non-compliance with compensatory rest	Clinical Director Obstetrics and Gynaecology	28 February 2024
2. RCOG guidance on compensatory rest where Consultants and Senior (SAS) Doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day	Ensure all clinicians have an in date job plan	Clinical Director / Business Manager	1 April 2024
3.RCOG guidance on compensatory rest where Consultants and Senior (SAS) Doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day	Network with other Obstetric Units of a similar size to explore how Maternity Units are achieving compliance	Divisional Director/Clinical Director/Obstetric Lead/Business Manager	31 December 2023

There has been no recorded incidents of consultant non-attendance in an emergency in this month.

13. Conclusion

This report contains the details of the Trust performance against local and nationally agreed measures to monitor maternity services, the risks in relation to training compliance are highlighted and the Trust assessment of compliance with meeting the new CNST standards is detailed, the Trust Board of Directors are asked to consider the assurance provided in this report.

NE&Y Regional Perinatal Quality Oversight Group
Highlight Report

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

LMNS: South Yorkshire and Bassetlaw

Reporting period: July 2023 – September 2023

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

Maternity unit: DBTH – Doncaster

KPI (see slide 4)	Measurement / Target		Doncaster Rate		
			July	Aug	Sept
Caesarean Section rate	Elective	<13.2 %	17.5%	14.4%	16.1%
	Emergency	<15.2 %	30.5%	31.1%	33.3%
Preterm birth rate	≤26+6 weeks	0	1	0	1
	≤36+6 weeks	<6%	9.85	7.5%	8.6%
Massive Obstetric Haemorrhage	≥1.5l	<2.9%	3.3%	4.9%	2.7%
Term admissions to NICU		<6%	5.3%	3.78%	4.31%
3rd & 4th degree tear	SVD (unassist'd)	<2.8%	0.8%	0.8%	3.6%
	Instrumental (assisted)	<6.05 %	4.5%	3.8%	5.3%
			5.5%	0.75%	1.9%
Right place of birth		95%	99%	100%	99%
Smoking at time of delivery		<11%	9.6%	8.6%	10.4%
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
			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)	
2022/2023	July	30	105	0	0	0	0	1	0	0	0	0	0	0	0	0
	Aug	30	86	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sept	29	152	0	1	0	0	0	0	0	0	0	0	0	0	0
	Q2															

Maternity Red Flags (NICE 2015)

		July	Aug	Sept
1	Delay in commencing/continuing IOL process	25	24	25
2	Delay in elective work	0	0	0
3	Unable to give 1-1 care in labour	2	1	0
4	Missed/delayed care for > 60 minutes	3	5	4
5	Delay of 30 minutes or more between presentation and triage (LWAU)	0	0	0

NE&Y Regional Perinatal Quality Oversight Group
Highlight Report

LMNS: South Yorkshire and Bassetlaw

Reporting period: July 2023 – September 2023

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

Maternity unit: DBTH – Bassetlaw

KPI (see slide 4)3.9%	Measurement / Target		Bassetlaw Rate		
			July	Aug	Sept
Caesarean Section rate	Elective		12.4%	12.8%	13.3%
	Emergency		32.6%	39.1%	31.3%
Preterm birth rate	≤26+6 weeks	0	0	0	0
	≤36+6 weeks	<6%	5.46%	4.5%	6.25%
Massive Obstetric Haemorrhage	≥1.5l	<2.9%	4.7%	2.3%	3.1%
Term admissions to NICU		<6%	1.65%	3.96%	4.23%
3rd & 4th degree tear	SVD (unassist'd)	<2.8%	0%	0.74 %	2.0%	1.5%	4.9%	2.3%
	Instrumental (assisted)	<6.06 %	7.1%		6.7%		0%	
Right place of birth		95%	100%	100%	100%
Smoking at time of delivery		<11%	12.5%	11.4%	11%
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	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	July	18	34	0	0	0	0	1	0	0	0	0	0	0	0	0
	Aug	9	31	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sept	18	50	0	0	0	0	0	0	0	0	0	0	0	0	0

Maternity Red Flags (NICE 2015)

		July	Aug	Sept
1	Delay in commencing/continuing IOL process	11	8	10
2	Delay in elective work	0	0	0
3	Unable to give 1-1 care in labour	4	1	4
4	Missed/delayed care for > 60 minutes	3	0	4
5	Delay of 30 minutes or more between presentation and triage (LWAU)	0	0	0

Assessed compliance With 10 Steps-to-Safety

		July	Aug	Sept
1	Perinatal review tool			
2	MSDS			
3	ATAIN			
4	Medical Workforce			
5	Midwifery Workforce			New starters starting October
6	SBLCB V3	Predicted Green, awaiting evidence	Predicted Green, awaiting evidence	Will be green for CNST requirement of 50% of each element and 70% overall
7	Patient Feedback			
8	Multi-professional training			
9	Safety Champions			
10	Early notification scheme (HSIB)			

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

Evidence of SBLCB V3 Compliance

Element		July		Aug		Sept	
		CURRENT %	CNST 50%	CURRENT %	CNST 50%	CURRENT % 73.1%	CNST 50%
1	Reducing smoking	60%		60%		60%	
2	Fetal Growth Restriction	70%		70%		85%	
3	Reduced Fetal Movements	100%		100%		100%	
4	Fetal monitoring during labour	80%		80%		60%	
5	Reducing pre-term birth	66.6%		66.6%		66.6%	
6	Diabetes	50%		50%		67%	

Assessment against Ockenden Immediate and Essential Action (IEA)

	July	Aug	Sept
Audit of consultant led labour ward rounds twice daily			
Audit of Named Consultant lead for complex pregnancies			
Audit of risk assessment at each antenatal visit			
Lead CTG Midwife and Obstetrician in post			
Non Exec and Exec Director identified for Perinatal Safety			
Multidisciplinary training – PrOMPT, CTG, Obstetric Emergencies (90% of Staff)			PROMPT 80% / K2 60%
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			

Maternity unit	JULY	AUGUST	SEPTEMBER
Freedom to speak up / Whistle blowing themes	None		
Themes from Datix (to include top 5 reported incidents/ frequently occurring)	Weight unexpectedly below the 10th centile PPH Shoulder dystocia Unexpected admission to NNU Staffing	Weight unexpectedly below the 10th centile PPH Unexpected admission to NNU PH <7.1 Injury to baby during CS	3rd / 4th degree tear PPH Unexpected admission to NNU
Themes from Maternity Serious Incidents (Sis)	No serious Incidents in July June SI (HSIB ongoing) initial review highlighted 3 hour interval between CTG and IOL – guidance changed immediately IOL must be started within 1 hour of CTG – awaiting HSIB draft report	No Serious Incidents declared in August	Serious Incident declared in September Incident occurred in July 31+5 week delay in treatment. MRI changes to baby profound acute hypoxic insult highlighted in the neonatal period, the changes can be attributed by labour cares but can also be common with preterm deliveries and / or neonatal resuscitation – full investigation to highlight route cause
Themes arising from Perinatal Mortality Review Tool	July meeting graded 3 cases	August meeting graded 2 cases B and B B and B	September meeting graded 2 cases and an offpathway delivery B and B A and B Off pathway: B
Themes / main areas from complaints	Anaesthetic concerns Care delivery Treatment / observations neonate Investigation report Medicines management Delayed bloods been taken Attitude, behaviours and communication of staff Placental histology	Care delivery Attitude, behaviours and communication of staff	Care delivery Attitude, behaviours and communication of staff Visiting times
Listening to women (sources, engagement / activities undertaken) CQC Women's Experience	MNVP invited to governance meetings, guideline meeting and being involved in guideline and patient leaflets - Patient experience	MNVP invited to governance meetings, guideline meeting and being involved in guideline and patient leaflets - Patient experience	MNVP attended Governance meeting and shared presentation around the co-production work that has been ongoing
Evidence of co-production			Guideline production Governance meetings
Listening to staff (eg activities undertaken, surveys and actions taken as a result)	Ongoing OCR meeting Ongoing skills and drills scenarios Education lead now back in post supporting education needs of staff PROMPT going back to face to face in August	Ongoing OCR meeting Ongoing skills and drills scenarios PROMPT back to face to face Debrief being conducted with staff following incidents	Live SIMS ongoing Debrief being conducted with staff following incidents
Embedding learning (changes made as a result of incidents / activities / shared learning/ national reports)	WHATS HOT and safety brief Ward briefs and emails Face to face discussions with staff Closing the loop proformas LMNS meetings	WHATS HOT and safety brief Ward briefs and emails Face to face discussions with staff Closing the loop proformas LMNS meetings	WHATS HOT and safety brief Ward briefs and emails Face to face discussions with staff Closing the loop proformas LMNS meetings

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 / Definitions for use with maternity papers

AN - Antenatal (before birth)

ATAIN - Avoiding term admissions to neonatal unit (Term 37-42 weeks)

BAPM - British Association of Perinatal Medicine (neonatal)

BR+® - Birthrate plus (workforce tool to calculate the number of midwives required to look after a cohort of women)

Cephalic - Head down

CNST - Clinical Negligence Scheme for Trusts

CTG - Cardiotocography (fetal monitor)

CQC - Care Quality Commission (Our regulator)

Cooling - baby actively cooled lowering the body temperature

DoM - Director of Midwifery

EFW - Estimated fetal weight

FTSU - Freedom to speak up

G - Gravis (total number of pregnancies including miscarriages)

GIRFT - Getting it right first time (Benchmarking data)

HSIB - Health Service Investigation bureau

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

IUD - intrauterine death (in the uterus)

LMNS - Local maternity and neonatal system (the fours trusts in south Yorkshire)

MNVP - Maternity and neonatal voices partnership (our service users)

MSDS - Maternity dataset

NED - Non-executive director

NICU - neonatal intensive care unit

NMPA - National maternity and perinatal Audit (provide stats & benchmarking)

OCR - Obstetric case review (learning meeting for interesting cases)

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

PFDR - Prevention of future deaths

PMRT - Perinatal Mortality Review Tool (system used assess care given)

PPH - Postpartum haemorrhage (after birth)

PROMPT - Practical Obstetric Multi-professional training (skill based training)

QI - Quality Improvement

RDS - respiratory distress syndrome (breathing problems)

Red Flag - Indicator that the system is under pressure (quality indicator)

RIP - rest in peace

SVD - Spontaneous vaginal delivery

SBLCBV2 - Saving babies Lives care bundle (bundle of care to reduce poor outcomes)

MCoC - Midwifery continuity of Care (6-8 midwives working in a team to provide care)

Other information

Term is 37-42 weeks long

Viability is 24 weeks (in law) - gestation a pregnancy is considered to be viable

Resuscitation of an infant can be considered from 22 weeks (parent will be counselled about the possible outcomes)

3^{rd} / 4^{th} degree tear - significant tearing of perineum / muscles during birth requiring repair in theatre

2310 - B3 MIDWIFERY WORKFORCE

Discussion Item | Lois Mellor, Director of Midwifery | 09:50

10 minutes

REFERENCES

Only PDFs are attached

B3 - Midwifery Workforce.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	31 October 2023	**Agenda Reference:**	**B3**
Report Title:	**Midwifery Workforce**		
Sponsor:	Karen Jessop, Chief Nurse		
Author:	Lois Mellor, Director of Midwifery		
Appendices:	n/a		

Report Summary

Executive Summary

- An update on the current midwifery staffing position, which is improving but does not meet birthrate+® recommendations
- Key quality metrics such as 1:1 care in labour, and supernumerary coordinators remain stable
- The pastoral team has supported the newly qualified midwives resulting in the largest number of new starters since 2019
- Red flags reported remain stable, and are managed appropriately

Recommendation:	For the Trust Board of Directors to take assurance from the oversight and mitigations for Midwifery staffing provided within this workforce report and to continue to support recruitment up to Birthrate + recommendations.			
Action Require:	~~Approval~~	~~Discussion~~	**Take assurance**	Information only
Link to True North Objectives:	**TN SA1:** *To provide outstanding care and improve patient experience*	**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*
We believe this paper is aligned to the strategic direction of:	**South Yorkshire ICS**		**NHS Nottingham & Nottinghamshire ICS**	
	Yes		**Yes**	

Implications	
Board assurance framework:	Risk to strategic aim - that we fail to provide outstanding care and that patient experience does not meet expectations - SA1
Risk register:	ID 16 - Inability to recruit a sufficient workforce and to ensure colleagues have the right skills to meet operational needs
Regulation:	CQC - Regulation 12
Legal:	N/A
Resources:	

Assurance Route	
Previously considered by:	Governance Meetings Children's & Families Board (verbal updates)

Date:	15 October 2023
Any outcomes/next steps	To continue to monitor Continue to actively recruit midwives
Previously circulated reports to supplement this paper:	

Contents

No.		Page
1	Introduction	4
2	Birthrate Plus Recommended Midwife WTE	4
3	Workforce Model 23/24	4
4	Planned versus actual	4-5
5	Recruitment	5
6	Midwife to Birth ratio	5
7	One to one care in labour	6
8	Supernumerary Labour Ward Coordinator	6
9	Mitigation of Risk	6
10	Red flags	7-8
11	Addressing areas of risk	8
12	Action plan	9

1. Introduction

Birthrate Plus®

A robust decision support tool Birthrate Plus® has been used in conjunction with professional judgement to calculate the workforce required to deliver safe maternity services at DBTH. The most recent assessment report was received in August 2022.

2. Birth Rate Plus Recommended Midwife WTE

	2022
DRI	157.44
BDGH	63.63
Specialist / Managerial	22.11
Total	**243.18**

Skill Mixing

Birthrate Plus suggests up to 10% of the WTE midwife requirement can be skill mixed with Band 3 Maternity Support Workers (MSW) where clinically appropriate. Skill mixing can predominantly be undertaken on the post-natal ward, and in community, where band 3 maternity support workers can support midwives.

3. Workforce Model for 23/24

Applying a 10% skill mix across the service using Band 3 MSW (as suggested by Birthrate Plus) the following workforce is required to meet the BR+ recommendations.

Total Workforce by Role

Below is the current funded workforce model, and the proposed birthrate + ® recommended workforce model.

Role	Current Budget	Proposed
Midwives 6 /7	189.45	218.04
MSW Band 3	31	27
HCA Band 2	29.15	30.2

4. Planned Versus Actual Staffing levels

Below is the current funded workforce model and the proposed workforce model from the 2022 assessment together with the people in post currently.

Funded model		In post	Variance
Midwives	168.05	141.04	-27.01
Managerial & Specialist	21.4	27.47	+6.07
MSW Band 3	31	20.17	-10.83
HCA Band 2	29.15	38.4	+9.25

The Ockenden monies currently funds a number of posts to deliver the maternity transformation programme, hence the specialist and managerial midwife posts are over recruited. These are out with the BR+ model recommendations and considered separately.

The Trust has agreed to fund recruitment up to the birthrate+® recommendations. Therefore this has been included in this report. The service is also expecting 29.2 WTE newly qualified midwives (NQM) on 16th October 2023. These have been included in the right hand column.

Birthrate + Model	Funded	In post	Variance	Including NQM
Midwives	195.7	141.4	-54.3	-25.1
Managerial & Specialist	22.34	27.47	+ 5.13	
MSW Band 3	27	20.17	-6.83	
HCA Band 2	30.2	38.4	+8.2	

Currently work is undergoing to convert the current band 2's to band 3 maternity support workers. There is a plan in place to continue to support any current band 2 to undertake the education and training required to meet the requirements of a band 3. Over the next 1-2 years it is anticipated that all the band 3 posts will be filled by current band 2's.

5. Recruitment & Retention

The service has invested in a recruitment and retention lead and pastoral team to support the midwives and midwifery support workers. The team complete a monthly return to NHS England, monitoring the work undertaken.

They have provided support to all the newly qualified midwives since the offer of jobs, resulting in 29.2 WTE starting in the organisation. This is the largest number of newly qualified midwives starting since 2019.

6. Midwife to Birth Ratio

The recommended midwife to birth ratio nationally is 1:28, and the current ratio (midwives in post) to births 4579 (DBTH). 2999 (DRI) and 1576 (BDGH) is;

TRUST - 1:27.6
DRI - 1:25.6
BDGH - 1:29.9

This ratio is a guide and needs to be used in conjunction with birthrate +® and clinical judgement.

7. One to One Care in Labour

The aim is to achieve 100% one to one care in labour, this means one midwife for one woman once in established labour (4 cms dilated with regular painful contractions). The midwife caring for a woman in established labour should not have any other women in her care, and this forms part of the CNST Safety Actions.

This is monitored on a monthly basis on the maternity dashboard and is reported non-compliant if during any period (however short) this has not been achieved. A recent deep dive into the data showed that babies born before arrival (BBA) were included in error this was corrected in March 2023. For the last 6 months we have achieved the following (please note March data includes BBA's);

	March	April	May	June	July	August
Trust	100%	100%	100%	100%	99.6%	100%
DRI	100%	100%	100%	100%	100%	100%
BDGH	100%	100%	100%	100%	99.2%	100%

8. B7 Labour Ward Coordinator

There is a supernumerary Band 7 Coordinator who have oversight of the labour ward on each shift. This is an experienced midwife available to provide advice, support and guidance to clinical staff and able to manage activity and workload through the labour ward. If the coordinator is unable to remain supernumerary this is escalated to the manager of the day (in hours) and the manager on call out of hours. Staff then will be redeployed to ensure that coordinator is supernumerary and / or the escalation policy is enacted.

In the last six months there have been 4 occasions at Doncaster where the coordinator was unable to be supernumerary out of 1104 times this could be recorded (4 hourly). This means that the coordinator has remained supernumerary 99.7% of the time. At Bassetlaw there have been 14 times recorded, however after clarification 4 of these recorded episodes are not looking after a woman requiring 1:1 care in labour, therefore this reduced to 10 which is 99.1% of the time.

9. Mitigation of Risk

To ensure that clinical risks are mitigated the Maternity Escalation Policy is used. In the first instance a divert is put in place and women are redirected to the sister site, until the situation is resolved. If both sites are in escalation the clinical risks and mitigations will be reviewed and potentially consider implementing service suspension (diversion to another provider) until the situation is resolved. There is a Local Maternity and neonatal System (LMNS) escalation policy that supports system wide support to the service who have declared OPEL 4 (suspension of services).

All women who contact the service during a suspension will be risk assessed and redirected if appropriate (with prior agreement to another provider).

10. Red flags

The service implemented the Birthrate plus App in June 2020 which records staffing and acuity data on a 4 hourly basis. Any management actions and red flags can also be recorded on the system.

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed.

Below is the table of the reported Red Flags in the maternity service;

Doncaster

Red Flag	**March**	**April**	**May**	**June**	**July**	**August**
Delayed or cancelled critical time activity	1	9	2	1	2	4
Delay between admission for induction and beginning of process		1		1	2	2
Missed or delayed care						1
Delay in providing pain relief					1	
Delay between presentation and triage			1			
Coordinator unable to be supernumerary – providing 1:1 care				2	2	
Any occasion when 1 midwife is not able to provide continuous 1:1 care and support a woman in established labour						1
Total red Flag reported	***1***	***10***	***3***	***4***	***7***	***8***
Management Actions taken						
Redeploy staff internally	10	16	22	32	4	18
Staff unable to take allocated breaks	1	1	2	2		2
Specialist midwife working clinically	1			1		
Matron or manager working clinically					1	1
Utilise on call midwife	1					
Unit on divert	3	1	8	8	10	7
Escalate to Manager on call	3	3	2	4	5	3

Bassetlaw

Red Flag	March	April	May	June	July	August
Delayed or cancelled critical time activity					1	
Delay between admission for induction and beginning of process			2			1
Missed or delayed care				1		
Delay in providing pain relief				1		
Coordinator and unable to be supernumerary – providing 1:1 care				8	4	2
Total Red Flag reported	***0***	***0***	***2***	***10***	***5***	***3***
Management Actions taken						
Redeploy staff internally	3	4	4	6	9	8
Redeploy staff from community		3				
Utilise on call midwife						1
Manager / Matron working clinically				2		3
Staff sourced from bank / agency				1		
Staff unable to take allocated breaks	1	2	2	6	4	
Unit of divert	5	6	3	15	18	14
Escalate to Manager on call	5	7	2	11	9	2

The manager of the day, and the manager on call overnight are in place to address any acute issues in the service. Trends in red flags are discussed at the maternity governance group, and mitigations/ changes in service made to address these.

The number of red flags has been variable in the last six months, and the management action undertaken to address the red flag and / or to mitigate the risks are either;

- Redeploying staff
- Diverting care between units

11. Addressing areas of Risk

There are twice daily huddles to manage staffing and make plans to ensure the services remains safe at all times. The service has a 24/7 manager rota to support the clinical areas to maintain safe staffing levels at all times, and they can liaise with the site on call team, and the LMNS for support.

12. Action Plan

No.	Action	Lead	Target Date
1	Ensure that the budget is available in 24/25 to fund birthrate+® recommended midwifery staffing model	Chief Nurse	1.4.24
2	Continue to retain and recruit midwives to meet birthrate+® recommendations	DoM	Review quarterly until the service achieves full recruitment

Conclusions

Despite the current national midwifery recruitment challenges the service has seen an increase in the recruitment of early career midwives and continues to recruit into band 6 posts.

The paper highlights the robust escalation policy in place including the twice-daily huddles, which provide an oversight of the maternity unit's acuity verses staffing. The Board is asked to take assurance from the mitigations in place and the oversight of the Trust Midwifery workforce.

Recommendations

The Board continues to support recruitment up to the proposed birthrate +® recommendation.

2310 - C TRUE NORTH SA4 - FINANCE AND PERFORMANCE

2310 - C1 CHAIR'S ASSURANCE LOG - FINANCE & PERFORMANCE COMMITTEE

Discussion Item | Mark Day, Non-executive Director | 10:00

To follow - meeting takes place 30 October 2023
5 minutes

2310 - C2 FINANCE UPDATE

Discussion Item | Jon Sargeant, Chief Financial Officer | 10:05

10 minutes

REFERENCES

Only PDFs are attached

C2 - Finance Update - Month 6.pdf

Report Cover Page			
Meeting Title:0	**Board of Directors**		
Meeting Date:	**31 October 2023**	**Agenda Reference:**	**C2**
Report Title:	**Financial Performance – Month 6 (September) 2023**		
Sponsor:	Jon Sargeant, Chief Financial Officer		
Author:	Alex Crickmar, Deputy Director of Finance Finance Team		
Appendices:			

Executive Summary	
Purpose of report:	To set out to the Board an update with regards to the Trust's financial position at Month 6.
Summary of key issues:	The Trust's reported deficit for month 6 (September 2023) was £4.1m, which was £1.4m adverse to plan. Year to Date (YTD) the Trust's reported deficit at month 6 was £23.9m, which again was £1.4m adverse to plan. The variance to plan is mainly driven by Elective Recovery Fund (ERF) under performance (£0.9m) and strike costs of (£1.5m). As at month 6 the Trust's ERF performance was 98%, equating to a £911k under-performance against the adjusted baseline target value, which includes the 2% target reduction for industrial action (applied across the year). No further adjustments for other industrial action since April have been agreed by the national team at this point. Pay spend is favourable to plan by c.£1.7m YTD (£0.3m favourable to plan in month), mainly driven by Nursing and Admin staff. Medical staff have overspent by £2.0m, which includes junior doctor strike costs of £1.5m. It is increasingly worrying that temporary staffing spend has not reduced further following good gains in March and April. This is especially noticeable for medical staff and therefore the effectiveness of grip and control meetings needs to be picked up as we enter the second half of the year as part of the temporary staffing CIP workstream. Excluding the Medical staff pay award, the pay run rate has increased slightly this month by £0.1m compared to month 5. This is mainly driven by Medics (£0.5m increase) and offset by Nursing (£0.2m decrease) with smaller changes in other staff groups. This needs to be closely monitored over the coming months. Non-pay spend is £4.1m adverse to plan YTD (£1.1m adverse to plan in month), driven by continued overspends related to the phasing of the independent sector usage (£1.2m – where independent sector usage has been front loaded by the Division), drugs (£1.6m) and Medical and Surgical equipment (£1.0m) which are under review with Divisions. The level of independent sector spend also indicates core activity is not being delivered in line with plan given the current ERF performance. Financing costs are favourable to plan by £0.5m due to higher interest receivable than plan. This is because of a higher-than-expected cash balance in the first quarter of the year, with cash being tightly controlled and the delays in the capital programme. However, this is not expected to continue into future months as the Trust draws down on national cash support which comes at a cost of 3.5% interest. **Capital** Capital spend in month 6 was £2.9m against a plan of £4.6m giving an in-month under-performance of £1.7m. The YTD position is £10.3m against a plan of £20.7m showing an under-performance of £10.3m. The main underspends are against

	Montague Elective Orthopaedic Centre (MEOC) of £1.8m and Bassetlaw Emergency Village (BEV) of £6.9m. A revised cashflow for both MEOC and BEV shows current spend is in line with expectations. **Cash** The cash balance at the end of September was £21.6m (August: £14.9m), meaning cash has increased by £6.7m in the month driven by the Trust receiving £13.4m in month through revenue and capital cash support. This is offset by the Trust's deficit position, as well as the 6-monthly PDC Revenue payment that took place in the month of £3.8m. This month there has been continued focus on maximising available cash and deferring levels of payment by one week which has impacted on the Trust's performance against Better Payment Practice Code (BPPC). The Trust has an approved cash drawdown request of £14.9m for Quarter 3, with £6.3m of this due to come in in October. This is in line with the Trust's deficit position and in line with what has been formally agreed at Board previously. If the financial plan is not achieved including ERF this would impact on the amount of funding needed from the central team. We will keep this position under review and keep the Board updated on this throughout the year. **CIPs (Cost Improvement Programme)** In month, the Trust has delivered £1.4m of savings versus the plan submitted to NHSE of £1.8m and therefore is £0.4m adverse to plan. YTD the Trust has delivered £7.8m of savings versus the plan submitted to NHSE of £6.7m and is therefore favourable to plan by £1.1m. Whilst the Trust is ahead of plan at this point, the phasing of the CIP programme has started to increase in Q2, as seen with the adverse in month variance, and will significantly increase in Q3. Significant work is underway to identify further opportunities to meet the full year target of £22.1m. **Year end Forecast (Income and Expenditure)** In month the Trust has been completing a "bottom up" forecast with Divisions. The results of which have been reviewed at Finance and Performance Committee. At a top level this shows the Trust is currently forecasting to be £4m off plan under the "reasonable" case if action is not taken.
Recommendation:	The Board is asked to note: • The Trust's deficit YTD at month 6 (September 2023) was £23.9m, which was £1.4m adverse to plan.

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:			N/A
Date:		**Decision:**	
Next Steps:			
Previously circulated reports to supplement this paper:			

FINANCIAL PERFORMANCE

Month 6 – September 2023

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

M6 September 2023

1. Income and Expenditure vs. Budget

Performance Indicator	Monthly Performance			YTD Performance		
	Actual £'000	Variance to budget £'000		Actual £'000	Variance to budget £'000	
Income	(44,545)	648	A	(268,344)	(472)	F
Pay	30,744	(294)	F	185,109	(1,721)	F
Non Pay	17,444	1,111	A	104,387	4,098	A
Financing Costs	523	(60)	F	3,004	(494)	F
(Profit)/Loss on Asset Disposals	0	0	A	0	0	A
(Surplus)/Deficit for the period	**4,166**	**1,405**	**A**	**24,155**	**1,410**	**A**
Adj. for donated assets	(41)	(7)	F	(247)	(42)	F
Adjusted (Surplus)/Deficit for the purposes of system achievement	**4,125**	**1,398**	**A**	**23,908**	**1,368**	**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 / Unidentified	947	994	F	3,258	5,020	F	3,780
Cross Cutting - Pay - Job Plans / Ag	217	298	F	1,300	2,277	F	500
Cross Cutting - Elective - Theatres/	365	16	A	1,107	265	A	6,000
Cross Cutting - Procurement	69	49	A	261	185	A	720
Cross Cutting - Major Contracts	111	16	A	348	53	A	2,750
Cross Cutting - RPA	56	0	A	167	0	A	500
Cross Cutting - Corp Pay/Benefits f	42	0	A	250	0	A	7,850
Total CIP	**1,806**	**1,373**	A	**6,691**	**7,800**	F	**22,100**

3. Statement of Financial Position

	Opening balance £'000	Closing balance £'000	Movement £'000
Non Current Assets	**296,302**	**297,792**	**1,490**
Current Assets	53,533	59,005	**5,472**
Current Liabilities	-101,397	-92,890	**8,507**
Non Current liabilities	-16,375	-16,033	**342**
Total Assets Employed	**232,063**	**247,874**	**15,811**
Total Tax Payers Equity	**-232,063**	**-247,874**	**-15,811**

4. Other

Performance Indicator	Monthly Performance		YTD Performance		Annual
	Plan £'000	Actual £'000	Plan £'000	Actual £'000	Plan £'000
Cash Balance		21,675		21,675	1,900
Capital Expenditure	4,587	2,916	20,688	10,339	65,051

5. Workforce

	Funded WTE	Substantive WTE	Bank WTE	Agency WTE	Total in Post WTE
Current Month	6,828.17	5,945.80	371.73	147.13	6,464.66
Previous Month	6,782.94	5,903.98	389.06	144.87	6,437.91
Movement	45.23	41.82	-17.33	2.26	26.75

1. Month 6 Financial Position Highlights

Income and Expenditure

The Trust's reported deficit for month 6 (September 2023) was £4.1m, which was £1.4m adverse to plan. Year to Date (YTD) the Trust's reported deficit at month 6 was £23.9m, which again was £1.4m adverse to plan. The variance to plan is mainly driven by Elective Recovery Fund (ERF) under performance (£0.9m) and strike costs of (£1.5m).

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Financing costs are favourable to plan by £0.5m due to higher interest receivable than plan. This is because of a higher-than-expected cash balance in the first quarter of the year, with cash being tightly controlled and the delays in the capital programme. However, this is not expected to continue into future months as the Trust draws down on national cash support which comes at a cost of 3.5% interest.

Capital

Capital spend in month 6 was £2.9m against a plan of £4.6m giving an in-month under-performance of £1.7m. The YTD position is £10.3m against a plan of £20.7m showing an under-performance of £10.3m. The main underspends are against Montague Elective Orthopaedic Centre (MEOC) of £1.8m and Bassetlaw Emergency Village (BEV) of £6.9m. A revised cashflow for both MEOC and BEV shows current spend is in line with expectations.

Cash

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The Trust has an approved cash drawdown request of £14.9m for Quarter 3, with £6.3m of this due to come in in October. This is in line with the Trust's deficit position and in line with what has been formally agreed at Board previously.

If the financial plan is not achieved including ERF this would impact on the amount of funding needed from the central team. We will keep this position under review and keep the Board updated on this throughout the year.

CIPs (Cost Improvement Programme)

In month, the Trust has delivered £1.4m of savings versus the plan submitted to NHSE of £1.8m and therefore is £0.4m adverse to plan. YTD the Trust has delivered £7.8m of savings versus the plan submitted to NHSE of £6.7m and is therefore favourable to plan by £1.1m. Whilst the Trust is ahead of plan at this point, the phasing of the CIP programme has started to increase in Q2, as seen with the adverse in month variance, and will significantly increase in Q3. Significant work is underway to identify further opportunities to meet the full year target of £22.1m.

Year end Forecast (Income and Expenditure)

In month the Trust has been completing a "bottom up" forecast with Divisions. The results of which have been reviewed at Finance and Performance Committee. At a top level this shows the Trust is currently forecasting to be £4m off plan under the "reasonable" case if action is not taken.

2306 - D GOVERNANCE, ASSURANCE & STRATEGY

2310 - D1 TRUE NORTH, BREAKTHROUGH & CORPORATE OBJECTIVES Q2 2023/24

Discussion Item | Richard Parker OBE, | 10:15

10 minutes

REFERENCES

Only PDFs are attached

- D1 - True North, Breakthrough & Corporate Objectives Q2 2023-24.pdf
- D1 - Appendix 1 Q2 Executive Objectives.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	31 October 2023	**Agenda Reference:**	**D1**
Report Title:	**True North, Breakthrough and Corporate Objectives 2023/2024- Quarter 2**		
Sponsor:	Richard Parker OBE, Chief Executive Officer		
Author:	Richard Parker OBE, Chief Executive Officer		
Appendices:	Appendix 1 Q2 Executive Objectives		

Report Summary

Executive Summary

This paper provides the quarter 2 update to the Board of Directors on progress towards the delivery of the 2023/ 24 Corporate Objectives. The report also completes the work to align progress on the delivery of the corporate objectives to reducing or mitigating the risks identified in the Board Assurance Framework (BAF).

Recommendation:	The Board of Directors is asked to note the content of the paper and appendix and advise on any changes, or actions, which may need to be taken to ensure that delivery of the objectives ensure that progress is being made towards the delivery of the Trusts Strategic Vision and the risks identified in the BAF.			
Action Require:	Approval	**Discussion**	Take assurance	Information only
Link to True North Objectives:	**TN SA1:** ***To provide outstanding care and improve patient experience***	**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***
Is the content of this paper is aligned to the strategic direction of:	**South Yorkshire ICS**		**Nottingham & Nottinghamshire ICS**	
	Delivery of the Corporate Objectives supports the delivery of ICB and System priorities.		Delivery of the Corporate Objectives supports the delivery of ICB and System priorities.	

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.
Risk register:	Delivery of the Corporate Objectives for 2023/2024 will support the reduction in known and reasonably foreseeable risks.
Regulation:	The Corporate Objectives for 2023/2024 identify actions which will be taken to maintain and 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 2023/2024 aim to maintain the Trusts progress and compliance with statutory responsibilities.
Resources:	The resources needed to deliver the Corporate Objectives for 2023/2024 were identified as part of the planning processes for 2023/2023.

Assurance Route	
Previously considered by:	Executive team. Corporate Objectives are reviewed at Board Committees and aligned to the Board Committees review of the BAF prior to quarterly submission to the Board of Directors.
Date:	Board Committees
Any outcomes/next steps	Specific Objectives will be reviewed at Board Committees with overall progress reported to the Board of Directors: • Quarter 2 - October 2023 • Quarter 3 - January 2024 • Quarter 4 - April 2024
Previously circulated reports to supplement this paper:	2022/2023 Corporate Objectives, True North and Breakthrough Objectives, Board of Directors Papers, and Performance Reports.

1. INTRODUCTION

This paper updates the Board of Directors (BoD) on the progress which has been made during quarter 2 towards the delivery of the 2023/24 Corporate Objectives.

2. BACKGROUND

During quarter 2 (Q2) the previously identified challenges have continued with significant, and combined industrial action, which has impacted upon the work to restore services to the pre pandemic levels.

Specific work has been undertaken within the Trust and also with partners across our two integrated care systems, and Places with specific collaborative work on Urgent and Emergency Care recovery, Elective and Diagnostic recovery and Cancer Recovery has been undertaken with the South Yorkshire Acute Federation and partnership work to deliver the Boards commitment to be a strong partner in both our Integrated Care Systems and Places continues.

During quarter 2 the Trust has been subject to an unannounced and well led inspection by the CQC which involved Maternity, Emergency Care, Medicine, Surgery and Cancer services and Diagnostics and Imaging.

At the time of writing the draft report is outstanding but once received will provide confirmation of the current position in respect of whether the Trust has achieved the objective of maintaining, or and improving the CQC rating; 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.

In addition to the submission of a quarterly update to the Board of Directors progress on the delivery of the objectives and alignment to the BAF is subject to monitoring through the Board's Committees; Finance and Performance (F&P), Quality and Effectiveness (QEC), People Committee (PC), Charitable Funds Committee (CFC)and Audit and Risk Committee (ARC), ensuring that delivery is subject to the detail of the objective and where appropriate specific, measurable, achievable, relevant and time based (SMART).

3. PROGRESS DURING Q2

The progress each Director has made towards the delivery of their agreed objectives are identified in appendix 1. At the end of Q2 all objectives are assessed as in progress.

As confirmed at the April BoD meeting the Chair has completed the CEO's appraisal and objective setting and in addition to supporting the Executive Team to deliver the Trust Strategic objectives. For the quarter 3 update the CEOs updates will be included in the Monday.com report to be consistent with the Executive Director updates.

SA 1 Quality and Effectiveness

- Ensure that the completion of internal audit actions achieve the standard required to demonstrate significant assurance.

  Progress on delivering the agreed actions from internal audit reports is being maintained with an 82% follow up rate and an 86% implementation of actions rate. Discussions related to the

23/24 internal audit programme are underway and it is expected that the final programme will reflect the previously identified areas, closure of previously identified actions and feedback from the recent CQC inspection programme.

- Ensure that the Trust maintains a clear focus on the delivery of safe and sustainable services and with Place and System partners has robust plans to manage the expected pressures of the winter period.

  Work continues within both Integrated Care Systems and Places to deliver a robust winter plan to reduce the known and reasonably foreseeable risks associated to the delivery of urgent and emergency care, surgical and diagnostic recovery and the health and wellbeing of colleagues. Key programmes of work include the use of virtual wards, morning discharges to maintain flow, admissions avoidance, and reductions in the number of patients who experience delayed transfer of care once medically fit for discharge.

SA 2 and 3 People and Organisation Development

- Ensure that a structured programme of development and team building is in place to facilitate a high performing Executive team.

  A facilitated Team building programme is in place.

- Ensure that the Trust has appropriate succession planning and leadership development in place to ensure business continuity across all key Executive, Director, and Senior Leadership roles.

  Work is being undertaken to establish robust programmes to support delivery of this objective and acting up, and business continuity cover is identified for each Executive Director.

- Ensure that the Trust builds upon the successes of the internal and external communication, and health and well-being support which was achieved during the pandemic to develop a modern business as usual approach to colleague and public involvement and engagement.

  The Trust has a comprehensive programme and suite of support offers and has recently been shortlisted for national awards. Most recently the comms Team have been nominated for the Best In-house team for the corporate communications aware 2023 with other shortlisted teams coming including Ikea, YouGov and Adidas. DBTH are the only shortlisted team from the NHS.

- Ensure that the positive work which happens across the Trust is increasingly recognised at local and national level.

  In 2023 the Board is aware that the Trust has been shortlisted for a number of local and national awards.

SA 4 Finance and Performance

- Following confirmation that the Trust will not be part of the new Hospital program ensure that the Trust works with System, Place and elected representatives to identify a deliverable program of work which reduces the risk associated to the infrastructure, and provides modern, fit for purpose facilities for patients and colleagues.

Work to develop appropriate plans and cases for funding continues and a business case has continued, and with advice from colleagues at the Department of Health and Social Care, NHSE and the Integrated Care System a specific business case is being prepared for additional capital to support the reduction of back log maintenance.

- Work with partners to ensure the delivery of the Acute Federations commitment to maximise the benefits of Electronic Patient Records.

  The Trust is working with all of the Acute Trusts in South Yorkshire to develop an ICS wide EPR solution with maximises the use of resources to enhance the quality and safety of patient care.

- Ensure that the strategy for a modern vibrant DBTH charity is completed and implemented.

  Work continues to identify a new strategy for the DBTH Charity.

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 2023/2024

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Deputy CEO

Name	Deputy CEO	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status
Working with the CEO, take a lead role in working with Partners at Place, Collaborative to identify and achieve opportunities to ensure safe, sustainable services and Place and Systems Objectives and Outcomes for 2023/ 24.		Zara Jones	DCEO01	BOD	DBTH to be an active partner at Place, Collaboratives and System to provide safe and sustainable care and the delivery of the agreed quality and performance standards. Monitored through Board report updates and via regular report into Board sub committees.	2023-07-26	Continuing to support Nottingham & Nottinghamshire's system, attending meetings and have brought strategy document through Trust Board	Working on it	Building on the work to date we will create a clear partnership strategy for DBTH to be created to set out our intent, and how we will best engage in the variety of ICS and other partnership activities. This will provide clarity on how our approach to partnership working will also support delivery of the agreed DBTH enabling strategies.	Working on it
Engage at Place and ICS to identify transformation and development opportunities which enhance the services for our communities and staff		Zara Jones	DCEO02	BOD	Plans will be in place for services which reduce inequalities and improve outcomes.	2023-07-26	Working with Place teams on joint plans for Doncaster Place in particular. As part of the Doncaster Place and Health and Well Being Committees focus on reducing Health Inequality three priority areas have been identified and submitted to the programme lead.	Working on it	Clear partnership strategy for DBTH to be created to set out clearly our intent and how we will best engage in the variety of ICS and other partnership activities (building on the work to date). This will provide clarity on how our approach to partnership working will also support delivery of other DBTH strategies.	Working on it
Ensure that the Trust Corporate and Clinical Governance systems and processes achieve the delivery of the Trusts strategic objectives.		Zara Jones	DCEO03	BOD	The Trust has a refreshed Corporate and Clinical Governance strategy which identifies the continued development of corporate and clinical governance strategies.	2023-07-26	Specific work will be undertaken from Q3.	Working on it	Fresh eyes review being undertaken by DCEO who joined DBTH in October. Key recommendations will be shared with Trust Executive Team (TET), Trust Executive Group (TEG), Audit and Risk Committee (ARC) and Board of Directors (BoD) as appropriate. Clarity of the link between our governance systems and processes and our decision making architecture will be set out as part of this work, linking back to our BAF and delivery of Strategic Objectives.	Working on it
Working with the CEO ensure that internal and external audit recommendations are completed within the agreed timeframes.		Zara Jones	DCEO04	ARC	Compliance with the closure of audit recommendations will be at, or above the peer group average or 75%.	2023-07-26	Delivery of this objective will be led by the CEO to ensure that work on internal actions completed on time. At July ARC there should be 8 of 9 actions complete as per report to Trust Executive Group in June. Working with External Audit to implement a plan to ensure that any lessons from the submission of the 2022/23 annual report and accounts are acted upon for the 2023/24 submission.	Working on it	All historic (KPMG) actions now all closed. Actions outstanding are all 360 assurance. The Trust's follow up rate in 2023/24 is currently 82% first follow up and 86% overall implementation... a much improved position. 1 stage IAO action x 2 , follow-up & embedding of BAF at Board & Committees. External Audit Annual Report received at ARC 19/10/23.	Working on it

Executive Medical Director

Name	Executive Medical Director	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status
Move the job planning process to match the service to demands. Ensuring that specialities job plans are manageable, less reliant on additional time, locum and agency cover, support leadership development, recruitment and retention and clinical engagement in the Trusts achieving its strategic objectives to provide high quality, safe and sustainable care.		Tim Noble	MD01	F&P / QEC	Divisions and Directorates will have the capacity, capability and support to ensure the delivery of the operational and strategic plans in an effective and efficient way.	2023-07-26	Work is ongoing with the Deputy Director of Finance, and supported by the Project Management Office (PMO) to recover job planning performance during 2023/24 in line with internal audit timescales, along with identifying project areas to achieve job planning efficiencies,. Medical Directors are supporting job planning of Divisional Directors and Clinical Directors in Division of Surgery. The Trust's job planning policy has been refreshed, using the BMA published policy as the basis for adaptation specific to DBTH. This will be shared with Clinical Directors and Divisional Directors for feedback before wider circulation for Executive level, and Local Negotiating Committee (LNC), agreement and sign off. Divisional level trajectories are currently in development and these will be monitored through Performance, Overview and Support meetings (POSM). A job planning workshop was delivered on 5 July 2023 to the operational teams including Deputy COO, Divisional General Managers and Business Managers. This generated a lot of discussion around the job planning process to match service demands and greater divisional management involvement	Working on it	Work is ongoing with senior finance colleagues, supported by Programme Management Office (PMO), to identify job planning efficiencies. Medical Directors are supporting focussed job planning discussions within surgical division now the new Divisional Director (DD) is in post. Following consultation with DDs and Clinical Directors (CD's) the Trust's updated job planning policy will be shared at exec level and with the Local Negotiating Committee (LNC) for agreement and sign off. Divisional level trajectories have been set and performance monitored at Performance Outcome and Support Meetings (POSM). Divisional General Managers are now more involved in the process and are sighted on job plan changes enabling this to be embedded within the business planning process.	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	PC	Divisions and Directorates will have plans in place to ensure that recruitment and retention strategies proactively mitigate reasonably foreseeable workforce challenges in an effective and efficient way.	2023-07-26	Work continues with Divisions and the Chief People Officer's team on medical workforce challenges. Alongside job planning, there is a focus on supporting the assessment of medical workforce supply as part of the wider multi-disciplinary team; ensuring job plans are manageable, with less reliance on additional time, locum and agency cover. This includes working with divisions and specialties to understand demand analysis, to ensure the focus is on work that needs to be delivered, strategically scaling specialties to enable us to deliver objectives. Specific examples include supporting development of options for operational models moving towards paediatrics provide 24/7 on-site rotas, and supporting the potential development of 'hot weeks' in acute services.	Working on it	Work continues with Divisions and the Chief People Officer's team on medical workforce challenges. Alongside job planning, there is a focus on supporting the assessment of medical workforce supply as part of the wider multi-disciplinary team; ensuring job plans are manageable, with less reliance on additional time, locum and agency cover. A Standard Operating Procedure (SOP) is now in place to support divisions with a standardised approach to ensuring services are covered appropriately, maintaining patient safety. Work is ongoing with divisions and specialties to understand demand analysis, to ensure the focus is on work that needs to be delivered. The Medical Director for Workforce provides update reports to the People Committee.	Working on it

Name	Deputy CEO	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status
Maintain and improve governance frameworks to ensure that effective learning is used to support the delivery of safer care.		Tim Noble	MD03	QEC	The Trust will maintain and improve our NHSE and CQC ratings by achieving improvements in quality and outcomes.	2023-07-26	The clinical governance framework has recently been reviewed and updated and is in the process of full implementation, with well-established assurance and controls in place. Risk Management Board is now well established which ensures the Trust has a robust and reliable risk management system which learns and disseminates good practice to mitigate current and reasonably foreseeable future risks	Working on it	Implementation of the new clinical governance framework is underway with the EMD's office and Chief Nursing team working closely together, supported by PMO. This collaborative approach will ensure that the action plan and implementation process (on Monday.com) support effective learning in delivery of safer care for patients. Risk Management Board is now well established which ensures the Trust has a robust and reliable risk management system which learns and disseminates good practice to mitigate current and reasonably foreseeable future risks.	Working on it
Ensure that medical appraisal and revalidation systems and processes maintain high professional standards and the delivery of safe and sustainable care.		Tim Noble	MD04	QEC	There will be Trust wide improvement in the culture, care and compassion to drive improvement in patient and colleague feedback.	2023-07-26	The revalidation team manage the medical appraisal system, record appraisal due dates and completion dates, send doctor reminders, link with ESR team to ensure all activities are recorded correctly and provide monthly reports Lead appraiser in post who assures the quality of appraisals and documentation Lead appraiser, AMD and EMD provide an independent review of doctors' appraisal documentation and other evidence in order to determine their application for revalidation meets the standards set by the GMC to enable a recommendation to be made. The team are in the process of implementing a new electronic web-based medical appraisal system which will automate a lot of the current manual processes making it easier for users to complete their appraisal documentation and upload other supporting information	Working on it	The revalidation team continue to manage the medical appraisal system, record appraisal due dates and completion dates, send doctor reminders, link with ESR team to ensure all activities are recorded correctly and provide monthly reports. 96% of appraisals were completed in the last financial year. Lead appraiser in post who assures the quality of appraisals and documentation. Lead appraiser, Associate Medical Director (AMD) and EMD provide an independent review of doctors' appraisal documentation and other evidence in order to determine their application for revalidation meets the standards set by the General Medical Council (GMC) to enable a recommendation to be made. Interim Responsible Officer arrangements have been put in place in the absence of the Executive Medical Director. Progress is being made on the implementation of the electronic web-based medical appraisal system.	Working on it
Working with the Chief Nurse ensure the achievement of the three year delivery plan for maternity and neonatal services		Tim Noble	MD05	BOD / QEC	Work closely with Chief Nurse, Divisional Director and Director of Midwifery to ensure the delivery of the 11 outcomes to ensure that services and safer, more personalised and more equitable.	2023-07-26	The single delivery plan was published at the end of March 2023 and the Chief Nurse discussed this in detail at the May Board Level Safety Champions meeting with Midwifery and Neonatal services. In June the Local Maternity and Neonatal System agreed a document to measure progress would be produced to ensure that as a system we are measuring the same outputs. Progress is monitored via the oversight committee in maternity services but includes Quarterly review against the maternity self assessment tool, commenced implementation of Saving Babies lives version 3 care bundle, Senior leadership team commenced the national perinatal culture and leadership programme and involvement in the PSIRF implementation at Trust and LMNS level. Ongoing recruitment as previously described at relevant trust committees.	Working on it	The Local Maternity and Neonatal service (LMNS) are working on an assurance document to incorporate all elements of the three year delivery plan. This document will be reviewed by the Director of Midwifery once received. Maternity safety champions visits and meetings are becoming more established with Neonatal Colleagues engaged. The MNVP chair attended the September meeting and now has a standing invitation.. The leadership team continue to engage with the NHSE perinatal culture programme and also the Trust programme that is running alongside it. The Newly Qualified Midwife cohort is now approx. 30 WTE and expected to commence work in the next 2 months.	Working on it
Ensure that mortality indicators are quality assured, peer reviewed and benchmarked. Optimising learning to improve patient care and outcomes.		Tim Noble	MD06	BOD / QEC	Benchmarked Hospital Standard Mortality Ratio (HSMR), Standardised Hospital Mortality Index (SHMI) will show improvement.	2023-07-26	The mortality data assurance group was established at the beginning of 2023 to review mortality indicators, benchmarking against others and undertaking peer review. Through this investigatory process, the Medical Examiners' Office and the Structured Judgement Review processes were found to be robust. Further work is needed to improve quantitative factors that are impacting on performance, such as clinical coding differences, ensuring depth of coding, case mix and pathway changes to ensure that the appropriate information is fully captured, as well as information extracts for mortality reports, along with improved senior medical engagement in the SJR process. Since this process commenced, the Trust's reported mortality rate has fallen in the past 4 consecutive months.	Working on it	The mortality data assurance group was established at the beginning of 2023 to review mortality indicators, benchmarking against others and undertaking peer review. Through this investigatory process the Medical Examiners' process was found to be robust. There is a process in place for Structured Judgement Reviews, however the completion rate has been found to be poor. Work has commenced on improving this through identification of clinicians trained in the SJR process across the Trust and introducing a method of protecting time to complete the reviews. In terms of HSMR, the Trust has seen 8 consecutive months on a downward trend.	Working on it

Name	Deputy CEO	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status
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	MD07	QEC/ F&P	Demonstrate clear improvements in efficiency and effectiveness to achieve and where possible exceed national, system and local benchmarking.	2023-07-26	Work ongoing with support from PMO and clinical leads to establish a GIRFT Steering group as a forum to monitor and drive forward GIRFT actions. Good progress is being made with virtual ward and extending eligibility criteria to a number of services. The aim is to increase utilisation of the virtual ward capacity making full use of community resource to relieve pressure in the system ahead of winter. Progress has been made with the new patient pathway tracking system in terms of testing, training and demonstrations across the Trust. Once implemented, this will support clinical prioritisation particularly for non-admitted pathways where visibility and tracking of patient pathways has been difficult. Medical Director supporting the radiology service to review pathways and criteria to manage demand into the service which has increased significantly.	Working on it	Work on GIRFT actions with divisions is ongoing, recent meetings have included finance business partners to identify financial opportunities. Good progress is now being made with virtual ward and extending eligibility criteria to a number of services. The aim is to increase utilisation of the virtual ward capacity making full use of community resource to relieve pressure in the system ahead of winter. Digital Transformation team are leading on implementation of the new patient pathway tracking system in terms of testing, training and demonstrations across the Trust. Once implemented, this will support clinical prioritisation particularly for non-admitted pathways where visibility and tracking of patient pathways has been difficult. Medical Director supporting the radiology service to review pathways and criteria to manage demand into the service which has increased significantly. The MD team are developing a Clinical Harm policy to support this area of work to ensure patients are not disadvantaged due to pathway delays.	Working on it

Chief Finance Officer/ Director of Recovery, Innovation and Transformation

Name	Director of Finance	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status
Work with the Corporate and Divisional Directors to ensure the delivery of the Trust revenue plan		Jon Sargeant	DOF01	F&P / A&R	Ensure the delivery of the Trust's financial plan.	2023-07-26	Control environment in place, with escalation meetings in place. Currently the trust is on plan, but with risk concerning higher levels CIP starting later in the year.	Working on it	At end of Q2 the Trust was on plan to deliver the 2023/24 financial plan. However there remains significant risks in terms of Cost Improvement Plan delivery and operational pressures mean significant work will be required to deliver the financial plan.	Working on it
Ensure delivery of the large scale business cases for the Bassetlaw Emergency Care Village and the Montage Elective Orthopaedic Centre.		Jon Sargeant	DOF02	F&P / A&R	Approval of business cases.	2023-07-26	Despite difficulties with engagement with Partner Trusts the MEOC design has been signed off and work has started on the Mexborough site and in the Module Co factory. A revised governance structure has been implemented and the MEOC project board has met twice. BEV is moving at pace with orders raised initially at risk to maintain the timeline. Scheme received final approval on June 30th and MOU signed to allow drawdown of PDC.	Working on it	all of the major capital schemes have progressed and capital programmes all running to time and budget. Mexborough Elective Orthopaedic Centre (MEOC)is expected to be handed over on Dec 6th for final commissioning with expectation that unit be available from January 8th.	Working on it
Ensure the delivery of the Electronic Patient Record Business case.		Jon Sargeant	DOF03	F&P / A&R	Approval of business cases.	2023-07-26	The original plan and procurement for the EPR started to plan. Subsequently the procurement has been paused whilst the convergence issue is resolved with partners in the ICS.	Working on it	Now working with colleagues in NHSE and the ICB on a joint business case production. the change in direction has caused delay in the timetable for delivery of a Full Business Case to the January Board meeting.	Working on it
Refresh the Trusts financial controls to ensure the delivery of the Trusts financial plan. Identifying opportunities to improve the Trusts financial position to support the delivery of safe, sustainable, efficient and effective care.		Jon Sargeant	DOF04	F&P / A&R	Financial controls will be in place to ensure that the Trust resources are used to maximum effect	2023-07-26	SFI's and SO's updated for July ARC. Review of key controls undertaken in April and May. Grip and control meetings re-introduced.	Working on it	Completed.	Done
Support the delivery of capacity and capability for improvement to demonstrate compliance with NHS Impact.		Jon Sargeant	DOF05	F&P / A&R	The Trust will build upon the work already undertaken to demonstrate compliance with the actions and outcomes of NHS Impact.	2023-07-26	Initial plan taken to TEG and QI Business partners have been advertised to support divisions	Working on it	Resources are in place to support internal projects. Trusts approach is compliant with NHS Impact. Board workshop is planned for October 31st.	Done
Complete the Final Business Case for a New Hospital or an alternative strategy if funding from the New Hospital programme is unavailable.		Jon Sargeant	DOF05	F&P / A&R	The Trust will join the new hospital programme or begin the development of an alternative strategy to provide improved facilities for patients and colleagues.	2023-07-26	Board discussion held and next steps paper going to F&P.	Working on it	Work is currently underway to complete the potential bid should additional capital be identified in the Chancellors upcoming Autumn Statement	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
Ensure the delivery of the year 1 priorities in the new People Strategy		Zoe Lintin	CPO01	BOD / PC	Achieve the success measures in the delivery plan.	2023-07-26	Detailed delivery plans for each theme developed together with an agreed assurance reporting format for People Committee and through to Board. V1 of delivery plans presented at PC on 2 May and assurance report presented at PC on 4 July. Delivery plans on track. PC assured.	Working on it	People Strategy assurance reports presented at every People Committee meeting, highlighting key actions in previous 2 months, actions planned for next 2 months, success measures and risks/escalation. Underpinned by detailed delivery plans. PC assured in Q2 meetings.	Working on it

Name	Deputy CEO	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status
Ensure the delivery of year 1 priorities in the new Research and Innovations Strategy		Zoe Lintin	CPO02	BOD / PC	Achieve the success measures in the delivery plan.	2023-07-26	Delivery plan drafted and presented at Teaching Hospital Board for partner engagement and input. Assurance overview presented at People Committee on 4 July (PC assured). Successful external launch of the Research & Innovation Strategy on 29 June with partners. Board presentation scheduled for July.	Working on it	Further iteration of the delivery plan developed, following engagement with external partners. Agreed to use the same method of assurance reporting to People Committee as the People Strategy. Bi-annual reports/presentations to PC & Board July & January. Teaching Hospitals Board retain oversight at every meeting.	Working on it
Ensure development of a Trust wider strategic workforce plan including ambitions on development of new roles, supported by annual business planning processes and education programmes.		Zoe Lintin	CPO03	PC	Completion of the strategic workforce plan with appropriate success measures.	2023-07-26	Workforce planning and Learning Needs Analysis integrated into business planning processes. First deep dive workforce planning workshops held. Implementation of strategic workforce planning tool progressing with stakeholder engagement and scenario modelling - project on track. Reports on Workforce Supply & Demand to May & July People Committee (PC assured)	Working on it	Focused workforce planning support sessions introduced to complement deep dive workshops. Moved into third (& final) stage of the implementation of Strategic Workforce Planning tool, approach drafted to incorporate the tool within 2024/25 business planning processes. Quality improvement approach undertaken on 2023/24 business/workforce planning round, internally within DBTH and externally in collaboration with system partners. Workforce Supply & Demand reports presented at every People Committee meeting (PC assured in Q2 meetings)	Working on it
Launch the new DBTH Way Framework. Embedding as 'Life at DBTH, including recruitment, appraisals, and the leadership development offer.		Zoe Lintin	CPO04	BOD / PC	Implementation of the framework	2023-07-26	DBTH Way framework approved by Trust Executive Group and Board in May. Launched in June/July with further communications planned for Sept. Embedding plan being developed, with actions over a period of time.	Working on it	Communications launch continued over the Summer and included on all communications channels & the Hive. Email signature banner introduced, DBTH Way session included in corporate induction. Posters and large display boards being introduced at all 3 sites in early October. Facilitated sessions exploring what DBTH Way means for individuals & leaders held with Council of Governors and Trust Executive Group, with sessions planned for Leadership Assembly in November. Engagement & Leadership reports presented at every People Committee meeting (PC assured in Q2 meetings)	Working on it
Ensure the delivery of key organisational development/ cultural change programmes including flexible working and just culture, speaking up strategy and equality, diversity and inclusion plan.		Zoe Lintin	CPO05	PC	Implementation of agreed change programmes	2023-07-26	Flexible Working - well-attended Qi event on 13 June, project leads identified for each pillar of the workstream with volunteers from across the organisation, Steering Group recently established. Just Culture - Steering Group established with leads and action plan, Board pledges being rolled-out. EDI - action plan refreshed to incorporate NHSE High Impact Actions. Speaking Up - policy launched, engagement work ongoing. Regular reports to PC on all aspects (PC assured)	Working on it	Flexible Working - steering group meeting regularly, action plan built on Monday.com and project leads progressing actions. Just Culture - continued roll-out of pledges, ongoing programme of review of key HR policies including language, development sessions held with several teams. EDI - completion of Cohort 1 of new Board Development Delegate Programme with positive feedback & Cohort 2 commenced in Sept. Speaking Up - 'big conversations' and drop-in sessions continued, strategy in development phase, report to July Board. Regular reports to PC on all aspects (PC assured)	Working on it
Embed a new approach to year-round colleague engagement to achieve continued improvement in staff survey and learner survey feedback results and high participation in surveys.		Zoe Lintin	CPO06	PC	High participation in surveys & improving outcomes	2023-07-26	National staff survey results published in March. Engagement sessions with teams ongoing throughout Q1 to discuss local results and identify improvement actions - in line with new approach. Local improvement plans developed with summary plans at divisional/directorate level. Oversight through People & OD and overview of plans presented at People Committee on 4 July (PC assured). Trust-wide communications on improvement actions also ongoing with more planned in Q2.	Working on it	Engagement sessions and improvement/action planning on 2022 results continued during Q2. Preparations & communications/ engagement plan developed for 2023 survey, to build on new approach - survey went live 27/09/23. Completion rate at 43% at 13/10, survey closes end Nov. Engagement & Leadership report presented at every PC meeting (PC assured in Q2 meetings)	Working on it

Chief Operating Officer

Name	Chief Operating Officer	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status
Ensure the Trust has robust emergency planning, resilience and response arrangements in place, including an annual work plan and assurance process		Denise Smith	COO01	ARC	Effective EPRR plans will be in place	2023-07-26	Annual review of 2022/23 complete. Annual work plan for 2023/24 developed	Working on it	Annual Assurance self assessment completed. Annual workplan in place. Focus continues on remedial actions to achieve compliance with core standards	Working on it
Ensure the delivery of the urgent and emergency care improvement plan, in collaboration with system partners		Denise Smith	COO02	F&P	The Trust will deliver the national standards	2023-07-26	UEC improvement plan for Doncaster in place, SROs agreed and Project Charters complete. Project Groups established, improvement activities supported by ECIST	Working on it	Elective Care Intensive Support Team (ECIST) support formally withdrawn. No additional resource identified, impact on pace of change noted. SROs across Doncaster Place providing leadership.	Working on it

Name	Deputy CEO	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status
Ensure the delivery of access standard improvement trajectories, activity and improvement plans related to diagnostic services.		Denise Smith	COO03	QEC	The Trust will deliver the national standards	2023-07-26	Diagnostic deep dive completed. Diagnostic improvement plan agreed, project charter in place, project group established.	Working on it	Improvements in DM01 performance noted in Endoscopy and Non obstetric ultrasound. iRefer implemented in medical imaging, benefits realisation includes reduced CT demand and improved compliance with clinical guidelines	Working on it
Ensure the delivery of access standard improvement trajectories, activity and improvement plans related to elective care.		Denise Smith	COO04	F&P	The Trust will deliver the national standards	2023-07-26	Outpatient and Theatre improvement plan agreed, project charter in place, project group established. Elective Care Improvement Support Team invited to undertake a review.	Working on it	Delivery of 78 week waits in the majority of specialties. 65 week modelling complete.	Working on it
Ensure the delivery of access standard improvement trajectories, activity and improvement plans related to cancer care.		Denise Smith	COO05	F&P	The Trust will deliver the national standards	2023-07-26	Leadership and management of the Cancer Services Team moved to Chief Operating Officer. Weekly reporting of key metrics in place and monthly cancer services meeting established	Working on it	Sustained delivery of Faster Diagnosis Standards (FDS) and 31 day diagnosis to treatment standards. Improvements noted in 62 day standard	Working on it
Develop, agree and implement robust plans to manage 2023/24 winter pressures		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.	2023-07-26	Review of winter 2022/23 complete. Initial scoping for winter plan 2023/24 complete	Working on it	Winter planning priorities developed, in conjunction with divisional and corporate teams. Doncaster Place winter plan in development. Focus on robust escalation to maintain patient flow	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
Working with the Executive Medical Director ensure the achievement of the three year delivery plan for maternity and neonatal services		Karen Jessop	CN01	QEC	Work closely with Executive Medical Director, Divisional Director and Director of Midwifery to ensure the delivery of the 11 outcomes to ensure that services and safer, more personalised and more equitable.	2022-10-17	The single delivery plan was published at the end of March 2023 and the Chief Nurse discussed this in detail at the May Board Level Safety Champions meeting with Midwifery and Neonatal services. In June the Local Maternity and Neonatal System agreed a document to measure progress would be produced to ensure that as a system we are measuring the same outputs. Progress is monitored via the oversight committee in maternity services but includes Quarterly review against the maternity self assessment tool, commenced implementation of Saving Babies lives version 3 care bundle, Senior leadership team commenced the national perinatal culture and leadership programme and involvement in the PSIRF implementation at Trust and LMNS level. Ongoing recruitment as previously described at relevant trust committees.	Working on it	The Local Maternity and Neonatal service (LMNS) are working on an assurance document to incorporate all elements of the three year delivery plan. This document will be reviewed by the Director of Midwifery once received. Maternity safety champions visits and meetings are becoming more established with Neonatal Colleagues engaged. The MNVP chair attended the September meeting and now has a standing invitation.. The leadership team continue to engage with the NHSE perinatal culture programme and also the Trust programme that is running alongside it. The Newly Qualified Midwife cohort is now approx. 30 WTE and expected to commence work in the next 2 months.	Working on it
Develop and commence the implementation of a comprehensive Nursing, Midwifery and Allied Health Professional Quality Strategy that improves patient outcomes and experience.		Karen Jessop	CN02	QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet and exceed the CQC standards	2022-10-17	Quality Strategy has been developed and draft discussed in various forums across the Trust, the Head of Patient Experience has shared with Healthwatch and patient representatives. All Divisions were asked to engage with their teams in relation to the content and Allied Health Professionals (AHPs) have been consulted via the Director of AHPs. The Quality Strategy (draft) was shared and discussed at Quality and Effectiveness Committee on 6th June 2023 and at a Chief Nurse listening event. Next steps are to agree final sign off and development of detailed delivery plans	Working on it	Following feedback from the Non Executive Directors (NED's) and other stakeholders at the Quality and Effectiveness committee in June a final version of the strategy was presented and approved at the Trust Board of Directors in September. A senior responsible officer has been identified for each theme, (some of the Directors of Nursing (DN's) only commenced in post within the last few weeks) and they will be responsible for providing detailed delivery plans of each strategic theme. A prioritisation of the outcomes over the 4 years of the plan is underdevelopment.	Working on it
Develop and implement a ward to board assurance process, incorporating peer review,		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	The Accreditation framework has now been drafted and shared widely for comments. Engagement sessions with colleagues have taken place. The accreditation process links with Tendable and the planned Quality Dashboard, to enable good triangulation of data. The draft accreditation documentation is being trialled in 4 clinical areas. Peer assessment questions are being developed to ensure consistency of the peer assessment process and the full launch is planned for September when the first peer visits will take place. A CARE excellence study day is being planned to support teams in relation to both the Quality strategy and accreditation.	Working on it	Accreditation questions drafted and undergoing final review before piloting in maternity and acute. These will then be uploaded to Tendable. Care excellence study day in progress Some slight slippage in roll out of pilot, due to the feedback on questions and uploading to tenable	Working on it

Name	Deputy CEO	Person	Reference	Oversight	Expected Outcomes	Date of next update required for Board	Q1 update	Q1 Status	Q2 update	Q2 Status
Achieve implementation of the Patient Safety Response Framework (PSIRF) in line with the National Implementation timescales.		Karen Jessop	CN04	QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet and exceed the CQC standards	2022-10-17	The PSIRF implementation group meets monthly with further task and finish groups established as required, the key stakeholders include active participation from place colleagues. The Trust links with both ICB safety groups to support plans/progression with shared learning. The 6 transition phases are monitored and measured on Monday.com and are aligned with the NHSE recommended plans. Phase 1 - Orientation is complete 2. Diagnostic and Discovery, progress made as planned, including joint launch of the Just Culture with P&OD 3. Governance and Quality - all existing incident management processes in divisions mapped by QI and recommendations for future incident triage and action management are being developed 4. PSIR Planning - Thematic analysis now underway with support from the University of Sheffield. Once complete the PSIR plan will be drafted to present to Board and divisional clinical governance meetings to consider the data and identify key priorities. Progress has already been made with using PSIRF methodology in Falls and the Skin integrity improvement streams	Working on it	Implementation meetings continue, Chaired by the Chief Nurse, and with good attendance from internal and external stakeholders North of England Commissioning completed the external validation of thematic analysis of Patient Safety Incidents and Patient Experience Data to support the identification of the Patient Safety incident profile to inform the Patient safety incident response plan Draft of the Patient Safety Incident response Policy and Plan circulated for comments and to be presented for approval at relevant Trust committees Meeting planned with SY ICB to discuss formal transition dates Business case in draft for training requirements, Family Liaison Officers and Patient Safety Partner roles, for submission to relevant Trust committees Patient Safety Incident Review Framework (PSIRF) communication plan implemented including, 4 trust wide PSIRF teams listening events, attendance by team at a wide range of Trust committees, production of comms materials including an animation, and PSIRF page on the HIVE. Training at level 1 and level 2 advertised and waiting compliance figures.	Working on it
Embed safe staffing principles for nursing and midwifery, incorporating the use of relevant professional evidence based decision support tools to ensure safe, evidence based nursing and midwifery staffing levels across the Trust.		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	Established a comprehensive "safe staffing" report in line with national quality board guidance that is reported regularly via the People Committee NHS England regional colleagues undertook a review of DBTH processes at our invitations that report has now been received, a summary of recommendations and actions will be reported to the People Committee Risk has been identified in relation to establishment skill mix, added to the risk register and mitigations in place with a plan to be presented and approved by executive colleagues to resolve. Twice daily staffing meetings are established across the Trust on both sites, 7 days a week to support safe staffing decision making. Safer Nursing Care Tool data collected in November has been reviewed and scrutinised by external CNO safe staffing fellows and the second biannual data collection has been completed in June, these data will be analysed and once completed, presented to the Trust Board following ratification through trust processes and in alignment with National guidance.	Working on it	Biannual establishment reviews for Children and Young People, Emergency Department (ED)and Adult Inpatients and assessment areas have commenced and up to date Safer Nursing Care Tool (SNCT) licenses held by DBTH to utilise the evidence based tools Plan in place for "update" training and inter reliability assessments for all involved in SNCT data collection Trust processes now include clear evidence of the use of Professional judgement and involvement of every ward/dept leader, collated using the nationally recommended documentation June 2023 data collection complete for Adult IP and assessment areas, draft report review in progress by CN, Exec and People committee presentation planned for Q3 Support requested from PMO team for data analysis, to establish a more efficient process for the November data collection and subsequent analysis Safe Care pilot to be completed in Q3 with ongoing work to refine data reporting processes in relation to availability of divisional information for effective rostering and use of red flags.	Working on it

2310 - D2 BOARD ASSURANCE FRAMEWORK (RISKS 1-7) & TRUST RISK REGISTER 15+

Discussion Item | Zara Jones, Deputy Chief Executive | 10:25

Executive Directors
25 minutes

REFERENCES

Only PDFs are attached

- D2 - Board Assurance Framework.pdf
- D2 - Appendix 1 BAF (Risks 1-7).pdf
- D2 - Appendix 2 Trust Risk Report 15+.pdf
- E1 - Board Assurance Framework.xlsx

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	31 October 2023	**Agenda Reference:**	**D2**
Report Title:	**Board Assurance Framework (BAF) & Trust Risk Register (TRR15+)**		
Sponsor:	Zara Jones, Deputy Chief Executive Officer		
Author:	Fiona Dunn, Director Corporate Affairs		
Appendices:	Appendix 1 BAF (risk 1-7) Appendix 2 TRR15+		

Report Summary

Following review at each of the Board Committees held after July 2023 the new Board Assurance Framework (BAF) has been updated to meet the recommended requirements from the Head of Internal audit opinion during 2022/2023 to clearly articulate the strategic risks that could impact on the strategic objectives.

The revised format enables the Board and Board Committees to have a clear understanding of, and focus on the agreed risks, current risk level, current controls, what assurance is available to confirm the level of risk and what actions can and are being taken to bring the risk to a target score.

The Board Assurance Framework is enclosed in appendix 1 for Board review and assurance. The BAF will be presented quarterly to the Board of Directors with the Trust Risk Register TRR15+ and the quarterly Corporate Objectives update (April, July, October, January) commencing from October 2023 Board.

All new BAF risks (1-7) have been reviewed by Board Committees since its initial launch July and a list of the dates are shown below:

- Quality & Effectiveness Committee – 1st August
- People Committee – 5th September
- Finance & Performance Committee – 21st September

Assurance on the BAF risks discussed at each meeting was captured in the respective meeting minutes and summarised for assurance in the relevant committee chairs quadrant highlight report.

Further work on the BAF development will include validation as to which Committee the deep discussion on each of the BAF risks will occur at, along with alignment of the levels of assurance to the new four level model now described within the guidance section of the BAF.

The new Trust Risk Register (TRR15+) has been included as appendix 2 and compliments the BAF with details of operational risks that may impact on the strategic risks highlighted in each BAF risk 1-7.

The new Trust Risk Register (TRR15+) is compiled of all Risks with a grade of 15 or more. It contains the overarching and stand-alone risks and notates the dependent risks. Dependent risks can be seen on linked records field of the Overarching risk. The top 3 risk themes on the Trust Risk Register still pertain to:

1.Workforce
2.Finance
3.Infrastructure (Estate and Equipment)

The risk register details the status of each risk, from newly identified to archived risks including the review status by the Risk Management Board. All details pertaining to each risk can be accessed via the DATIX risk management system.

Risks impacting on any strategic risk are referenced within the individual BAF risk.

Summary

DBTH Internal auditors (360 Assurance) have confirmed that the refreshed BAF now articulates seven strategic risks which link to its extant strategies and that the reviewed Risk Management Policy reflects the current strategic risk management arrangements.

DBTH will continue to develop the BAF and embed the risk management processes as the year progresses and 360 Assurance will evaluate assurance of this through stages 2 and 3 of their Head of internal Audit opinion.

Recommendation:	The Board is asked to note the updated BAF strategic risks for 2023/ 2024 (appendix 1) & updated Trust Risk Register (TRR15+)			
Action Required:	~~Approval~~	~~Discussion~~	**Take assurance**	~~Information~~
Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**
	To provide outstanding care and improve patient experience	*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***
Is the content of this paper is aligned to the strategic direction of:	**South Yorkshire ICS**		**Nottingham & Nottinghamshire ICS**	
	N/A		N/A	

Implications	
Board assurance framework:	The entire Board Assurance framework (BAF) has been reviewed at each of the three Board Committees
Risk register:	The revised BAF strengthens the relationship between corporate risks and risks to the delivery of the Trust Strategic objectives.
Regulation:	All NHS Trusts are required to have a Board Assurance framework and systems in place to identify and identify and manage risks effectively.
Legal:	Compliance with regulated activities and requirements in Health and Social Care.
Resources:	Actions required are currently being delivered within existing Trust resources and highlighted in the individual risks.

Assurance Route	
Previously considered by:	The Executive team Board Committees
Date:	Sub committees
Any outcomes/next steps	The BAF's will be reviewed at Board Committees as determined by the Committee, with oversight of the full BAF reported to the Board of Directors: • Quarter 2 - October 2023 • Quarter 3 - January 2024 • Quarter 4 - April 2024

Previously circulated reports to supplement this paper:	During 2022/2023 draft BAFs, and development work has been undertaken by the Board and Trust Executive Group.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK

October 2023


NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust
Our vision
The ambition of the Trust
To be the safest trust in England, outstanding in all that we do.
True north
How we arrive at our vision
Objective one: To provide outstanding care and improve patient experience.
Objective two: Everybody knows their role in achieving the vision.
Objective three: Feedback from colleagues and learners in top 10% in UK.
Objective four: The Trust is in recurrent surplus to invest in improving patient care
Breakthrough
How we will move to deliver our True North in 2023/24.
Objective one: Maintain and improve CQC ratings by achieving improvements in quality and outcomes.
Objective two: Ensure Divisions and Directorates have the capacity, capability and support to deliver our 2023/24 objectives.
Objective three: Demonstrate Trust-wide cultivation of an inclusive, caring and kind culture to ultimately drive improvement in patient and colleague feedback.
Objective four: Demonstrate clear improvements in efficiency and effectiveness to achieve our financial control totals.
People
Performance
Patients
Partners
Prevention
Our Foundations

BOARD ASSURANCE FRAMEWORK SUMMARY

Oct-23

Strategic Objective	BAF Ref	BAF Executive Owner	Strategic Risk IF	Strategic Risk THEN	Oversight Committee	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-22	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Current LxC	Current	Target Score
PATIENTS	BAF 1	Chief Nurse	DBTH is not a safe trust which demonstrates continual learning and improvement	Risk of avoidable harm and poor patient outcomes/experience and possible regulatory action	QEC	NA	NA	NA	12	12	12	16						4 (L) x 4 (C)	16	16
PEOPLE	BAF 2	Chief People Officer	DBTH is unable to recruit, motivate, retain and develop sufficiently skilled workforce to deliver services	Patient and colleague experience and service delivery would be negatively impacted and would not be embedded inclusive culture in line with our DBTH Way	PEOPLE	NA	NA	NA	9	12	12	12						4 (L) x 3 (C)	12	12
PERFORMANCE (Operational)	BAF 3	Chief Operating Officer	Demand for services at DBTH exceeds capacity	Impacts on safety, effectiveness, experience of patients and meeting national and local quality standards	F&P	NA	NA	NA	16	16	16	12						4 (L) x 3(C)	12	12
PERFORMANCE (Estates)	BAF 4	Chief Financial Officer	DBTH's estate is not fit for purpose	DBTH cannot deliver services and this impacts on experience for patients and colleagues	F&P	NA	NA	NA	16	20	20	20						4/5 (L) x 4 (C)	20	20
PERFORMANCE (Financial)	BAF 5	Chief Financial Officer	DBTH cannot deliver the financial plan	DBTH will be unable to deliver services and the Trust may not be financially sustainable in long term	F&P	NA	NA	NA	16	16	16	16						3 (L) x 4 (C)	16	12
PARTNERS/ PREVENTION	BAF 6	Dep CEO	DBTH does not effectively engage and collaborate with its partners and communities will miss opportunities to address strategic risks which require partnership solutions	DBTH fails to meet its' duty to collaborate and deliver integrated care for benefit of people of Doncaster and Bassetlaw	ARC	NA	NA	NA	6	6	6	6						2 (L) x 3 (C)	6	6
QUALITY IMPROVEMENT	BAF 7	Chief Financial Officer	DBTH does not deliver continual quality improvement, research, transformation &innovation	the Organisation won't be sustainable in long term	F&P	NA	NA	NA	6	6	6	6						2 (L) x 3 (C)	6	6

Links to Strategic Ambitions	Strategic Objective	Breakthrough Objective
True North Strategic Aim 1 Patients	To provide outstanding care and improve patient experience	Ensure Divisions & Directorates have the capacity and capability and support to deliver our 2023/24 objectives

BAF 1 Executive Owner	Strategic Risk		Current Risk Score
Karen Jessop Chief Nurse	BAF1	If DBTH is not a safe trust which demonstrates continual learning and improvement then risk of avoidable harm and poor patient outcomes/experience and possible regulatory action	16

Key Issues

Lack of learning from incidents, risks,complaints inquests and deaths
Lack of consistent standards of care
Mental capacity act and deprivation of liberty safeguards compliance
Accessible information standard (AIS)
Safeguarding compliance with National Safeguarding accountability and assurance framework
Learning from Patient Safety Events
Clinical Negligency Scheme for Trusts (Yr 5) published
Awaiting draft CQC report following inspection

Overseeing Committee

Quality & Effectiveness Committee (QEC)

Date of last Committee review

1st August 2023

Risk Assessment	onsequenc	Likelihood	Risk Score
Initial Risk assessment (July -23)	4	3	12
Current Risk assessment	4	4	16
Target Risk (Plan for Dec 23)	4	4	16
Target Risk (Plan for Mar 24)	3	4	12

Risk Appetite

Quality- (OPEN)-We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards
Regulatory / Compliance (MINIMAL) We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.

Key controls currently in place to manage the risk	Key assurances relating to effectiveness of the controls & associated Line of Defence	Current Assurance Level Assigned
1) Nursing Midwifery and Allied Health Professional Quality Strategy (2023-2027) will be reported via the Quality and Effectiveness Committee	Chief Nurse Senior leadership team (1)	Partially assured
	Reporting to Quality and Effectiveness Committee (2)	*
	Quality steering Group (2)	Full Assurance
	PSIRF Implementation Group (2)	Full Assurance
	Approved NMAHPS Quality Strategy with SROs for each theme	Significant assurance
2) Chief Nurse Quality Oversight framework, developed and implementation commenced	Chief Nuse Quality and Safety Report to QEC (2)	Full Assurance
	Picker Patient surveys UEC and Maternity (3)	Partial Assurance
	CQC Monthly engagement meetings (3)	Full Assurance
	Chief Nurse Executive Group (2)	Significant Assurance
	Patient Experience and Involvement Committee (2)	Full Assurance
	Recent CQC Core Services Inspection with immediate action plan	Partial Assurance
3) Maternity services has executive level oversight: CN Board level Safety Champion	CNST and Ockenden Oversight Meeting (1)	Full Assurance
	Children and Families Board (2)	Significant Assurance
	Maternity and Neonatal report to Board Monthly (2)	Full Assurance
	Bi Monthly ED and NED safety champion visits & mtg	Full Assurance
	LMNS CNST Check and Challenge Meeting (3)	Awaiting written confirmation
4) Clinical Goverance processes in place and established	Trust Clinical Governance Meeting (2)	Partial Assurance
	Divisional Governance meetings (1)	Partial Assurance
	Mortality Governance and Data Assurance Group (1)	Not Assured
	Audit and Effectiveness Committee (2)	Partial Assurance
	Internal audit Report Clinical Audit (3)	Partial Assurance
	Learning from deaths Quarterly report (2)	Not Assured
	Medical Examiner external review (3)	Full Assurance
5) Risk Management Board established and working effectively	Risk Management Board monthly meeting (2)	Partial Assurance
	Internal audit Report - Divisional Risk Management (3)	Partial Assurance

Significant gaps in current controls	Areas where further assurance against controls is required
Lack of Quality Dashboard	CNST Year 5 evidence collation ongoing
Divisional Clinical Audit processes	
High level delivery plans for NMAHPs Quality Strategy to be developed	
CNST Year 2 NHSR review, potential for repayment due to ? Non compliance	
Learning from deaths, SJR processes under review by EMD (interim)	

Key actions to close gaps

	Lead	Target Date	Progress
SNCT biannual report	CN	Nov-23	report in draft, will be finalised and submitted November People Committee
MHA SLA to be agreed with Notts	EMD	Nov-23	EMD team in communication with Notts, awaiting formal sign off
MCA & Dols 360 audit commissioned	CN and EMD	Quarter 3	Audit planned for End of October 2023
IT developing Quality Dashboard	CFO	Quarter 3	Still in development, some delays due to metrics/data
CQC Immediate action plan	CN	Dec-23	Immediate actions implemented, plan to finalise before draft report
Accessible information standards gap analysis complete	CN	Quarter 4	Trust Task and Finish group established to progress
Delivery of complete action plan internal Audit on risk	EMD	Quarter 4	Action plan developed with timelines for all actions in progress
Planned meeting with NHSR to review CNST Year 2	CN	Nov-23	Review of 2019 submission underway, mtg in the diary
Associate MD developing LFD/SJR action plan	EMD	Quarter 4	1 day a week SJR support identified.

Links to Operational Risks

Ref Consequence Likelihood Risk Score

3112	3	2	6	Patient Safety Incident Response Framework- compliance with meeting deadline for completing implementation of PSIRF
3291	3	4	12	Behaviour of Concern
3197	4	4	16	Safeguarding Compliance
3063	3	4	12	Receipting of Mental Health Act Papers (Bassetlaw)
3246	5	3	15	Mental Capacity Act and Deprivation of Liberty Safeguards
3350	5	4	20	Risk of Non Compliance with Year 5 CNST
3198	3	4	12	Lack of Quality Dashboard

Board Assurance Framework 2023/24

Links to Strategic Ambitions	Strategic Objective	Breakthrough Objective
True North Strategic Aim 3 People	Team DBTH feel valued and feedback from colleagues and learners in top 10% in UK	Demonstrate Trust-wide cultivation of an inclusive, caring and kind culture to ultimately drive improvement in patient and colleague feedback

BAF 2 Executive Owner	Strategic Risk		Current Risk Score
Zoe Lintin Chief People Officer	BAF2	If DBTH is unable to recruit, motivate, retain and develop a sufficiently skilled workforce to deliver services then patient and colleague experience and service delivery would be negatively impacted and we would not embed an inclusive culture in line with our DBTH Way	12

Key issues

Availability of overall workforce in context of national shortages in some areas
National context of continuing industrial action
Introduction of NHS Long Term Workforce Plan and alignment with our People Strategy

Overseeing Committee

People Committee

Date of last Committee review

Committee review
Board - 31 Oct, PC - 7 Nov

Risk Assessment	Consequenc	Likelihood	Risk Score
Initial Risk Assessment **(Jul- 23)**	3	4	**12**
Current Risk Assessment	3	4	**12**
Target Risk **(Plan for Dec-23)**	3	4	**12**
Target Risk **(Plan for Mar-24)**	3	3	**9**

Risk Appetite

People- (OPEN)-We are open to developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with our statutory duties.
We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.

	Key controls currently in place to manage the risk	Key assurances relating to effectiveness of the controls & associated Line of Defence	Current Assurance Level Assigned
1	People Strategy 2023-27 launched May 2023, with detailed delivery plans and regular assurance reporting to People Committee	Chief People Officer Senior Leadership Team (1)	Assured
		Reports to every People Committee meeting (2)	Assured
		Annual staff survey results and learner surveys (3)	Assured
		Recognition and award nominations at national level (3)	Assured
2	Development of strategic Trust-wide workforce plan, including implementation of strategic workforce planning tool and embedding of deep dive/focus workshop approach	Workforce & Education Committee (1)	Assured
		Reports to every People Committee meeting (2)	Assured
		Internal audit report - Recruitment (22/23) (3)	Partial Assurance
		Inernal audit report - Return to work interviews (22/23) (3)	Moderate assurance
3	Launch and ongoing embedding of the DBTH Way to set out expectations on behaviours and embed an open and inclusive organisational culture	Reports to Trust Executive Group (1)	Assured
		Reports to People Committee (2)	Assured
		Annual staff survey results and learner surveys (3)	Assured
4	Equality, diversity and inclusion action plan including NHS England high impact actions	EDI Committee (1)	Assured
		Reports to People Committee (2)	Assured
		Annual staff survey results and learner surveys (3)	Assured
		NHS England Dashboard (3)	Uses WRES & WDES data currently
5	Provision of quality education, learning and development	Workforce & Education Committee (1)	Assured
		Reports to Trust Executive Group (1)	Assured
		Reports to every People Committee meeting (2)	Assured
		Education quality visits (Q 3/4 22/23) (3)	Assured
		Learner surveys (3)	Assured

Significant gaps in current controls	Areas where further assurance against controls is required
Estates/environment impacts on colleague morale and training capacity	Strategic issue, local mitigation
2. Succession and talent management approaches to be embedded	2. Succession planning approach agreed for roll-out Q3, Talent management tools under development in Q3 - plan to launch to complement Appraisal season 2024, with a pilot initially
3. Retention data requires review through exit interview themes	3. New format for capturing exit interview data launched Q2 to increase amount of data received, plan to review data from end Q3, to present at WEC & PC Q4

Key actions to close gaps

Ref	Action	Lead	Target Date	Progress
1	Delivery of year 1 of People Strategy in line with agreed delivery plan	Zoe Lintin	31/03/2024 for year 1	Delivery plans updated Oct 23 and assurance report to be presented at People Committee on 7 Nov. Plans on track, actions completed.
3	Launch DBTH Way with communications and embedding plan	Zoe Lintin	30/09/2023 for launch - to be completed 31/10/23. Embedding is throughout 2023/24 & future years	Launch started in June/July 2024 & continued in Sept & Oct. Update to be presented to PC on 7 Nov as part of Engagement & Leadership report.
2	Implementation of strategic workforce planning tool and embedding of deep dive and focus workshops	Zoe Lintin/Anthony Jones	Mar-24	Implementation phase continues with scenario building, modelling, training and ongoing engagement. Update & demo of the tool to be presented to PC on 7 Nov in Workforce Supply & Demand report.
4	Refresh of EDI plan to include NHSE High Impact Actions and delivery of 2023/24 actions in the plan	Zoe Lintin/Gavin Portier	Mar-24	EDI action plan refreshed to reflect NHS High Impact Actions with new actions added. Presented to People Committee on 4 July, Committee assured. Summary to Board on 25 July . Board Assured. Update EDI report
1	Delivery of education priorities within People Strategy and Research & Innovation Strategy including new Education Quality Framework	Zoe Lintin/Sam Debbage	31/03/2024 for year 1	Plans on track. Education report and Widening participation Q2 report to be presented at People Committee on 7 Nov. Education Quality Framework developed, approved and introduced - to be launched on larger scale at the first Quality seminar in Nov (aligned with the Quality Strategy).

Links to Operational Risks

Ref	Consequen	Likelihood	Risk Score	Risk Title
19 PEO1	4	3	12	Inability to engage with and involve colleagues, learners and representatives to improve experiences at work

Board Assurance Framework 2023/24

Links to Strategic Ambitions	Strategic Objective	Breakthrough Objective
True North Strategic Aim 2 Performance (Operational)	Everybody knows their role in achieving the vision	Ensure Divisions & Directorates have the capacity and capability and support to deliver our 2023/24 objectives

BAF 3 Executive Owner	Strategic Risk		Current Risk Score
Denise Smith Chief Operating Officer	BAF3	**If Demand for services at DBTH exceeds capacity then this Impacts on safety, effectiveness, experience of patients and meeting national and local quality standards**	12

Key issues

Increased waiting list size following the pandemic
Increased waiting times following the pandemic with long waits for elective surgery
Lack of capacity to meet the demand and clear the backlog
Underutilisation of clinical capacity
High bed occupancy and low bed base per 1000 population compared to peers

Overseeing Committee

Finance & Performance Committee

Date of last Committee review

Sep-23

Risk Assessment	Impact	Likelihood	Risk Score
Initial Risk Assessment **(Jul- 23)**	4	4	**16**
Current Risk Assessment	3	4	**12**
Target Risk **(Plan for Dec-23)**	3	4	**12**
Target Risk **(Plan for Mar-24**)	3	3	**9**

Risk Appetite

Quality- (OPEN)-We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards
Regulatory / Compliance (MINIMAL) We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.

Key controls currently in place to manage the risk	Key assurances relating to effectiveness of the controls & associated Line of Defence	Current Assurance Level Assigned
1. Urgent and Emergency Care Improvement Programme which includes maximising same day emergency care and reducing length of stay in order to reduce inpatient bed demand and bed occupancy	Monthly SRO oversight through the Programme Board (1) Monthly highlight reports to Doncaster UEC Delivery Board (2) Monthly report to Transformation Board (2) Monthly report to F&P (2) National data submissions confirm Trust position / performance (2) Monthly ICB / Regional report detailing performance / benchmarking (2) GIRFT reports (3) Model health reports (3) Trust participation in national benchmarking programme (3)	Partially Assured
2. Diagnostic Improvement Programme to ensure demand is in line with clinical guidelines / best practice and to maximise productivity and efficiency	Monthly SRO oversight through the Programme Board (1) Monthly Diagnostic & Elective Oversight Group for Acute Fed performance (2) Monthly Programme Board report to Transformation Board (2) Monthly Access Standards report to F&P (2) National data submissions confirm Trust position / performance (2) GIRFT reports (3) JAG accreditation for Endoscopy (3) Model Health reports (3)	Partially Assured
3. Outpatient Improvement Programme to manage demand for new / follow up appointments, maximise technology enabled care and maximise productivity and efficiency	Monthly SRO oversight through the Programme Board (1) Monthly Diagnostic & Elective Oversight Group for Acute Fed performance (2) Monthly report to Transformation Board (2) Monthly Access Standards report to F&P (2) National data submissions confirm Trust position / performance (2) GIRFT reports (3) Model health reports (3) Trust participation in national benchmarking programme (3) Internal audit report (waiting list management) (3)	Partially Assured
4. Theatres Improvement Programme to maximise productivity and efficiency	Monthly SRO oversight through the Programme Board (1) Monthly Diagnostic & Elective Oversight Group for Acute Fed performance(2) Monthly report to Transformation Board (2) Monthly Access Standards report to F&P (2) National data submissions confirm Trust position / performance (2) GIRFT reports (3) Model health reports (3) Trust participation in national benchmarking programme (3) Internal audit report (waiting list management) (3)	Partially Assured

Significant gaps in current controls	Areas where further assurance against controls is required
Lack of Harm Review Policy	Elective IST review of cancer services to be undertaken
Capacity and demand modelling not yet complete	Development of cancer waiting times dashboard
Revised elective operational governance framework not yet in place	
Improvement plan not yet in place for the excellence in basics of elective care	
Clinical categorisation of patients not currently in line with national guidance	
Comprehensive elective recovery plan not yet in place	
Bed modelling not yet complete	

Key actions to close gaps

Ref	Action	Lead	Target Date	Progress
1	Harm Review Policy in place and implemented	COO	Dec-23	Policy drafted, to be circulated for comment and ready for sign off at TEG in Nov 23

2	Complete capacity and demand modelling (using nationally recognised tools)	COO	Jan-24	BI teams developing as part of 24/25 planning round, to be shared with Operational Teams once drafted
3	Implement revised elective governance arrangements, in line with Elective IST recommendations	COO	Dec-23	Access Manager in post. Deputy COO (Elective) appointed, start date TBC. Corporate PTL meetings to recommence Nov 23. Elective Governance structure to be shared with TED in Nov 23
4	Develop elective care improvement plan	COO	Dec-23	Review of national guidance underway and this, together with recommendations from the Elective IST report will form the basis of the elective care improvement plan. Plan to be shared with TEG in Nov 23
5	Clinical categorisation of patients not currently in line with national guidance	COO	Dec-23	Review of current processes complete. Internal audit report received. Trust Policy to be developed and implemented. Policy to be shared with TEG by Dec 23
6	Comprehensive elective recovery plan not yet in place	COO	Sep-23	65 week trajectories complete. Divisions to confirm actions to mitigate risk / close the gap
7	Bed modelling not yet complete	COO	Dec-23	Initial bed modelling complete (supported by ECIST). Scenario modelling complete (supported by ECIST). Final bed modelling to be share with TEG Dec 23

Links to Operational Risks

Ref	Consequence	Likelihood	Risk Score	Risk Title

Board Assurance Framework 2023/24

Links to Strategic Ambitions	Strategic Objective	Breakthrough Objective
True North Strategic Aim 4 Performance (Estates)	To be In recurrent surplus to invest in improving patient care	Demonstrate clear improvements in efficiency and effectiveness to achieve our financial control totals.

BAF 4 Executive Owner	Strategic Risk		Current Risk Score
Jon Sargeant Chief Financial Officer	BAF4	If DBTH's estate is not fit for purpose then DBTH cannot deliver services and this impacts on outcomes & experience for patients and colleagues	20

Key issues

Failure to ensure that estates infrastructure is adequately maintained and upgraded in line with current legislation(i) Breaches of regulatory compliance and enforcement including:

Risk of Failure of Critical Ventilation Plant Throughout the Trust due to Condition and Operating Standard Non-Conformance. A significant number of the critical air handling systems providing supply and exhaust ventilation to operating theatres and other critical areas Trust wide are not fit for purpose and do not comply with the standards of: HTM 03-01, Health Building Note 26 and NHS Model Engineering Specification CO4. In many cases the 6/7 facet information and annual verification reports identify the plant as being
- Aged
- Life expired
- Unsuitable
- Inappropriate

Fire - Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the RRFSO. Increased Risk to Life and Property in the Event of Fire Due to Current Inadequacy of Fire Compartmentation ire compartmentation has been identified as being inadequate in each of the Trust's properties. Fire compartmentation is required to minimise the spread of fire and smoke, and to facilitate progressive horizontal evacuation (PHE) strategies. As a result there is currently an increased risk to life and property in the event of fire. Update: Suspected Fire Incident occured 22nd October in South Block, full evacuation required due to strong smell of smoke, smoke and presence of soot/ash covering S12. SYFR investigated, felt to be ventialtion system pulling in smoke/odour from external bonfires in neighbouring gardens.

Electrical - Risk of electrical failure due to age and condition of HV/LV infrastructure AE Audit reports completed across Trust properties for HV/LV electrical systems have identified a number of non-compliances with the requirements of HTM 06-01, HTM06-02 & HTM 06-03.

Water Systems/Legionella - Local Water Storage Tanks Local cold water storage tanks located Trust-wide have been identified as requiring remedial work and/or replacement due to their age and condition.The tank condition has been verified by both 6 facet surveys and water quality risk assessments.Failure to maintain clean, safe and appropriate water storage systems poses an increased risk of unsafe water systems, leading to a risk to all users

Lifts - 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

Overseeing Committee

Finance & Performance Committee

Date of last Committee review

Risk Assessment	Impact	Likelihood	Risk Score
Initial Risk Assessment **(Jul- 23)**	4	4	16
Current Risk Assessment	4	5	20
Target Risk **(Plan for Dec-23)**	4	5	20
Target Risk **(Plan for Mar-24**)	4	5	20

Risk Appetite

Finance/VFM- (OPEN) We strive to deliver our services within the budgets set out in our financial plans and are prepared to accept some financial risk as long as appropriate controls are in place.
We have a holistic understanding of VFM with price not the overriding factor.

	Key controls currently in place to manage the risk	Key assurances relating to effectiveness of the controls & associated Line of Defence	Current Assurance Level Assigned
1	Granger Review 2021 & action plan contians a number of actions that are either completed or on track. Incldues an action to purchase Top-Up Insurance for DRI site Monitored via F&P	Reports to Audit and Risk Committee (via H&S Report) (2) Reports to Finance & Performance Committee (2)	Significant Assurance - with minor improvement opportunities Significant Assurance - with minor improvement opportunities
2	Full Asset capture 2022/23 - informing bussiness case to increase Planned Preventative Maintenance schedule to reflect infrastrucutre risks in line with industry standard SFG 20. Review incldued all sites. Business case due to November CIG	Reports to Finance & Performance Committee (2)	Significant Assurance - with minor improvement opportunities Partial Assurance - with improvements required
3	Report provided to BoD June regarding way forward for DRI site to invest in the current site, and progress the support for the new build bid. Both pieces of work aim to eradicate risk of poor infrastrucutre of the DRI site. Update: Request from DHSC to develop bid (s) to reduce risk and backlog on DRI site, focus on highest risk block east Ward Block, additional bids for theatres/relocation of DCC to ESAC/Complete W&C fire works and refurb	Board Report (1)	Partial Assurance - with improvements required
4	Annual Capital Programme developed using Risk Based methododlogy - focus on DRI backlog/Critical infrastrucutre risk reduction. £74m invested in DRI site in last 5 years	Annual Porgramme to Board of Directors for approval (2) Annual Programme to ICB for information (3) Reports to Finance & Performance Committee (2)	Significant Assurance - with minor improvement opportunities Significant Assurance - with minor improvement opportunities
5	Key Financial Control Processes in place: Vacancy Control Panel, CIG, Grip and Control, Capital Monitoring Committee, Cash Committee. Reintroduction of financial escalation process with Divisions from June.	POSM & Transforamtion meetings (1) 360 assurance performance mgt audit Q4 2022/23 (3)	Significant Assurance - with minor improvement opportunities Significant Assurance - with minor improvement opportunities
6	Comprehensive EFM Risk Register in place, containign actions to mitigate and eradicaqte risk	Internal Audit 21/22 (3) Reports to Audit and Risk Committee (via H&S Report) Reports to Finance & Performance Committee (2)	Significant Assurance - with minor improvement opportunities

Significant gaps in current controls	Areas where further assurance against controls is required
Sufficient investment to eradicate backlog/infrastuructre risk at the DRI site	Further assurance Enhanced planned preventative matainten
lack of an effective capital regime	

A requirement for additonal revenue to support Top Up Insurance of £500k pa and increased estates resource value tbc	

Key actions to close gaps

Ref	Action	Lead	Target Date	Progress
3	Develop options for investment of the current DRI site, as per request from DHSC to develop bid (s) to reduce risk and backlog on DRI site, focus on highest risk block east Ward Block, additional bids for theatres/relocation of DCC to ESAC/Complete W&C fire works and refurb	JS	Dec-23	Paper to Board in June, Paper F&P 26th July 2023. updated paper to F&P and BoD in Sept re Autumn statement funding announcement
3	Progress with bid for new DRI site	JS	Mar-25	Paper to Board in June, Paper to F&P 26th July 2023
3	Discuss National Audit Office findings relating to DRI being removed from the list of 40 new hospitals with DoHSC and NHSE	RP/JS	Aug-23	Paper to Board in June, Paper to F&P 26th July 2023
2	Prepare to submit Short Form Business case for any funding that may become available in the Autumn of 2023	JS	Sep-23	Paper to Board in June, Paper to F&P 26th July 2023
2	Business case to CIG November to support PPM	JS	Aug-23	
1	Business case for Top Up Insurance went to CIG Sept - approved	JS	Nov-23	Purchase Order being rasied with Griffiths & Armour Oct

Links to Operational Risks

Ref	Consequence	Likelihood	Risk Score	Risk Title
12	4	3	20	Risk of Fire to the Estate

Risk Number	Risk Description
12	Failure to ensure that estates in upgraded in line with current le
1214	Increased Risk to Life and Prope of Fire Compartmentation
1277	Increased Risk of Fire and Smok Compartmentation
1246	Risk of Failure of Critical Ventilat and Operating Standard Non-Co
1782	LV Electrical Distribution PPU 'if

Board Assurance Framework 2023/24

Links to Strategic Ambitions	Strategic Objective	Breakthrough Objective
True North Strategic Aim 4 Performance (Financial)	To be In recurrent surplus to invest in improving patient care	Demonstrate clear improvements in efficiency and effectiveness to achieve our financial control totals.

BAF 5 Executive Owner	Strategic Risk		Current Risk Score
Jon Sargeant Chief Financial Officer	BAF5	If DBTH cannot deliver the financial plan then DBTH will be unable to deliver services and the Trust may not be financially sustainable in long term	16

Key issues

1) The Trust submitted a deficit financial plan of £26.8m with an assumed CIP delivery of £22.1m. The Trust is under scrutiny given its financial position, including a national review of the Trust's financial plan, pressure from the ICB and needing a national request for revenue cash support. It is likely the Trust will be asked to improve on its plan position further when the ICB decides how it is going to deliver the c £100m of savings held centrally in the ICB financial plan. However the Trust is currently on plan at Q1 in terms of its deficit financial position.

2) The Trust has a c£50m underlying deficit entering the financial year, placing pressure on its long term financial sustainability. A key issue is delivering recurrent cash releasing CIPS in order to support reducing this deficit position.

3) Cash - the Trust's financial deficit in 22/23 and planned deficit in 23/24 along with the significant capital programme means cash will significantly reduce in 23/24 to the point in which central cash support will be required to meet its obligations. This will need somewhere between £20-30m depending on financial performance in year with central support expected to be required from Q2 onwards.

4) Productivity and Length of Stay (LOS) Impacts - reductions in productivity and increases in LOS have been seen during COVID, where activity being delivered is below pre-pandemic levels, whilst resource has increased. The challenge in 23/24 is to deliver above pre-pandemic levels of activity within resources allocated whilst providing safe and sustainable services. If activity is not delivered in line with plan the Trust's income position will be at risk as elective income for 23/24 is based on delivery of activity targets. National guidance is awaited on any changes to rules regarding the Elective Recovery Fund.

5) Non-pay inflation is currently very high in the economy and is not funded at those levels within the funding allocations. There is a risk that inflation assumptions are not sufficient to cover the actual cost increases both in terms of revenue and capital projects.

6) Temporary Staffing Spend - agency spend remains above pre-pandemic levels but has reduced significantly in recent months. Further work in this area is required to reduce agency spend (e.g. recruitment).

7) Impact of industrial action and pay awards - this includes the risk that the source of funding for pay awards has not yet been made clear and therefore this may impact on other national budgets which reduces potential resource for the Trust. Industrial action is impacting on pay costs in the Trust and also impacting on the Trust's ability to deliver its elective activity targets and thereby may impact on levels of income for the Trust and thereby delivery of the Trust's financial plan.

Overseeing Committee

Finance & Performance Committee

Date of last Committee review

Jul-23

Risk Assessment	Consequence	Likelihood	Risk Score
Initial Risk Assessment **(Jul- 23)**	4	4	16
Current Risk Assessment	4	4	16
Target Risk **(Plan for Dec-23)**	4	3	12
Target Risk **(Plan for Mar-24**)	4	3	12

Risk Appetite

Finance/VFM- (OPEN) We strive to deliver our services within the budgets set out in our financial plans and are prepared to accept some financial risk as long as appropriate controls are in place.
We have a holistic understanding of VFM with price not the overriding factor.

	Key controls currently in place to manage the risk	Key assurances relating to effectiveness of the controls & associated Line of Defence	Current Assurance Level Assigned
1	Key Financial Control Processes: Vacancy Control Panel, Corporate Investment Group (CIG), Grip and Control Nursing and Medics, Capital Monitoring Committee, Cash Committee. Escalation through financial meetings with Divisions and to POSM. SFI's/SOs.	Internal Audit - HFMA Review	Significant Assurance - with minor improvement opportunities
		Internal Audit - Temporary Staffing	Partial Assurance - with improvements
		External Audit - 22/23	Significant Assurance - with minor improvement opportunities
		DoF Senior Leadership Team @ POSM	Significant Assurance - with minor
		SFI's/SO's updated and being reviewed by ARC and Board in July	FULL Assurance
		Reports to Audit and Risk Committee	Significant Assurance - with minor improvement opportunities
		Reports to Finance and Performance Committee	
2	Commissioning of drivers of underlying financial deficit. Final report from Deloittes expected soon	Draft Report from Deloitte (26/6). Final report rec'd October	Significant Assurance - with minor improvement opportunities
3	Budget Setting and Business Planning	Board and F&P sign off of plan (June 2023)	Assured
		Review of financial plan by national team	Partial Assurance - with improvements required
4	Internal and external audit programme including counter fraud	Internal Audit - HFMA 22/23 Review	Significant Assurance - with minor improvement opportunities
		Internal Audit - Temporary Staffing	Partial Assurance - with improvements required
		Counter Fraud reports to ARC	Significant Assurance - with minor
		External Audit - 22/23	Significant Assurance - with minor
7	23/24 financial forcast prepared for F&P	Report to F&P october	Partial Assurance - with improvements required
5	Working with the ICB and Doncaster PLACE through CEO's and DoFs regarding financial delivery and saving opportunities	Reports to Finance and Performance Committee	Partial Assurance - with improvements required
6	Development and Delivery of CIP plan	Reports to Finance and Performance Committee	Significant Assurance - with minor improvement opportunities

Significant gaps in current controls	Areas where further assurance against controls is required
Medical Agency Spend	Implementation of medical grip and control meetings
Estates critical infrastructure risk at DRI key financial issue, risk level 20, frequent incidents occuring.	Develop options for investment of the current DRI site, as per request from DHSC to develop bid (s) to reduce risk and backlog on DRI site, focus on highest risk block east Ward Block, additional bids for theatres/relocation of DCC to ESAC/Complete W&C fire works and refurb

Key actions to close gaps

Ref	Action	Lead	Target Date	Progress
1	Review and progress of national actions on the 23/24 financial plan including independent assessment of the Trust's underlying financial position.	CFO	Jul-23	Most of the actions from the national review have been implemented or are being progressed which has been sent to the national team. External assessment of underlying position has been commissioned with final report to Board and F&P shortly. Draft presentation at June Finance and Performance Committee. CLOSED
2	Delivery of external and internal audit recommendations	CFO	Dec-23	Internal audit actions implemented on time relating to 22/23. Internal Audit in 23/24 due in Q3. External audit actions progressed significantly since 22/23 per ISA 260 report.
3	Development and delivery of CIP plan	CFO	Ongoing	The development of the CIP plan is ongoing with a number of schemes identified. Confirm and challenge meetings being held with Divisions to progress further schemes. An update was presented to Finance and Performance Committee in June. Work with Doncaster PLACE ongoing to identify further opportunities.
4	Delivery of reduced temporary staffing spend including grip and control in medic areas.	CPO	Ongoing	Nursing temporary staffing spend has reduced to £0.3m down from an average of £0.7m in 22/23 due to reduction in agency and bank rates, usage and improved controls. Further assurance now required in medic spend including robust implementation of medic grip and control meetings. Medical Director (Workforce) is now reviewing and chairing these meetings.
5	Daily cash flow forecast and submission of national request for central cash support	CPO	Ongoing	Daily cash flow in place, with more robust controls in place regarding payment sign off (e.g. sign off by Deputy Dof and Head of Procurement). National request for cash support in September completed and signed off by national team (c£6m).

Links to Operational Risks

Ref	Consequence	Likelihood	Risk Score	Risk Title
13	4	3	12	Risk of economic crime against the Trust by not complying with Government Counter Fraud Functional Standard GovS 013 – Counter Fraud

Board Assurance Framework 2023/24

Links to Strategic Ambitions	Strategic Objective	Breakthrough Objective
True North Strategic Aim 1 Partners/Prevention	To provide outstanding care and improve patient experience	Maintain and improve CQC ratings by achieving improvements in quality outcomes

BAF 6 Executive Owner	Strategic Risk		Current Risk Score
Zara Jones Deputy Chief Executive	BAF6	**If DBTH does not effectively engage and collaborate with its partners and communities then DBTH fails to meet its' duty to collaborate, will miss opportunities to address strategic risks which require partnership solutions and will fail to deliver integrated care for benefit of people of Doncaster and Bassetlaw**	6

Key issues	Overseeing Committee
Lack of a clear partnership strategy for DBTH aligned to its other Trust strategies (to enable their delivery) Failure to develop effective partnerships and achieve agreed outcomes DBTH aligned to 2 different ICS's causing complexity and inefficient working for DBTH	Audit & Risk Committee (to be reviewed at a late date)
	Date of last Committee review 01-Oct-23

Risk Assessment	Impact	Likelihood	Risk Score
Initial Risk Assessment **(Jul- 23)**	3	2	**6**
Current Risk Assessment	3	2	**6**
Target Risk **(Plan for Dec-23)**	3	2	**6**
Target Risk **(Plan for Mar-24**)	3	2	**6**

Risk Appetite

Quality- (OPEN)-We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards
Regulatory / Compliance (MINIMAL) We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.

	Key controls currently in place to manage the risk	Key assurances relating to effectiveness of the controls & associated Line of Defence	Current Assurance Level Assigned
1	Duty to collaborate evidence: Partnership working: ICS, Provider Collaboratives ,Place, Neighbourhood - agreements & Memorandums of Understanding	informal feedback to Trust through committees and Board (1) Sign off of Partnership agreements & MOU's at BOD (2) Increased capacity at Exec Director & NED level to support attendance and influence at ICS forums (1) ICB , Provider collaborative minutes, repots and strategies (2)	Partial Assurance - with improvements required Significant Assurance - with minor improvement opportunities Significant Assurance - with minor improvement opportunities Significant Assurance - with minor improvement opportunities
2	Duty to collaborate evidence: Supporting the Governor body in achieving its statutory duty	Briefing sessions to governors with leaders from both ICB's (1) Governor annual conference & Workshops around duties to hold to account across ICS and individual Trusts (2)	Significant Assurance - with minor improvement opportunities Significant Assurance - with minor improvement opportunities
3	Health Inequalities strategy at Trust and Place level led by Directorate of Recovery, Innovation & Transformation to ensure focused in business planning and performance processes.	Monitored via F&P meetings (2)	Partial Assurance - with improvements required
4	Additional Executive capacity created (new DCE post) for partnership working with a particular focus on Nottinghamshire ICS relationships	New in post since 2nd October. To be populated in coming months - linked to DCE Director Objectives with delivery monitored through the Board of Directors.	to be reviewed
5			

Significant gaps in current controls	Areas where further assurance against controls is required
5 Lack of overall partnership strategy linked to other Trust strategies	

Key actions to close gaps

Ref	Action	Lead	Target Date	Progress
5	External meetings and engagements mapping to develop clarity of purpose and input for DBTH in partnership forums	ZJ	Dec-23	New action.
5	Development of Partnership Strategy linking to our existing DBTH strategies to support delivery and clearer intent and actions for our partnership working	ZJ	Mar-24	New action.

Links to Operational Risks

Ref	Consequence	Likelihood	Risk Score	Risk Title

Board Assurance Framework 2023/24

Links to Strategic Ambitions	Strategic Objective	Breakthrough Objective
True North Strategic Aim 3 Quality Improvement	Team DBTH feel valued and feedback from staff and learners in top 10% in UK	Demonstrate Trust-wide cultivation of an inclusive, caring and kind culture to ultimately drive improvement in patient and colleague feedback

BAF 7 Executive Owner	Strategic Risk		Current Risk Score
Jon Sargeant Chief Financial Officer	BAF7	**If DBTH does not deliver continual quality improvement, research, transformation & innovation then the Organisation won't be sustainable in long term**	6

Key issues	Overseeing Committee
There is a risk that DBTH & PLACE/ICB quality improvement methodology and objectives are not aligned	Finance & Performance Committee
New Research & Innovation Strategy to take account of Improvement Innovation in addition to Research Innovation	
Qii Strategy 2022 Out of date - review linked to NHSE Impact published March 23	
Requirment for Board fo Directors to receive training in Quality Improvement methods aligned to NHSE Impact Guidance	**Date of last Committee review**
Risk that Innovation ideas are not captured and taken forward due to staff not knowing where to access the right support, Qii or Research Team	

Risk Assessment	Impact	Likelihood	Risk Score
Initial Risk Assessment **(Jul- 23)**	3	2	**6**
Current Risk Assessment	3	2	**6**
Target Risk **(Plan for Dec-23)**	3	4	**6**
Target Risk **(Plan for Mar-24**)			

Risk Appetite

Innovation (OPEN) The Trust has a risk tolerant appetite to risk where benefits, improvement and value for money are demonstrated. Innovation is encouraged at all levels within the organisation, where a commensurate level of improvement can be evidenced, and an acceptable level of management control is demonstrated

	Key controls currently in place to manage the risk	Key assurances relating to effectiveness of the controls & associated Line of Defence	Current Assurance Level Assigned
1	Head of Qii part of PLACE/ICB network. Self assessment of DBTH Qii methods are aligned to new NHSE Impact guidance	Reports to TEG (1) Reports to F&P (2) Reports to QEC Annual Review (2) Links to Clinical Audit Work with PMO and Monday.com	Significant Assurance - with minor improvement opportunities
2	Collaboration with Director of Education and Director of Innovation & Infrastructure, Head fo Research and Head fo Qii to inform content of both strategies	Reports to TEG (1) Reports to F&P (2) Reports to QEC Annual Review (2) People Committee (2) Education Board (1)	Significant Assurance - with minor improvement opportunities
3	Outdated Qi Strategy 2022 currently being updated with new NHSE Impact Guidance by October 23	Reports to TEG (1) Reports to F&P (2) Reports to QEC Annual Review (2) New strategy to TEG November 23	Significant Assurance - with minor Significant Assurance - with minor Significant Assurance - with minor
4	Proposal for BoD Qii Training dveloped and submitted to Exec Team for 2nd August meeting for disucssion. Update BoD workshop taking place 31st October	Reports to TEG (1) Reports to F&P (2) Reports to QEC Annual Review (2)	Significant Assurance - with minor improvement opportunities
5	Collaboration with Director of Education and Director of Innovation & Infrastructure, Head fo Research and Head of Qii to develop joint Innovation Form via Hive for streaming and selection	Reports to TEG (1) Reports to F&P (2) Reports to QEC Annual Review (2)	Significant Assurance - with minor Significant Assurance - with minor Significant Assurance - with minor

Significant gaps in current controls	Areas where further assurance against controls is required

Key actions to close gaps

Ref	Action	Lead	Target Date	Progress

Links to Operational Risks

Ref	Consequence	Likelihood	Risk Score	Risk Title

Trust Risk Report 15+ (October 2023)

Summary of data pulled from Datix Risk Management System 11th October 2023.

Trust Risk Register

The Trust Risk Register is compiled of all Risks with a grade of 15 or more. It contains the overarching and stand-alone risks and notates the dependent risks. Dependent risks can be seen on linked records field of the Overarching risk. See below for the individual risks 15+ on the Trust Risk Register. Detailed mitigating control and actions can be found by accessing the risk record within the DATIX risk management system. The Risk Management Board (RMB) reviews a more detailed report which is, in turn, shared with the Audit and Risk Committee.

Top 3 Risks

The top 3 risk themes on the Trust Risk Register pertain to:

1. **Workforce**
2. **Finance**
3. **Infrastructure (Estate and Equipment)**

Overall, there are 563 risks on Datix, of which there are 31 low risks, 157 Moderate risks. 293 High Risks and 82 Extreme Risks. Clinical Specialist Services has the greatest number of risks and cover the greatest number of individual specialties.

Trust Risk Report 15+ (October 2023)

Summary of data pulled from Datix Risk Management System 11th October 2023.

ID	Risk Owner	Title	Existing controls	Review date	Rating - current	Risk level - current	Rating - Target	Risk Authority	RMB - Status	Reviewed by RMB / RM	Dependent Risks	Action ID	Due date	Done date
7	Smith, Denise	Failure to achieve compliance with performance and delivery aspects of the SOF, CQC and other regulatory standards	[13/09/2022 13:08:34 George Briggs] ICB now in place as overarching structure for SYB	02/01/2023	16	Extreme Risk	9	Overarching	RMB approved grading - for management at Divisional level	Yes	Extreme 2349	1903 1904 1905 6096 16843	20/10/2023 30/06/2016 31/03/2015 30/09/2014 30/06/2015	30/09/2014 30/10/2014 01/03/2015 27/12/2016
11	Sargeant, Jonathan	Failure to achieve compliance with financial performance and achieve financial plan	[16/05/2023 10:02:21 Fiona Dunn] 22/23 achieved financial plan. 23/24 - trust has a significant CIP target which will have a decreasing effect on the organisational run rate. This sets a significant risk to operational & financial position. The trust is mitigating this with the following actions: 1. Review of financial controls including authorised signatory list 2. Review of staff grip & control to cover rota compliance, sickness management, use of temporary staff and vacancy control process. 3. Strict management of cost pressures 4. Complete an analysis of the drivers of deficit with Deloites 5. Enhanced scrutiny of CIP programme 6. Enhanced working with partners at both Place and System level.	30/06/2023	16	Extreme Risk	8	Overarching	RMB approved grading - for management at Divisional level	Yes	High 3017, 3170, 3179 Moderate 3174, 3175	15992 15993 16844	20/10/2023 30/06/2023 30/06/2023	

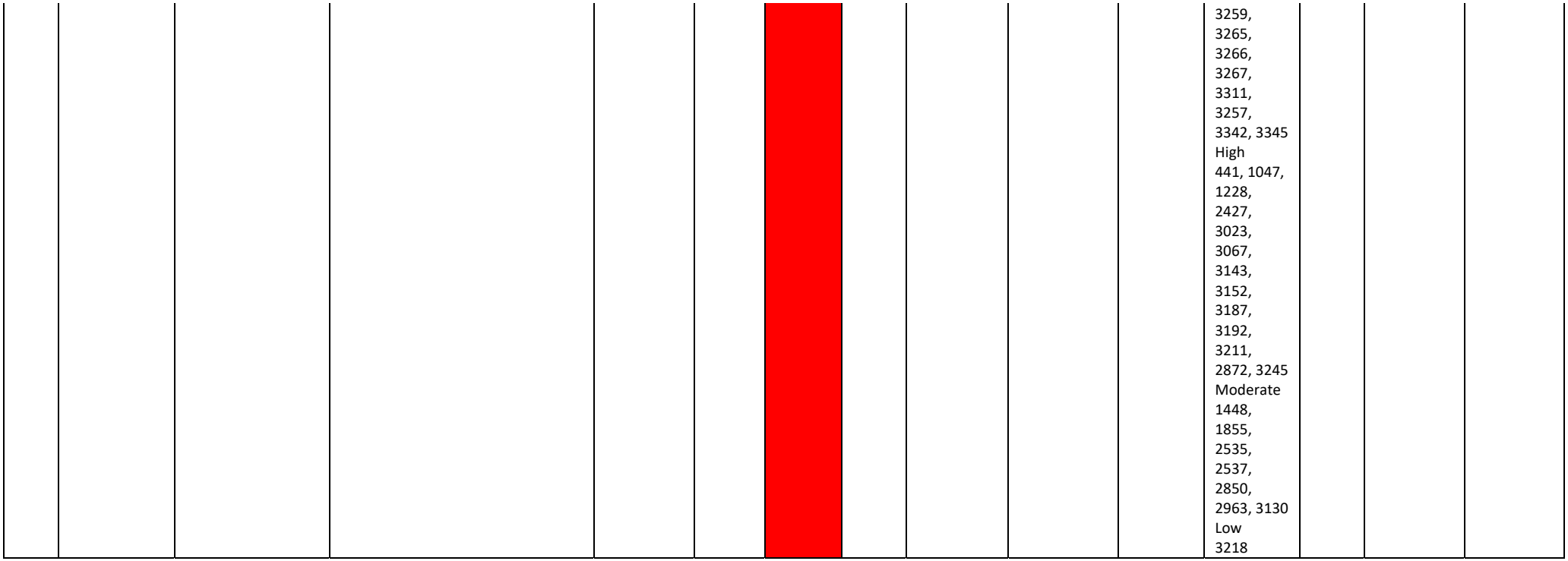
Trust Risk Report 15+ (October 2023)

Summary of data pulled from Datix Risk Management System 11th October 2023.

ID	Risk Owner	Title	Existing controls	Review date	Rating - current	Risk level - current	Rating - Target	Risk Authority	RMB - Status	Reviewed by RMB / RM	Dependent Risks	Action ID	Due date	Done date
12	Howard Timms	Failure to ensure that estates infrastructure is adequately maintained and upgraded in line with current legislation	[11/10/2023 08:15:08 Howard Timms] Asset Capture Complete Estates Business Case being finalised to support additional staffing requirements and compliance with SFG20 [11/04/2023 16:20:35 Sean Alistair Tyler] DRI Asset capture continuing to progress, BDGH Asset capture reviewed against SFG20 requirements. Updated as part of E&F SMT risk management review meeting.	29/03/2024	20	Extreme Risk	10	Overarching	RMB approved grading - for management at Divisional level	Yes	Extreme 1078, 1082, 1083, 1095, 1096, 1097, 1208, 1209, 1246, 1264, 1274, 1277, 1782, 2335, 2863, 2868, High 1781, 2867, 3190 Moderate 2878,	1914 6207 16159	13/12/2023 31/03/2020 31/03/2017	 12/08/2017
16	Lintin, Zoe	Inability to recruit a sufficient workforce and to ensure colleagues have the right skills to meet operational needs	[16/05/2023 09:21:36 Zoe Lintin] - Work ongoing to develop Trust-wide multi-year strategic workforce plan and further mature workforce planning approach, supported by various activities - Implementation of strategic workforce planning tool ongoing working with KPMG, divisions and corporate support colleagues - reintroduction of deep dive workforce planning workshops in specialty areas - 'Agency & Sickness Management' identified as a Trust-wide CIP programme for 23/24 with workstreams being established - will report to Transformation Board	20/11/2023	16	Extreme Risk	12	Overarching	RMB approved grading - for management at Divisional level	Yes	Extreme 26, 2465, 2768, 2781, 2865, 2948, 3006, 3010, 3043, 3120, 3127, 3159, 3197, 3200, 3212, 3213, 3219, 3244, 3250,	1920 15995 15996	31/05/2016 31/03/2024 31/08/2023	13/09/2018

Trust Risk Report 15+ (October 2023)

Summary of data pulled from Datix Risk Management System 11th October 2023.



Trust Risk Report 15+ (October 2023)

Summary of data pulled from Datix Risk Management System 11th October 2023.

ID	Risk Owner	Title	Existing controls	Review date	Rating - current	Risk level - current	Rating - Target	Risk Authority	RMB - Status	Reviewed by RMB / RM	Dependent Risks	Action ID	Due date	Done date
1410	Linacre, David	[Cyber] Failure to protect against cyber attack	[28/09/2023 13:31:11 Wayne Chapman] Network access control and perimeter firewalls were not funded in capital budget allocations for 23/24. Will high priority for 24/25 capital allocations in line with suitable platform for EPR. Immutable storage capacity pressures are being managed on a risk level basis, and additional Immutable capacity is being implemented for PACS and other image archiving systems. Infrastructure Workshop taken place to formerly discover and asses Infrastructure risks, and profile them by severity, proximity, and cost for remediation. Outputs from workshop to feed into individual risks and overarching risk. Insider Threat - The introduction of multi factor authorisation for NHS Mail will lead to a reduction in accidental disclosure of user credentials and associated email accounts compromised.	31/03/2024	15	Extreme Risk	5	Overarching	RMB approved grading - for management at Divisional level	Yes		16841 16842 16884	29/09/2023 29/09/2023 31/01/2024	28/09/2023 28/09/2023
1412	Howard Timms	Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the RRFSO	[07/09/2023 15:24:45 Howard Timms] Works in progress as part of 23/24 Capital Programme [14/04/2023 10:23:49 Howard Timms] Further fire improvement works programmed for FY23/24 as part of the Capital programme.	29/03/2024	15	Extreme Risk	10	Overarching	RMB approved grading - for management at Divisional level	Yes	Extreme 1077, 1214, 1216, 1225, 2941, Moderate 147,	16703 16704 16705	19/02/2024 20/05/2024 13/05/2024	

Trust Risk Report 15+ (October 2023)

Summary of data pulled from Datix Risk Management System 11th October 2023.

ID	Risk Owner	Title	Existing controls	Review date	Rating - current	Risk level - current	Rating - Target	Risk Authority	RMB - Status	Reviewed by RMB / RM	Dependent Risks	Action ID	Due date	Done date
1670	Linacre, David	[Cyber] Failure of network protection from internal malicious or otherwise actions	[01/09/2023 09:24:03 Wayne Chapman] Additional measure of MFA now implemented across the Trust. [04/04/2023 14:48:44 the reporter] Regular communications to all staff for all staff via Buzz / Hive Maintain defence in-depth - includes anti-virus, security operations centre, detection of unusual behaviour or users and software, multi- factor authentication currently for administrators, rolled out to all users end July 2023. Maintain perimeter firewalls Participate in NHS cyber intelligence forum	05/01/2024	15	Extreme Risk	10	Stand alone	RMB approved grading - for management at Divisional level	Yes		15799 16928	29/12/2023 31/07/2023	31/07/2023
1807	Hutchinson, James	Risk of Critical Lift Failure in a Number of Passenger Lifts Trust Wide	[11/04/2023 16:13:21 Sean Alistair Tyler] No change to current existing controls [21/02/2023 14:10:51 Sean Alistair Tyler] Work commenced on South block and Women's and children's hospital lifts DRI. MMH pain management lift included within the MEOC project FY23/24.	29/03/2024	20	Extreme Risk	8	Overarching	RMB approved grading - for management at Divisional level	Yes	Extreme 1224, 1239, 2682, High 885, 1240, 2798, 3154 Moderate 2608, 2681,	10218 10219 16158	13/06/2024 31/03/2020 31/03/2017	 12/08/2017
2320	Mark Luscombe	Non conformity to the HBN 04-02 guidance (2013)	[16/06/2020 00:46:24 David Pryor] Requires capital investment to the Estate. Most of the issues are regarding the physical structure and size of bedspaces which are too small. This cannot be easily remedied in the current accommodation. We have no "pendant" technology, for piped gases or electrical connections.	22/02/2024	15	Extreme Risk	1	Stand alone	NEW 12 plus Risk for discussion at RMB	No		16846 16925	31/01/2024 20/10/2023	

Trust Risk Report 15+ (October 2023)

Summary of data pulled from Datix Risk Management System 11th October 2023.

ID	Risk Owner	Title	Existing controls	Review date	Rating - current	Risk level - current	Rating - Target	Risk Authority	RMB - Status	Reviewed by RMB / RM	Dependent Risks	Action ID	Due date	Done date
2685	Linacre, David	[Telephony] Existing 'Multitone' bleep system goes out of support in December 2023	[18/08/2023 09:57:03 Jo Hutchinson] * Multitone will not attend any faults after 31 Dec 2023. This puts the Trust in an extremely vulnerable position regarding its ability to provide emergency 2222 cover. Any system failure would result in direct risk to patient safety. Meeting with Multiple on 10/08/2023 confirmed that some hardware will remain supported – Supplier sending confirmation.	01/12/2023	15	Extreme Risk	5	Stand alone	RMB approved grading - for management at Divisional level	Yes		15798 16927	24/11/2023 29/12/2023	17/05/2023
2717	Crookes, Tracy	[Cyber] Internally developed systems present PID to any domain authenticated users (inc generic account)	[07/11/2021 14:00:33 Roz Wilson] Work plan in place with the Dev team, to get an update and review risk	15/01/2024	16	Extreme Risk	8	Stand alone	RMB reviewed - further information required - resubmit to RMB	Yes		16840	25/09/2023	
2779	Debbage, Sam	Inability to access sufficient RC (UK) NLS Course places to meet regulatory compliance	[23/08/2023 10:49:36 Lisette Caygill] Approval to submit business case to support development of regional centre via September CIG. There are no additional places available nationally to support gaps. We have agreed a reserve list for cancellations for the courses held at RDGH.	16/11/2023	16	Extreme Risk	8	Stand alone	RMB approved grading - for management at Divisional level	Yes		15391 16852	16/11/2023 18/09/2023	05/10/2023
2839	Muniyappa, Suresha	Risk to patients with Diabetes due to lack of Community Diabetes Specialist Nurse support	[01/06/2023 11:10:59 Dawn Rayner] Risk still applies. [18/04/2023 14:54:48 Suresha Muniyappa] Hospital Diabetic specialist Nurses (DSN) look after in-patient diabetic patients only. They are not responsible for outpatient and community diabetic patients. These patients are looked after by community DSNs cDNS). This is historical.	13/09/2023	15	Extreme Risk	6	Stand alone	RMB approved grading - for management at Divisional level	Yes		16849 16872	20/10/2023 20/10/2023	

Trust Risk Report 15+ (October 2023)

Summary of data pulled from Datix Risk Management System 11th October 2023.

ID	Risk Owner	Title	Existing controls	Review date	Rating - current	Risk level - current	Rating - Target	Risk Authority	RMB - Status	Reviewed by RMB / RM	Dependent Risks	Action ID	Due date	Done date
3114	Debbage, Sam	Door access rights to areas for resus team - system process	[05/10/2023 08:39:46 Lisette Caygill] Ongoing as previous. [18/09/2023 14:39:14 Lisette Caygill] Work is ongoing with E&F to mitigate any risk. The NETS2 meetings continue and it is now likely that the equipment/IT will not be in place until the end of November 2023. JS business manger continues to meet with E&F to progress this work however limitations on progress are reliant on IT support to progress further. full discussion at RMB 18.9.23.	16/11/2023	15	Extreme Risk	10	Stand alone	RMB - Mitigations in place, awaiting Long-term Plan	Yes		16347	30/11/2023	
3157	Ramanan Rajasundaram	One Stop BDGH Prostate Clinic not running and patients seen at separate appointments - inequitable service across Trust	[20/09/2023 14:31:24 Sally Jones] lh awaiting fiance input chased again today as a matter of urgency awaiting revised radiology [05/09/2023 11:13:25 Sally Jones] awaiting capacity update from CSS, Matt working on data due to higher cost, CSS have to justify why they need more slots - LH to follow up on email	20/10/2023	16	Extreme Risk	4	Stand alone	RMB approved grading - for management at Divisional level	Yes		16223 16800 16873	18/10/2023 28/06/2023 29/12/2023	20/09/2023
3203	Lister, Simon	Failure of RIS (Zillion) to receive all ICE referrals	[19/07/2023 16:33:30 Sally Jones] Discussed at RSMT and risk accepted. We did discuss the risk grading and although there are some mitigations are in place there is still a risk that some ICE referrals do not make it to Zillion. Information team to email a list off all rejected referrals to the radiology team leaders inbox each day. Team leaders check the inbox daily and triage the referrals - all 2 week wait and urgent referrals are manually inputted onto Zillion each day. Routine referrals are added to Zillion each week. The IT team have arranged a visit by	31/10/2023	20	Extreme Risk	4	Stand alone	Risk Not Reviewed	No		16794	31/10/2023	

Trust Risk Report 15+ (October 2023)

Summary of data pulled from Datix Risk Management System 11th October 2023.

			the Zillion technical team on the 20.02.23 and they expect the problem to be resolved at this visit. Additional admin staff hours have been arranged to manage this additional workload until the 20.02.23.											

Trust Risk Report 15+ (October 2023)

Summary of data pulled from Datix Risk Management System 11th October 2023.

ID	Risk Owner	Title	Existing controls	Review date	Rating - current	Risk level - current	Rating - Target	Risk Authority	RMB - Status	Reviewed by RMB / RM	Dependent Risks	Action ID	Due date	Done date
3209	Smith, Denise	Inaccuracies in patient tracking across multiple pathways leads to potential harm to patients	[26/09/2023 12:22:41 Wayne Chapman] 1) Current SOPs to be reviewed by services, and identify current anomalies 2) Staff should be released to participate in user acceptance training, and general training for the upcoming patient tracker to be implemented 24/25.	08/09/2023	20	Extreme Risk	6	Overarching	RMB unable to mitigate risk - For escalation to TEG	Yes	Extreme 3051 High 3094	15703 15704 15705 15706 15707	20/03/2023 20/03/2023 20/03/2023 19/06/2023 17/04/2023	09/03/2023
3246	Brown, Simon	Mental Capacity Assessment and Deprivation of Liberty Safeguards	[26/09/2023 10:45:25 Simon Brown] existing controls remain. External audit has commenced. [20/07/2023 07:58:48 Simon Brown] existing controls remain MCA / DOLS audit proforma created and audit about to commence MCA assessment on nerve centre MCA / DOLs training as part of safeguarding training	26/10/2023	15	Extreme Risk	9	Stand alone	RMB approved grading - for management at Divisional level	Yes		16329	31/07/2023	20/07/2023
3258	Anand, Mrinal	Lack of paediatric ophthalmology capacity - risk to 52/78 week breech positions	[20/09/2023 15:32:02 Sally Jones] lh vacancy out for pead fellow if successful risk will be mitigated in part [05/09/2023 11:28:33 Sally Jones] LH requires from KA status of waiting list and if they have stablised [03/08/2023 15:47:59 Sally Jones] awaiting confirmation of data from KS however LH believes that this risk now has certain mitigations in place Try and add additional sessions for SS / AK where possible and swap general activity for specialist activity and look at options for review of patients through a shared care route.	20/10/2023	16	Extreme Risk	6	Stand alone	RMB reviewed - further information required - resubmit to RMB	Yes		16327	04/08/2023	

Trust Risk Report 15+ (October 2023)

Summary of data pulled from Datix Risk Management System 11th October 2023.

ID	Risk Owner	Title	Existing controls	Review date	Rating - current	Risk level - current	Rating - Target	Risk Authority	RMB - Status	Reviewed by RMB / RM	Dependent Risks	Action ID	Due date	Done date
3282	Linacre, David	Trust wide Wi-Fi - EOL for security remediation March 2022	Only controls in place are for replacement hardware. Extreme have confirmed that no further security updates will be available.	04/12/2023	15	Extreme Risk	1	Stand alone	NEW 12 plus Risk for discussion at RMB					
3283	Linacre, David	[Cyber] Doncaster Firewalls - EOL for security remediation July 2024	[15/09/2023 11:45:00 Wayne Chapman] No funding available via 23/24 capital plan. Will be submitted in 24/25 capital plan. Review meeting for Digital Infrastructure priorities due to take place on 21/09/2023 to discuss priority funding areas. Current support contract will renew until June 2024 at which point we will no longer be able to procure any further support on this infrastructure.	10/11/2023	15	Extreme Risk	2	Stand alone	RMB reviewed - further information required - resubmit to RMB	Yes		16220 16746 16839	27/10/2023 28/06/2023 30/11/2023	15/09/2023
3292	Potts, Andrew	Risk in diagnosis and follow of cancer patients due to limited capacity	[19/09/2023 20:39:19 Sara Elliott] Additional sessions group have authorised additional CT scanning in August, September and October to help with additional capacity. Additional funding received from CDC for more CT scanning to the end of the financial year. Significant increases have been seen in CT, 26.7% increase in 2 ww referrals in the past 6 months, 3.4 % in urgent referrals and 12.3% in routine. Information team are investigating why large increase in referrals from CT as only two pathways available for them. Irefer goes live on Monday 25th September to help educate referrers to select most appropriate radiology test	31/10/2023	25	Extreme Risk	5	Stand alone	RMB reviewed - further information required - resubmit to RMB	Yes		16795 16796 16797	25/09/2023 30/09/2023 31/10/2023	

Trust Risk Report 15+ (October 2023)

Summary of data pulled from Datix Risk Management System 11th October 2023.

ID	Risk Owner	Title	Existing controls	Review date	Rating - current	Risk level - current	Rating - Target	Risk Authority	RMB - Status	Reviewed by RMB / RM	Dependent Risks	Action ID	Due date	Done date
3296	Vivek Kumar	Delays in treatment of prostate cancer patients due to capacity issues re robotics at STH	[09/10/2023 14:30:50 Sally Jones] discussed with DED still ongoing issue no further change received or noted by STH [05/09/2023 11:35:44 Sally Jones] service to service issue and currently no regional solution [20/08/2023 16:55:35 Sally Jones] discussed with DED ongoing discussion still in place with STH as they do not have capacity for all the patients and the surgery is carried out in STH not DBTH Ongoing discussions over SLA with STH	06/11/2023	16	Extreme Risk	8	Stand alone	NEW 12 plus Risk for discussion at RMB	No		16807	18/10/2023	
3309	Howard Briggs	Sleep Studies Service Continuity Risk due to out of service equipment	One NOX T3 remains, so service is still being provided.	01/12/2023	20	Extreme Risk	6	Stand alone	RMB downgraded - for management at Divisional Level	Yes		16874 16878	01/12/2023 01/12/2023	
3315	Hutchinson, James	Inadequate temperature control of rooms in which controlled drugs are stored	Temperatures to be monitored and escalated as required. Estates team already aware	29/12/2023	15	Extreme Risk	6	Stand alone	RMB approved grading - for management at Divisional level	Yes		16826	22/04/2024	
3321	Hussain, Omar	If dental chair water supply cleaning protocols not followed , resulting in delays and cancellation of clinics	[20/09/2023 14:46:38 Sally Jones] been to meg at cig on Monday, risk title changed as per rmb request awaiting further info [31/08/2023 12:26:11 Paul Scott] patients requiring use of water currently cancelled currently being sterilised	20/10/2023	16	Extreme Risk	8	Stand alone	RMB approved grading - for management at Divisional level	Yes		16809 16876	04/10/2023 29/12/2023	

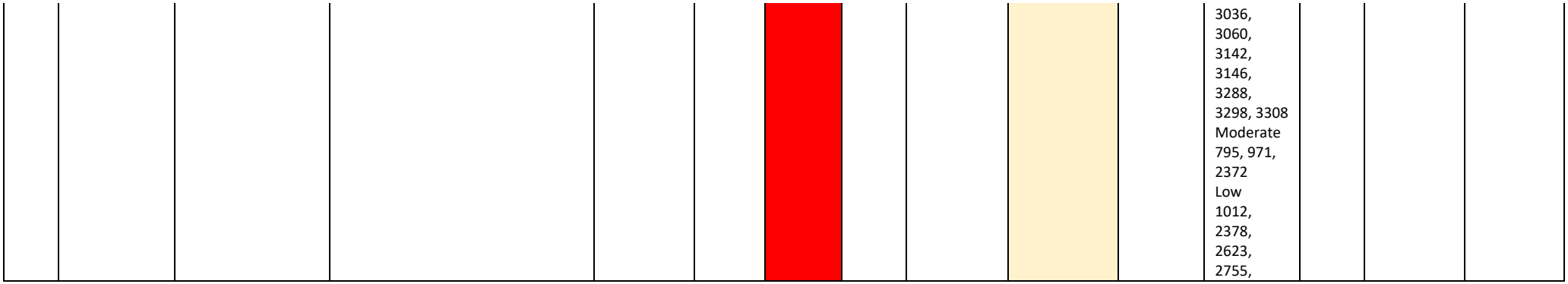
Trust Risk Report 15+ (October 2023)

Summary of data pulled from Datix Risk Management System 11th October 2023.

ID	Risk Owner	Title	Existing controls	Review date	Rating - current	Risk level - current	Rating - Target	Risk Authority	RMB - Status	Reviewed by RMB / RM	Dependent Risks	Action ID	Due date	Done date
3331	Mathew Gleadall	Risk of ceiling tiles falling on wards following 2 incidents resulting in potential harm to all	[20/09/2023 15:02:05 Mathew Gleadall] - Ceilings inspected by Estates. Tiles posing an immediate risk removed - Structural engineer inspected ceiling and confirmed no inherent structural issues. Issues thought to relate to age and condition of tiles. - Daily inspections in place to check condition of ceilings - Supports being installed under affected ceilings as a control	13/10/2023	15	Extreme Risk	3	Stand alone	RMB approved grading - for management at Divisional level	Yes		16828 16829 16830 16831	06/10/2023 29/03/2024 15/09/2023 15/09/2023	 15/09/2023 15/09/2023
3336	Hutchinson, James	Ambient temperature of medication & fluid storage areas exceeding 25C on wards	[15/09/2023 14:16:46 Kay Hattersley] Updated Safe & Secure handling of medicines policy (went to D&T September 23 for review) includes formal daily monitoring of all areas where medicines and fluids are stored. New ambient temperature monitoring sheet also included in this with clearer escalation plan - awaiting D&T sign off Ambient temperature monitoring is currently mentioned in the Safe & Secure Handling of medicines part A MM 1 advising to refer to pharmacy if excursions of temperature happen	11/10/2023	15	Extreme Risk	12	Stand alone	NEW 12 plus Risk for discussion at RMB					
3348	Nicholas Mallaband	As a result of equipment being near EOL there is a risk of malfunction & will be unable to meet service objectives	Business cases for replacement or updates are discussed at MEG. Goodwill gestures from the companies or our internal team to maintain the machines as best they can	06/11/2023	20	Extreme Risk	10	Overarching	NEW 12 plus Risk for discussion at RMB	Yes	Extreme 2819, 3147, 3184, 3237, 3238, 3251, 3320, 3346 High 53, 2398, 2534, 2581, 2935,			

Trust Risk Report 15+ (October 2023)

Summary of data pulled from Datix Risk Management System 11th October 2023.



BREAK - 10:50 - 11:00

2310 - D3 CHAIR'S ASSURANCE LOG - AUDIT & RISK COMMITTEE

Discussion Item | Kath Smart, Non-executive Director | 11:00

5 minutes

REFERENCES

Only PDFs are attached

D3 - Chair's Assurance Log - Audit & Risk Committee.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

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

Subject:	Audit & Risk Committee	**Board Date: October 2023**
Prepared By:	Kath Smart, Committee Chair & Non-executive Director	
Approved By:	Audit & Risk Committee Members	
Presented By:	Kath Smart, Committee Chair & Non-executive Director	
Purpose	The paper summaries the key highlights from the Audit and Risk Committee meeting held on 19 October 2023	

Matters of Concern (with Moderate, Partial or No Assurance)	**Work Underway / Major actions commissions**
Internal Audit Reports issued:- • Waiting List Clinical Prioritisation Audit - Limited Assurance outcome. This audit reviewed the systems in place for prioritising the Trust waiting list and agreed a number of recommendations to improve the approach. 2 x high risk and 3 x medium risks relating to ensuring the Trusts policies and procedures are upto date and in line with national guidance; access & storage of patient records; application and management of categories to ensure the Trust effectively manages its waiting list. All are due for completion by 31 December. • Staff Retention – Return to Work Conversations – Moderate Assurance outcome. This audit evaluated the process of return-to-work conversations following periods of sickness absence. Assurance can be gained from the outcome of an Internal Audit exercise which indicated that over 80% of staff were having Return to Work Interviews following periods of sickness absence. There were 3 medium recommendations agreed by management to give clear guidance, training on sickness absence management and to agree a single Trust wide approach for the recording of completion of return-to-work interviews. Emergency Planning Core Standards Return – Following managements self-assessment of the Trusts processes against the required standards, 41/62 standards are fully compliant, 21/62 are partially compliant. This gives an overall score of 66% and equates to a "non-compliant" score in line with the assessment process. There is a full action plan which aims to increase compliance, but with dates past the end of March 2024, the Trust needs to declare non-compliant.	a) All the internal audit reports have agreed deadlines for implementation of actions. ARC will continue to monitor delivery b) Board Assurance Framework – This was reviewed by ARC alongside the Stage 1 HOIA feedback from Internal Audit which showed there are areas for improvement which are currently being addressed by the Executive. This will be reviewed by IA in Q4. c) Risk Management Board & Trust Risk register– ARC received a report evidencing the work of RMB in continuing to improve the Trusts Risk Management process & oversight. Progress has been made in reviewing 15+ risks (and now 12+ risks); linking to actions on Datix & reducing the number of extreme risks by ensuring consistency of scoring. This will be reviewed by IA in Q4. d) Emergency Preparedness – (EPRR) – Further work is continuing to progress areas which are off track, especially Business Continuity and updates will be brought to future ARC e) Security Management – Lone Worker systems – discussion was held around staff safety devices for Lone workers and their utilisation within Divisions. Further data to be reviewed and work to be done to give clearer assurances on usage. Clarify if reporting into ARC or People Committee

Significant or Full Assurances to Provide	Decisions Made
a) Counterfraud Progress 23/24 – Significant assurance on the update on work for 23/24 and cases being progressed. b) Internal Audit Progress & delivery – 23/24 – Significant assurance on the delivery of the IA plan. One item (Complaints) has been deferred to 24/25 c) EY Auditors Annual Report – final report for 22/23 confirmed the position as reported to June and July's Board and September Council of Governors as Significant Assurance. d) Single Tender Waivers – Significant assurance over compliance with the Trust process e) Losses & Compensations – Significant Assurance over compliance with the Trust process f) Security Management - The report demonstrated that overall system for Security Management is in place and working to mitigate Security risks with significant assurance. Additional Police activity and CCTV have been commissioned to assist with vehicle thefts. However, ARC requested more work on Lone Worker devices and utilisation (see Work Commissioned)	a) ARC Recommends Board approval of the newly refreshed Risk Management Policy which has been amended to reflect current working arrangements and feedback from Internal Audit colleagues.

Assurance Levels	
Internal - Second Line of Defence	
Full Assurance	The system design and existing controls are working well. Potential innovations being considered all relate to achieving recognised best practice
Significant Assurance - with minor improvement opportunities	The system design and existing controls are working well. Some minor improvements have been identified. Identified manangement actions are not considered vital to achievemnet of strategic aims & objectives - although if unaddressed may increase likelihood of risk
Partial Assurance - with improvements required	The system design and existing controls require strengthening in areas. A few operational weaknesses have been recognised. Existing performance presents some areas of concern regarding exposure to reputational or other strategic risks. Weaknesses identified present an unacceptable level of risk to achieving strategic aims & objectives. A small number of priority actions havae been accepted as urgently required.
No Assurance	The system design & existing controls are ineffective. Several fundamental operqational weaknesses have been recognise. Existing performance presents an unaccpetable exposure to reputational or other strategic risks. Weaknesses identified are directly impacting upon the prevention to achieving strategic aims & objectives. Several priority management actions have been accpeted as urgently required.
External - Third Line of Defence	
Substantial	IA - That the framework of governance, risk management and control has been effectively designed to meet the organisation's objectives, and that controls are consistently applied in all areas reviewed.
Significant	IA - That there is generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently.
Moderate	IA - That there is generally sound framework of governance, risk management and control, however, inconsistent application of controls puts the achievement of the organisation's objectives at risk.
Limited	IA - That there are weaknesses in the design and/or inconsistent application of the framework of governance, risk management and control that could result in failure to achieve the organisation's objectives.
Weak	IA - That there are weaknesses in the design and/or inconsistent application of the framework of governance, risk management and control that will result in failure to achieve the organisation's objectives.

2310 - D4 CHAIR'S ASSURANCE LOG - CHARITABLE FUNDS COMMITTEE

Discussion Item | Hazel Brand, Non-executive Director | 11:05

5 minutes

REFERENCES

Only PDFs are attached

D4 - Chair's Assurance Log - Charitable Funds Committee.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Charitable Funds Committee - Chair's Highlight Report to Trust Board

Subject:	**Charitable Funds Committee** (CFC)	**Board Date:** October 2023
Prepared By:	Hazel Brand, Committee Chair and Non-executive Director	
Approved By:	Charitable Funds Committee Members	
Presented By:	Hazel Brand, Committee Chair and Non-executive Director	
Purpose:	This paper summarises the key highlights from the Charitable Funds Committee, held on Friday 29 September 2023	

Matters of Concern/Key Risks to Escalate	Major Actions Commissioned/Work Underway
• Errors and omissions in the process of dealing with investment income were catalogued in a late paper. The CFC had not had input to the decision. Corrective action was proposed, which members approved • Questions were asked about the Charitable Funds Development Committee's awards, particularly those funding staff: did they meet the 'additionality' criteria? It was noted that certain funding for staff could be pilot projects and hence qualify. If roles/posts are to be funded from charitable funds, they need to be fixed term, or fully taken account of in the Trust's workforce headcount because of the ongoing cost burden. The Chief Nurse will look at these posts in the context of the workforce strategy • Assurance was sought that projects funded by CFC and the Charitable Funds Development Committee could demonstrate their effectiveness. When major projects are completed, presentations to CFC were supported • fundraising regulation needs to be put in place: there must be transparency on what donations are used for. Donations may be used to fund posts, which donors might expect to be funded by the NHS	• Fund-raising/Grant-making strategy in hand. To be finalised once the Strategic Update paper (on the future management of the fund-raising function) has been received and discussed • An additional meeting of the CFC will be arranged to complete the action above • 3 business cases for projects that might be funded by the Fred & Anne Green Legacy will be presented at the December meeting having been through DBTH's governance processes
Positive Assurances to Provide	**Decisions Made**
• Broadly supportive comments on ethical investments had been received from trustees and will be collated to inform future discussions with CFC's investment advisers • An updated Policy and Terms of Reference were approved, recognising that there may be changes if proposals in the strategic update paper are agreed • A governor observer raised a number of points that were satisfactorily answered • Following heightened publicity, the Charitable Funds Development Committee has received a considerable number of bids	• Corrective action in relation to the General Funds Update paper were agreed: to reallocate investment income from 2021/22 and 2022/23; to merge DRI, Bassetlaw, and Montagu General Funds (not including the Fred & Ann Green Legacy); and consolidate/close dormant funds • Comments on ethical investments and will be forward to the CFO to inform future discussions with investment managers, Aberdeen Standard • The Charitable Fund Policy and Terms of Reference were approved • It was agreed that recipients of major awards be invited to present their projects/outcomes to CFC

2310 - D5 CHARITABLE FUNDS POLICY & COMMITTEE TERMS OF REFERENCE

Decision Item | Angela O'Mara, Deputy Company Secretary | 11:10

Front cover to follow
5 minutes

REFERENCES

Only PDFs are attached

- D5 - Charitable Funds Policy & Terms of Reference.pdf
- D5 - Draft Charitable Funds Policy V5..pdf
- D5 - Draft Charitable Funds TOR October 2023.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	31 October 2023	**Agenda Reference:**	**D5**
Report Title:	**Charitable Funds Policy & Terms of Reference**		
Sponsor:	Fiona Dunn, Director Corporate Affairs / Company Secretary		
Author:	Angela O'Mara, Deputy Company Secretary		
Appendices:	Corp/FIN 8 Charitable Funds Policy Charitable Funds Committee Draft Terms of Reference		

Report Summary

Executive Summary

Minor changes have been made to the Charitable Funds Policy. In addition to the removal of the terms of reference, as an appendix to the policy, changes have been made to the language used to describe the membership, which now identifies voting executive directors as trustees, rather than by job title.

The Terms of Reference and the policy now accurately reflect membership of the Committee and recognise that where a governor representative is in attendance, this is as an observer and not a member of the Committee.

Due to ongoing efforts to progress the work of the Charity and the development of a fundraising strategy a review date within the next 12 months is expected.

Recommendation:	The Board is asked to approve the Charitable Funds Policy and the terms of reference for the Charitable Funds Committee.			
Action Required:	**Approval**	~~Discussion~~	~~Take assurance~~	~~Information only~~
Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**
	To provide outstanding care and improve patient experience	*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*
We believe this paper is aligned to the strategic direction of:	**South Yorkshire ICS**		**NHS Nottingham & Nottinghamshire ICS**	
	NA		**NA**	

Implications

Board assurance framework:	
Risk register:	
Regulation:	
Legal:	

Resources:		
Assurance Route		
Previously considered by:		Charitable Funds Committee
Date:	29 September 2023	
Any outcomes/next steps		Approval by the Board of Directors -31 October 2023
Previously circulated reports to supplement this paper:		

APD TEMPLATE FOR THE DEVELOPMENT OF A PROCEDURAL DOCUMENT

CORP/FIN 8 v.~~5~~5

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Charitable Funds

This procedural document supersedes: CORP/FIN 8 v.3 – Charitable Funds

Did you print this document yourself?

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

Executive Sponsor(s):	Alex Crickmar
Author/reviewer: (this version)	Alex Crickmar – Interim Director of Finance Matthew Bancroft – Head of Finance Control
Date written/revised:	~~March 2022~~Sept 2023
Approved by:	Charitable Funds Committee
Date of approval:	~~September 2022~~
Date issued:	October 2022
Next review date:	~~March 2024~~
Target audience:	Trust-Wide

Amendment Form

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

Version	Date Issued	Brief Summary of Changes	Author
Version 5	September 2023	Removal of Terms of Reference from the appendix	Fiona Dunn
Version 4	March 2022	• Updated job titles • Made reference to separate Investment Policy rather than embedded document • Removed reference to Fred & Ann Green Group • Reworded approval process for expenditure	Alex Crickmar Matthew Bancroft
Version 3	March 2020	• Reference to new donation envelopes, Above & Beyond Committee, guidance regarding fundraising practices	Jon Sargeant Matthew Bancroft
Version 2	August 2018	• Changes to Committee terms of reference, urgency rules and delegated limits	Jon Sargeant Matthew Kane
Version 1	May 2017	• Original Document	Andy Thomas

Formatted Table

Contents

Page No.

1 INTRODUCTION 4
1.1 **General** 4
1.1 Terminology .... Error! Bookmark not defined.
2 RESPONSIBILITIES & DELEGATION 5
2.1 Charitable Funds Committee 6
2.2 Scheme of Delegation of Expenditure 6
3 AUDITS AND ACCOUNTS 7
4 OPERATIONS OF THE CHARITABLE FUNDS 7
4.1 Allocation to individual funds 8
4.2 Purchasing 9
4.3 Banking 9
4.4 Charges 9
4.4 Investments and investment returns 10
4.5 Reserves 10
5 FUNDRAISING 10
6 TRAINING/SUPPORT 12
7 EQUALITY IMPACT ASSESSMENT 12
8 DATA PROTECTION 12
APPENDIX 1 – RECEIPT OF DONATIONS DOCUMENTATION 13
APPENDIX 2 – INSTRUCTIONS TO COMPLETE DONATION ENVELOPES 14
~~**APPENDIX 3 – CHARITABLE FUNDS COMMITTEE TERMS OF REFERENCE (TOR) .... 16**~~
APPENDIX ~~4~~ 3 – CHARITABLE FUNDS EXPENDITURE POLICY 18
APPENDIX ~~5~~ 4 – EXPENDITURE REQUEST FORM FOR THE CHRITABLE FUNDS DEVELOPMENT COMMITTEE 22
APPENDIX ~~6~~ 5 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING 24

1 INTRODUCTION

1.1 General

This policy covers the governance and operation of the Doncaster & Bassetlaw Teaching Hospitals Charitable Funds.

It should be noted that, whilst this is a free standing arm's length body from the Foundation Trust itself, the relevant Trust policies and procedures (including SFIs and SOs) apply unless superseded by the contents of thispolicy.

Failure to comply with this policy and related procedures is a disciplinary matter which could result in dismissal.

1.2 Terminology

Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and

"the Board"	means the board of directors of the Trust as constituted in accordance with the Trust Constitution;
"Chair"	means the chair of the Charitable Funds committee appointed in accordance with the Trust Constitution;
"Chief Executive"	means the Chief Executive Officer of the Trust appointed in accordance with the terms of the Trust Constitution;
"Director"	means a director on the Board of Directors of the Trust;
"Executive Director"	means an executive director of the Trust appointed in accordance with the Trust Constitution;
"Funds held on Trust"	means those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument or chooses to accept under powers derived under S.90 of the 2006 Act;
"Legal Adviser"	means the properly qualified person appointed by the Trust to provide legal advice;
"the charity"	means Doncaster & Bassetlaw Teaching Hospitals Charitable Fund;
"Unrestricted Fund"	means funds donated for a specific purpose but where, should this purpose be deemed unachievable, the fund may be redirected for other charitable purposes

"Restricted Fund"	means funds donated to the Trust with a specific purpose for which they must be used
"Designated Fund"	means monies donated which may be used for any purpose but for which a separate 'fund' has been created for purely legal purposes.
"Charitable Funds Committee"	means the committee of the Board of Directors set up to govern and administer the Charitable Funds.
"Corporate Trustee"	a Charitable Fund may have one corporate body as a sole Trustee. In this case the Trust is the sole corporate Trustee of the charity.
"the Trust"	means Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust.

Wherever the title Chief Executive, Director of Finance, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

Wherever the term "employee" is used, and where the context permits, it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

2 RESPONSIBILITIES & DELEGATION

Doncaster & Bassetlaw Teaching Hospitals NHS FT shall be designated the sole corporate Trustee of the Charitable Fund.

The Board of Directors shall act as this Trustee. Therefore that body is responsible for running the operation of the Charitable Funds and ensuring a good governance structure is maintained.

The Board of Directors, when acting as the Trustee, needs to demonstrate that the decision making process is:

- Clear – i.e. can be easily understood and recorded as such;
- Open – decisions are made by the Board, acting as corporate Trustee, once all relevant and necessary information is available.
- Independent – i.e. the decision making process is independent of any decision making concerning the use of exchequer funds.

The Trust Board is set up as a Corporate Trustee for the Charitable Funds, this means that individuals are not responsible in law for the actions of the charity, however the Trust as a legal entity is. The Trustee cannot delegate their duties and responsibilities, including major decisions in relation to the management and use of the Charitable Funds. What can however be delegated is the implementation of Trustee's decisions.

To this end the Board shall set up a Charitable Funds Committee which acts for the Corporate Trustee and is responsible for the overall management of the Charitable Fund.

2.1 Charitable Funds Committee

The membership of the charitable Funds sub-committee shall be as follows:

- NED Chair
- The Chair and all other Non-Executive Directors of the Trust
- Chief Executive
- All voting Executive Directors
- ~~Deputy Chief Executive~~
- ~~Director of Finance~~
- ~~Medical Director~~
- ~~Chief Nurse.~~

The Committee may also invite these people to attend;

- A governor observer co-opted by the Board
- Where any specific fund represents greater than £1m of the fund balances (as defined as at the proceeding 31st March) the committee shall offer to co-opt an additional member with a specific knowledge and or interest in that fund.
- Director ~~Head~~ of Communications and Engagement
- Head of Financial Control
- Charity Fundraiser

The duties of this committee shall be as set out in the committee's terms of reference. ~~(See Appendix C).~~

The Charitable Funds Committee shall establish further sub-committees or working groups of itself as required at its discretion. As at March 2022, such working group currently constituted is the Charitable Funds Development Committee (also known as the Above and Beyond Committee).

2.2 Scheme of Delegation of Expenditure

The Board, as sole corporate Trustee, shall, upon the recommendation of the Charitable Funds Committee set up schemes of delegation for spending the funds. This will allow items, or groups of items, of up to £50,000 to be delegated to the Director of Finance following initial approval by the designated fund-holder. Any commitments will only be made via the Trust's normal processes and must comply with Standing Financial Instructions (SFI's).

Where an item is required on an unforeseen, urgent basis and it is impracticable to arrange an additional meeting of the Charitable Funds Committee approval may be given by the Director of Finance following consultation with the Chair of the Committee.

All items approved under the delegated powers rules as per 2.8 and 2.9 above shall be reported to the next meeting of the Charitable Funds Committee for noting.

Where a Business Case would be required to be considered by the Trust's Corporate Investment Group (CIG) if it was core revenue funded then the same process should apply for Charitable Fund funded items.

All bids relating to the General Fund should go to the Charitable Funds Development Committee in the first instance, prior to going into the below process.

- If the bid is for under £10k, then the Director of Finance can approve the expenditure.
- If the bid is between £10k and £50k, the bid needs Corporate Investment Group approval prior to Director of Finance approval.
- If the bid is between £50k and £1m, the bid needs Corporate Investment Group approval prior, then Director of Finance approval, and finally Charitable Funds Committee approval.
- If the bid is over £1m, the bid needs to follow the pathway for bids between £50k - £1m, with Trust Board additionally needing to approve the bid.

3 AUDITS AND ACCOUNTS

As outlined in the powers of the Charitable Funds committee in point 2.7 above there is a requirement to prepare and have audited annual accounts.

Therefore it shall be the responsibility of the Director of Finance to:

- Maintain the necessary financial records to enable the transactions and balances for each fund to bereported.
- Be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the Trustee to fulfil its statutory responsibilities
- Prepare annual accounts for the consolidated CharitableFunds
- Provide the necessary information and explanations to enable the appointed auditors to complete their work.
- Provide regular reports to the Charitable FundsCommittee

Once completed the auditors shall present their report to the Charitable Funds Committee for consideration.

4 OPERATIONS OF THE CHARITABLE FUNDS

It is the policy of the Trust that all gifts, donations or proceeds from any fund-raising activities which are intendted for the Trust's use, must be paid into the appropriate Charitable Fund.

Monies must NOT be retained on wards/departments, to be deposited into unauthorised Bank/Building Society accounts or paid temporarily into a member of staff's personal account.

Charitable Funds are administered by the finance team within the Trust.

Donations will be deposited into the appropriate Charitable Fund bank account in accordance with the Trust's Standing Orders and Financial Instructions. All donations, unless otherwise specified will be deposited into 'General' Charitable Funds.

It is vital that formal acknowledgement is made of monies received into the Charitable Fund. The use of donation envelopes or online donations are encouraged, as this route allows a full audit trail to be retained, and a formal letter of thanks to be sent out.

4.1 Allocation to individual funds

Within the over-arching Trust Charity funds held may be split into individual funds to better manage them. Each of these may, for example, represent a ward, department, or specific fundraising appeal, etc. These are called 'Designated Funds'.

Each sub fund shall, as required by legislation, be categorised in one of the following ways:

- Restricted – such funds must be used for specific purposes only as set out by the donors at the time of the donation or by the terms of a public appeal.
- Unrestricted – funds given to charity without any restrictions imposed by the donor. This would include proceeds from any appeals where the Trustees included a disclaimer to the effect that this is likely should the purpose of the appeal be unachievable.
- Designated – funds given to the hospitals' charity in general free to use at the discretion of the Trustee. In some cases such monies may be placed in a specific discretely defined fund for administrative ease only.

With the exception of restricted funds as defined above the allocation of monies into individual sub funds is purely for ease of administrative purposes only and has no legal force. The Trustee may, subject to other relevant laws and regulations, merge, split or otherwise amend these funds as seenfit.

Each fund shall have a number of authorised signatories ranging from one to five. All expenditure for a fund must first be authorised by one of these signatories before then going through the full authorisation process as defined above.

No fund may go 'overdrawn' i.e. have a negative balance. Any authorised signatories authorising such expenditure may be subject to disciplinary action as per the Trusts SFI's.

4.2 Purchasing

The authorisation procedures outlined in this document are additional to the applicable purchasing rules of the Trust. i.e. the need to obtain a number of quotes on smaller items, undertake full tender on large expenditures etc.

In considering the values of items being purchased it is not permissible to segregate sets of or related items to minimise the procurement process.

All other Trust purchasing policies also apply to the use of Charitable Funds

In all cases an order shall be raised on the Oracle system for all Charitable Funds purchasing.

All Charitable Funds expenditure should either be necessary for the running of the charity, or enhance the patient experience of patients at Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust. A separate Expenditure Policy can be found in Appendix D.

4.3 Banking

All payments will be made via the Trust's bank account. This will be to both ease the administrative burden and better manage overall cash resources.

A discrete Charitable Funds bank account will however be maintained to hold any unused cash resources and receive cash. The level of funds so held will be driven by the Reserves & Investment Policy (see below).

On a monthly basis the 'inter-company' account between the Trust and Charitable Funds will be reconciled to identify any aggregate sums due from/to the Charitable Funds and a payment/receipt actioned to return this to balance.

4.4 Charges

The Trust shall recharge the costs of administering the Charitable Funds to the Fund itself. This cost shall then be distributed proportionately over the various individual funds based on the balances.

The overall cost to be charged should be in line with the cost of providing the service. This will include, but not necessarily be restricted to:

- The costs of any Charitable Fund accounting system sused
- An appropriate proportion of the costs of other IT systems used in administeringthe fund
- The staff time of those in the Finance function and elsewhere delivering the service in support of Charitable Funds
- The staff time in Communications/Fundraising delivering the service in support of Charitable Funds

- A reasonable proportion of any other relevant costs

In some cases Trust members of staff will work on Trust funded projects. Where this is the case a proportionate element of their costs will be recharged.

It is not permissible for the Trust to either over- or under- charge the Charitable Funds.

The total of such charges shall be reported to the Charitable Funds Committee on an annual basis.

4.4 Investments and investment returns

Please see separate investment policy document.

4.5 Reserves

Please see separate reserves policy document.

5 FUNDRAISING

The Trust's Charitable Funds have four main ways of generating additional resources:

- Donations from users, patients, relatives etc.
- Fundraising – either general or for specific purposes
- Bequests included in wills
- Investment income (as outlined above).

For donations/fundraising, there are numerous ways that money can be received into the Charitable Funds. These can include the use of donation envelopes handed into wards/departments or the Cashiers' Office, online fundraising platforms, such as Just Giving, or bank transfers (details available from the Charity finance team)

It should be noted that it is not permissible to credit the following to Charitable Funds:

- Fees/salaries for additional work done where the individual earning the monies is in direct control of the fund. e.g. if an individual asks for any overtime or additional payments to be paid tax free into a Charitable Fund where the same individual has direct control over the subsequent expenditure of those sums. In such cases the fees/salaries should be paid to the employee net of tax in the usual manner then the recipient can subsequently donate to the Charitable Fund with the gift aid mechanism being used to maximise the donation.
- Where the income credited to the fund arises from activities undertaken by NHS staff in time paid by the NHS.

- Where the income relates to the sale of items purchased at NHS expense.
- Any other income where the expenditure to generate the income was funded by core exchequer funding. If in doubt the advice of the Director of Finance or his/her designated deputy should besought.

All fundraising activity should be approved by the Charitable Funds team in the first instance. This will be done by the Head of Communications and Engagement. This is to ensure that all fundraising is duly accredited, there are mechanisms in place to ensure that all funds raised are credited to the relevant fund, and that all legal aspects are fully covered. Once a fundraising event has been approved, then it will be followed up by the Finance department, ensuring that the money has been received and accounted for infull.

When fundraising, the general aims of the Foundation Trust should be considered. Whilst all fundraising is encouraged, and it is accepted that non-standard activities are often the most successful, care should be taken that no activities that could be deemed to bring the Trust into disrepute are undertaken.

Please note, that tombola's and raffles are actively discouraged and alternative fundraising streams should be sought. This is because of the risk to all stakeholders of cash being transacted, as well as potential non-compliance against Gambling Commission guidelines.

When accounting for fundraising care must be given to the need to ensure that the Trusts Charitable Funds do not become fragmented into a large number of small funds. The establishment of too many 'restricted' funds (see 4.1 above) is likely to lead to a lack of flexibility in not being able to deploy significant resources as and when required

To avoid the over fragmentation of the funds the following principles should be applied:

- When receiving donations the appropriate form should be used as shown in Appendix A. This states that all donations are made to the Charitable Funds 'General Fund' and as such may be used for any charitable purpose as determined by the Trustee. However there is an additional opportunity for the donor to indicate, in a non-legally binding way, the purpose for which he/she would like their donation used. This will enable the Charitable Funds to both attribute the item to a specific designated fund whilst maintaining the opportunity and flexibility to fund large schemes and reallocate donations to where they can be best used.

- Where a specific appeal is being launched for a significant sum the literature should clearly state that, should the funding not be required for the specified purpose, then the Trustee retains the right to use it elsewhere within the general charitable purposes of the Trust. Examples of where this might happen is where insufficient funding is raised, funding in excess of the cost of the item required is raised, due to changes in technology and/or service patterns and a different development might now be considered preferable to deliver the original purpose,etc.

- Where a significant bequest is received it may be necessary to set up a 'Restricted' fund (see 4.1 above). In some cases this will be unavoidable. However, where future

bequests are being encouraged and/or discussed with the Trust in advance of the donor's death the use of an unrestricted or designated fund should be encouraged.

The use of gift aid and other such mechanisms to maximise the effects of donations is to be integral to all fundraising. As such, it is advisable that the name and address of all donors are kept, where possible, alongside an agreement by them that they permit for Charitable Funds to reclaim Gift Aid from thedonation.

The Board has approved a separate Fundraising Strategy which should also be read in conjunction with this section.

6 TRAINING/SUPPORT

Please note: The training requirements of staff will be identified through a learning needs analysis (LNA). Role specific education will be co-ordinated/ delivered by the topic lead. Alternatively, training may be accessed via an approved e-learning platform where available.

7 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified.

8 DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the UK General Data Protection Regulation (GDPR) 2021.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website: https://www.dbth.nhs.uk/about-us/our-publications/information-governance/

APPENDIX 1 – RECEIPT OF DONATIONS DOCUMENTATION

Donor's details

Reference number: 0000

Title: ..... Full name: .....

Home address (inc postcode): .....

.....

Telephone: .....

Email: .....

I wish to give Doncaster & Bassetlaw Teaching Hospitals Charitable Fund

the sum of £ ..... ☐ To the charity itself

☐ Or to a specific department .....

Date: .....

Signature: .....

Staff member details (who received donation)

Name: .....

Signature: .....

Ward/department: .....

Date: .....

Second signature for cash donations:

Name: .....

Signature: .....

DBTH Charity registered in England and Wales No.1057917.

giftaid it Boost your donation by 25p of Gift aid for every £1 you donate. See reverse for details.

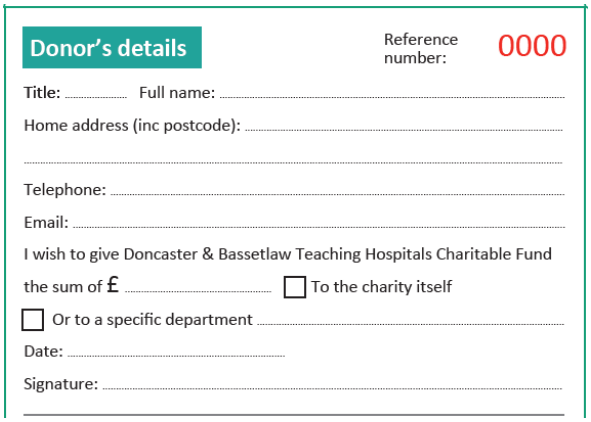
1

APPENDIX 2 – INSTRUCTIONS TO COMPLETE DONATION ENVELOPES

When a patient/relative wishes to donate to **DBTH Charity**, it needs to be as easy as possible for them.

However, we need to make sure that we follow the correct procedures so that staff are protected and the donation is used in accordance with the donor's wishes.

If a donor wishes to donate, you can either direct them to Cashiers (DRI) /General Office (Bassetlaw/Montagu) or ask them to donate on the ward/department, using a **donation envelope**. When using the donation envelope, the donor needs to complete this section first:



Donor's details Reference number: 0000

Title: ..... Full name: .....

Home address (inc postcode): .....

.....

Telephone: .....

Email: .....

I wish to give Doncaster & Bassetlaw Teaching Hospitals Charitable Fund

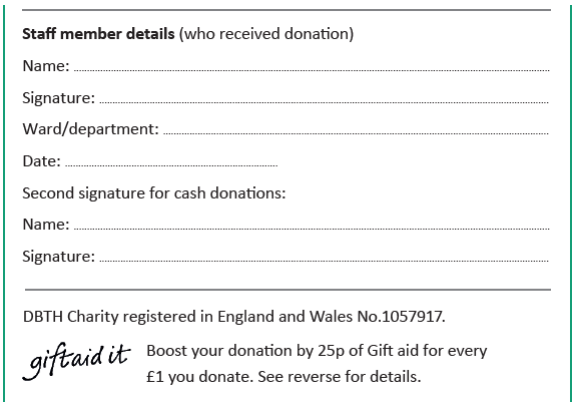
the sum of £ ..... ☐ To the charity itself

☐ Or to a specific department .....

Date: .....

Signature: .....

and 2 members of staff need to countersign the section below:



Staff member details (who received donation)

Name: .....

Signature: .....

Ward/department: .....

Date: .....

Second signature for cash donations:

Name: .....

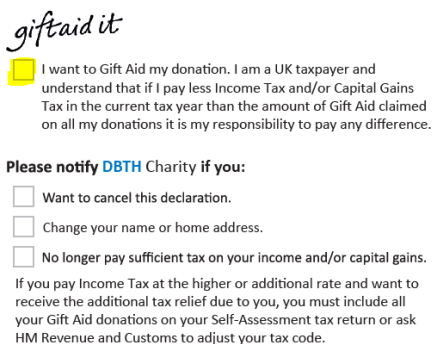
Signature: .....

DBTH Charity registered in England and Wales No.1057917.

giftaid it Boost your donation by 25p of Gift aid for every £1 you donate. See reverse for details.

Having 2 members of staff to countersign is really **important** because it ensures that the amount of money which is being donated has been validated.

If the donor is a UK taxpayer, then please encourage them to tick the **Gift Aid** box (highlighted), which is underneath the tear-off section of the envelope. By doing this, the Charity can claim an extra 25% from the Treasury, at no cost to the donor. We need the donor's address to be able to do this, which is why we have asked for it at the beginning.


giftaid it

I want to Gift Aid my donation. I am a UK taxpayer and understand that if I pay less Income Tax and/or Capital Gains Tax in the current tax year than the amount of Gift Aid claimed on all my donations it is my responsibility to pay any difference.

Please notify DBTH Charity if you:

- Want to cancel this declaration.
- Change your name or home address.
- No longer pay sufficient tax on your income and/or capital gains.

If you pay Income Tax at the higher or additional rate and want to receive the additional tax relief due to you, you must include all your Gift Aid donations on your Self-Assessment tax return or ask HM Revenue and Customs to adjust your tax code.

Finally, the blue tear off section can be completed with the donation amount, and this is given to the donor. The amount on this slip should be the same as the amount entered previously, and the amount of money within the envelope.

This envelope needs to be sealed and kept in a **secure location** until someone takes the sealed envelope to Cashiers/General Office during office hours.

The donor should receive a "Thank You" letter acknowledging the donation 2-3 weeks after making the donation. Should the donor not receive this letter, please encourage them to contact the Trust using the contact details on the acknowledgement slip.

Although the donor will receive a "Thank You" letter, please feel free to send a personalised letter from the Ward/Department.

APPENDIX 3 – CHARITABLE FUNDS COMMITTEE TERMS OF REFERENCE (TOR)

Name	**Charitable Funds Committee (CFC)**
Purpose	To oversee and manage the Trust's Charitable Funds i.e. Doncaster & Bassetlaw Teaching Hospitals Charitable Funds. To fulfil the sole objective of the Charity which is to support the work of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust. This is to be achieved through the provision of resources that help contribute to the improved welfare and amenities of patients and staff.
Responsible to	Trust Board (as the Corporate Trustee)
Delegated authority	The Committee has the following delegated authority: • Authorise expenditure from the Charitable Funds as laid down in the Trust's Scheme of Delegation. • Ensure compliance with Charity Commission standards. • Manage the affairs of the Charitable Fund within the terms of the Trust Deed. • Develop and implement a fund raising strategy. • Invest the available fund monies in line with Policy. • Oversee the management and monitoring of the Trust's Charitable Funds. • Ensure that policies and procedures are in place such that all decisions regarding fund expenditure are appropriate and consistent with the objectives of both the Charity and Trust. • Develop and maintain a rolling three year expenditure strategy for the Charitable Funds. • Approve the annual report and accounts of the Charitable Fund. • Appoint an appropriate auditor to report on the annual accounts. • Appoint an appropriate investment consultant to manage the Fund's investments • Manage the investment of funds as laid down by both statute and the charity's reserves investment policy. • To develop and monitor the Funds' approach to risk including risk appetite. • To continue to keep its own effectiveness under regular review.
Chair	• Designated Non-executive Director

Membership	• All Non-Executive Directors of the Trust • Trust Chief Executive • Trust Director of Finance • Trust Medical Director • Chief Nurse • A designated governor representative may observe the meeting
In attendance	As required by the business to be discussed
Secretary	Trust Board Secretary
Quorum	3 (Inc. at least 1 Executive Director AND at least 2 Non-Executive Directors)
Voting	Each member has one vote, with the chair of the meeting having the casting vote in the event of a tie.
Decision making	The Committee may make decisions and approve proposals outside of meetings where the issue is considered urgent. The procedures for such decisions are set out in the Charitable Funds Policy. Any such decisions will then be reported at the next meeting for inclusion in the minutes.
Attendance requirements	Committee members must attend at least 75% of meetings, and all members are expected to nominate alternates when they are unable to attend.
Frequency of meetings	Quarterly.
Papers	Papers will be distributed at least 5 days in advance of the meeting.
Permanency	The committee is a permanent committee.
Reporting committees	• Charitable Funds Development Committee
Circulation of minutes	Members of the Committee

Date approved by the committee:	27/9/22
Date approved by Board of Directors:	delgated authority 27/9/22
Review date:	March 2024

APPENDIX 4–3 – CHARITABLE FUNDS EXPENDITURE POLICY

Scope

This document sets out the policy of the DBTH Charitable Funds concerning charitable expenditure from the funds of the charity.

DBTH Charity meets its fundraising and governance costs from current income. This type of expenditure is outside the scope of this policy.

Policy

All expenditure from 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 new additional services where the NHS body has no obligation and insufficient resources to do so; or
- enhance existing services over and above the level that can be provided by exchequer funds; or
- maintain services on a time limited basis.

There may be exceptional circumstances that justify departure from this advice, but this advice should be followed unless such circumstances can be demonstrated.

Authorisation of charitable expenditure is regulated by the DBTH scheme of delegation, which must be adhered to at all times. Fund Holders must follow this guidance in making expenditure decisions under delegated authority.

Balances should not be accumulated within charitable funds unless there are clear plans for the use of such funds for charitable purposes. In circumstances where there is no expenditure for over a year and Fund Holders are not able to demonstrate future spending plans consistent with this policy then the trustees may re-assign funds to other purposes, subject to any restrictions imposed bygifts.

Fund Holders are encouraged to plan for the strategic use of their charitable funds, rather than building them up 'for a rainy day' and then turning to them on a reactive basis.

Further explanation of criteria

Consistency with DBTH Charitable Objectives

'Objectives' describe and identify the purposes for which a charity exists. DBTH Charitable Fund Objectives, which are defined by statute, are 'for the patients, staff and carers of Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust'.

These objectives are intentionally broad. Examples of expenditure they would ***exclude*** include:

- research which has little prospect of generating knowledge of relevance to the National Health Service within a short to medium-term timescale;
- healthcare undertaken in a non-NHS setting and not funded by the NHS.

Note that in these examples both research and healthcare are charitable purposes (see below) but this is not, in itself, sufficient. Expenditure must also fall within the DBTH Charitable Funds objectives.

For charitable purposes

The Charities Act 2011 defines a charitable purpose, explicitly, as one that falls within one of thirteen descriptions of purposes and is for the public benefit. This statutory list of purposes includes three that are of likely relevance to expenditure of DBTH Charitable Funds.

- The advancement of health or the saving of lives
- The advancement of [the arts, culture, heritage or] science.
- The advancement of education.

In practice, most expenditure associated with the work of the hospital will fall under one or more of these headings, with the possible exception of some income-generating activities.

For public benefit

There is no automatic presumption that expenditure with a stated aim that falls within one of the descriptions of purposes is charitable. To be a 'charitable purpose' it must also be for the public benefit. This has to be demonstrable in each case.

There are two aspects of public benefit: the 'benefit aspect' and the 'public aspect'. Both must be satisfied to pass the public benefit test.

To satisfy the **benefit aspect**, a purpose must be beneficial and any detriment or harm that results from the purpose must not outweigh the benefit.

Clinical research is an activity to which the benefit test is of obvious relevance because its outcomes are inherently uncertain and it has the potential to harm as well as to benefit. However, in practice, compliance with the research governance policies and processes of DBTH will ensure that this matter is scrutinised. For this reason, DBTH will seek to ensure that all expenditure on research has been subject to research governance. For other expenditure, DBTH will ensure that there has been adequate clinical governance, prior to Charitable Funds approving the expenditure.

To satisfy the **public aspect**, the purpose must benefit the public in general or a sufficient section of the public and not give rise to more than incidental private benefit. (Private benefit may accrue to either individuals or organisations).
Most of DBTH Charitable Funds' expenditure will benefit a section of the public, rather than the public in general, because it will support the healthcare of a group of people with a specific disease, injury or long-term condition living within the hospital's catchment area. In some cases, for example

when dealing with rare diseases, the section of the public may be small in number. This satisfies the definition of 'a section of the public'.

Charity law prohibits the definition of a 'section of the public' with reference to specified criteria, such as skin colour. However the Equality Act permits charities to benefit people defined by reference to 'protected characteristics' provided this is justified with reference to the charities purpose. This is a complex area of law and Fund Holders are asked to contact the Charitable Funds Team where in doubt.

Personal (or 'private') benefit is 'incidental' where (having regard to both nature and amount) it is a necessary result or by-product of carrying out the purpose.

The question of incidental personal benefit may arise in relation to expenditure on professional education, training, development and attendance at conferences. In these circumstances, the public benefit (e.g. the advancement of education through the presentation of new knowledge to a conference) must be weighed against the private benefit (advancement of personal profile, networks and career prospects) and the former *must* outweigh the latter for the expenditure to be charitable.

The question also arises in the case of staff social functions, e.g. Christmas parties. The justification for subsidies to social functions is that it improves staff morale and thereby leads to better care of patients. In practice, this is hard to demonstrate. The DBTH Charitable Funds policy is to support to one event a year and not to use charitable funds for the purchase of alcohol, in line with Trust Expenses Policy.

Consistent with the objectives of restricted fund

In addition to the objects of DBTH Charity as a whole, the charity maintains a register of objects for restricted funds. These typically restrict expenditure to a particular ward, clinic, group of patients, field of research etc. Expenditure from restricted funds must be consistent with fund objects.

Additional, enhanced and maintained services

The Charity Commission says that NHS Charities should not fund items that the NHS body is legally bound to fund. In practice, this is a very limited exclusion. Although the Secretary of State is required by statute to promote a comprehensive health service, this requirement has consistently been interpreted by the courts with reference to the resources at his/her disposal. Despite this situation, the range and standard of services to be provided by an individual NHS Foundation Trust has become ever more tightly defined by the regulatory regime. Drawing an objective line as to what an NHS body is 'legally bound' to fund is, therefore, problematic.

DBTH Charitable Funds must consider the perceptions of donors when approving expenditure. Many supporters have an expectation that their gifts will fund items or activities that are 'over and above' the 'core service' that should be funded from exchequer sources, regardless of the difficulty in establishing precisely what an NHS body is legally bound to fund. Unless these supporter expectations are met, gifts will not be forthcoming and so expenditure decisions must also take into account the subjective views of donors, in so far as these can be discerned and generalised.

Charitable funds may therefore 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.

Every spending decision should be patient-focussed and should address patient needs as directly as possible, although not every piece of spending will be directly on patient services or facilities.

The Trustees will always consider the following issues, and expect those acting under delegated authority to do likewise:

- How far the spending is removed from the patients and the needs that have brought them into the care of the NHS body. Links to patient benefit from the proposed spending must not be tenuous.

- The value for money to be achieved by the proposed spending.

- Fit with donors' reasonable expectations of how their donations would be used. Would donors view some spending as substituting for exchequer funding, especially for core services? Or as frivolous or unlikely to be effective in benefiting patients?

APPENDIX ~~5~~ 4 – EXPENDITURE REQUEST FORM FOR THE CHRITABLE FUNDS DEVELOPMENT COMMITTEE

Name of Project:
Prepared by: (name) (contact details)
Department:
Reference number: (to be provided by Charitable Funds team)
Amount requested:
Estimated timeframe of spend:
Description of project:
Which site(s) does the project relate to?
How would it benefit patients over and above what is ordinarily expected?
How would it benefit staff over and above what is ordinarily expected?

Have quotes/costings been provided or are they estimates? (if estimates, the Charitable Funds Development Committee may seek costings on a case-by-case basis)

Please provide a breakdown of the estimated costs (please seek advice regarding VAT)

Are there any ongoing costs that are expected? Who will be meeting those costs?

Has the expenditure been approved in principal (if relevant) by:	
	Yes/No/Not Applicable
Division	
IMT Group	
Medical Equipment Group	
Estates Group	

Have any ward/department Trust funds been approached for funding? If so, what was their response?

Has any fund raising taken place for the expenditure, or is planned? (Please note that this is not a prerequisite for funding)

This form will be submitted to the Charitable Funds team within Finance, who may ask for additional information or clarification prior to the next ~~Above and Beyond~~\Charitable Funds Development Committee meeting, which are held on a monthly basis.

APPENDIX ~~6~~ 5 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Division	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
CORP FIN 8 ~~v4~~v5	Finance	~~Matt Bancroft~~	Existing	27/9/~~22~~23

1) Who is responsible for this policy? Name of Division/Directorate: FInance

2) Describe the purpose of the service / function / policy / project/ strategy? Sets out Trust process fro charitable funds

3) Are there any associated objectives? Comply with Standing Orders, Standing Financial Instructions and the Bribery Act 2010. Also to accord with NHS England guidance

4) What factors contribute or detract from achieving intended outcomes? – None

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]–

6) Is there any scope for new measures which would promote equality N/A

7) Are any of the following groups adversely affected by the policy? No

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

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

Outcome 1			

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 – see CORP/EMP 27.

Date for next review:

Checked by: ~~Alex Crickmar~~ **Date:** ~~27/9/2022~~

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CHARITABLE FUNDS COMMITTEE TERMS OF REFERENCE (TOR)

Name	**Charitable Funds Committee (CFC)**
Purpose	To oversee and manage the Trust's Charitable Funds i.e. Doncaster & Bassetlaw Teaching Hospitals Charitable Funds. To fulfil the sole objective of the Charity which is to support the work of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust. This is to be achieved through the provision of resources that help contribute to the improved welfare and amenities of patients and staff.
Responsible to	Trust Board (as the Corporate Trustee)
Delegated authority	The Committee has the following delegated authority: • Authorise expenditure from the Charitable Funds as laid down in the Trust's Scheme of Delegation. • Ensure compliance with Charity Commission standards. • Manage the affairs of the Charitable Fund within the terms of the Trust Deed. • Develop and implement a fund raising strategy. • Invest the available fund monies in line with Policy. • Oversee the management and monitoring of the Trust's Charitable Funds. • Ensure that policies and procedures are in place such that all decisions regarding fund expenditure are appropriate and consistent with the objectives of both the Charity and Trust. • Develop and maintain a rolling three year expenditure strategy for the Charitable Funds. • Approve the annual report and accounts of the Charitable Fund. • Appoint an appropriate auditor to report on the annual accounts. • Appoint an appropriate investment consultant to manage the Fund's investments • Manage the investment of funds as laid down by both statute and the charity's reserves investment policy. • To develop and monitor the Funds' approach to risk including risk appetite. • To continue to keep its own effectiveness under regular review.
Chair	• Designated Non-executive Director

Membership	• The Chair and all Non-Executive Directors of the Trust • Trust Chief Executive • All voting Executive Directors • ~~Trust Director of Finance~~ • ~~Trust Medical Director~~ • ~~Chief Nurse~~ • ~~Chief People Officer~~ • ~~Chief Operating Officer~~
In attendance	• Head of Financial Control • Director of Communications & Engagement • Charity Fundraiser • Where any specific fund represents greater than £1m of the fund balances (as defined at the preceding 31 March) the Committee shall offer to co-opt an additional member with a specific knowledge and or interest in that fund • A designated governor representative may observe the meeting As required by the business to be discussed
Secretary	Trust Board Secretary
Quorum	3 (Inc. at least 1 Executive Director AND at least 2 Non-Executive Directors)
Voting	Each member has one vote, with the chair of the meeting having the casting vote in the event of a tie.
Decision making	The Committee may make decisions and approve proposals outside of meetings where the issue is considered urgent. The procedures for such decisions are set out in the Charitable Funds Policy. Any such decisions will then be reported at the next meeting for inclusion in the minutes.
Attendance requirements	Committee members must attend at least 75% of meetings, and all members are expected to nominate alternates when they are unable to attend.
Frequency of meetings	Quarterly.
Papers	Papers will be distributed at least 5 days in advance of the meeting.
Permanency	The committee is a permanent committee.
Reporting committees	• Charitable Funds Development Committee

Circulation of minutes	Members of the Committee
Date approved by the committee:	29 September 2023
Date approved by Board of Directors:	
Review date: ***** review date to align with approved fundraising strategy, currently under development	* September 2024

2310 - D6 REVIEW OF RISK IDENTIFICATION, ASSESSMENT AND MANAGEMENT POLICY

Decision Item | Angela O'Mara, Deputy Company Secretary | 11:15

5 minutes

REFERENCES

Only PDFs are attached

- D6 - Review of Risk Identification, Assessment & Management Policy.pdf
- D6 - Risk Policy v5 DRAFT v3 - final.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	31 October 2023	**Agenda Reference:**	**D6**		
Report Title:	**Review of Risk Identification, Assessment, and Management Policy**				
Sponsor:	Zara Jones, Deputy Chief Executive Officer				
Author:	Fiona Dunn, Director Corporate Affairs/Company Secretary				
Appendices:	D7i - Risk Management Policy				
Executive Summary					
Purpose of report:	To update the Risk management Policy in line with current/best practice and recommendations made from 360 Assurance Internal auditors audit opinion on the Trust risk management process.				
Summary of key issues:	The documents have been reviewed, with the following adjustments made following consultation with Executives, Non-executive Directors, Risk Management Board and Trust Internal auditors: • Complete update of the risk management policy to reflect changes in the Trust Risk Register (TRR15+) • Categorisation of overarching, standalone and dependant risks • Update to refreshed Board Assurance Framework and reporting schedule				
Recommendation:	The Board is asked to ratify the changes made in the risk management policy in order to address the recommendations from the Risk management review and the Internal audit opinion for 2022.				
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:	The entire BAF has been reviewed to incorporate changes to these processes The corresponding TN SA's have been linked to the corporate risks.
Corporate risk register:	N/A
Regulation:	All NHSF trust are required to have a system in place to identify & manage risk effectively.
Legal:	Compliance with regulated activities and requirements in Health and Social Care Act 2008.
Resources:	Actions required are currently being delivered within existing trust Resources highlighted in individual risks
Assurance Route	

Previously considered by:			Risk Management Board 16/10/23 & Audit & Risk Committee 19/10/23
Date:	October 2023	**Decision:**	Comments incorporated into document & recommendations actioned
Next Steps:			Approved, for ratification at Board 31st October 2023
Previously circulated reports to supplement this paper:			Draft document of the above

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Risk Identification, Assessment, and Management Policy

This procedural document supersedes: CORP/RISK 30 v.4 – Risk Identification, Assessment and Management Policy

Did you print this document yourself?

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

Executive Sponsor	Chief Executive
Author/reviewer:	Fiona Dunn, Director Corporate Affairs
Date written/revised:	August 2023
Approved by:	Board of Directors
Date of approval:	
Date issued:	
Next review date:	
Target audience:	Trust-wide

Amendment Form

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

Version	Date Issued	Brief Summary of Changes	Author
Version 5	August 2023	Update to include new BAF process Categorization of overarching, standalone and dependant risks Clarification Trust Risk Register (TRR15+) as new terminology for Corporate risk register (CRR) Update to reference "risk management on a page document" for training and noticeboards	F Dunn
Version 4	June 2022	Changes to reflect new risk committee structure and reformatted Board Assurance Framework following review of process. Addition of Risk appetite, risk tolerance and updated scoring matrices.	F Dunn
Version 3	15 November 2017	Changes to reflect new committee structure and reformatted Board Assurance Framework	M Kane
Version 2	September 2015	Minor changes to reflect the implementation of the online integrated risk management system (Datix).	M Dixon
Version 1	11 August 2014	This is a new procedural document and replaces CORP/RISK 18 v.2 – Risk Assessment Policy (Clinical and Non Clinical) and CORP/RISK 10 v.4 – Risk Management Strategy.	M Dixon

Contents

1 INTRODUCTION 5
2 PURPOSE 5
3 RISK MANAGEMENT 6
4 DUTIES AND GOVERNANCE FOR RISK MANAGEMENT 8
4.1 Chief Executive 8
4.2 Executive Medical Director 8
4.3 Director of Corporate Affairs / Company Secretary 8
4.4 Executive/Corporate Directors 8
4.5 Board of Directors 8
4.6 Board Committees 8
4.7 Trust Executive Group (TEG) 9
4.8 Risk Management Board (RMB) 9
4.9 Risk Manager 9
4.10 Senior Information Risk Owner (SIRO) 9
4.11 Clinical Governance Quality Committee (CGQC) 10
4.12 The Health and Safety Committee 10
4.13 Trust Business Resilience Group 10
4.14 Divisional Directors /Managers or Head/Managers of Corporate areas 10
4.15 Employees 10
5 BOARD ASSURANCE FRAMEWORK AND RISK REGISTERS 11
5.1 Board Assurance Framework 11
5.2 Corporate Risk Register (all risks scored 15+ following TEG Escalation) 12
5.3 Divisional and Directorate Risk Registers (all risks in a division scored <15) 13
6 ORGANISATIONAL RISK PRINCIPLES 14
7 RISK ASSESSMENT PRINCIPLES 14
7.1 Risk Identification 14
7.2 Legal Requirements 15
7.3 Risk Assessment Documentation 15
8 RISK ASSESSMENT PROCESS – ALL RISKS 16
9 REVIEW, APPROVAL AND MONITORING OF RISKS 18

10 TRAINING/ SUPPORT 19
11 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT 20
12 EQUALITY IMPACT ASSESSMENT 20
13 ASSOCIATED TRUST PROCEDURAL DOCUMENTS 21
14 REFERENCES 21
APPENDIX1 Flowchart for monitoring & review of risks assessments 22
APPENDIX 2 – Risk matrix (Conseqence vs Likelihood) & 5 Ts Control 24
APPENDIX 3 – Glossary of Common Terms used in Risk Management 28
APPENDIX 4 – equality impact assessment - part 1 initial screening 30

1 INTRODUCTION

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

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

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

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

This policy is intended for use by all employees and contractors engaged on Trust work in respect of any aspect of that work. Although the management of key strategic risks is monitored by the Board, operational risks are managed on a day-to-day basis by employees throughout the Trust. The Trust's Board Assurance Framework and Trust Risk Register (TRR15+) provide a central record of the organisation's principal risks.

2 PURPOSE

2.1 The purpose of this policy is to ensure that risks to the following areas are identified, assessed, and managed; in addition to being prevented and controlled so far as is reasonably practicable:

a. the Trust's patients, visitors and members of the public
b. the Trust's strategic objectives
c. the Trust's employees,
d. the reputation, finances and business continuity of the Trust
e. the property, sites and equipment owned by the Trust

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

3 RISK MANAGEMENT

3.1 Risk Management is the responsibility of all staff and managers at all levels. All staff are expected to take an active lead in risk management. The policy applies to all Trust staff referred to in section 4.
A risk is the chance of something happening that will have an adverse impact on the achievement of the Trust's objectives and the delivery of high-quality care.
Risk Management is the proactive identification, classification and control of events and activities to which the Trust is exposed. See Appendix 3 for further definitions that relate to this Policy.

3.2 Principles of successful Risk Management

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

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

3.3 Risk Appetite

The risk appetite is the amount of risk that the Trust is willing to seek or accept in the pursuit of its long-term objectives and organisational strategies.
If the organisation's collective appetite for risk and the reasons for it is unknown, then leaders of the organisation will not know the levels of risk that are legitimate for them to take, or will not take important opportunities when they arise, which may stifle growth and development of the organisation, and patient / user outcomes may be affected.
In practice, an organisation's risk appetite should address several dimensions:

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

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

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

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

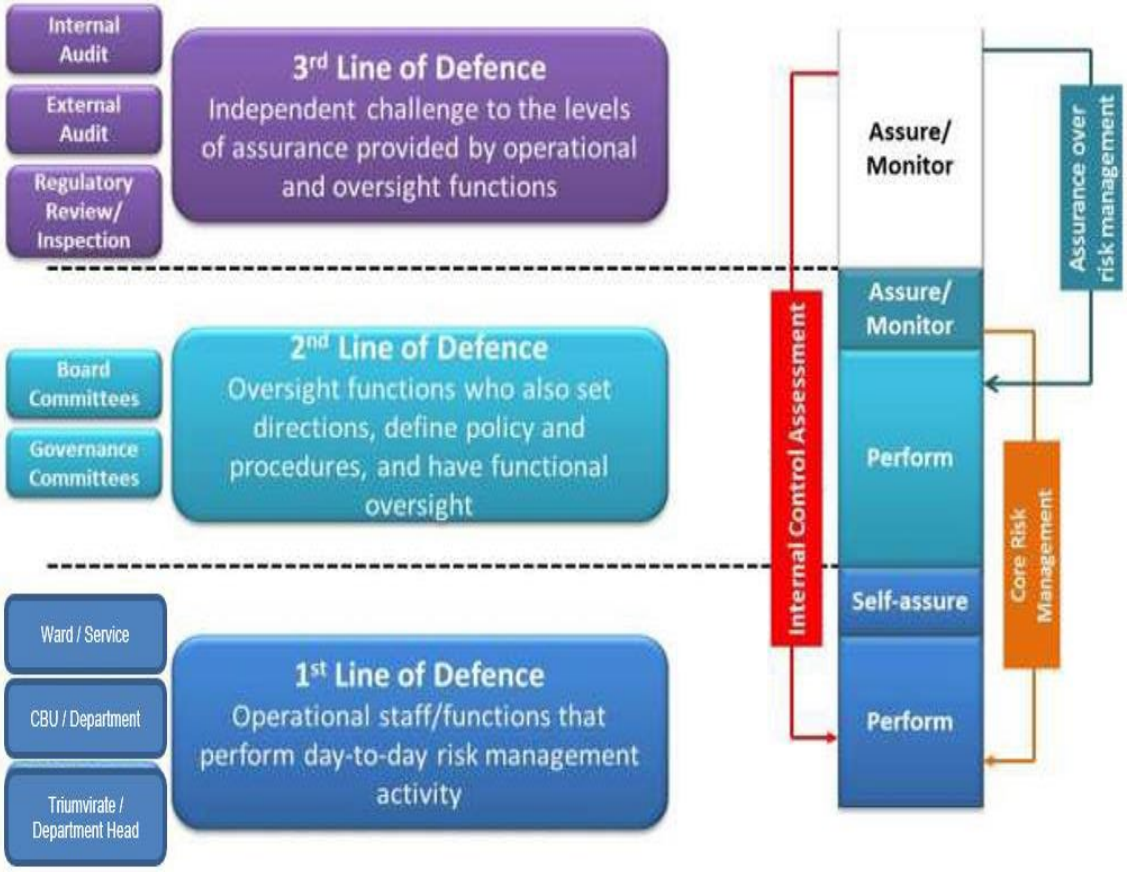
3.4 Risk Tolerance

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

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

3.5 Risk Management Assurance

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



4 DUTIES AND GOVERNANCE FOR RISK MANAGEMENT

4.1 Chief Executive

The Chief Executive has overall accountability and responsibility for risk management within the Trust and for compliance with the relevant regulations and is responsible for making the Trust's Annual Governance Statement. Delegated responsibility for the implementation of this policy is as shown below.

4.2 Executive Medical Director

The Executive Medical Director is the Board member with operational responsibility for risk management and ensuring Divisional Directors and managers are supported to fulfil out their responsibilities in line with this policy. This is facilitated by the Risk Management Board, chaired by the Executive Medical Director.

4.3 Director of Corporate Affairs / Company Secretary

The Director of Corporate Affairs, on behalf of the Chief Executive, is responsible for the Board Assurance Framework and ensuring that mechanisms are in place so that the Trust Risk Register (TRR15+) is available for Board of Directors and Board Committee oversight as appropriate.

4.4 Executive/Corporate Directors

The Executive and Corporate Directors are responsible for those risks which are relevant to their areas of responsibility. In particular, the Executive Medical Director and Chief Nurse, are responsible for risk that has a direct impact upon patient care, safety and quality of care, and the Director of Finance for financial risk. The allocation of risks to individual Directors is shown in both the Board Assurance Framework and Corporate Risk Register.

4.5 Board of Directors

The Board of Directors is responsible for ensuring that robust systems of internal control and management are in place, and for reviewing the effectiveness of internal controls through its assurance framework. This responsibility is supported through the governance committees of the Board of Directors (see 4.6).

To inform the Annual Governance Statement made by the Chief Executive in the annual accounts, the Board of Directors must be able to demonstrate that it has been informed, through the Board Assurance Framework, about all significant risks and that it has arrived at its conclusions on the totality of risk, based on the evidence presented to it.

4.6 Board Committees

The Audit and Risk (ARC), Finance and Performance (F&P), People (PEO) and Quality and Effectiveness (QEC) Committees are established as governance committees of the Board of Directors. The committees' primary role in respect of risk management is to seek assurance on behalf of the board that internal control and risk management systems are sufficiently robust to ensure delivery of organisational objectives and strategies. Where there are significant

concerns or gaps in assurance or control, the committees escalate these to the Board of Directors.

Each committee owns relevant risks on the board assurance framework and Trust Risk Register (15+). The committees review both documents at each of their meetings. The ARC has ultimate oversight of the Board Committees role in risk management and also monitors the integrity of the financial statements of the Trust, while the QEC monitors clinical governance standards.

4.7 Trust Executive Group (TEG)

The Trust Executive Group is responsible for monitoring and reviewing the Trust Risk Register (TRR15+) on a monthly basis by receiving an update and details of any risk escalations from the Risk Management Board where appropriate.

4.8 Risk Management Board (RMB)

The Risk Management Board meets monthly and is an operational group reporting to TEG. It is made up of the Divisional Directors and other appropriate members of the Trust to ensure that assurance on risks can be received by providing challenge on overdue risk reviews and actions.

The RMB receives assurance from the Divisional Directors on all low and moderate and high risks in their divisions/corporate areas, that they are being actively managed and reviewed (Risk rated scores <12).

The RMB also considers all risks due for review since previous meeting and ensure that they are reviewed, and the risk information has been appropriately updated in the Trust's integrated risk management system.

The Risk Management Board reviews all the Trust's risks rated ≥12, monthly. The RMB will consider if the risk scores are still correct for any risk they review and if it needs adjusting, they will adjust as appropriate, which may escalate or de-escalate a risk. RMB will submit all ≥15 risks for review by TEG, as required.

4.9 Risk Manager role

The Risk Manager role is to ensure the maintenance of a comprehensive risk register system and that the inclusion of prioritised risk issues are reported to the Risk Management Board.

The Risk Manager role is to ensure that standards and procedures relating to risk are embedded throughout the organisation and to oversee the delivery of a risk management training programme.

4.10 Senior Information Risk Owner (SIRO)

The Chief information Officer is the SIRO for the Trust and is the nominated lead to ensure the Trust's information risk is properly identified and managed and that appropriate assurance mechanisms exist.

4.11 Clinical Governance Quality Committee (CGQC) Risks

The Clinical Governance Quality Committee is responsible for the operational aspects of clinical risk, clinical governance, and patient safety risks.

4.12 The Health and Safety Committee Risks

The Health and Safety Committee is responsible for the operational aspects of Health and Safety risks. The process to follow in identifying/recording/managing/reporting Health and Safety Risks is the same as any other risk identified within the Trust. Risks graded 8 and over must be logged on Datix (Trust's online integrated risk management system). Risks graded below 8, must be logged using the Trust's Health and Safety Risk Assessment and held locally in the department.

4.13 Trust Business Resilience Group

The Trust Business Resilience Group is responsible for managing all risks related to Emergency Preparedness, Resilience and Response (EPRR). The process to follow in identifying/recording/managing/reporting EPRR Risks is the same as any other risk identified within the Trust.

4.14 Divisional Directors /Managers or Head/Managers of Corporate areas

Divisional or Corporate Directors and managers will ensure that they have a lead for:

- The management of a divisions/directorates risks using the Trust's online integrated risk management system.
- Ensuring attendance of staff at appropriate education and training sessions.
- Ensuring divisional risk management procedures are up to date.
- The implementation of risk management systems and processes, both clinical and non-clinical, in each ward or department and specialty concerned.
- Review of all the divisions/ directorates risk in line with the appropriate review frequency. (Annually for low risks, quarterly for moderate risks, monthly for high & extreme risks.)
- Providing appropriate reporting and assurance for all the divisions/directorates risks to the RMB
- Raising risk awareness amongst all staff at operational level.
- Ensuring compliance with external assurance assessments and standards.
- Confirming **the DATIX Risk Owner** who then approves the risk within the DATIX system. **Risk Owners and Risk Handlers** actively manage the risk

4.15 Employees

Management of risk is a fundamental duty of all employees whatever their grade, role or status. Employees are required to follow Trust policies and procedures, which explain how this duty is to be undertaken.

In particular, all employees must ensure that identified risks and incidents are reported and dealt with swiftly and effectively, reported in line with relevant Trust policies and divisional/ directorates procedures to their immediate line manager and, if appropriate, their health &

safety representative, in order that further action may be taken where necessary. Health and Safety is a core element of each employee's responsibility.
Employees are responsible for keeping their Risk Management Training up to date.

5 BOARD ASSURANCE FRAMEWORK AND RISK REGISTERS

5.1 Board Assurance Framework (BAF)

The Board Assurance Framework is a tool to enable the Board to assure itself that the principal risks to the achievement of its organisational objectives are being appropriately managed. It is interlinked with the Trust Risk Register (TRR15+) and is structured around the Board's strategic objectives.

The framework summarises the controls in place to mitigate each risk, and highlights where there are gaps in these controls. It also provides a summary of positive assurances received by the Board and its committees in relation to these controls, highlighting where there are gaps in assurance.

The Chief Executive is required to sign an Annual Governance Statement each year, and the board assurance framework informs the declarations to be made in this statement.

The framework shows a summary description of each risk and when this was reviewed. The assurance framework also shows the executive lead, the relevant committee, the direction of travel, controls in place, assurance received, gaps in assurance, action being taken to address gaps and target rating to ensure that the measures in place will address the gaps to ensure the strategic risk appetite has not been exceeded.

When considering how a risk will be managed to ensure that it is within the Trusts agreed risk appetite, it Is important to understand the role of the risks target score. The target score of a risk is the ultimate level of risk that needs to be achieved given the available means and resource. Once the target level of risk is achieved and the risk continues to exist, the Trust must then tolerate this risk. In situations where the controls to manage a risk are effective and the risk is being tolerated at its target score, the current and target risk scores may be the same.

The framework will be continually reviewed and updated to ensure that it continues to provide the Board with assurance and will be discussed, with discussions logged in the minutes at the appropriate committee it is presented.

The table below highlights the assurance level descriptions for use within the BAF.

Assurance Levels	
Internal - Second Line of Defence	
Full Assurance	The system design and existing controls are working well. Potential innovations being considered all relate to achieving recognised best practice
Significant Assurance - with minor improvement opportunities	The system design and existing controls are working well. Some minor improvements have been identified. Identified manangement actions are not considered vital to achievemnet of strategic aims & objectives - although if unaddressed may increase likelihood of risk
Partial Assurance - with improvements required	The system design and existing controls require strengthening in areas. A few operational weaknesses have been recognised. Existing performance presents some areas of concern regarding exposure to reputational or other strategic risks. Weaknesses identified present an unacceptable level of risk to achieving strategic aims & objectives. A small number of priority actions havae been accepted as urgently required.
No Assurance	The system design & existing controls are ineffective. Several fundamental operqational weaknesses have been recognise. Existing performance presents an unaccpetable exposure to reputational or other strategic risks. Weaknesses identified are directly impacting upon the prevention to achieving strategic aims & objectives. Several priority management actions have been accpeted as urgently required.

The board committees review the Board Assurance Framework in addition to receiving the Trust Risk Register (TRR15+) for information, in order to avoid taking a fragmented approach to risks at this level.

The board committees each focus on the risks which pertain to their remit and terms of reference. They seek assurance on behalf of the Board that key controls are in place and review risks through their annual work plans. The assurance framework is used to drive the agenda for the committees who will undertake occasional deep dives into the risks for which they are responsible.

The Board receives the board assurance framework and Trust Risk Register (TRR15+) quarterly (April, July, October, January).

At each meeting the Audit and Risk Committee (ARC) will review whether the assurance framework process and format remain fit for purpose and recommend changes to the Board where appropriate.

5.2 Trust Risk Register (TRR15+)

The Trust Risk Register (TRR15+) is a tool to enable Trust Executive Group (TEG) to review and manage the organisation's most important risks. It is interlinked with the Board Assurance Framework and is held on the Trust's online integrated risk management system.

Risks are added to the TRR15+ if it is thought they may affect the delivery of the Corporate Objectives (from a strategic, clinical and business risk perspective).
The high level strategic risks identified in the TRR15+ are underpinned and informed by risk registers overseen at the local operational level within Divisions/directorates.

The register will include:

- Source and consequence of the risk
- Risk owner

- The original, current and target risk rating
- Controls that are in place
- New and developing controls with actions as required
- Owner of the new/developing controls and target date

Escalation of risks for consideration by Trust Executive Group and subsequent feedback shall be via the chair of the Risk Management Board.

The Risk Management Board shall review and approve the Trust Risk Register (TRR15+) on a monthly basis. Where changes to risks are made, this shall be reflected in the assurance framework where appropriate and reported to the Trust Executive Group and Board committees as appropriate.

The Trust Executive Group will receive assurance regarding all risks rated ≥15 or more via the Risk Management Board.

Where changes to the Trust Risk Register (TRR15+) are proposed which affect the content of the assurance framework (i.e. addition or deletion of risks), the proposed change shall be reported to the board committees as appropriate in addition to being presented to the Board of Directors.

The board assurance framework and Trust Risk Register (TRR15+) will be reported to each board committee meeting and to the Board of Directors bimonthly meeting.

At least once a year, the Trust Executive Group will review whether the corporate risk register process and format remain fit for purpose and agree changes where appropriate.

5.3 Divisional and Directorate Risk Registers (all risks in a division scored <15)

Each Division and Directorate will be responsible for maintaining their own risks on the Trust's online integrated risk management system (DATIX). The registers will be populated as a result of risk assessments, incidents, complaints and claims. The Divisional and Directorate risk register will be a standing agenda item at all Divisional and Directorate Senior Management Team meetings.

Any risk identified ≥12 must be escalated to the Risk Management Board for scrutiny.
All risks identified ≥15 within the Trust Risk Register (TRR15+) will require a supporting action plan to ensure that the risk is managed to a level that can be tolerated.
The action plans must be monitored by the Lead Director within the Division or Directorate

6 ORGANISATIONAL RISK PRINCIPLES

The Board of Directors has agreed the following principles with regard to its role in relation to risk:

(i) The Board will consider all aspects of risk in relation to the decisions it makes and the information it receives. This will include:
   a. The risk of inaction
   b. Reward, where applicable
   c. How risks link to the Trust strategy, values and culture
   d. The adequacy of risk management and controls
   e. Structures and escalation processes
   f. The overall risk profile and risk burden of the Trust, and its capacity to manage that risk

(ii) The Board will assess risks both initially and on an ongoing basis, recognising that where risks are dynamic its risk tolerance and strategies must be dynamic to reflect this.

(iii) The Board will work to ensure it has sufficient information regarding key risks by, among other things:
   a. Seeking external advice where appropriate.
   b. Seeking ongoing assurance from management regarding the control and management of risks.

(iv) The Board will mitigate risk as far as it feels that it is sensible and appropriate to do so.

(v) The Board will ensure that risk surveillance and triangulation are factored into its work and discussions on an ongoing basis.

7 RISK ASSESSMENT PRINCIPLES

Risk assessment is the process of identifying, describing, measuring and recording risks. Judgments are made about the harm that might arise from an activity and the probability that the harm will occur.

The main purpose of risk assessment is to determine whether planned or existing control measures are adequate or need to be improved. It also promotes an improved awareness of risk and a better appreciation of the necessity for control measures.

7.1 Risk Identification

The Trust operates two major systems to facilitate the identification of risk:

- Proactive risk identification, through identification of risks before they lead to harm. This includes interventional near miss reporting.
- Reactive risk identification, through the adverse incident reporting process; Datixweb.

In order to identify risk, teams should conduct a detailed review of the activity or area being reviewed, including any hazards perceived, and any incidents that have occurred. Once hazards and potential risks have been identified, they should be formally assessed.

Divisional/directorate risk assessment process should be followed (see sections 8 and 9) and the risk assessment given to divisional/directorate management who will assess and input the risk onto Datix.

7.2 Legal Requirements

The Management of Health and Safety at Work Regulations 1999 (MHSWR) require employers to assess the risks to the health and safety of the groups below which are created by their undertaking, in order to identify the measures that are required in order to comply with statutory provisions.

- employees whilst they are at work;
- non-employees
- new or expectant mothers
- young persons, taking into account the young persons' inexperience, immaturity and lack of awareness of risks;

Further specific risk assessments that are required to be completed in accordance with the MHSWR 1999 include:

- Lone Working
- Violence and aggression
- Stress
- Slips, Trips and Falls, including Working at Height
- Musculoskeletal Disorders

There are a number of other regulations which suggest a requirement for risk assessments, including the Health and Safety (First-aid) Regulations 1981; the Environmental Protection Act 1990 and the Provision and Use of Work Equipment Regulations 1998. The relevant regulations should be referred in relation to any area of work undertaken as part of the business of the Trust, in order to determine where a risk assessment may be required.

The process to follow in identifying/recording/managing/reporting Health and Safety Risks is the same as any other risk identified within the Trust. Risks graded 8 and over must be logged on Datix (Trust's online integrated risk management system). Risks graded below 8, must be logged using the Trust's Health and Safety Risk Assessment and held locally in the department.

7.3 Risk Assessment Documentation

The findings of the risk assessment must be recorded using the Trust's online integrated risk management system (http://dbhdatixweb/datix/live/index.php). All staff who document risks using this system should receive appropriate training. All fields must be completed where appropriate by following instructions in Datix fields and/or using standalone step by step guidance given at training. Additional document to support mitigation of the risk should be attached within the system.
Documenting a risk using the Trust's online integrated risk management system requires the

employee documenting the risk assessment to:

- describe the risk in full, covering the cause (situation giving rise to the risk), the event that may occur, and the effect of that event ie the risk should be described in the formulation "due to X, there is a risk that Y, and the impact of which is Z".
- assign a 'risk owner' (the senior manager who is responsible for the area which the risk assessment affects)
- identify the appropriate review frequency (monthly for all risks rated 8 or above)
- it is essential to describe any action already taken and control measures already in place
- determine the adequacy of existing control measures
- determine the likelihood of injury or harm arising, quantify the severity of the consequences of this harm, and assign a risk rating
- determine the target risk rating using the same principles
- identify potential additional control measures or actions, with timescales for implementation or details of process being followed.
- identify any specific legal duty or requirement which is relevant to the risk
- identify any reported incidents that relate to the risk
- provide sufficient information to enable the risk owner to monitor and manage the risk appropriately.

8 RISK ASSESSMENT PROCESS – ALL RISKS

The risk assessment process can be broken down into steps as follows:

(a) Identify potential hazards or risks - Carry out a pre-assessment walkthrough or review of the activity to identify hazards or potential risks. Be systematic, list all credible/foreseeable hazards and consider all possibilities.

(b) Plan the assessment - Assessments should be planned and prioritised for a specific area or activity and should cover likely risk issues including:

- work activities
- property and equipment
- known hazards
- accident and incident reports
- known 'near misses'
- risks to achievement of specified objectives or targets

(c) Define the nature of the risk – Once identified, the risk should be defined. What might occur, or is occurring, and what adverse consequences might this cause?

(d) Identify the people at risk - Identify all those who might be at risk including staff, contractors, patients, and the public.

(e) Analyse exposure - Identify under what conditions, when and how exposure to the risks

takes place.

(f) Detail and evaluate the existing controls in place - Evaluate how the risk is being controlled, taking into consideration statutory compliance requirements and whether the controls are effective in practice.

(g) Quantify the risk – Determine the likelihood and consequences of the risk being realised using the Risk Matrix shown at **Appendix 2.**

- Use these scores to allocate a risk rating. (The formula to calculate the risk score. Risk Score = Consequence Score x Likelihood Score. But DATIX will complete automatically)

(h) Identify further controls - Identify further control measures or actions required to reduce the risk and prioritise these. (See the use of **5T's in the Appendix 2** for understanding risk control) and ensure fully documented within the DATIX system

(i) Develop action plan - An action plan must be drawn up to implement if any further control measures are required. This should identify who is responsible for actions, and timescales for completion. This plan should be monitored at the identified appropriate level, dependent on the risk rating. Where actions require escalation in order to gain approval, this should be undertaken. This action plan must be in DATIX.

(j) Quantify the target residual risk - The target residual risk is the lowest level which the department anticipates being able to reduce the risk to, following completion of the action plan. The target residual risk should be quantified, and a timescale set for achieving this reduction.

NB: In some cases, the target residual risk may be the same as the current risk rating. In these cases, no action is required, although existing control measures must be maintained.

(k) Record the findings - The significant findings of the assessment together with any actions identified should be recorded using the Trust's online integrated risk management system (DATIX). The risk assessment is passed on to divisional/ directorate management to review, approve and record the risk into Datix.

(l) Agree the Divisional/Corporate Risk owner is agreed. The Risk owner then approves risk within the DATIX system. Risk Owners and Risk Handlers actively manages the risk.

(m) Inform staff - Staff should be informed of:

- Any risks to their health and safety identified by the assessment
- Control measures in place
- Any emergency measures identified & planned action to be taken

NB .Refer to "Risk Management on a Page" summary chart will be displayed throughout the Trust on noticeboards and on the trust HIVE for quick information to support this policy

9 REVIEW, APPROVAL AND MONITORING OF RISKS

(a) The responsibility for the risk assessment lies with the Manager who is responsible for the area which the risk assessment affects (e.g. on a ward, the ward manager/sister) and should be logged as the risk owner or handler depending on the severity of the risk within the DATIX system.

(b) Following completion of the online risk assessment, the head of department/senior manager will approve the assessment on the Trust's online integrated risk management system, to confirm agreement with both the risk assessment and action plan at the Departmental/Divisional SMT.

(c) The Head of department/Senior manager will ensure an action plan has been developed where appropriate in order to mitigate the risk and appoint a lead person for each action point together with a completion date. Once finalised, the risk assessment and action plan will be notified to all persons who could be affected by the outcome of the risk assessment.

(d) A programme of quarterly review must be established for risks rated 8 to 12 and monthly for ≥15 rated, to ensure that all agreed actions are carried out within timescales. The Risk Owner approves risk on Datix and Risk Owner and Risk Manager actively manage risk on DATIX.
All risk assessments rated lower than 8 should be reviewed on an annual basis as a minimum, or if there has been a change.

(e) Risks rated ≥12 should be escalated for discussion to the Risk Management Board to ensure the Trust Risk Register (TRR15+) remains validated as per the process outlined above (section 5.2). Risks will then be categorised into one of the following categories by the RMB for ease of oversight for themes:

- Overarching risk – which may have dependant risks linked to it eg workforce, estate risk
- Standalone risk – has no other risks linked to it
- Dependent risk – impacts/linked to an overarching risk described above.

(f) In addition to the above, risk assessments should be reviewed if they meet the criteria outlined below:

- If new equipment is introduced
- If new substances or premises are used
- If new clinical techniques are introduced which impact on staff rosters or patient handling duties
- If other processes or operational parameters change significantly

- Following an accident
- If there is reason to suspect that the assessment is no longer valid
- If there has been a significant change in matters to which the assessment relates

10 TRAINING/ SUPPORT

The effective implementation of this policy will facilitate the delivery of a quality service, alongside employee training and support to provide an improved awareness of the measures needed to prevent, control and contain risk.

An assessment of the risk management training needs of all staff will be documented within the Trust's Learning needs analysis which will be reviewed on an annual basis and action plans developed. This assessment will be linked to incidents, claims, complaints, risk assessments, external assurance and performance indicators. The Risk Manager role has responsibility to ensure this training process is in place and will liaise with Trusts Health and Safety Advisor in delivering the H&S Risk assessment process.

Local risk management training needs identified by individual areas will be discussed with the Risk Manager.
"Risk Management on a Page" will be displayed throughout the Trust on noticeboards and on the trust HIVE for quick information to support this policy.

The Education Department will maintain records of actual and expected completion of statutory and essential to role training, including corporate induction, and will address and rectify inadequate attendance. Divisions and Directorates will address and promote rectification of inadequate attendance at local mandatory training courses.

The Trust will:

- Ensure all employees and stakeholders have access to a copy of this policy and risk awareness training (e-learning packages available) and an understanding of the role of risk management in the organisation.
- Provide new employees with risk awareness training and an understanding of the role of risk management in the organisation (e-learning or other methods)
- Provide general risk awareness training, Risk assessment training, Risk register training and management of risk for all senior managers.
- Provide risk management awareness training to Board members, (both Executive, Corporate and Non-executive Directors) Divisional/Directorate Management teams on a minimum biennial basis.

Those carrying out assessments should be competent to do so and should have completed the Trust's internal training. The assessor should have an understanding of the workplace, an ability to make sound judgements, and knowledge of the best practicable means to reduce those risks identified. Competency does not require a particular level of qualification but may be defined as a combination of knowledge, skills, experience and personal qualities, including the ability to recognise the extent and limitation of one's own competence.

The Health and Safety Advisor, Trust Risk Manager role are available to provide support and advice to employees experiencing difficulties in assessing risk.

11 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

Risk escalation in the Trust has been supported by initial internal audit reviews to date and the risk management system will continue to be reviewed by the internal auditors.

What is being monitored?	Who will carry out the monitoring?	How often	How reviewed / Where reported to?
Correct completion of risk assessments.	Risk lead for ward/department	Monthly	Audit via Divisional/Corporate SMT meetings/Clinical Governance meetings
Completion of action plan with each risk assessment where further action is necessary.	Risk lead for ward/department	Monthly	Audit via Divisional/Corporate SMT meetings/Clinical Governance meetings
Ward/department level risk register monitored monthly by ward/ department manager.	Risk lead for ward/department	Annually	Audit and or minutes / Divisional /Corporate SMT meetings/Clinical Governance meetings
Division / Directorate level risk register monitored monthly at appropriate forum.	Risk Manager Role	Annually	Meeting minutes / Risk Management Board
Trust Risk Register (TRR15+) monitored monthly by the Risk Management Board and/or Trust Executive Group	Risk Manager Role	Annually	Meeting minutes / Trust Board Office
BAF & Trust Risk Register (TRR15+) monitored	Audit & Risk Committee (ARC)	Quarterly	Meeting minutes / Trust Board Office

12 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.
An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment for All Policy (CORP/EMP 4).
The purpose of the EIA is to minimise and if possible, remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix 4).

13 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

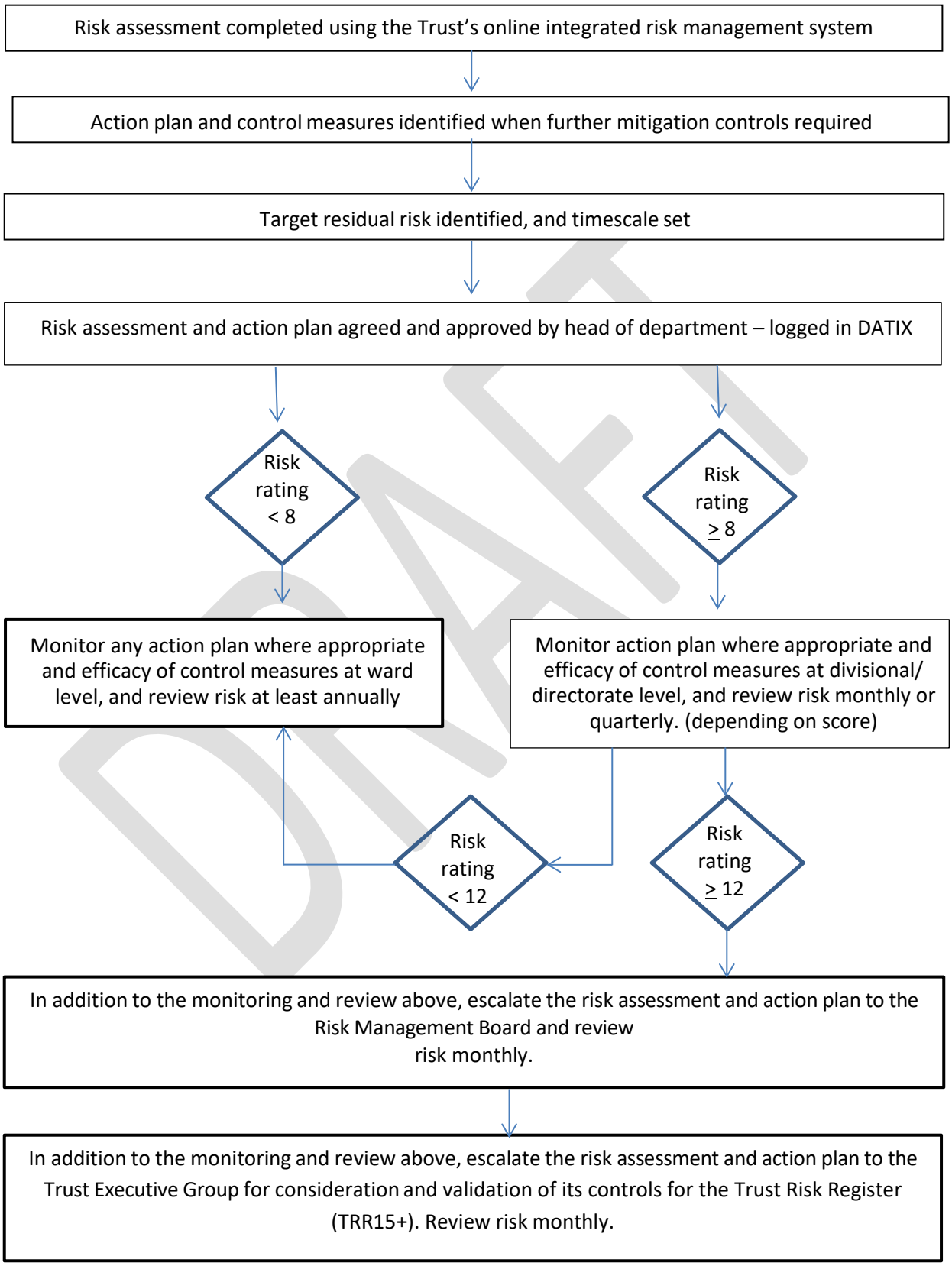
- Claims Handling Policy - CORP/RISK 5
- Serious Incidents (SI) Policy - CORP/RISK 15
- Maternity Service Risk Management Strategy - CORP/RISK 16
- Incident Management Policy – CORP/RISK 33
- Complaints, Concerns, Comments and Compliments: Resolution and Learning - CORP/COMM 4
- Fair Treatment for All Policy – CORP/EMP 4
- Equality Analysis Policy – CORP/EMP 27
- Freedom to Speak Up Policy 'Speak up to make a difference' CORP/EMP 14
- Health and Safety Policy - CORP/HSFS 1
- Security Policy - CORP/HSFS 15
- Fraud, Bribery and Corruption Policy and Response Plan – CORP/FIN1 D

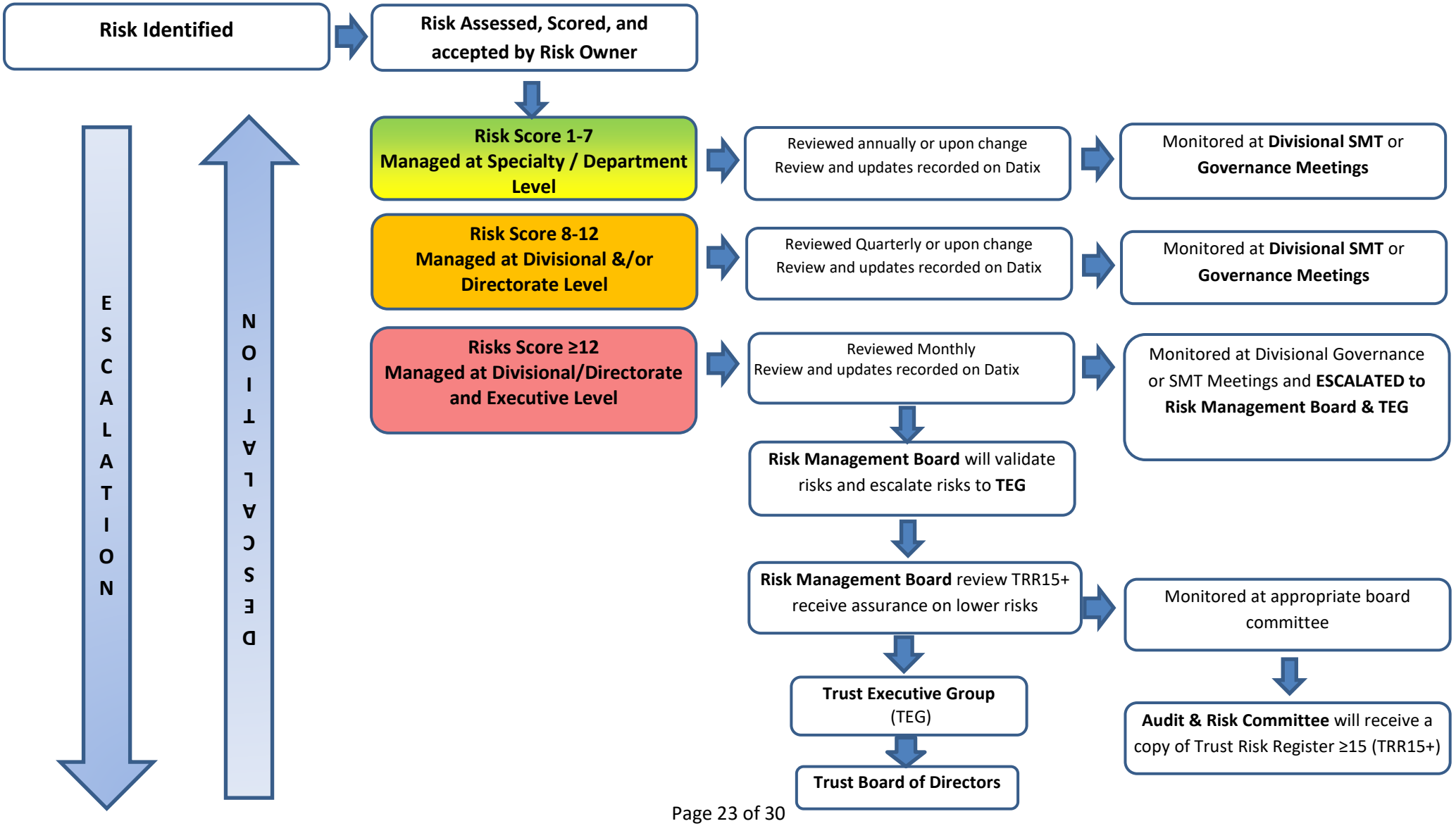
14 REFERENCES

- Control of Asbestos Regulations 2012
- Control of Lead at Work Regulations 2002
- Control of Substances Hazardous to Health Regulations 2002 (COSHH)
- Data Protection Act 1998
- Health and Safety at Work Act 1974
- Health and Safety (Display Screen Equipment) Regulations 1992
- Ionising Radiation Regulations 1999
- Management of Health and Safety at Work Regulations 1999 (SI No 3242).
- Management of health and safety at work - Approved Code of practice and Guidance (L21 - HSE)
- Manual Handling Operations Regulations 1992
- Noise at Work Regulations 2005

Personal Protective Equipment at Work Regulations 1992

APPENDIX1 FLOWCHART FOR MONITORING & REVIEW OF RISKS ASSESSMENTS




Risk Identified
Risk Assessed, Scored, and accepted by Risk Owner
ESCALATION
DESCALATION
Risk Score 1-7
Managed at Specialty / Department Level
Reviewed annually or upon change
Review and updates recorded on Datix
Monitored at Divisional SMT or Governance Meetings
Risk Score 8-12
Managed at Divisional &/or Directorate Level
Reviewed Quarterly or upon change
Review and updates recorded on Datix
Monitored at Divisional SMT or Governance Meetings
Risks Score ≥12
Managed at Divisional/Directorate and Executive Level
Reviewed Monthly
Review and updates recorded on Datix
Monitored at Divisional Governance or SMT Meetings and ESCALATED to Risk Management Board & TEG
Risk Management Board will validate risks and escalate risks to TEG
Risk Management Board review TRR15+ receive assurance on lower risks
Monitored at appropriate board committee
Trust Executive Group (TEG)
Audit & Risk Committee will receive a copy of Trust Risk Register ≥15 (TRR15+)
Trust Board of Directors

APPENDIX 2 – RISK MATRIX (CONSEQENCE VS LIKELIHOOD)

Table 1 - Consequence Score

Choose the most appropriate domain for the identified risk from the left-hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column. Consider how severe the impact, or consequence, or the risk would be if it did materialise.
The Formula for calculating the risk score: Risk Score = Consequence Score x Likelihood Score

	Consequence score (severity levels) and examples of descriptors				
	1 -Insignificant	**2 - Minor**	**3 - Moderate**	**4 - Major**	**5 - Catastrophic**
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work.	Minor injury or illness, requiring minor intervention. Requiring time off work for <3 days. Increase in length of hospital stay by 1-3 days.	Moderate injury requiring professional intervention. Requiring time off work for 4-14 days. Increase in length of hospital stay by 4-15 days. RIDDOR/agency reportable incident. An event which impacts on a small number of patients.	Major injury leading to long-term incapacity /disability. Requiring time off work for >14 days. Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects.	Incident leading to death. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality / complaints / audit	Peripheral element of treatment or service suboptimal. Informal complaint/ inquiry.	Overall treatment or service suboptimal. Formal complaint - local resolution. Single failure to meet internal standards. Minor implications for patient safety if unresolved. Reduced performance rating if unresolved.	Treatment or service has significantly reduced effectiveness. Formal complaint. Local resolution (with potential to go to independent review). Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on.	Non-compliance with national standards with significant risk to patients if unresolved. Multiple complaints /independent review. Low performance rating. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety if findings not acted on. Inquest/ombudsman inquiry. Gross failure to meet national standards.
Human resources / organisational development /staffing	Short-term low staffing level that temporarily	Low staffing level that reduces the	Late delivery of key objective/ service	Uncertain delivery of key objective /service due to	Non-delivery of key objective /service

/competence	reduces service quality (< 1 day).	service quality.	due to lack of staff. Unsafe staffing level or competence (>1 day). Low staff morale. Poor staff attendance for mandatory/key training.	lack of staff. Unsafe staffing level or competence (>5 days). Loss of key staff. Very low staff morale. No staff attending mandatory/ key training.	due to lack of staff. Ongoing unsafe staffing levels or competence. Loss of several key staff. No staff attending mandatory training /key training on an ongoing basis.
Statutory duty/ inspections	No or minimal impact or breach of guidance / statutory duty.	Breach of statutory legislation. Reduced performance rating if unresolved.	Single breach in statutory duty. Challenging external recommendation / improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low performance rating. Critical report.	Multiple breaches in statutory duty. Prosecution. Complete systems change required. Zero performance rating. Severely critical report.
Adverse publicity/ reputation	Rumours. Potential for public concern.	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House). Total loss of public confidence.
Business objectives / projects	Insignificant cost increase / schedule slippage.	<5% over project budget. Schedule slippage.	5–10% over project budget. Schedule slippage.	10–25% over project budget. Schedule slippage. Key objectives not met.	>25% over project budget. Schedule slippage. Key objectives not met.
Finance including claims	Small loss. Risk of claim remote.	Loss of 0.1–0.25% of budget. Claim less than £10k.	Loss of 0.25–0.5% of budget. Claim(s) between £10k and £100k.	Uncertain delivery of key objective /Loss of 0.5–1% of budget Claim(s) between £100k and £1m Purchasers failing to pay on time	Non-delivery of key objective / Loss of >1% of budget. Failure to meet specification /slippage. Loss of contract / payment by results. Claim(s) >£1m.
Service / business interruption	Loss /interruption of >1 hour.	Loss /interruption of >8 hours.	Loss /interruption of >1 day.	Loss /interruption of >1 week.	Permanent loss of service or facility.

Environmental impact	Minimal or no impact on the environment.	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic impact on environment.

Table 2 - Likelihood Score

What is the likelihood of the consequence described in the above Consequence Table, actually happening? The frequency-based score is appropriate in most circumstances and should be used whenever it is possible to identify a frequency. In the case of projects then the probability or chance of recurrence-based score should be used.

Frequency – How often might it /does it happen	**Description of Likelihood Scale Based on time/broad description & probability**					
	Likelihood Score	**1**	**2**	**3**	**4**	**5**
	Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
	Time Framed	Not expected to occur **for years**	**Expected to occur at least annually**	**Expected to occur at least monthly**	**Expected to occur at Least Weekly**	**Expected to occur at least daily**
	Broad Descriptor	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	This will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
	Probability for projects & Business	**1-5%**	**6-30%**	**31-70%**	**71-90%**	**>90%**

Calculate the consequence and likelihood rating using the scales below:

	Likelihood Score				
	1	**2**	**3**	**4**	**5**
Consequence Score	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

First, cross reference the likelihood and impact scores on the matrix above.

For example, if you have a *„moderate*" consequence and *„almost certain'* likelihood then the overall risk rating would be:

Consequence x Likelihood = Overall risk rating
3 x 5 = 15
Moderate x Almost certain = Extreme Risk

The likelihood and consequence of a risk occurring is always a question of judgement, past records, relevant experience, expert judgements, and any relevant publication can be used to inform a judgement.

In grading risk the scores obtained from the risk matrix are assigned grades as follows:

1-3	Low Risk	Normal risks which can be managed by routine procedures
4-6	Moderate Risk	Risks requiring assessment and action planning allocated to Divisions & Directorates
8-12	High Risk	Risks requiring urgent Divisional/directorate & /or RM Board review linked with Action Plan
15-25	Extreme Risk	Risks requiring immediate action by Director & Risk Management Board for TEG consideration with Action Plan

Key Controls:
Not all risks can be dealt with in the same way. The '5 T's provide an easy list of options available to consider how to manage risk:

- **Tolerate** – the likelihood and consequence of a particular risk happening is accepted
- **Treat** – work is carried out to reduce the likelihood or consequence of the risk (this is the most common action)
- **Transfer** – shifting the responsibility or burden for loss to another party, e.g. the risk is insured against or subcontracted to another party
- **Terminate** – an informed decision not to become involved in a risk situation, e.g. terminate the activity
- **Take the opportunity** - actively taking advantage, regarding the uncertainty as an opportunity to benefit

In most cases the chosen option will be to treat the risk. When considering the action to take remember to consider the cost associated with managing the risk, as this may have a bearing on the decision. The key questions in this instance are:

- Action taken to manage risk may have an associated cost. Make sure the cost is proportionate to the risk it is controlling.
- When agreeing responses or actions to control risk, remember to consider whether the actions themselves introduce new risks or affect other people in ways which they need to be informed about.

Contingency Plans – if a risk has already occurred and cannot be prevented or if a risk is rated red or orange (extreme or high) then contingency plans should be in place should the risk materialise. Contingency plans should be recorded underneath the key controls on the risk register. Good risk management is about being risk aware and able to handle the risk, not risk averse.

APPENDIX 3 – GLOSSARY OF COMMON TERMS USED IN RISK MANAGEMENT

Action Plan	A plan outlining additional strategies/activities or mitigating actions the Trust needs to develop and implement should the risk level be at a level that cannot be tolerated. after controls are applied. An action plan should be specific to the risk and SMART (Specific, Measurable, Attainable, Relevant and Time bound) to evidence how the risk score can be reduced.
Assurance	Evidence that risks are being effectively managed.
Consequence (Impact)	The result of a particular threat or opportunity should it actually occur.
Control(s)	Existing strategies and processes currently in place such as systems, policies, procedures, standard business processes and practices to manage the likelihood or consequence of a risky practice.
Trust Risk Register (TRR15+)	A record of the risks identified through internal process that will impact on the Trust's business objects or major programmes and so are scored 15+.
Current Risk	Risk likelihood, consequence and total score with the current controls in place to manage the risk.
Gaps in Controls or assurances	Where an additional system or process is needed, or evidence of effective management of the risk is lacking and needs to be put into place.
Hazard	A potential source of risk/threat. Eg Damage or harm.
Incident / Issue	An event that has happened, was not planned, requires a management action, and be reported as appropriate and where required in line with the Incident Reporting Policy and Procedure.
Initial Risk (Inherent Risk)	The risk score where there are no controls in place to manage the risk.
Likelihood	A measure of the probability or chance that the threat or opportunity will happen including a consideration of the frequency with which it may arise.
Mitigating Actions	Actions taken to reduce the likelihood or Consequence of the risk. Mitigating actions should be specific to the risk and SMART (Specific, Measurable, Attainable, Relevant and Time bound) to be able to measure the impact of the action and evidence how the risk score can be reduced.
Operational Risks	These risks are by-products of the day-to-day running of the Trust and include a broad spectrum of risks including clinical risk, financial risk (including fraud), legal risks (arising from employment law or health and safety regulation), regulatory risk, risk of loss or damage to assets or system failures etc. Operational risks should be managed by the department or directorate which is responsible for delivering services.
Opportunity	An uncertain event that would have a favourable impact on objectives or benefits if it occurred.

Risk	An uncertain event or set of events that have not occurred, but should it occur, will have an effect on the achievement of business, project or programme objectives. A risk can be a threat or an opportunity.
Risk Appetite	The phrase used to describe where Trust considers itself to be on the spectrum ranging from willingness to take or accept risk through to an unwillingness or aversion to taking some risks.
Risk Assessment	The process used to evaluate the risk and to determine whether controls are adequate or more should be done to mitigate the risk within the organisations risk appetite.
Risk Management	This is about the Trust's culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse events. The risk management process covers all processes involved in identifying, assessing and judging risks, assigning ownership, taking action to mitigate or anticipate them, and monitoring and reviewing progress.
Risk Registers	These are repositories for electronically recording and dynamically managing risks that have been appropriately assessed. Risk Registers are available at different organisational levels across the Trust.
Strategic risks	These risks are those that represent a threat to achieving the Trust's strategic objectives or to its continued existence. They also include risks that are widespread beyond the local area and risks for which the cost of control is significantly beyond the scope of the local budget holder. Strategic risks must be reported to the Board of the Directors and should be managed at executive level, directly or by close supervision.
Target Risk	The risk score the Trust aims to get achieve with sufficient and effective controls in place.
Threat	An uncertain event that could have a negative impact on the delivery of objectives or benefits, should it occur.

APPENDIX 4 – EQUALITY IMPACT ASSESSMENT - PART 1 INITIAL SCREENING

Service/Function/Policy/Project/Strategy	Care Group/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Risk Identification, Assessment & Management Policy	Chief Executive	Fiona Dunn	Existing Policy	Sept 2023

1) Who is responsible for this policy? Name of Care Group/Directorate: Fiona Dunn – Chief Executive

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes? To provide a framework for risk management

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

4) What factors contribute or detract from achieving intended outcomes? Compliance with the policy

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? No

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

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

7) Are any of the following groups adversely affected by the policy? No

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

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

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

Date for next review: July 2024

Checked by: F Dunn Date: Sept2023

2310 - D7 USE OF TRUST SEAL

Decision Item | Angela O'Mara, Deputy Company Secretary | 11:40

5 minutes

REFERENCES

Only PDFs are attached

D7 - Use of Trust Seal.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	31 October 2023	**Agenda Reference:**	**D7**
Report Title:	**Use of Trust Seal**		
Sponsor:	Fiona Dunn, Director Corporate Affairs / Company Secretary		
Author:	Fiona Dunn, Director Corporate Affairs / 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.

Executive Summary

Seal No	Description	Signed	Date of sealing
133	Contract relating Bassetlaw Emergency Village (BEV) to Stage 4 NEC Contract. Project between Robert McAlpine Ltd, Vinci Construction UK Ltd & DBTH	Richard Parker OBE Chief Executive Fiona Dunn Company Secretary	28 September 2023

The contract has been scrutinised by the Head of Procurement and Chief Financial Officer before signing.

Recommendation:	The Board is requested to note and take assurance of appropriate use of the Trust Seal			
Action Required:	Approval	Discussion	**Take assurance**	Information only
Link to True North Objectives:	**TN SA1:** *To provide outstanding care and improve patient experience*	**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*
We believe this paper is aligned to the strategic direction of:	**South Yorkshire ICS**		**NHS Nottingham & Nottinghamshire ICS**	
	Yes		**Yes**	

Implications	
Board assurance framework:	*N/A*
Risk register:	*N/A*
Regulation:	Board of Directors Standing Orders

Legal:	*N/A*
Resources:	*N/A*
Assurance Route	
Previously considered by:	Executive Directors
Date:	27/9/2023
Any outcomes/next steps	Approved
Previously circulated reports to supplement this paper:	Contract

23010 - E OTHER ITEMS

2310 - E1 - ANY OTHER BUSINESS (TO BE AGREED WITH THE CHAIR PRIOR TO THE MEETING)

Discussion Item | Suzy Brain England OBE, Chair | 11:45

5 minutes

2310 - E2 GOVERNOR QUESTIONS REGARDING THE BUSINESS OF THE MEETING *

Discussion Item | Suzy Brain England OBE, Chair | 11:50

10 minutes

2310 - E3 MINUTES OF THE MEETING HELD ON 26 SEPTEMBER 2023

Decision Item | Suzy Brain England OBE, Chair | 12:00

5 minutes

REFERENCES

Only PDFs are attached

E3 - Draft Public Board Minutes - 26 September 2023.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS – PUBLIC MEETING

Minutes of the meeting of the Trust's Board of Directors held in Public on Tuesday 26 September 2023 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
Mark Day - Non-executive Director
Karen Jessop - Chief Nurse
Dr Emyr Jones - Non-executive Director
Zoe Lintin - Chief People Officer
Lucy Nickson - Non-executive Director
Richard Parker OBE - Chief Executive
Jon Sargeant - Chief Financial Officer
Kath Smart - Non-executive Director / Deputy Chair
Denise Smith - Chief Operating Officer

In attendance:
Fiona Dunn - Director of Corporate Affairs / Company Secretary
Dr Kirsty Edmondson-Jones – Director of Innovation & Infrastructure (agenda item E7)
Sean Humphrey - Domestic Abuse Liaison Officer (agenda item B1)
Lois Mellor - Director of Midwifery
Dr Nick Mallaband – Medical Director for Workforce & Specialty Development
Angela O'Mara - Deputy Company Secretary (Minutes)
Denise Philp - Head of Safeguarding (agenda item B1)
Caitlyn Porter - Domestic Abuse Liaison Officer (agenda item B1)
Dr Anna Pryce - Guardian of Safe Working (agenda item D3)
Emma Shaheen - Director of Communications & Engagement

Public in attendance:
Anas Ahmed - 360 Assurance
Claire Booth - Staff Observer
Laura Brookshaw - 360 Assurance
Gina Holmes - Staff Side
Joseph John - Staff Observer
Andrea Johnson - Staff Observer
George Kirk - Public Governor Doncaster
Ben Kumar - Staff Observer
Helena Lelew – Care Quality Commission
Lynne Logan - Public Governor Doncaster
Andrew Middleton - Public Governor Bassetlaw
Carol Orr - Staff Observer
Vivek Panikkar – Staff Governor
Faisal Salam- 360 Assurance
Lynne Schuller - Public Governor Bassetlaw
Sheila Walsh - Public Governor Bassetlaw
Jenny Wilkes – Care Quality Commission

Apologies: Jo Gander - Non-executive Director
Dr Tim Noble - Executive Medical Director

P23/09/A1 **Welcome, apologies for absence and declaration of interest (Verbal)**

The Chair welcomed everyone to the virtual Board of Directors meeting, including governors and observers. The above apologies were noted and no declarations were made.

P23/09/A2 **Actions from Previous Meetings**

There were no active actions.

P23/09/B1 **Domestic Abuse Liaison Officers (Enclosure B1)**

The Chair welcomed the Head of Safeguarding and Domestic Abuse Liaison Officers to the meeting. The Liaison Officers had commenced in March/April 2023 and the posts were funded by South Yorkshire Police and Crime Commissioner until 31 March 2025. The role of the Domestic Abuse Liaison Officer included supporting survivors of domestic abuse, facilitating appropriate referrals to outside agencies, attending multi-agency risk assessment conferences and raising awareness with, and providing training to Trust colleagues. Key achievements were shared and priorities noted and colleagues reflected on the impact of their interventions using an example case and survivor feedback.

In response to a question from Non-executive Director, Hazel Brand, the Head of Safeguarding confirmed a business case would be developed to allow service provision post funding; the case would be built upon the evidence of impact and key achievements. Whilst the current funding supported service delivery in Doncaster, awareness and education ensured colleagues were upskilled to identify, support and signpost patients and colleagues across site.

Non-executive Director, Mark Day sought clarity on the use of Datix, which was confirmed as a tool for reporting, to capture actions, outcomes and allow an audit trail.

Non-executive Director, Kath Smart recognised the invaluable support offered in difficult circumstances and enquired what support was extended to the Liaison Officers. The Head of Safeguarding confirmed their safeguarding was her priority, colleagues received the support of external specialist training, had regular 1:1 discussions with the Safeguarding Lead and worked closely with the wider team.

In response to a question from Non-executive Director, Emyr Jones, the Head of Safeguarding confirmed the Liaison Officers worked closely with the drug and alcohol and mental health teams, receiving referrals, and supporting visits to ensure a co-ordinated and appropriate patient approach.

The Board:

- ***Noted the Domestic Abuse Liaison Officers Presentation***

P23/09/C1 **Chair's Assurance Log – Quality & Effectiveness Committee (Enclosure C1)**

Emyr Jones, Deputy Chair of the Quality & Effectiveness Committee highlighted the four quadrants of the Chair's assurance log, including positive assurance, areas of major works, areas of focus and decisions made at September's meeting. Following receipt of a limited assurance internal audit report on the governance of clinical audit, arrangements had been made to hold a deep dive with the relevant executive directors, Associate Medical Director for Clinical Safety, and fellow non-executive Committee members to understand the plans for improvement.

The Board:

- ***Noted and took assurance from the Chair's Assurance Log***

P23/09/C2 **Executive Medical Director Update (Enclosure C2)**

The Medical Director for Workforce & Speciality Development brought the Board's attention to the key highlights of the current programmes of work across the Executive Medical Director's portfolio.

Following the appointment of the Divisional Director of Surgery, a focused approach to recover the number of completed job plans would take place, the division was currently responsible for 50% of the total outstanding job plans. With the support of the Quality Improvement team process efficiencies would be explored and an opportunity to integrate within the divisional business planning cycle would be taken, with stakeholder feedback informing next steps.

Positive feedback was reported on the various forums for medical colleagues, including the Clinical Director leadership development sessions, which had recently been extended to include senior medical colleagues undertaking leadership roles.

Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator data was presented in the report, a reduction in HSMR had been seen over the previous six months, however, the Trust's SHMI was high and the Trust was identified as an outlier, compared to its peer group and nationally. The Mortality Assurance Group continued to analyse key aspects that underpin mortality rates, including data, informatics, quality, and patient safety which had identified the need for remedial action to the structured judgement review process.

In response to a question from Non-executive Director, Lucy Nickson, the Medical Director for Workforce & Speciality Development confirmed that the reduction in virtual ward patients in August related to clinician's annual leave and steps to address the use of the Virtual Ward being colleague dependent had been taken.

In respect of CT demand, the introduction of iRefer software, as part of the diagnostic improvement programme, had seen a reduction in requested scans.

Non-executive Hazel Brand acknowledged the reassurance offered in respect of actions to reduce outstanding job plans, as evidence of a signed off job plan would be a requirement of future Clinical Excellence Awards, along with mandatory training compliance and a

completed appraisal, sign off would be evidenced as part of the application and award process.

In relation to the work of the Mortality Data Assurance Group, and in response to a question from Non-executive Director, Kath Smart, the Chief Executive confirmed that the review had been commissioned as a time limited piece of work. There was a need to ensure robust processes were embedded, the data from which could be triangulated to sources including Healthcare Evaluation Data (HED) and CQC insights. It was vital that Healthcare Evaluation Data was utilised as part of this review, in order to understand identified variance and the required actions to address this. Non-executive Director, Emyr Jones recognised the importance of quality assurance, learning identified as part of the analysis would be considered by the Quality & Effectiveness Committee and findings sense checked to ensure consistency with identified risks.

With reference to the audit of the governance of clinical audit, the Chief Executive confirmed alongside core audits, the Trust identified specific areas where an external view was welcomed.

The Chair of the Board shared her appreciation and that of the Board with the Medical Director for Workforce & Specialty Development for presenting in the absence of the Executive Medical Director.

The Board:

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

P23/09/C3 **Chief Nurse Update (Enclosure C3)**

The Chief Nurse Update provided information, outcomes, and assurance on the key deliverables for patient safety and experience and safe staffing numbers.

The draft Patient Safety Incident Response Plan would be taken to the Board's Quality & Effectiveness Committee in October for approval, the supporting Trust policy was noted to be in the final stages of development.

The Board's attention was drawn to learning in respect of the recording of lying and standing blood pressure to support falls prevention, C.difficile post incident reviews and a national webinar to support current infection, prevention and control challenges and share learning opportunities.

Following the unannounced inspection by the Care Quality Commission, the Chief Nurse confirmed a detailed action plan had been developed to respond to the initial feedback, with delivery monitored via Monday.com. This would be shared with the Quality & Effectiveness Committee. A further CQC inspection of the diagnostic and imaging service had commenced today, with the final well-led inspection due to take place 2-4 October 2023.

Non-executive Director, Kath Smart acknowledged the focus on increasing the Friends and Family response rate and enquired how feedback was received by the service areas and triangulated with other evidence. The Chief Nurse recognised the value of the free text narrative, which would be incorporated into future reporting for more detailed awareness and action planning.

Non-executive Director, Emyr Jones recognised the importance of the Just Culture work cutting across all professions, the Chief People Officer confirmed this could be seen in employee relations, Speaking Up and Patient Safety. In response to a question from Non-executive Director, Mark Day, the Chief Nurse confirmed that where learning was identified from a serious incident investigation this was not paused pending conclusion of the matter.

In response to a question from Non-executive Director, Hazel Brand the Chief Nurse confirmed the use of statistical process control charts had been introduced to identify the trend over time and identify variation for investigation, as could be seen on the Parliamentary Health Service Ombudsman (PHSO) graph. It was confirmed that no common themes had been identified from the increase in PHSO contacts.

Non-executive Director, Mark Bailey welcomed the use of Nerve Centre for the recording of lying and standing blood pressure as part of the fall's initiative work; in respect of future usage, the Chief Nurse confirmed that Nerve Centre data would link to the quality dashboard, which was currently under development.

The balanced reporting of complaints and compliments was acknowledged and in response to a question from Mark Bailey, the Chief Nurse confirmed that learning was shared through the Patient Experience & Engagement Committee across wards and service areas. The use of the "call me" initiative had recently been launched which had seen a positive response and the link to improved culture and behaviour was noted by the Chair of the Board.

Non-executive Director, Lucy Nickson enquired of the barriers and associated risks to not achieving the 50% reduction in hospital acquired pressure ulcers by the end March 2024. The Chief Nurse confirmed education, safety huddles and the use of e-systems to capture and raise awareness were key to success; without which an increase would be seen in infections, patient harm and extended lengths of stay.

The Board:

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

P23/09/C4 **Nursing, Midwifery & Allied Health Professionals (NMAHPs) Quality Strategy (Enclosure C4)**

The Quality Strategy had been developed around six strategic themes aligned to the Trust's True North objectives; after extensive consultation, including review by the Board's Quality & Effectiveness Committee it was received for Board approval.

Non-executive Director, Hazel Brand enquired if the strategy should extend beyond the named professions and have a trust wide focus, the Chief Nurse confirmed that the underpinning delivery plans would provide clarity on the need to collaborate across professions, with the strategy resetting the expectations of the fundamentals of care. Engagement across clinical colleagues, including trainees was encouraged by Emyr Jones.

The Chief Executive acknowledged the need to ensure the strategy was relevant to those responsible for its delivery and recognised the work as a positive step towards achieving the Trust's vision.

In response to a question from Non-executive Director, Mark Bailey regarding the need to consider the connectivity of the enabling strategies, the Chief Executive confirmed the recently appointed Deputy Chief Executive's portfolio would include a fresh eyes review of corporate and clinical governance, which was likely to include the Trust's strategies. In the short term, the Trust had sound strategies to deliver its core business and progress towards its vision of being outstanding. The Chair of the Board suggested a future Board workshop to consider enabling strategies would be helpful.

As a newly appointed non-executive director, Lucy Nickson expressed an interest in the supporting actions plans and the inclusion of mental health needs, in addition to physical needs. The Chief Nurse confirmed the wide range of colleagues and learners involved in the iterative development of the strategy. Support in respect of mental health was a thread that ran through the whole of the strategy but was explicitly referenced in strategic theme five and there was a refreshed focus in strategic theme two on John's Campaign which supported open visiting for those patients with complex needs and dementia.

The Board confirmed its support and approval of the NMAHP's Quality Strategy.

The Board:

- ***Approved the Nursing, Midwifery & Allied Health Professionals (NMAHPs) Quality Strategy***

P23/09/C5 **Launch of the first NHS Sexual Safety Charter – Domestic Abuse & Sexual Violence (Enclosure C5)**

In response to recent national publicity and NHSE's launch of a Sexual Safety Charter for colleagues and patients, the Trust's commitment to adopt a DBTH Sexual Safety Charter which reflected the principles of the national charter was sought.

The Charter identified a vision, along with supporting principles and actions for implementation by July 2024. The designated executive lead was confirmed as the Chief Nurse, whose portfolio included safeguarding.

In response to a question from Non-executive Director, Kath Smart, the Chief Nurse confirmed that from a governance perspective this would feed into safeguarding and ultimately report into the Quality & Effectiveness Committee.

The Board provided its unanimous support and approved the Trust's Sexual Safety Charter.

The Board:

- ***Approved the Sexual Safety Charter***

P23/09/C6 **Maternity & Neonatal Update (Enclosure C6)**

The Board received the Maternity & Neonatal Update, which provided the findings of perinatal deaths, Health Safety Investigation Branch (HSIB) referrals, training compliance, service user voice feedback and compliance in respect of the Clinical Negligence Scheme for Trusts (CNST).

The Director of Midwifery confirmed that despite significant progress over recent months, achievement of 90% training compliance of all staff groups by 5 December 2023 would require careful management.

Data related to the triage service would become a regular feature of the report going forwards, which audits assessment within 15 minutes of arrival.

In response to a question from Non-executive Director, Kath Smart, the Director of Midwifery confirmed that delays to induction of labour were subject to individual risk assessment and care planned according to need, the process was managed internally or where escalation was required via the Local Maternity and Neonatal System.

In response to Non-executive Director, Mark Bailey question on the recognition of the extensive maternity safety reporting requirements, the Director of Midwifery confirmed that of the seven immediate actions within the Ockenden Report (Part 1) the Trust was compliant with all but the training compliance action. The single three year delivery plan had been received and was currently being cross referenced to existing reports, evidence was being populated and the process was overseen by the LMNS. As Chair of the LMNS Board, the Chief Executive recognised the volume of information and welcomed a single return against the single plan, which would support and strengthen the process. Considering the extensive requirements and to ensure the sharing of knowledge was relevant and appropriate, the Director of Midwifery confirmed midwives received support from specialist midwives, matrons and her deputies, with individual training needs being influenced by the safety requirements.

The Chair of the Board shared her appreciation with all colleagues involved in the recent visit of HRH Anne, the Princess Royal, to the Women & Children's Hospital. The planning and colleague engagement was commended and it had been a pleasure to welcome Princess Anne as patron of the Royal College of Midwives.

The Board:

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

P23/09/D1 **Chair's Assurance Log – People Committee (Enclosure D1)**

Non-executive Director, Mark Bailey shared the key highlights from the People Committee's Chair's Assurance log, including positive assurance, ongoing major programmes of work related to the Board Assurance Framework and implementation of the People Strategy, areas of concern and decisions taken. There were no items to escalate to the Board.

The Board

- ***Noted and took assurance from the Chair's Assurance Log***

P23/09/D2 **People Update (Enclosure D2)**

The Chief People Officer provided an overview of work to improve people metrics, colleague experience and delivery of the People Strategy.

The 2023 appraisal season had now closed, 88% of non-medical appraisals had been completed, an increase from the previous year's performance, but below the aspiration of 90%. Work to understand the barriers to completion and learning for next year's appraisal season was in hand.

Members of the Board were asked to raise awareness and encourage completion of 2023's Staff Survey, which was due to launch this week. In response to a question from the Chief Nurse, the Chief People Officer confirmed that learning from feedback would be shared.

In response to a question from Non-executive Director Mark Day, the Chief People acknowledged the interconnectivity between Just Culture, Speaking Up and Patient Safety and recognised that as the Just Culture work matured, the person centred approach would become the culture of the organisation – the DBTH Way. A refresh of the Trust's breakthrough objective reflected this focus, with the inclusion of a kind and caring culture.

Non-executive Director and Freedom to Speak Up (FTSU) champion, Hazel Brand recognised the wide range of speaking up opportunities, beyond the FTSU Guardian and in response to a question about the consistency of approach the Chief Executive confirmed the benefit of an extended offer and recognised the need to ensure identification and triangulation of any key of themes across all routes.

The Board:

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

P23/09/D3 **Guardian of Safe Working Quarterly Report (Enclosure D3)**

The Chair of the Board welcomed the Guardian of Safe Working to the meeting.

The Board noted the continuing low level of exception reporting, a small increase had been seen in August, which was not unexpected and coincided with the new intake of Junior Doctors. The majority of exception reports continued to be from trainees working in General Medicine, very few reports related to missed educational opportunities.

The cost of locum cover had fallen in August, which coincided with a reduction in rota gaps. Locum cover had been required during Junior Doctor industrial action, during this time there had been no increase in exception reporting and no immediate safety concerns.

Non-executive Director, Emyr Jones was encouraged by the number of trainees who subsequently went on to apply for employment in the Trust, which was a positive indication of their level of satisfaction.

Non-executive Director, Kath Smart reflected on the exception reporting within General Medicine and enquired if support was required to understand the drivers. Workload and the emergency management of patients were recognised to be the cause, as rota gaps in July and August had increased a review may be helpful in the coming months.

The Board:

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

P23/09/E1 Chair's Assurance Log – Finance & Performance Committee (Enclosure E1)

Non-executive Director, Mark Day presented the Chair's assurance log. The refreshed Board Assurance Framework had been subject to extensive discussion, with five of the seven risks considered by the Committee; to ensure consistency, the adoption of the defined four levels of assurance were recommended to the Board. Delivery of the Urgent & Emergency Care Improvement Plan and Cost Improvement Programme continued to be areas of concern.

The Board:

- ***Noted and took assurance from the Chair's Assurance Log***

P23/09/E2 <u>Finance Update (Enclosure E2)</u>

The Chief Financial Officer reported a month five deficit of £3.4m, £19.8m deficit year to date and in line with the financial plan.

Capital expenditure in month five was £4m against a plan of £3.5m, the year to date position was £7.7m against a plan of £16.1m.

The cash balance at the end of August was £14.9m.

The Trust had delivered £2.2m of savings in month, £0.4m favourable to plan, £6.4m year to date and £1.5m favourable to plan.

The Chief Financial Officer advised the Board that the Trust had moved to segment three of the NHS Oversight Framework, considering the Trust's need for cash support the change was not unexpected.

The Board's support was sought to complete the £25m national cash support submission, in line with the Trust's deficit to the end of January 2024. Non-executive Director, Emyr Jones accepted the need for cash support but sought clarity of any negative consequences , the Chief Financial Officer confirmed the cash support was subject to a 3.5% interest charge and enhanced reporting.

In response to a question from Non-executive Director, Lucy Nickson with regards to the identified over usage of the independent sector, the Chief Financial Officer confirmed this was predominately due to efforts to spend the annual budget over a reduced timeframe on orthopaedic work (hips and knees). Once the Mexborough Orthopaedic Elective Centre (MEOC) was operational, this work would be completed in-house.

In response to a question from the Chair of the Board, it was confirmed that Trauma & Orthopaedics work was not delivering the Getting it Right First Time standard and along with three other specialties was subject to review.

As the Trust moved into Q3 the Chief Executive acknowledged the risks associated with delivery of winter plans and the importance of a Place plan to support out of hospital capacity. Clarity was required on Place and System capacity to support plans and mitigating actions; improved patient flow and discharge would be critical to success.

The Board:

- ***Noted the Finance Update and approved the submission of the request for £25m cash support***

P23/09/E3 **Directorate of Recovery, Innovation & Transformation Update (Enclosure E3)**

The Director of Recovery, Innovation & Transformation provided an overview of the Directorate's work. The Bassetlaw Emergency Village programme of work was progressing at pace, with enabling works to remove the Reinforced Aerated Autoclaved Concrete complete.

The MEOC project team were meeting on a fortnightly basis, the majority of enabling work was complete and a completion date of January 2024 was expected. Workforce remained the greatest risk and should this impact upon the opening date, the Chief Operating Officer had shared alternative plans for usage over the winter period.

In response to a question from Non-executive Director, Kath Smart, the Chief Financial Officer confirmed discussions at the Performance, Overview & Support Meeting were triangulated with the divisional risk register. A standard agenda supported discussions, and over time this would be developed to focus on identified areas of improvement.

The Board:

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

P23/09/E4 **Operational Performance Update (Enclosure E4)**

The Chief Operating Officer's report highlighted the Trust's performance against August's access standards and elective activity plan and cancer waiting times for July 2023.

The Board's attention was drawn to the impact of industrial action on access standards and the continuing challenges in diagnostics.

The change to the national cancer standards would come into effect from 1 October 2023, with existing standards rationalised into three core measures: 28 day Faster Diagnosis, 62 day referral to treatment and 31 day decision to treat to treatment standards.

In response to a question from Non-executive Director, Hazel Brand with regards to virtual wards, the Medical Director reported good clinical engagement, work to address some reliance on individuals was in train and opportunities were being explored to extend the service across specialities.

The Board:

- ***Noted and took assurance from the Operational Performance Update***

P23/09/E5 **2023/24 Winter Plans – Delivering Operational Resilience across the NHS PRN00645 (Enclosure E5)**

NHSE guidance, issued in July 2023, identified the national approach to 2023/2024 winter planning, the basis of which was the Urgent & Emergency Care (UEC) Delivery Plan and Primary Care and Elective Recovery Plans, recommended system roles and responsibilities were clarified.

Four key areas of focus were identified and the Place UEC Improvement Plan aligned to the majority of the high impact actions. Forecasting suggested the Trust should plan for a normal flu season, with Covid and respiratory syncytial virus (RSV) anticipated.

Urgent care demand had been assessed, in conjunction with bed modelling and Place partners were in the process of reviewing an escalation framework to support peaks when demand exceeded capacity.

Divisional and corporate teams had taken part in winter planning workshops where potential schemes had been identified should funding become available. These schemes were being prioritised for further consideration by the Trust Executive Group. Vaccination of colleagues would be actively promoted, to support health and wellbeing.

The detailed operational winter plans would be shared with the Trust Executive Group and the Board's Finance & Performance Committee in due course.

In response to a question from Non-executive Director, Emyr Jones, the Chief Operating Officer confirmed that both systems were actively engaged in planning, although the greatest impact of winter was expected to be seen at the Doncaster site.

The Chief Nurse confirmed that it was expected that the deep clean programme would continue throughout the winter months. In view of site limitations the operational detail to support this would be included within the winter plans.

Non-executive Director, Mark Bailey shared a concern in respect of the collective response to the UEC Improvement Programme, in terms of determining priorities the Chief Operating Officer recognised the challenge, especially if industrial action continued throughout the coming months. A focus on safe and timely discharge would be required to support the bed base, whilst continuing to support elective and diagnostic recovery plans.

The Chief Executive confirmed the need to determine plans in accordance with agreed standards. Learning from last winter had informed planning and preparation, although the impact of industrial action was acknowledged as a new variable this year and an early resolution would be welcomed.

The Board:

- ***Approved 2023/24 Winter Plans***

P23/09/E6 **Protecting & Expanding Elective Capacity – Self Certification PRN000673 (verbal)**

NHSE correspondence dated 4 August 2023 identified priorities to protect and expand elective capacity, with Trusts being asked to deliver against three key actions:

- to reduce outpatient follow up appointments,
- to ensure that no patient in the 65 week cohort waits for their first outpatient appointment beyond 31 October 2023, and
- to maintain an accurate and validated waiting by ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated by 31 October 2023

The Trust was required to self-certify against a set of activities to drive outpatient recovery, to be signed off by the Chair and Chief Executive. An initial draft of the self-certification had been presented to the Board's Finance & Performance Committee.

The Board:

- ***Noted and took assurance from the approach to Protecting & Expanding Elective Capacity Self Certification***

P23/09/E7 **Reinforced Aerated Autoclaved Concrete (RAAC) PRN00777 verbal)**

The Director of Innovation & Infrastructure brought the Board's attention to NHSE's correspondence of 5 September, which reiterated previous guidance for the removal of RAAC and to outline actions for board assurance on information returns related to the identification of RAAC and supporting mitigating actions.

Board members were reminded that in late 2019 RAAC was identified on the Bassetlaw site, removal of which had been completed ahead of the required timeframe. National guidance had been updated earlier this year and following recent publicity in educational establishments, and to maintain the confidence of staff, patients and visitors further surveys would be arranged across the remaining Trust sites.

In response to a question from Non-executive Director, Kath Smart, the Director of Innovation & Infrastructure confirmed where Trust colleagues occupied leased buildings this would need to be verified with the landlord of those buildings.

The Board:

- ***Noted the Reinforced Aerated Autoclaved Concrete Update***

P23/09/F1 **Lucy Letby - Freedom to Speak Up (Enclosure F1)**

Following the conviction of Lucy Letby, the Chief Executive reflected on publicly available information relating to the way in which concerns were managed and decisions taken. The paper identified the Trust's processes and systems in place to offer assurance and maintain the confidence of colleagues and the public, which included Speaking Up, quality standards, reporting of incidents, the regulation of senior managers and the Fit and Proper Person Test. Following completion of the statutory inquiry it was anticipated that further detail and supporting actions would be identified.

The various routes to raise concerns had been reinforced and escalation pathways identified for learners, doctors in training and pre-registration placements. The importance of triangulating evidence through the various sources was stressed.

With one of the highest response rates in the country the Trust's staff survey was seen as a source of anonymous feedback, alongside feedback provided to the Guardian of Safe Working and the Freedom to Speak Up Guardian.

Non-executive Director, Kath Smart confirmed the Freedom to Speak Up Guardian attended Board bi-annually and reminded Board members that feedback had confirmed that 100% of colleagues who had spoken up previously, would be happy to do so again.

The Chief Executive confirmed plans for a "fresh eyes" review of clinical and corporate governance processes, to be undertaken by the newly appointed Deputy Chief Executive.

The Board:

- ***Noted and took assurance from the Lucy Letby Update***

P23/09/F2 **Board of Directors Register of Interest & Fit & Proper Person Annual Review (Enclosure F2)**

The Company Secretary presented the annual review of director's interests and compliance with the Fit and Proper Person Test (FPPT).

In response to the recommendations of the Kark Review (2019) NHSE had published a Fit and Proper Person Test Framework in early August 2023 and a summary of the key elements was provided.

Processes had been reviewed by the Company Secretary and Chief People Officer and with effect from 30 September a standardised reference for members of the Board would be introduced. Recruitment of Board members would also be subject to change with the introduction of a Leadership Competency Framework, due for release in October 2023.

Information relating to the FPPT would be recorded on the Electronic Staff Record (ESR) and would be submitted on an annual basis to the Regional Director.

The Board:

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

P23/09/H **Information Items (Enclosure G1 – G7)**

The Board noted:

- G1 Chair and NEDs Report
- G2 Chief Executives Report
- G3 Integrated Quality & Performance Report
- G4 Minutes of the Finance and Performance Committee 26 June 2023
- G5 Minutes of the People Committee 4 July 2023
- G6 Minutes of the Quality & Effectiveness Committee 6 June 2023
- G7 Minutes of the Trust Executive Group 10 July & 14 August 2023

P23/09/H1 **Minutes of the meeting held on 25 July 2023 (Enclosure H1)**

The Board:

- ***Approved the minutes of the meeting held on 25 July 2023.***

P23/09/H2 **Any other business (to be agreed with the Chair prior to the meeting)**

No items of other business were received.

P23/09/H3 **Governor Questions regarding the business of the meeting (10 minutes) ***

On behalf of the Council of Governors, the Lead Governor asked the following question:

We note that the CQC initial feedback has raised multiple concerns. What remedial actions have been undertaken to ensure patient safety and reduce the possibility of these issues arising in the future.

The Chief Nurse confirmed that a comprehensive action plan had been developed to address all areas, this had been shared with Board members and reported to the Board's Quality & Effectiveness Committee.

The Board:

- ***Noted the governor question***

P23/09/H4 **Date and time of next meeting (Verbal)**

Date: Tuesday 31 October 2023
Time: 09:30am
Venue: MS Teams

P23/09/I **Close of meeting (Verbal)**

The meeting closed at 13:20

2310 - E4 DBTH SELF-CERTIFICATION - PROTECTING & EXPANDING ELECTIVE ACTIVITY

Denise Smith, Chief Operating Officer

REFERENCES

Only PDFs are attached

E4 - DBTH Protecting and Expanding Elective Capacity.pdf

E4 - Appendix DBTH Self Certification Protecting and Expanding Elective Capacity FINAL SBE-RP signed.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	31 October 2023	**Agenda Reference:**	**E4**
Report Title:	**DBTH Self-certification Protecting & Expanding Elective Activity**		
Sponsor:	Denise Smith, Chief Operating Officer		
Author:	Suzanne Stubbs, Deputy Chief Operating Officer		
Appendices:	Self-Certification		

Report Summary

Executive Summary:

NHS England wrote to Acute Trusts on 4 August 2023, setting out the priorities to protect and expand elective capacity. The letter sets out three key actions for Acute Trusts:

1. Revisit plans to reduce outpatient follow up appointments, to identify more opportunities for transformation
2. Set an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023
3. Maintain an accurate and validated waiting list by ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated by 31 October 2023 and ensuring that RTT rules are applied in with RTT national rules suite and local access policies are appropriately applied.

Trusts were asked to provide assurance against a set of activities that will drive outpatient recovery at pace and undertake a self-certification process, which was to be signed off, by Trust Chairs and Chief Executives by 30 September 2023. A copy of the final submission is provided for information.

Recommendation:	The Finance and Performance committee is asked to note the report for information			
Action Require:	~~Approval~~	~~Discussion~~	~~Assurance~~	**Information only**
Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**
	To provide outstanding care and improve patient experience	*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*
We believe this paper is aligned to the strategic direction of:	**South Yorkshire ICS**		**NHS Nottingham & Nottinghamshire ICS**	
	Yes		**Yes**	

Implications	
Board assurance framework:	No changes made at present
Risk register:	No changes made at present
Regulation:	No changes identified
Legal:	None identified
Resources:	None identified

Assurance Route	
Previously considered by:	Finance and Performance Committee
Date:	September 2023
Any outcomes / next steps	
Previously circulated reports to supplement this paper	

1. Introduction

This paper provides a copy of the final self-certification, against the activities to drive outpatient recovery at pace, signed by the Chair and Chief Executive and submitted to NHS England prior to the 30 September 2023 deadline.

2. Background

NHS England wrote to Acute Trusts on 4 August 2023, setting out the priorities to protect and expand elective capacity. The letter sets out three key actions for Acute Trusts:

(i) Revisit plans to reduce outpatient follow up appointments, to identify more opportunities for transformation
(ii) Set an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023
(iii) Maintain an accurate and validated waiting list by ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated by 31 October 2023, and ensuring that RTT rules are applied in with RTT national rules suite and local access policies are appropriately applied.

Trusts are asked to provide assurance against a set of activities that will drive outpatient recovery at pace and undertake a self-certification process, which is signed off, by Trust Chairs and Chief Executives by 30 September 2023.

3. Self-certification

The self-certification checklist includes four sections:

(i) Validation
(ii) First appointments
(iii) Outpatient follow ups
(iv) Support required

A copy of the final, signed and submitted, self-certification is provided for information.

4. Recommendations

The Trust Board of Directors is asked to note the final self-certification, signed by the Chair and Chief Executive Officer, and submitted prior to the 30 September 2023 deadline.

Appendix A: self-certification

About this self-certification

To deliver elective and cancer recovery ambitions, high-quality waiting list management and ambitious outpatient transformation are vital. We are now asking trusts to complete this return to provide assurance on these recovery plans.

Nationally and regionally, we will use this to identify providers requiring more support, as well as areas of good practice that can be scaled up to accelerate recovery. Please return this to NHS England by 30 September 2023, via NHS England regional teams.

Guidance for completing the self-certification

The return asks for assurance that the board has reviewed and discussed specific outpatient operational priorities and has signed off the completed checklist. Please return this to your NHS England regional team.

Trust return: Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

The chair and CEO are asked to confirm that the board:

Assurance area	DBTH
1. Validation The board:	
a. has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation.	The board does not currently receive a report showing validation rates, this will be provided in October 2023. The LUNA system shows 99.51% for Trust RTT confidence levels.
b. has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified. We are developing a range of digital support offers for providers to improve validation.	The Trust does not have a plan to achieve 90% validation of patients waiting > 12 weeks by the end of October 2023. As at the end of July 2023, the Trust had validated 67.2% of patients who had been waiting over 12 weeks. The Trust has invested in increased validation capacity and recruitment to new posts is underway. In the interim, the Trust is continuing with the externally commissioned validation provider. The Trust utilises the PEP provider 'quick question' facility to ask patients if they still require treatment.
c. ensures that the RTT rules and guidance and local access policies are applied and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. Further guidance on operational implementation of the RTT rules and training can be found on the Elective Care IST FutureNHS page. A clear plan should be in place for communication with patients.	The Trust Access Policy is currently under review (while still in use, the current policy is dated June 2019). The Elective IST has recently undertaken a review of RTT process and elective governance arrangements. The findings from this review will inform an improvement plan, which will include a training and development programme for all operational staff.
d. has received a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans.	The board has not yet received a report on the clinical risk of patients in the non-RTT cohorts. The Trust is developing a Risk Stratification, Clinical Prioritisation and Clinical Harm Review Policies
2. First appointments The board:	
a. has signed off the trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.	The Trust has completed a 65-week trajectory at specialty level; this will be shared with the board in October 2023 and will include the forecast position for the 65-week 'cohort' waiting for a first outpatient appointment after 31 October 2023.
b. has signed off the trust's plan to ensure that Independent Sector capacity is being used where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System, virtual outpatient solutions and whole pathway transfers. National support and information on utilisation of the Independent Sector is available via the IS Co-ordination inbox england.iscoordination@nhs.net	The Trust secured IS capacity for T&O activity at the same level as Q4 in 2022/23. This IS capacity forms part of the surgical activity / capacity plan for 2023/24. This was included in the annual business plan signed off by board. The Trust utilises the DMAS as appropriate.

Assurance area	DBTH
3. Outpatient follow ups The board:	
a. has received a report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and received an options analysis on going further and agreed an improvement plan.	The board receives a monthly report on outpatient follow up activity vs plan. The Trust has an Outpatient Improvement Programme in place; this incorporates GIRFT guidance to reduce outpatient follow up appointments, including: • Expansion of Patient Initiated Follow up • Continuation of Advice and Guidance • Standardisation of clinic templates • Reduction in missed appointments The board has not yet received an options analysis on going further.
b. has reviewed plans to increase use of PIFU to achieve a minimum of 5%, with a particular focus on the trusts' high-volume specialties and those with the longest waits. PIFU should be implemented in breast, prostate, colorectal and endometrial cancers (and additional cancer types where locally agreed), all of which should be supported by your local Cancer Alliance. Pathways for PIFU should be applied consistently between clinicians in the same specialty.	The board receives a monthly update on PIFU uptake; current performance is 3.1% PIFU implementation is monitored through the Outpatient Improvement Programme
c. has a plan to reduce the rate of missed appointments (DNAs) by March 2024, through: engaging with patients to understand and address the root causes, making it easier for patients to change their appointments by replying to their appointment reminders, and appropriately applying trust access policies to clinically review patients who miss multiple consecutive appointments.	The Trust Outpatient Improvement Programme includes plans to reduce the rate of missed appointments. The Trust has undertaken a diagnostic exercise to understand the root causes of missed appointments. A text reminder service is in place, however this does not currently support the option to change appointments.
d. has a plan to increase use of specialist advice. Many systems are exceeding the planning guidance target and achieving a level of 21 per 100 referrals. Through job planning and clinical templates, the Board understands the impact of workforce capacity to provide advice and has considered how to meet any gaps to meet min levels of specialist advice. The Trust has utilised the OPRT and GIRFT checklist, national benchmarking data (via the Model Health System and data packs) to identify further areas for opportunity.	Advice and Guidance is embedded across a number of specialties. As at June 2023, the Trust achieved a level of 38 per 100 referrals for Doncaster. The board does not receive reports on job plans and clinic templates in relation to advice and guidance. The Trust has utilised the OPRT and national benchmarking data to identify further areas for opportunity. The Trust does not currently utilise the GIRFT checklist
e. The Board has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity.	The Trust has an Outpatient Improvement Programme in place. This is currently focussed on: • Expansion of Patient Initiated Follow up • Continuation of Advice and Guidance • Standardisation of clinic templates • Reduction in missed appointments
4. Support required	
The board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.	The Trust board has discussed and agreed the need for additional support to delivering improvements in elective care. The Elective IST has recently undertaken a review of elective care and a data quality deep dive; a programme of support will be agreed with the Elective IST which will address the recommendations in the report. The Trust is working with the GIRFT regional team in a number of specialties.

Sign off

Trust lead (name, job title and email address):	Denise Smith Chief Operating Officer Denise.smith43@nhs.net
Signed off by chair and chief executive (names, job titles and date signed off):	 **Suzy Brain England OBE C Dir** Chair of the Board Dated: 27 September 2023  **Richard Parker OBE** Chief Executive Dated: 27 September 2023

2310 - E5 DATE AND TIME OF NEXT MEETING

Information Item | Suzy Brain England OBE, Chair | 11:10

Date: Tuesday 23 November 2023
Time: 09:30
Venue: MS Teams

MEETING CLOSE

11:10

*Governor Questions

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

For Governors in attendance, the agenda provides the opportunity for questions to be received at an appointed time. Due to the anticipated number of governors attending the virtual meeting, Lynne Schuller, Lead Governor will be able to make a point or ask a question on governors' behalf. If any governor wants Lynne to raise a matter at the Board meeting relating to the papers being presented on the day, they should contact Lynne by 4pm the day before the meeting to express this. All other queries from governors arising from the papers or other matters should be emailed to Fiona Dunn for a written response.

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

Suzy Brain England OBE
Chair of the Board