BOARD MEETING - PUBLIC

BOARD MEETING - PUBLIC

28 November 2023

09:30 GMT Europe/London

Virtual -TEAMS

Click here to join the meeting

AGENDA

- 2311 - A Meeting Business (09:30) 1
    00 - Board of Directors Public Agenda 28 November 2023 v4.pdf 2
  - 2311 - A1 Welcome, apologies for absence and declarations of interest (09:30) 6
    A1 - Register of Interests & FPP (22.11.23).pdf 7
  - 2311 - A2 Actions from previous meeting (no active actions) 10
- PRESENTATION (09:40) 11
  - 2311 - B1 Get Up, Get Dressed, Get Moving - Falls Prevention (09:40) 12
    B1 - Get up Get dressed Get moving.pdf 13
- 2311 - C True North SA1 Quality & Effectiveness 23
  - 2311 - C1 Executive Medical Director Update (09:55) 24
    C1- Executive Medical Director Update.pdf 25
  - 2311 - C2 Chief Nurse Update (10:05) 40
    C2 - Chief Nurse Update.pdf 41
  - 2311 - C3 Maternity & Neonatal Update (10:15) 51
    C3 - Maternity & Neonatal Update.pdf 52
    C3 - Appendix 1 - PMRT Q2 report.pdf 67
    C3 - Appendix 3 - Training needs analysis.pdf 84
    C3 - Appendix 5 - Thematic review of Early Notification cases.pdf 90
    C3 - Appendix 6 - Perinatal Surveillance Q3.pdf 96
    C3 - Glossary of Terms - Maternity.pdf 101
- 2311 - D True North SA2 & SA3 - People & Culture 103
  - 2311 - D1 Chair's Assurance Log - People Committee (10:25) 104
    D1 - Chairs Assurance Log - People Committee.pdf 105
  - 2311 - D2 People Update (10:30) 108
    D2 - People Update.pdf 109
  - 2311 - D3 Guardian of Safe Working Quarterly Report (10:40) 115
    D3 - Guardian of Safe Working Quarterly Report.pdf 116
- BREAK 10:50 - 11:00 132
- 2311 - E True North SA4 - Finance & Performance 133
  - 2311 - E1 Chair's Assurance Log - Finance & Performance Committee (11:00) 134
  - 2311 - E2 Finance Update (11:05) 135
    E2 - Finance Update - Month 7.pdf 136

- 2311 - E3 Directorate of Recovery, Innovation & Transformation Update (11:15) 143
    - E3 - Recovery, Innovation & Transformation Update.pdf 144
- 2311 - E4 Operational Performance Update (11:25) 155
    - E4 - Operational Performance Update.pdf 156
- 2311 - E5 Same Day Emergency Care Business Case (11:35) 177
    - E5 - SDEC Extended Opening Hours Board Nov 23.pdf 178
- 2311 - E6 Winter Plans (11:45) 180
    - E6 - Winter Plans.pdf 181
- 2311 - F Strategy 186
  - 2311 - F1 Health Inequalities Strategy (11:55) 187
    - F1 - Health Inequalities Strategy.pdf 188
- 2311 - G Governance & Assurance 240
  - 2311 - G1 Annual Emergency Preparedness, Resilience & Response Core Standards Compliance (12:05) 241
    - G1 - Annual Emergency Preparedness, Resilience & Response Core Standards Compliance.pdf 242
    - G1 - Appendix A DBTH Final Submission 21 November 23.pdf 246
    - G1 - Appendix B DBTH Assurance Assurance Process Statement of Compliance 2023-24.pdf 264
  - 2311 - G2 Quality & Effectiveness Committee Terms of Reference (12:.15) 265
    - G2 - Quality & Effectiveness Committee Terms of Reference.pdf 266
  - 2311 - G3 People Committee Terms of Reference (12:20) 270
    - G3 - People Committee Terms of Reference.pdf 271
- 2311 - H Information Items (12:25) 275
  - 2311 - H1 Chair and NEDs Report 276
    - H1 - Chair & Non-executive Directors' Board Report.pdf 277
  - 2311 - H2 Chief Executive's Report 283
    - H2 - Chief Executive's Report.pdf 284
  - 2311 - H3 Integrated Quality & Performance Report 288
    - H3 - Integrated Quality & Performance Report.pdf 289
  - 2311 - H4 Minutes of the Finance and Performance Committee ? 24 July & 21 September 2023 329
    - H4 - Finance & Performance Committee Minutes - 24 July 2023.pdf 330
    - H4 - Finance & Performance Committee Minutes - 21 September 2023.pdf 340
  - 2311 - H5 Minutes of the People Committee ? 5 September 2023 349

H5 - People Committee Minutes - 5 September 2023.pdf 350
- 2311 - H6 - Minutes of the Quality & Effectiveness Committee ? 1 August 2023 361
H6 - Quality & Effectiveness Committee Minutes - 1 August 2023.pdf 362
- 2311 - H7 Minutes of Charitable Funds Committee - 15 June 2023 370
H7 - Charitable Funds Committee Minutes - 15 June 2023.pdf 371
- 2311 - H8 Minutes of Audit & Risk Committee - 20 July 2023 378
H8 - Audit & Risk Committee Minutes - 20 July 2023.pdf 379
- 2311 - H9 Minutes of Trust Executive Group - 11 September & 9 October 2023 391
H9 - Trust Executive Group Minutes - 11 September 2023.pdf 392
H9 - Trust Executive Group Minutes - 9 October 2023.pdf 402
- 2309 - I Other Items 407
- 2311 - I1 Minutes of the Meeting held on 31 October 2023 (12:25) 408
I1 - Draft Public Board of Directors Minutes - 31 October 2023.pdf 409
- 2311 - I2 Any other business (to be agreed with the Chair prior to the meeting) (12:30) 418
- 2311 - I3 Governor Questions regarding the business of the meeting (12:30) 419
- 2311 - I4 Date and Time of Next Meeting (12:40) 420
- 2311 - I5 Withdrawal of Press and Public 421
- 2311 - J MEETING CLOSE (12:40) 422

2311 - A MEETING BUSINESS

Standing item | Suzy Brain England OBE, Chair of the Board | 09:30

REFERENCES

Only PDFs are attached

00 - Board of Directors Public Agenda 28 November 2023 v4.pdf

Board of Directors Meeting Held in Public
To be held on Tuesday 28 November at 09:30
Via MS Teams

Enc		Purpose	Page	Time
A	**MEETING BUSINESS**			**09:30**
A1	Welcome, apologies for absence and declarations of interest *Suzy Brain England OBE, Chair of the Board* *Members of the Board and others present are reminded that they are required to declare any pecuniary or other interests which they have in relation to any business under consideration at the meeting and to withdraw at the appropriate time. Such a declaration may be made under this item or at such time when the interest becomes known* *Members of the public and governor observers will have both their camera and microphone disabled for the duration of the meeting*			10
A2	Actions from previous meeting **(no active actions)** *Suzy Brain England OBE, Chair of the Board*	*Review*		
B	**PRESENTATION**			**09:40**
B1	Get Up, Get Dressed, Get Moving – Falls Prevention *Karen Jessop, Chief Nurse* *Jo McQuade, Therapy Assistant Practitioner - Falls*	*Note*		15
C	**True North SA1 - QUALITY AND EFFECTIVENESS**			**09:55**
C1	Executive Medical Director Update *Dr Nick Mallaband, Acting Executive Medical Director*	*Assurance*		10
C2	Chief Nurse Update *Karen Jessop, Chief Nurse*	*Assurance*		10
C3	Maternity & Neonatal Update *Lois Mellor, Director of Midwifery*	*Assurance*		10
D	**True North SA2 & 3- PEOPLE AND CULTURE**			**10:25**
D1	Chair's Assurance Log – People Committee *Mark Bailey, Non-executive Director*	*Assurance*		5
D2	People Update *Zoe Lintin, Chief People Officer*	*Assurance*		10

D3	Guardian of Safe Working Quarterly Report *Dr Anna Pryce, Guardian of Safe Working* *Zoe Lintin, Chief People Officer* *Dr Nick Mallaband, Acting Executive Medical Director*	*Assurance*		10
BREAK 10:50 – 11:00				
E	**True North SA4 - FINANCE AND PERFORMANCE**			**11:00**
E1	Chair's Assurance Log – Finance & Performance Committee *Mark Day, Non-executive Director*	*Assurance*		**5**
E2	Finance Update *Jon Sargeant, Chief Financial Officer*	*Note*		10
E3	Directorate of Recovery, Innovation & Transformation Update *Jon Sargeant, Director of Recovery, Innovation & Transformation*	*Assurance*		10
E4	Operational Performance Update *Denise Smith, Chief Operating Officer*	*Assurance*		10
E5	Same Day Emergency Care Business Case *Denise Smith, Chief Operating Officer*	*Approve*		10
E6	Winter Plans *Denise Smith, Chief Operating Officer*	*Approve*		10
F	**STRATEGY**			**11:55**
F1	Health Inequalities Strategy *Jon Sargeant, Director of Recovery, Innovation & Transformation* *Dr Kirsty Edmondson-Jones, Director of Innovation & Infrastructure* *Dr Kelly Mackenzie, Public Health Consultant*	*Approve*		10
G	**GOVERNANCE AND ASSURANCE**			**12:05**
G1	Annual Emergency Preparedness, Resilience & Response Core Standards Compliance *Denise Smith, Chief Operating Officer*	*Assurance*		10
G2	Quality & Effectiveness Committee Terms of Reference *Fiona Dunn, Director Corporate Affairs / Company Secretary*	*Approve*		5
G3	People Committee Terms of Reference *Fiona Dunn, Director Corporate Affairs / Company Secretary*	*Approve*		5
H	**INFORMATION ITEMS (To be taken as read)**			**12:25**
H1	Chair and NEDs Report *Suzy Brain England OBE, Chair of the Board*	*Information*		
H2	Chief Executive's Report *Richard Parker OBE, Chief Executive*	*Information*		

H3	Integrated Quality & Performance Report *Executive Directors*	*Information/ Assurance*		
H4	Minutes of the Finance and Performance Committee - 24 July & 21 September 2023 *Mark Day, Non-executive Director*	*Information*		
H5	Minutes of the People Committee - 5 September 2023 *Mark Bailey, Non-executive Director*	*Information*		
H6	Minutes of the Quality & Effectiveness Committee - 1 August 2023 *Jo Gander, Non-executive Director*	*Information*		
H7	Minutes of the Charitable Funds Committee - 15 June 2023 *Hazel Brand, Non-executive Director*	*Information*		
H8	Minutes of the Audit & Risk Committee - 20 July 2023 *Kath Smart, Non-executive Director*	*Information*		
H9	Minutes of the Trust Executive Group - 11 September & 9 October 2023 *Richard Parker OBE, Chief Executive*	*Information*		
I	**OTHER ITEMS**			**12:25**
I1	Minutes of the meeting held on 31 October 2023 *Suzy Brain England OBE, Chair of the Board*	*Approve*		5
I2	Any other business (to be agreed with the Chair prior to the meeting) *Suzy Brain England OBE, Chair of the Board*	*Discussion*		
I3	Governor questions regarding the business of the meeting (10 minutes) * *Suzy Brain England OBE, Chair of the Board*	*Discussion*		10
I4	**Date and time of next meeting: Date:** Tuesday 19 December 2023 **Time:** 9:30 **Venue:** MS Teams	*Information*		
I5	**Withdrawal of Press and Public** Board to resolve: That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. *Suzy Brain England OBE, Chair of the Board*	*Note*		
J	**MEETING CLOSE**			**12:.40**

*Governor Questions

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

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

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

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

Suzy Brain England OBE
Chair of the Board

2311 - A1 WELCOME, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST

Standing item Suzy Brain England OBE, Chair of the Board 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 (22.11.23).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
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 22 November 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

Karen Jessop , Chief Nurse
Husband VSM at Hull University Hospital (Chief Nurse Information Officer)

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:

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

(as at 22 November 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 22 November 2023)

2311 - A2 ACTIONS FROM PREVIOUS MEETING (NO ACTIVE ACTIONS)

Standing item Suzy Brain England OBE, Chair of the Board

No active actions

PRESENTATION

Information Item 09:40

2311 - B1 GET UP, GET DRESSED, GET MOVING - FALLS PREVENTION

Information Item | Karen Jessop, Chief Nurse | 09:40

Jo McQuade

15 minutes

REFERENCES

Only PDFs are attached

B1 - Get up Get dressed Get moving.pdf

Ward 17 – Get up, Get dressed, Get moving.

Preventing Deconditioning and Improving Patient Mobility

The Goals were…..

- To increase the number of patients out of bed on a daily basis to 70% consistently within 1 year.
- Reduce length of stay
- Reduce physiotherapy and occupational referrals by 20%
- Reduce falls and prevent deconditioning

What did I do?

- Trained staff to issue frames and sticks to normal users.
- Ensured staff had a constant supply of frames and sticks.
- I took over the therapy caseload, and worked very closely with the Discharge Co-ordinator, attending daily board rounds.
- Utilised staff as my second person when seeing double handed patients.
- Provided education on how to use the hoist and other manual handling equipment. Provided education on the effects of deconditioning.
- Discouraged the use of commodes and bedpans.
- Worked alongside staff fostering trust, providing ad hoc education.
- Put up a tally board filling in how many patients we had up that day.
- Rewarded staff with positive feedback and a gold star badge!

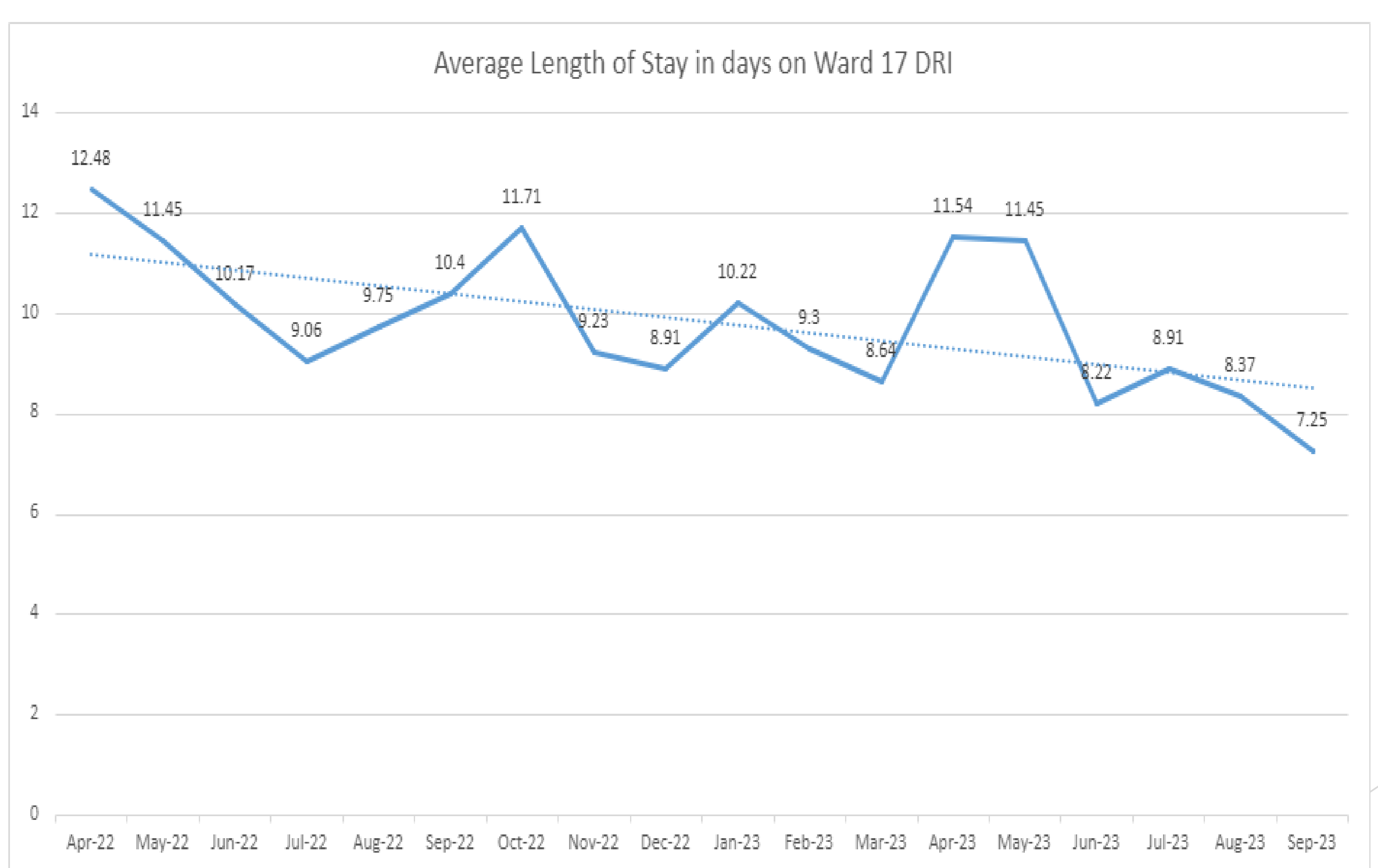
Things started to change….

- I started to notice a gradual increase in the number of patients out of bed without me having to prompt.
- Stroke patients were being hoisted out of bed into their tilt and space chairs on a daily basis.
- The patients that were sat out looked so much better and staff were beginning to recognise this.
- Staff were starting to have conversations with families about bringing in day clothes.
- Staff were walking more patients to the toilet, and felt confident doing so.
- I heard conversations between staff and patients about why it was important to get up.

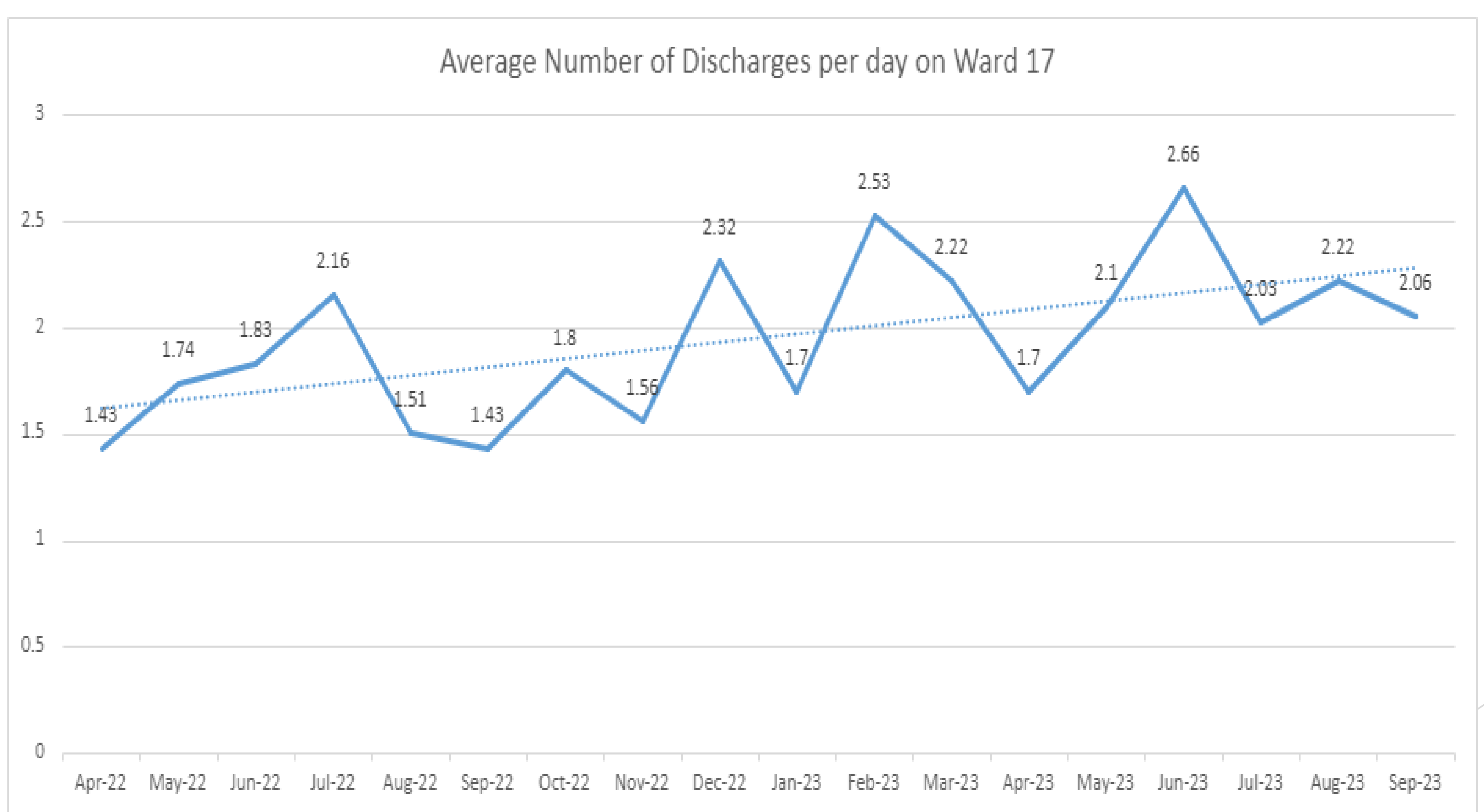
Successes………

- We won the Gold Medal in the Reconditioning the Nation games run by NHS England – first Trust in the North East to win both Silver and Gold.
- Featured in the local press.
- We won the 2023 DBTH Star award in the Change Champions category.
- Potential research paper.
- Patients out of bed running consistently at 96 – 100%
- Physiotherapy new patient referrals down by 66%
- Occupational therapy referrals down by 72%
- Reduced length of stay
- Average number of discharges per day increased
- Friends and family uptake up from 0% to 65%
- An early mobility culture, with a motivated and empowered staff
- Staff have an understanding of the role of the therapist

Length of stay data



Average number discharges per day



The Patient Experience…..

- “ I don’t like being in bed, I prefer to be in my own clothes”
- “I’m glad to be in my own clothes – I feel like a different person”
- “Being dressed makes me feel like I’m one step nearer to home”
- “My husband is in a better mood when dressed”
- “Being dressed helps me to differentiate between night and day”

The Next Steps…..

- A steering group has been established to look at how we roll out this model
- Qii are supporting with a sustainability review of the Ward 17 project to help inform us of the next steps
- Plans to communicate to all wards (nursing and therapy) the impact and relevance of the project and why this is fundamental to patient care
- Undertake a workshop to include all stakeholders from ward areas (nursing/therapy) to determine how we can roll out this model and where the priorities lie (January 2024)
- Linking with John Hopkins University, USA, to explore inclusion in a multi centre trial addressing deconditioning

Any Questions?

2311 - C TRUE NORTH SA1 QUALITY & EFFECTIVENESS

2311 - C1 EXECUTIVE MEDICAL DIRECTOR UPDATE

Discussion Item | Dr Nick Mallaband, Acting Executive Medical Director | 09:55

10 minutes

REFERENCES

Only PDFs are attached

C1- Executive Medical Director Update.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	28 November 2023	**Agenda Reference:**	**C1**
Report Title:	**Executive Medical Director Update**		
Sponsor:	Dr Nick Mallaband, Acting Executive Medical Director		
Author:	Julie Butler, Senior Manager		
Appendices:			

Report Summary

Executive Summary

1. Clinical Update and Overview of MD Team Activities

The clinical update provides an overview of the work being undertaken by the Medical Director team across each of the work-strands along with future plans to achieve the Directorate's objectives:

- Workforce and Specialty Development
- Professional Standards and Revalidation
- Operational Stability and Optimisation
- Clinical Safety

2. Martha's Rule

It is expected that Martha's Rule will become an obligation upon the NHS and could be given a statutory basis in law. Therefore, Trusts are being encouraged to begin considering what changes, if any, they should make now to deliver the safety benefits of Martha's rule.

Section 7 of this month's report provides a summary of the Trust's approach to Martha's Rule in anticipation of future NHS legislation.

Recommendation:	The Board is asked to note and take assurance from the content of the report.			
Action Require: *Highlight relevant action:*	~~Approval~~	~~Review and discussion/ give guidance~~	**Take assurance**	~~Information only~~

<table>
<tr><td>Link to True North Objectives:
Highlight which SAs this report provides assurance for:</td><td>TN SA1:
To provide outstanding care and improve patient experience</td><td>TN SA2:
Everybody knows their role in achieving the vision</td><td>TN SA3:
Feedback from staff and learners is in the top 10% in the UK</td><td>TN SA4:
The Trust is in recurrent surplus to invest in improving patient care</td></tr>
<tr><td rowspan="2">We believe this paper is aligned to the strategic direction of:</td><td colspan="2">South Yorkshire ICS</td><td colspan="2">NHS Nottingham & Nottinghamshire ICS</td></tr>
<tr><td colspan="2">Yes <s>/No/ NA</s></td><td colspan="2">Yes <s>/No/ NA</s></td></tr>
</table>

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

Assurance Route	
Previously considered by:	
Date:	
Any outcomes/next steps	
Previously circulated reports to supplement this paper:	

1. INTRODUCTION

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

Section 7 provides a briefing of Martha's Rule and a summary of the Trust's approach in anticipation of future NHS legislation.

2. MEDICAL DIRECTOR FOR WORKFORCE AND SPECIALTY DEVELOPMENT

2.1 Job Planning Performance

The table below shows job plan performance as at 12th November, 2023.

Job Plan Status	No.	%
Job Plans agreed and signed off	208	56%
Job Plans agreed and waiting Clinician or Manager sign off	42	11%
Job Plans previously agreed /re-published (within 12 months of last sign-off)	5	1%
Job Plans in discussion – of these 92 have never had a signed off e-JP = 78%	117	32%
Job Plans in mediation	2	
Total	**374**	

68% of job plans are either signed off, agreed and waiting sign off or have been republished but still within their 12 month agreed job plan period.

There are currently 52 doctors across the Trust who have 13 or more Programmed Activities (PAs) job planned, the breakdown as follows:

PA's	Total
>15 PA's	5
14.5 – 14.9	6
14 - 14.45	14
13.5 – 13.9	16
13-13.45	11

Further analysis is being undertaken to understand the drivers resulting in high numbers of job planned activities. Previous investigation into high earning medical staff has shown that the majority of this is mainly due to high levels of demand / intensity of work and vacancies in particularly hard to recruit specialties.

2.2 Job Planning Assurance

The Job Plan Consistency Committee is now in place with monthly meetings established. This committee provides a forum to ensure job planning is in line with Trust policy and that job plans are consistent between specialties and divisions.

2.3 Workforce Planning

Work continues with divisions and the Chief People Officer's team on medical workforce challenges, supporting divisions and specialties to understand demand analysis, to ensure efforts are focussed on work that needs to be delivered, strategically scaling specialties to enable us to deliver objectives.

A medical staffing Standard Operating Procedure (SOP) is now in place to support divisions with a consistent approach for ensuring services are covered appropriately, whilst maintaining patient safety. Monthly agency and sickness monitoring meetings are being held to monitor compliance.

2.4 Workforce Development and Engagement

The Clinical Directors leadership development sessions have now extended to all consultants in leadership roles. The workshops continue to receive positive feedback and are scheduled at 3 monthly intervals, the next one being the beginning of December.

In addition, the New Consultant Forum continues to offer advice and support for new senior medical staff to the Trust, with sessions scheduled for 2023/24.

3. MEDICAL DIRECTOR FOR OPERATIONAL STABILITY AND OPTIMISATION

3.1 Getting It Right First Time (GIRFT)

Work is ongoing with divisions to review progress against the GIRFT actions identified in January. Those actions that have been delayed or not started are being reviewed and prioritised. The report below gives a high level summary of progress from recent meetings with divisions, which will be updated for Trust Executive Group, Transformation Board and presented to Finance and Performance Committee as requested.

GIRFT Programme Highlight Report

Programme Summary

High	Priority for this year
Medium	Lower priority for this year
Low	Not for this year

	Total	Low	Medium	High	Already complete	Left to complete
C&F	7	2	1	4	0	4
Surgery	53	TBC	TBC	TBC	TBC	TBC
UEC	3		3			
CSS	22	4	6	12	9	3
Medicine	27	10	11	8	3	5

Financial Summary

Target (£)	Delivery Forecast (£)	Pipeline (£)	Gap (£)
?	?	?	?

Key recommendations

- Introduce digital pre-op solution
- Review booking process within Cardiology
- Re-establish Vascular working group
- Optimise use of Gynaecology SDEC
- Review patient pathways to support improvement in Gynaecology daycases
- Increase number of hysteroscopies and colposcopies in Gynaecology outpatients

Items for escalation

- No financial costing provided for any division yet

www.dbth.nhs.uk

DBTH is in the second cohort of acute Trusts DBTH in the GIRFT Further Faster programme, which is an accelerator programme to reduce waiting lists and patient waiting times in high volume specialties. A series of onboarding events into the different speciality areas commenced 13 November 2023.
A series of follow up events are being scheduled with divisions between January and February 2024, to ensure GIRFT delivery plans are included within the 2024/25 business planning cycle.

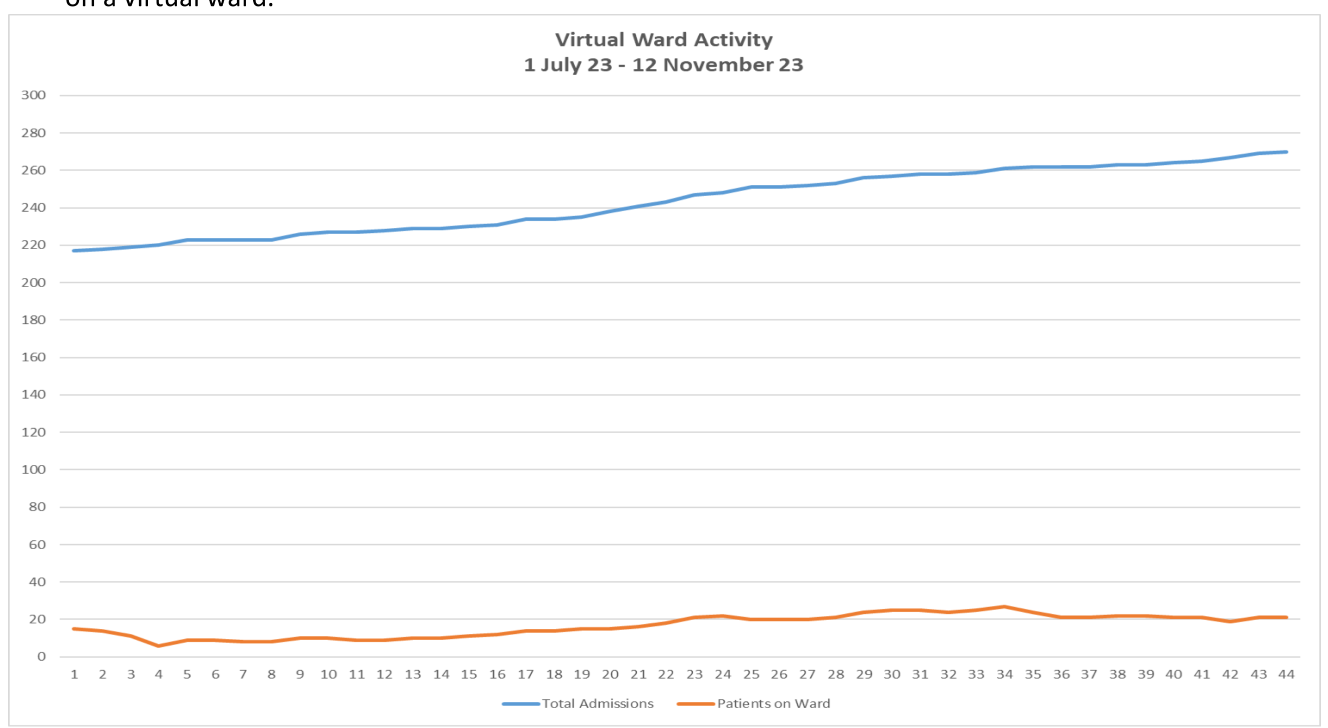
3.2 Virtual Ward

Good progress is being made on virtual ward (VW) pathways. There has been good clinical engagement enabling virtual ward pathways to be developed in other acute areas beyond the initial scope of frailty and respiratory.

3.2.1 Virtual Ward Activity

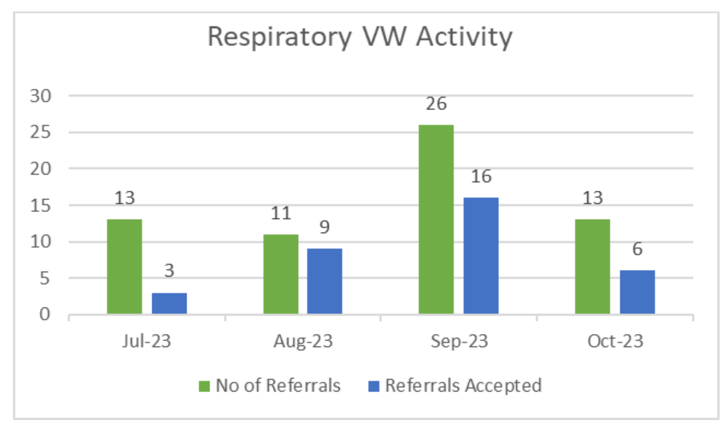
The VW service has reached a maximum of 34 patients on a virtual ward at any one time, the position fluctuates daily as patients are admitted and discharged. This will increase as the criteria for new VW services is agreed and pathways embedded, with plans to further maximise the use of community capacity.

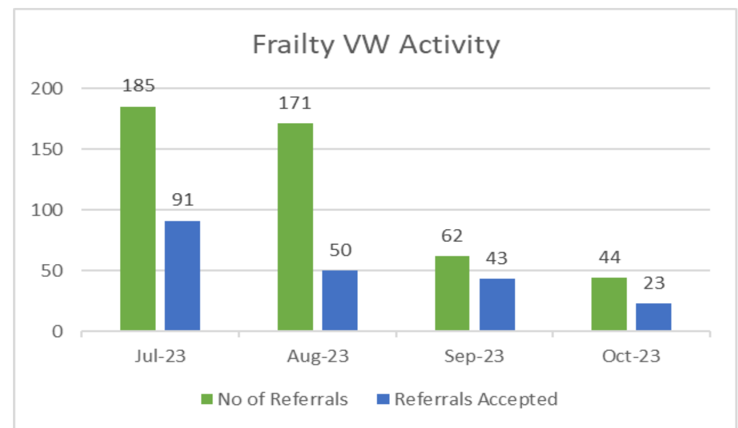
The chart below shows the cumulative number of referrals (blue) and the orange line is number of patients on a virtual ward.

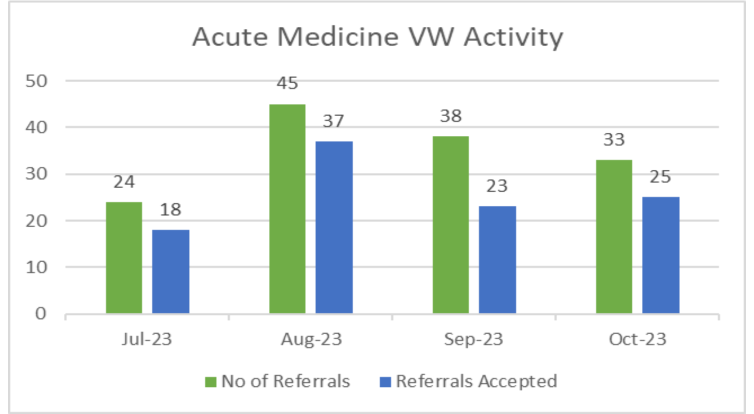


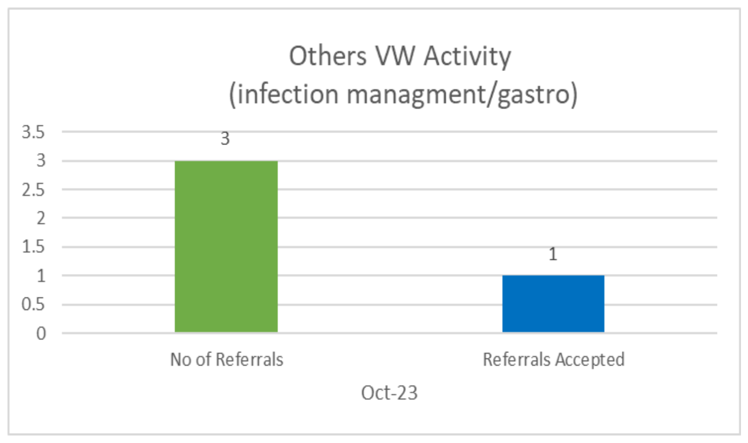
VW Activity Data Extract 1/7/23-12/11/23

3.2.2 Virtual Ward Activity by Specialty July – October 2023 inclusive









3.2.3 Future Plans and Next Steps

Consultant Cover – the pathways for Frailty, Respiratory and Acute Medicine are well established, although the consultant cover so far has been on an ad-hoc basis undertaken as overtime/additional sessions. This situation is challenging to manage especially during periods of annual leave, and when the priority needs to be on acute workload and patients.

Discussions to negotiate job planned time for VW are ongoing which will provide consistency and resilience in clinical cover for VW patients, with a general principle of 1 PA to cover 10 VW patients.

Future Plans – there has been good clinical engagement enabling VW pathways to be developed in other areas beyond the initial scope of frailty, respiratory and acute medicine.

Work is underway with RDASH to extend VW pathways and acceptance criteria in the following areas:

Virtual Ward Pathway	Timescale for implementation
Intravenous Antibiotic Therapy	01/11/2023
Gastroenterology	06/11/2023 (2 patients accepted)
Stroke	20/11/2023 (3 patients accepted on day 1)
Cardiology (heart failure)	20/11/2023
Therapy – Step up patients from community	01/12/2023
Diabetes and Endocrinology	In discussion – further development of pathway
Trauma and Orthopaedics	In discussion – further development of pathway

3.3 Risk Stratification, Clinical Validation and Prioritisation

Following the development of the draft Clinical Prioritisation and Risk Stratification policy in collaboration with the Chief Operating Officer's team, the Medical Director's office is in the process of producing a Clinical Harm Review Policy. The Clinical Harm Review process will follow the same principles and approach as the existing process for cancer pathways, with timescales to be confirmed.

Divisional plans are being developed on the management of patients on non-admitted pathways at specialty level and the resource needed for clinical validation, the information team are supporting this with reports that have been validated and data quality checks undertaken. Some of this is currently being piloted, with further work needed to ensure a process is in place for documenting the validation and additional funding to support additional clinical sessions for patients that need to be seen for urgent review.

3.4 Radiology

The Diagnostics Workstream has been focussing on the areas of high demand. Whilst there has been dedicated effort to implement measures in order to effectively manage demand, data demonstrates the extent at which demand has continued to grow exponentially across key diagnostic imaging modalities, in turn, outstripping available capacity. Below gives examples of the increased demand for CT scans and obstetric ultrasound.

3.4.1 Demand for CT

Daily ED demand for CT (in appt mins) 1 April– 30 September 2023, compared to same period 2022.

Metric	Apr – Sept 22	Apr – Sept 23
Mean Daily Demand	1252	1337
Median Daily Demand	1240	1340
80th Percentile Daily Demand	1440	1500
95th Percentile Daily Demand	1634	1664
Range of Daily Demand:	600 - 1940	860 - 2000

Daily Inpatient demand (in appt mins) 1 April–30 September 2023, compared to the same period 2022.

Metric	Apr – Sept 22	Apr – Sept 23
Mean Daily Demand	625	629
Median Daily Demand	640	640
80th Percentile Daily Demand	790	800
95th Percentile Daily Demand	887	920
Range of Daily Demand:	180 - 1060	200 - 1100

DBTH perform more CT scans than peers regionally per 100 thousand population. It is recognised most specifically through the emergency non-elective and emergency surgical pathways, in turn outstripping available capacity.

Routine referral vetting performed within CT modality before the patient referred is in the medical imaging department. The decision-making process relies heavily on information provided on the request form and the clinical indications/symptoms as described by the referring clinician. The current emergency surgical pathway protocol is not to accept a referral/admission from ED to surgical intervention without a CT scan.

Pathway controls are now starting to show a decline in the number of requests being made, this continues to be closely monitored.

3.4.2 Obstetric Ultrasound Demand

Based on 2022 data, in the five years since 2017, the number of Obstetric Ultrasound exams performed per year has risen by more than 5,600 each year **(+16.4%).** Results are consistent with model hospital data that shows DBTH is in the highest quartile nationally for OBS US activity compared to our peers and national providers.

2021/22 data shows we did 39,866 scans compared to our peer median of 15,345 and national provider median of 20,314.

The senior leadership team in maternity are reviewing pathways and protocols to manage this demand.

3.4.3 iRefer Decision Support Tool (CDS)

In September 2023 the Trust embedded iRefer CDS as part of a national steer to support clinical decision making for Radiology requests across all imaging modalities. Widely accepted as a major tool to promote evidence-based imaging, CDS software guides clinicians through the process of optimising referral for diagnostic imaging procedures using best practice guidelines at the point of order entry. It does not intend to replace clinical expertise.

There are valuable patient quality outcomes from iRefer implementation, e.g. patients receive the most appropriate diagnostic test, despite this there has only been a marginal reduction in demand to-date.

The support tool has been turned off for consultants. This is because the greatest benefit will be gained in requests for urgent scans for patients on emergency pathways which mainly come from junior doctors.

4. ASSOCIATE MEDICAL DIRECTOR PROFESSIONAL STANDARDS AND REVALIDATION

4.1 Appraisal Performance and Revalidation

Medical Appraisal Completion Rate:

2023/24	Q1 01/04/2023	Q2 01/07/2023	Q3 01/10/2023
Total Completed Appraisals	**61** (79.22%)	**45** (54.88%)	**11** (6.47%)

Revalidation period 02/09/2023 to 27/10/2023:

Status	No.
Recommendations for revalidation approved	6
Recommendations for deferral approved	1
On hold pending GMC investigation (MHPS tribunal scheduled May 2024)	1
Non-engagement recommendation	1
Trust referrals to GMC	0

4.2 Electronic Appraisal Platform

L2P Enterprise have been awarded the contract to supply an electronic medical appraisal system compliant with NHS England and Academy of Medical Royal Colleges. Following the internal information governance process the Data Protection Impact Assessment (DPIA) and Digital Technology Assessment Criteria (DTAC) were formally signed off 25 September 2023, following which time test data was shared with L2P.

The implementation plan will follow a phased process which gives an opportunity to review individual appraisal dates and manage any technical issues before final upload. This gives flexibility for a number of clinicians to undertake appraisals on the new system with effect from November 2023, prior to a formal launch date of 1 April 2024.

4.3 Maintaining High Professional Standards (MHPS) Investigation

There are three cases ongoing (2 conduct and 1 conduct/capability).

Further to September's report, 1 capability Investigation (doctor no longer working in the Trust) has been concluded, outcome of which has been shared with new Responsible Officer (Dr Joseph John) and GMC.

Timescales are actively monitored in accordance with policy and Designated Member kept informed of progress.

5. ASSOCIATE MEDICAL DIRECTOR CLINICAL GOVERNANCE/PATIENT SAFETY

5.1 Mortality

The HSMR and SHMI reports were discussed at Mortality Governance on the 8 September 2023.

Hospital Standardised Mortality Ratio (July 2023 data)

Hospital Standardised Mortality Ratio (HSMR) - July 2023 (Month 4)

HSMR Trend (monthly)

	2019	2020	2021	2022	2023
January	105.78	110.26	118.93	117.90	109.85
February	98.13	92.56	104.15	108.60	93.11
March	101.87	102.51	94.56	104.50	94.40
April	100.70	118.40	79.25	104.03	98.03
May	91.36	132.00	98.24	108.90	80.63
June	98.32	97.72	102.59	102.61	97.12
July	104.77	91.35	90.56	111.46	127.73
August	112.17	88.54	104.48	122.28	
September	83.64	87.38	101.46	122.04	
October	100.24	117.01	105.55	115.65	
November	88.64	131.37	109.36	98.03	
December	103.24	144.89	117.93	112.18	

Crude Mortality (monthly) - September 2023 (Month 6)
(number of deaths/number of patient discharged)

Crude Mortality (Trust)

Crude Mortality (DRI)

Crude Mortality (BDGH)

	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Trust	1.86%	1.42%	2.49%	2.07%	1.35%	1.61%	1.73%	1.03%	1.13%	1.52%	1.34%	1.28%
DRI	1.88%	1.40%	2.57%	2.02%	1.45%	1.62%	1.76%	1.06%	1.24%	1.54%	1.33%	1.33%
BDGH	2.18%	1.81%	2.59%	2.69%	1.22%	1.95%	1.94%	1.10%	0.92%	1.69%	1.64%	1.31%

Overall HSMR (Rolling 12 months)

105.44

HSMR - Non-elective Admission (Rolling 12 months)

106.04

HSMR - Elective Admission (Rolling 12 months)

56.96

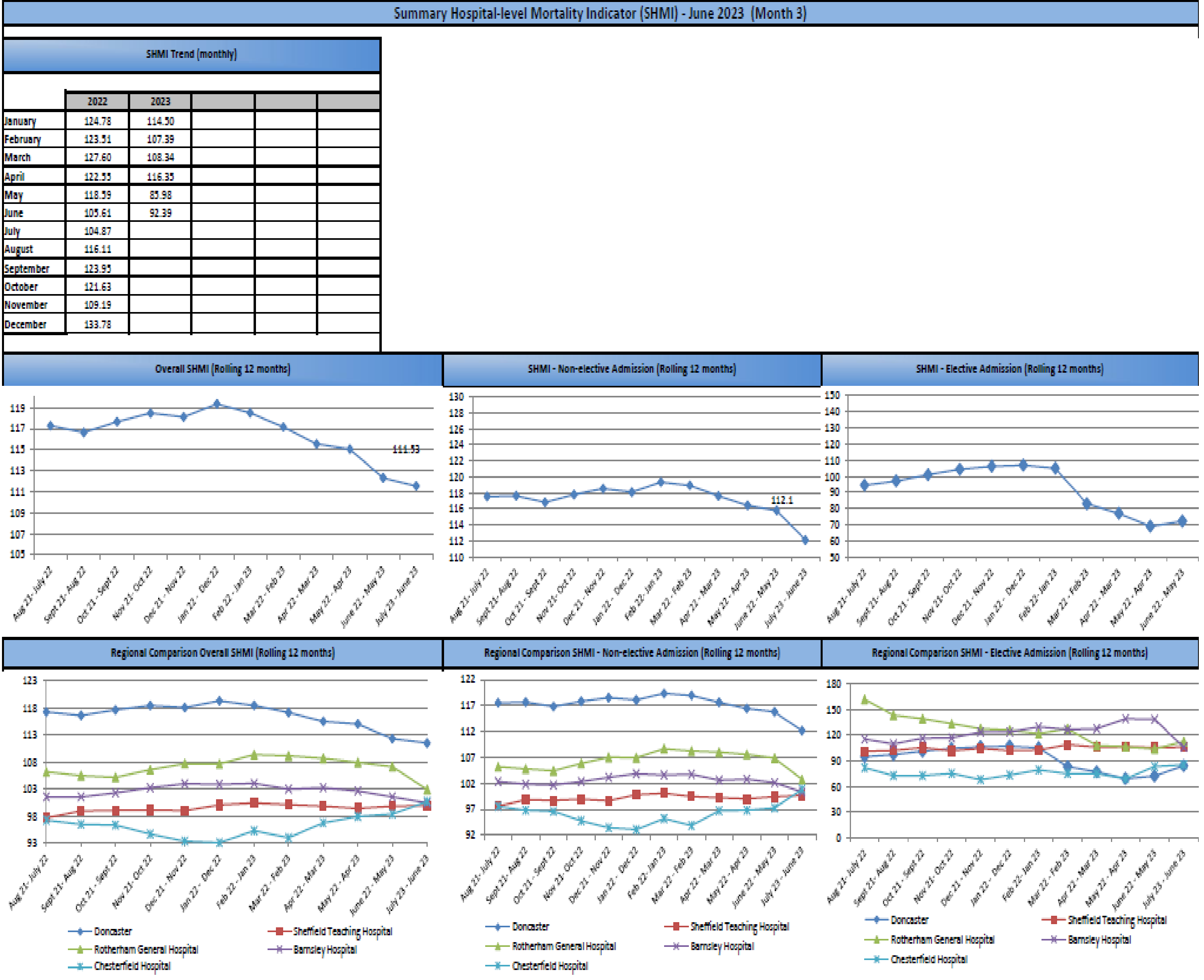
Regional Comparison Overall HSMR (Rolling 12 months)

Regional Comparison HSMR - Non-elective Admission (Rolling 12 months)

Regional Comparison HSMR - Elective Admission (Rolling 12 months)

Doncaster; Sheffield Teaching Hospital; Rotherham General Hospital; Barnsley Hospital; Chesterfield Hospital

Summary Hospital Mortality Indicator (June 2023 data)


Summary Hospital-level Mortality Indicator (SHMI) - June 2023 (Month 3)

SHMI Trend (monthly)

	2022	2023			
January	124.78	114.50			
February	123.51	107.39			
March	127.60	108.34			
April	122.55	116.35			
May	118.59	85.98			
June	105.61	92.39			
July	104.87				
August	116.11				
September	123.95				
October	121.63				
November	109.19				
December	133.78				

HSMR – the Trust is still doing very well with an 8 months period on a downward trend, although month 4 is showing a slight increase compared to the previous month.

SHMI – a more historical look at mortality showing DBTH is an outlier. Performance is higher than average but a reducing trend (112). Further analysis of Healthcare Evaluation Data (HED) shows Doncaster Royal Infirmary is within expected range, with Bassetlaw above.

On the whole, in comparison to peers, we are doing very well on HSMR performance and on a downward trend, which no other hospitals in South Yorkshire have been able to replicate. With regard to SHMI we are still higher, however the downward trend can be seen. Historically with the Trust, SHMI has been higher in winter months which comes down during the summer and we are not out of sync with that trend.

Further improvement is expected as a result of the work of the Data Assurance Group and resulting action plan.

5.2 Structured Judgement Reviews (SJRs) / Learning from Deaths

With the Medical Examiners team scrutinising 100% of hospital adult deaths the number of SJRs requested has reduced, whilst the ME process is robust the completion rate of SJRs is poor. This has resulted in limited opportunities to learn from deaths.

This low completion rate is mainly due to time constraints and no scope within job plans to undertake the work needed. However, there is a plan to improve this position:

i A review of clinical staff already trained in the SJR process has identified 23 colleagues who have had previous training

Ii There is an appetite from clinicians to undergo training and be involved in the SJR process

ii Learn from other Trusts in the region, understand their SJR process (e.g. Barnsley FT have a trained cohort of clinicians to undertake SJRs who are paid for their time to do this)

iii Appraise nationally available SJR software from NHS England that The Rotherham Hospital FT are using to understand whether this would benefit DBTH

iii Previous Trust mortality lead has returned to work with us for one day a week, to deliver the following:

a) In house SJR training
b) Meeting governance leads across the Trust regarding SJRs/Learning from Deaths
c) Quantify the time commitment needed to complete the backlog of SJRs, and whether more people need to be trained for us to be more proactive moving forward
d) Reinstate mortality MDT meetings
e) Development of an action plan for ongoing improvement

5.3 Clinical Governance

Implementation of the new clinical governance framework is underway, supported by the PMO team. A template has been developed for divisions to provide highlight reports to the Clinical Governance Committee which will standardise reporting across the Trust.

There are plans to review the Patient Safety Review Group and Audit and Effectiveness Forum, which will commence in line with implementation of the new clinical governance structure.

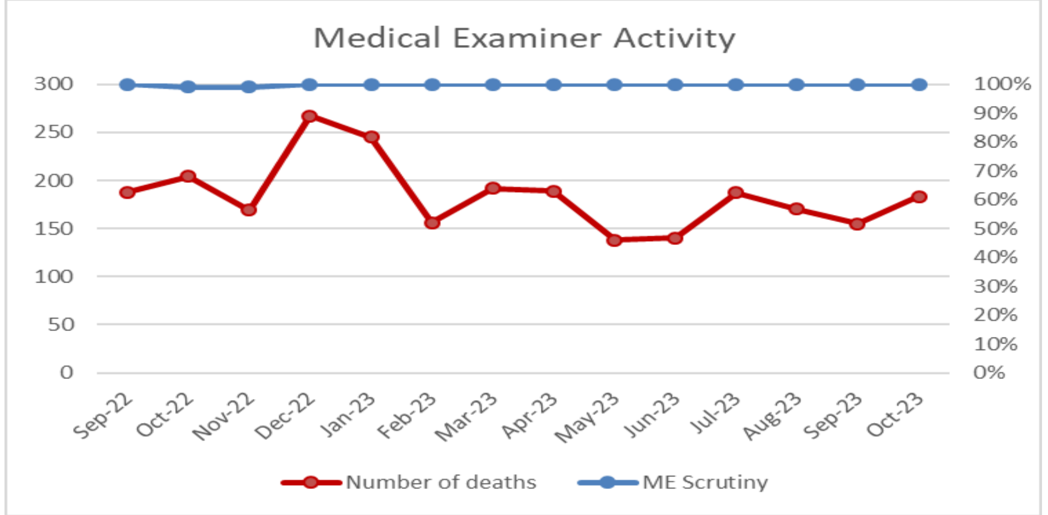
6. MEDICAL EXAMINER'S UPDATE

6.1 October 2023 Data – discussed at Mortality Governance Meeting 10 November 2023

Total Acute Adult Deaths* = 180 (Deaths in September 2023 = 155)
Total Community Adult Deaths = 146 (Deaths in September 2023 = 91)
Total adult deaths scrutinised = 326 (Total adult deaths scrutinised Sept 2023 = 246)

Inpatient and ED deaths over the age of 18 at 31/10/23

Acute Hospital Deaths (inpatient and emergency department) over the age of 18 as at 31/10/2023



6.2 Completion and issuing of Medical Certificates of Cause of Death (MCCD) and Referrals to His Majesty's Coroner (HMC)

October 2023 Acute Adult Deaths		% Scrutinised by ME team	MCCD issued	MCCD Issued > 3 days	HMC ref.*	HMC ref not required after ME scrutiny
DRI	141	100%	108 (77%)	20 (14%)	33 (23%)	2 (3%)
BDGH	39	100%	38 (98 %)	8 (20%)	1 (2%)	2 (1%)

6.3 Top 5 causes of death as listed at 1a) on MCCD

	Cause	DRI	BDGH	Total
1	Pneumonia	23	15	38
2	Metastatic Cancer	13	5	18
3	Cardiac related	12	5	17
4	COVID	7	1	8
5	MOF	6	2	8

6.4 Non-acute deaths

Oct 2023 Community Deaths		MCCDs released	HMC referrals	HMC ref not required after ME scrutiny	Families spoken to	Cases with no Next of Kin	N/A already referred to HMC
DRI	82	77	5	2	76	1	4
BDGH	64	46	18	3	63	0	0

6.5 Summary

- Total numbers of acute adult deaths for October 2023 have increased to 180 from 155 in September.
- 100% of acute adult deaths across both sites have been reviewed by a member of the ME team.
- 97% of families have been spoken to by a member of the ME team.

- Cases continue to be scrutinised by the ME team prior to sending to HMC.
- 100% of cases continue to be scrutinised by the ME team prior to sending to HM coroner. This continues to work well. Four acute cases and five community cases did not require HMC referral following ME scrutiny.
- Total Deaths scrutinised by the ME team October 2023 = 326

Data correct from Mortality Database as of 6/11/23

7. MARTHA'S RULE

7.1 Background

The rule is named after Martha Mills, who died in 2021, aged 13, at the King's College Hospital NHS Foundation Trust. She had been admitted with a pancreatic injury after falling off her bicycle, but she sadly died when her parents' concerns about sepsis were not acted upon. In 2022, a coroner ruled that Martha would most likely have survived if she had been transferred to intensive care earlier.

Martha's rule would give all patients in NHS hospitals in England (and those acting on their behalf) the legal right to request a second opinion from a senior clinician in the same hospital if a patient is deteriorating rapidly but it appears concerns are not being taken sufficiently seriously by medical staff.

7.2 NHS England Guidance

The NHS is rolling out a new early warning system for doctors and nurses treating children to quickly identify deterioration, escalate care, and act on parental concerns. The system allows doctors to track possible deterioration in a child's condition on a chart, measuring things like blood pressure, heart rate, oxygen levels and levels of consciousness, with different scores representing the level of concern.

This change will provide a single, national standardised process for patients, families, and staff to have a clear way of ensuring issues are detected and escalated quickly.

If a parent or carer raises a concern that their child is getting ill or sicker than the score shows, this will immediately escalate the child's care regardless of other clinical observations.

Working in partnership with the Royal College of Paediatric and Child Health and the Royal College of Nursing, NHS England has been developing the Paediatric Early Warning System for over three years with pilots running across 15 sites.

The NHS will be rolling out a leaflet and video content for parents, letting them know how to communicate concerns to healthcare staff and encouraging them to escalate if needed.

As the programme develops, the NHS will implement any guidance from Martha's Rule within the early warning system.

7.3 Trust Approach to Martha's Rule

As part of the Trust's response to improving outcomes for people with sepsis we have identified the need for a co-ordinated and standardised approach to improving the early recognition of sepsis across all clinical areas. A significant amount of work has already taken place at DBTH with the establishment of a Sepsis Action Group who have led a systematic approach to reviewing themes and trends in incidents attributed to missed or delayed treatment of sepsis, with corporate and divisional teams

taking forward actions and learning that put patient safety at the heart of our sepsis plan.

Sustained improvement is needed, driven by sepsis clinical lead roles in nursing and medical professions supported by digital transformation technology to link blood gas analysers to ICE (integrated clinical environment) and real time business intelligence (sepsis tracker and dashboard).

In terms of the legal right to request a second opinion from another senior clinician/team, this is dependent on the timescales set out by NHS England once the rule comes into force. For example, a request for a second opinion within a 72 hour timeframe during an acute admission would be different to an emergency situation if the timescale was within a 6-12 hour window which would be more challenging.

Further guidance is awaited from NHS England on its response to Martha's Rule.

8. EXECUTIVE MEDICAL DIRECTOR'S CLOSING SUMMARY

This report summarises the extensive work on going to help support and shape the direction of the Trust. In the absence of the substantive Executive Medical Director, work is focussed on key priority areas.

Key highlights are:

- Job Planning is progressing, with focus on:
    - Surgical Division to improve performance
    - Job plans over 14 PAs
- We are continuing to improve the leadership development offer for the Trust's clinical leaders
- Virtual Ward pathways are being developed across a range of specialties to increase utilisation of available capacity within the community
- Medical appraisal going well and plan to achieve similar high levels of completed appraisals this financial year. Implementation of medical appraisal software L2P going to plan.
- Work on mortality, governance and risk continues. There are ongoing concerns about the Trust's SHMI outlier status, however the expectation is that this will start to show an improving trend in the coming months in line with HSMR performance.
- Plan to improve the completion rate and timeliness of SJRs.
- Plan to improve the Learning from Deaths process.
- The Medical Examiner team continue to scrutinise 100% of hospital adult deaths and have commenced scrutiny of community deaths.

2311 - C2 CHIEF NURSE UPDATE

Discussion Item | Karen Jessop, Chief Nurse | 10:05

10 minutes

REFERENCES

Only PDFs are attached

C2 - Chief Nurse Update.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	28 November 2023	**Agenda Reference:**	**C2**
Report Title:	**Chief Nurse Report**		
Sponsor:	Karen Jessop, Chief Nurse		
Author:	Simon Brown, Deputy Chief Nurse		
Appendices:	None		

Report Summary

Executive Summary
The paper outlines the August and September 2023 outcomes in relation to the key patient safety measures identifying areas of good practice and improvement in:

- Falls prevention
- Prevention of hospital acquired pressure ulcers
- Infection prevention and control

The paper also details any reportable serious incidents and immediate safety actions.

The paper highlights patient experience, focused on the effectiveness of the complaints procedures, themes of complaints and how we evidence learning.

Key Points
Patient Safety Incident Response Framework (PSIRF) implementation remains on track with the Patient Safety Incident Response Plan (PSIRP) and Policy now approved via internal governance processes.

There were eight serious incidents logged across August and September 2023.

At the time of this report the Trust Clostridium difficile numbers remain within normal variation, however the threshold of 42 this year is noted as a significant challenge.

Recommendation:	To note the report and assurance provided.			
Action Require:	~~Approval~~	~~Review and discussion/ give guidance~~	**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 /~~No/ NA~~	**Yes /~~No/ NA~~**

Implications

Board assurance framework:	BAF Risk 1

Risk register:	None
Regulation:	CQC (reg 12) - Safe Care and Treatment NHSE - National Quality Board staffing reporting requirements
Legal:	N/A
Resources:	None

Assurance Route	
Previously considered by:	TEG
Date:	13 November 2023
Any outcomes/next steps	N/A
Previously circulated reports to supplement this paper:	N/A

Chief Nurse Report - November 2023

Introduction

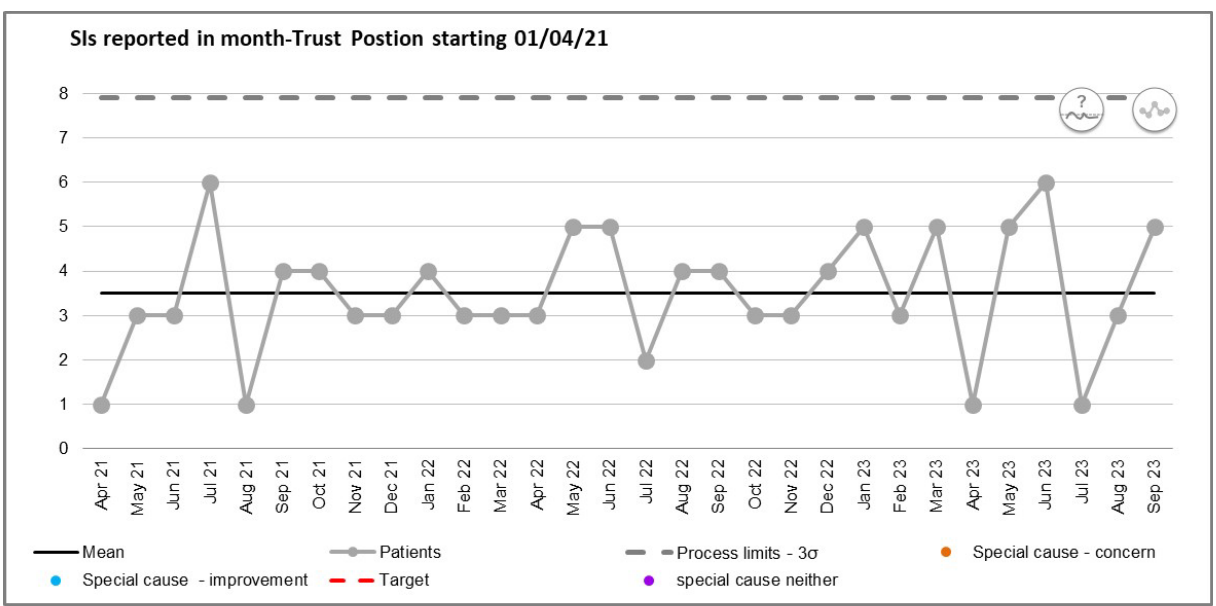
This report provides the Board of Directors with an update on the key issues, challenges and relevant information with regard to the Chief Nurses areas of responsibility.

Patient Safety Incident Response Framework (PSIRF) Implementation

The Patient Safety Incident Response Framework (PSIRF) was published on 16 August 2022, it is a major piece of guidance on how NHS organisations respond to patient safety incidents and ensure compassionate engagement with those affected. All providers contracted under the NHS standard contract are required to transition to PSIRF during the autumn of 2023. The PSIRF implementation group continue to meet monthly. The Chief Nurse is pleased to report the Patient Safety Incident Response Plan (PSIRP) and the Patient Safety Incident Response Policy have progressed through the internal governance routes. The PSIRP is now with the Integrated Care Board for final sign off. A transition date is being agreed with the Integrated Care Board. A business case has been finalised and will proceed to Corporate Investment Group to request funding to procure the required training and for the funding of additional posts as outlined in the plan. The PSIRF implementation group continue to monitor progress monthly.

Patient Safety Reporting

Serious Incidents



There were eight serious incidents logged across August and September 2023.

Serious Incident Detail	Immediate Safety Actions
Ophthalmology and Rheumatology patient lost to follow up since 2019 resulting in delayed identification of medication toxicity (Hydroxychoroquine).	Team to identify all current patients on Hydroxychoroquine for their last review date and schedule review.
Diagnosis delay, Radiological Services delay and discharge from ED. Multifactorial issues identified, the deterioration in the condition of a patient's foot was not escalated and the delay led to an amputation. Earlier vascular input may have supported the patient care pathway.	Review of vascular pathway by ED.
Attended Triage 16 June 2023 with a history of decreased fetal movement - Abnormal CTG. CTG monitoring continued, further decelerations noted - decision made for category 1 caesarean section. Decision for category 1 changed and requested to monitor further time period. CTG continued to deteriorate and delay in optimisation noted.	Discussed at Maternity CGC. Review of escalation and decision making.
Theatres - Patient had a STEMI prior to surgery in the anaesthetic room. Inappropriate listing and stopping of medication ahead of surgery following cardiac stenting.	Flow chart created by anaesthetics to inform pre-op when discussion should take place regarding listing for theatre.
Breast care team, patient's original pathology reporting positive result ER. Oncotype was requested. Based on this result the pathway was followed but oncotype testing revealed this was an incorrect result. Patient was actually ER negative. Therefore, referred to wrong pathway.	Urgent review of pathology sampling process. The identified issue with the supplementary report has been resolved by the cancer pathway team in relation to a previous lessons learnt from an SI.
Ureteric injury during gynaecology surgery.	Raise the awareness of the importance of tracking ureters post-surgery. Meeting held with Executive Medical Director and Divisions.
Ward St leger - Care issues identified on Falls Improvement Panel and SJR identified poor care.	Head injury guidance and post fall pro-forma review - falls lead.

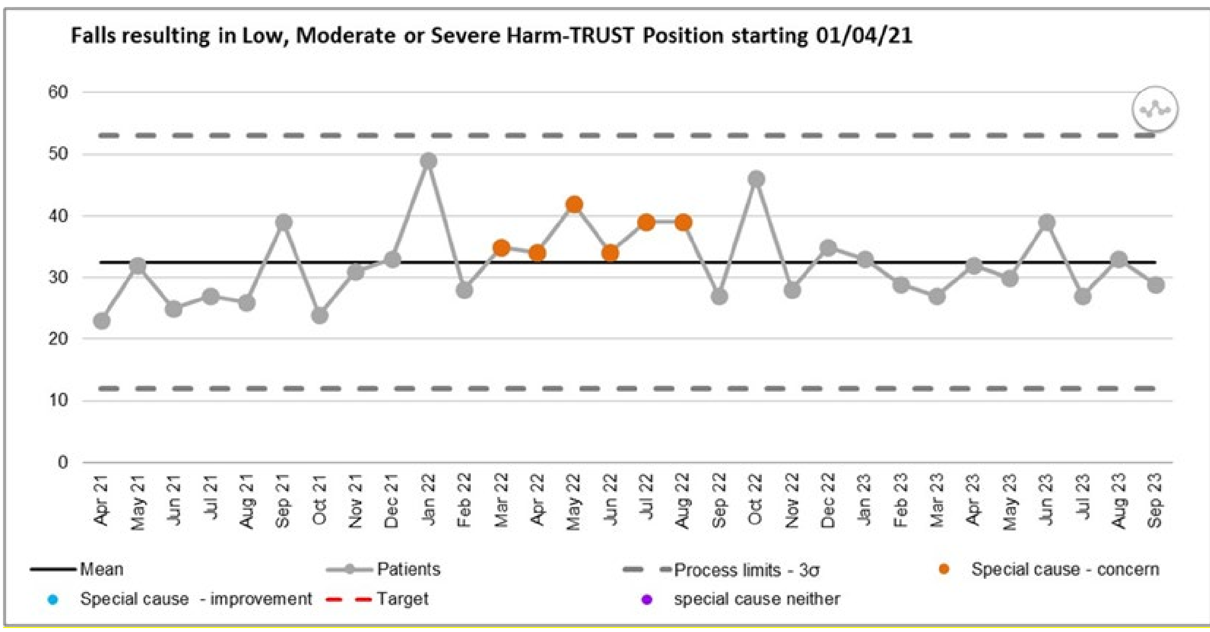
Unwitnessed fall resulting in cerebral bleed. Care issues identified. Enhanced care red supervision prescribed, and not in line of sight at the time of the fall.	Head injury guidance and post fall pro-forma review - falls lead.

This is a total of 20 Serious Incidents reported for the year 2023-24.

The Trust continue to have one serious incident paused due to this incident involving a police investigation and this will commence as soon as able.

Falls

There were 126 patient falls reported in August and 132 in September 2023, of these, 195 resulted in no harm, 56 resulted in low harm, five moderate harm and two in severe harm. It is to note information and data reported today may change in subsequent reporting following the incident reviews at falls panel.



TENDABLE audits in the falls and enhanced care question sets are carried out weekly. In September's audit, consistent compliance is reported with a score of 99%. This visual assessment audit focuses on the five principles for falls prevention.

Learning identified through the falls improvement panel:

- Recording of Lying and Standing BP. This is now on Nerve centre for all inpatients over 65 years old and shows a significant improvement in compliance.

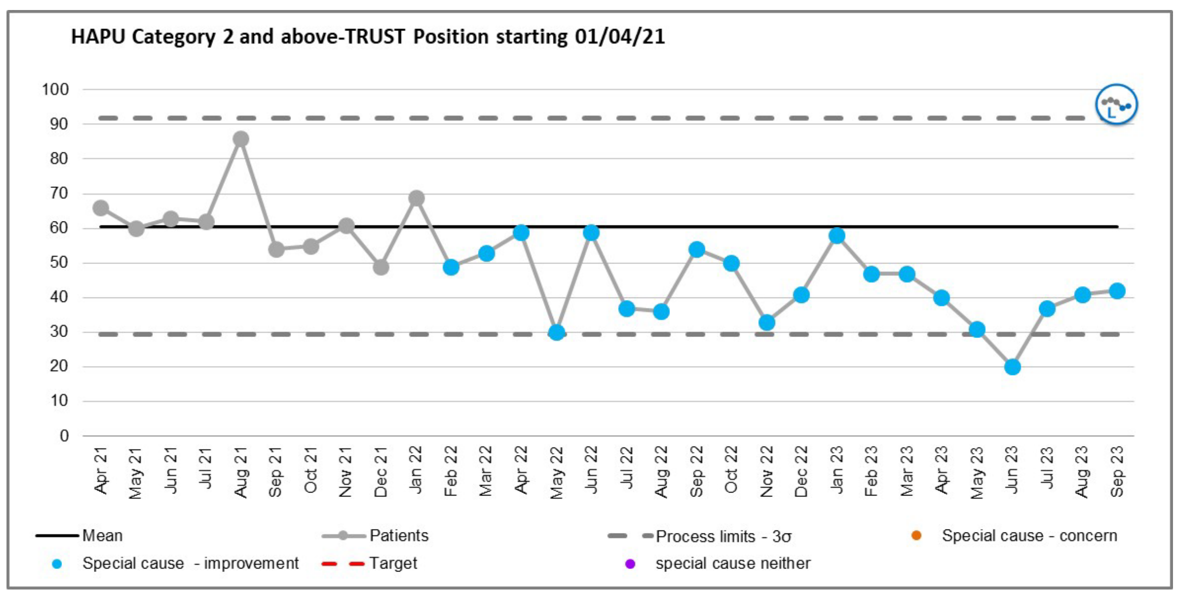
Areas of good practice:

Improvement planning is underway for transition to PSIRF. Falls is in our PSIRF plan as a key priority. All inpatient falls will require a hot debrief performed at ward/department level within 24 hours, this will ensure immediate safety measures are put in place to reduce further harm. Additionally this will allow the Trust to identify themes and target priority improvement work.

The Falls Champions Network has relaunched with a joint approach with AHP and nursing lead in falls improvement.

Hospital Acquired Pressure Ulcers (HAPU)

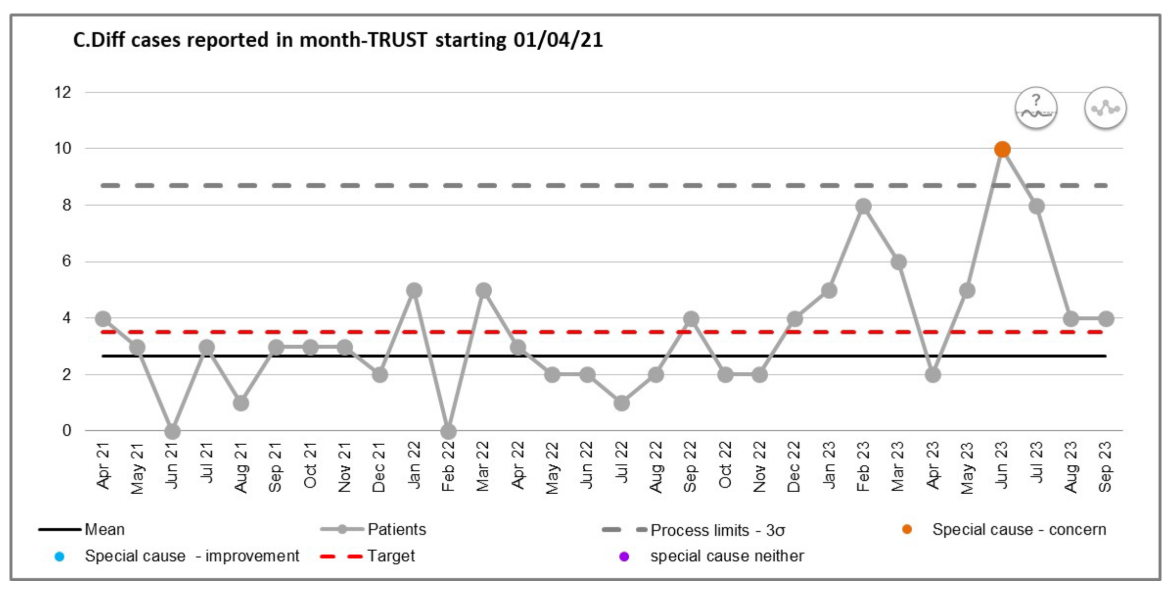
There were 92 HAPUs recorded across August and September 2023. There was one category four HAPU, 10 were category three HAPUs, five were unstageable HAPU and two were Mucosal Pressure Ulcer.



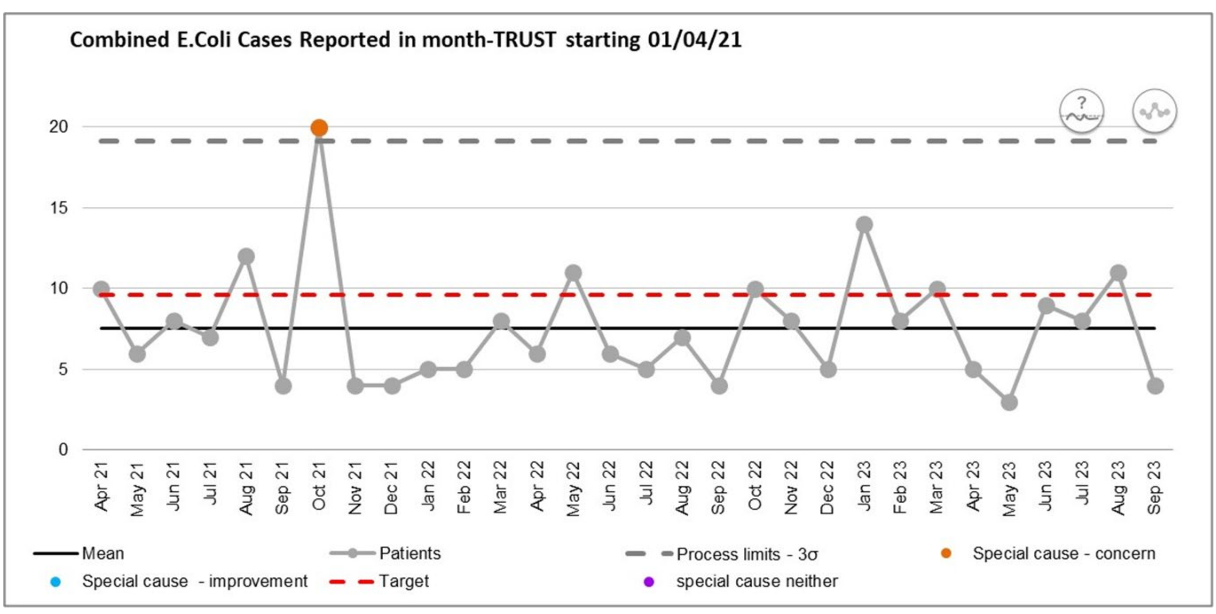
Infection Prevention and Control (IPC)

Clostridium difficile (C.diff): There were eight cases of Clostridium difficile across August and September 2023. All eight were Hospital Onset, Hospital Associated (HOHA) infections. The total number of cases of Clostridium difficile for the financial year is now 33, against a reduced trajectory of 42.

The figures remain just within normal variation, but the nationally set thresholds will be a challenge this financial year. Each division has a specific action plan in place and is monitored by the Infection Control Committee.

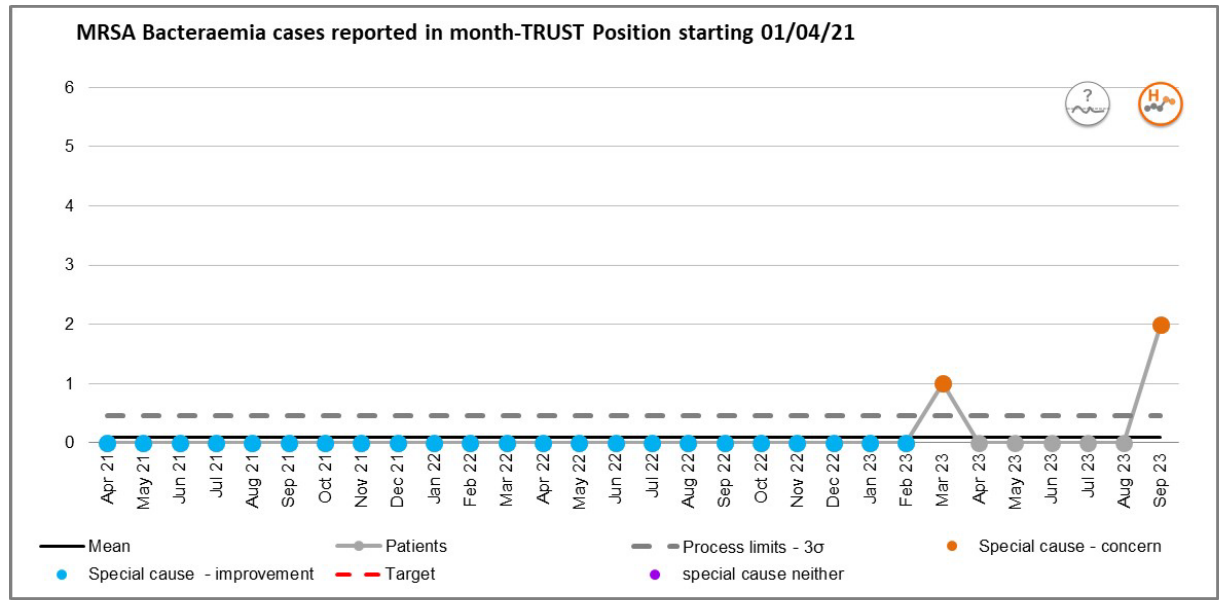


E-Coli Bacteraemia: There were 15 cases of E.coli bacteraemia across August and September 2023, 11 are classified as HOHA and four as COHA. The total for the year so far is 24 with a trajectory of 80.

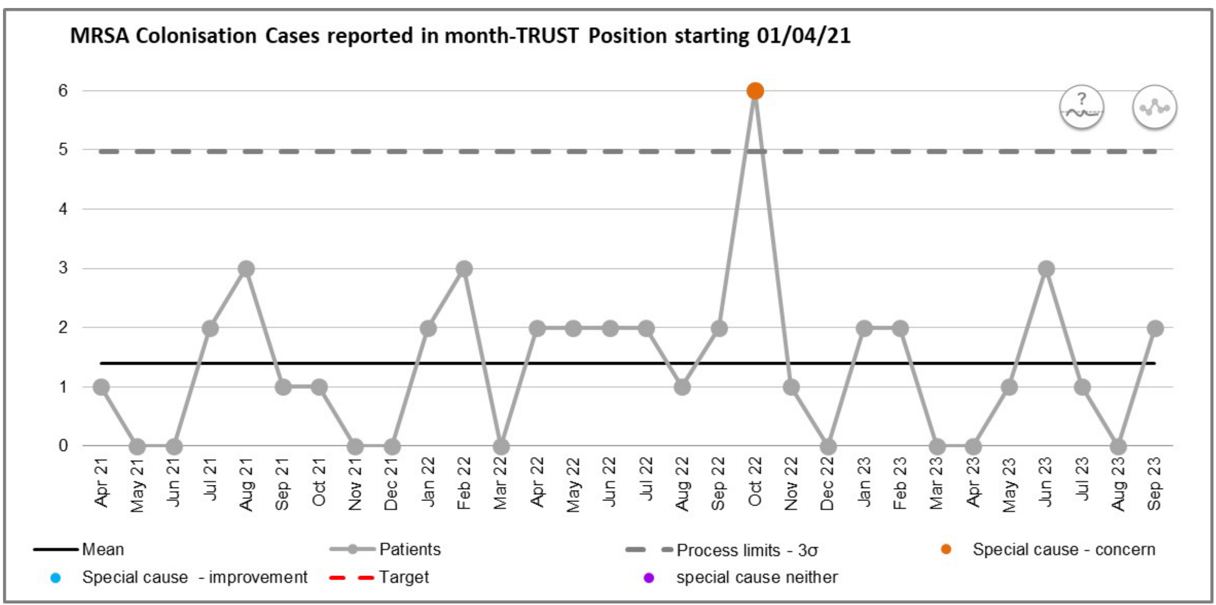


MRSA bacteraemia: There were two MRSA bacteraemia reported in September 2023. Total for year is zero against a trajectory of zero.

The learning has been discussed at post infection reviews. The key learning identified was increased awareness of the importance of complete screening for MRSA on admission, including wounds. Further cascade on the "My ED" platform has also taken place.



MRSA Colonisation: There were two reported MRSA colonisations across August and September 2023.



Glycopeptide Resistant Enterococci: The number of cases remain static at 31. The Director of Infection Prevention of Control has assured the Chief Nurse the numbers appear to be as expected with this infection, given the increased screening process. Additional control measures remain in place in addition to regular oversight meetings.

Improvement

Shared Learning

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

At September's PSRG, learning was shared from an incident relating to the care of a patient undergoing breast reconstruction surgery. Contributory factors included environment, personnel and equipment. Learning included patient temperature management in the intra and post-operative period, availability of expander implants and a review of the standard operating procedure relating to breast "flap" observations post operatively.

Patient Experience

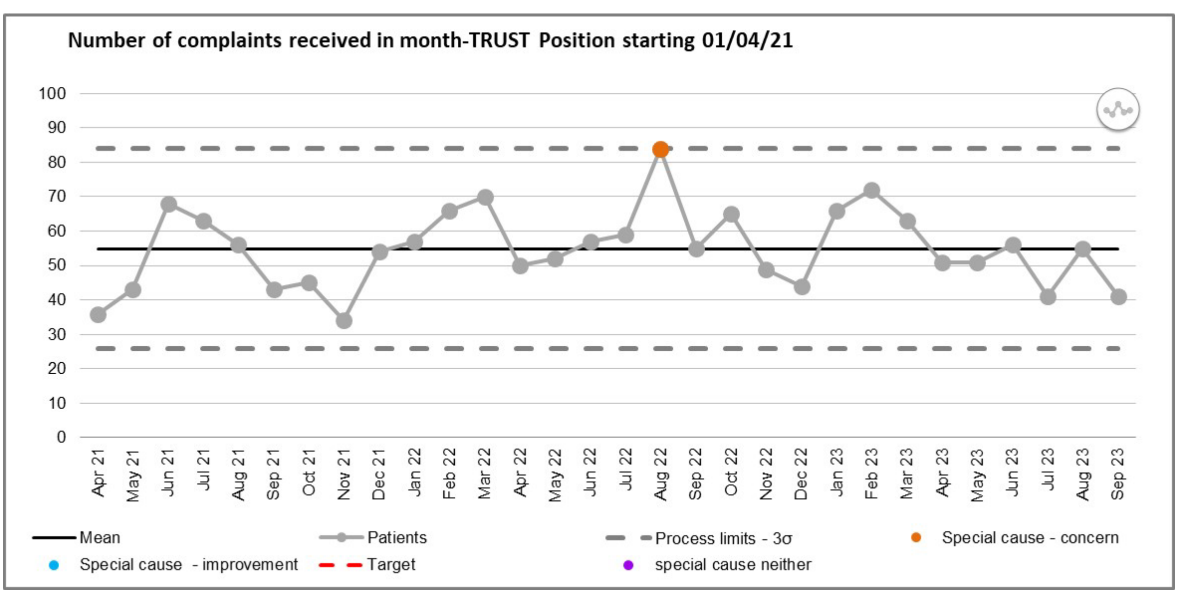
Friends and Family Test (FFT)

The FFT response rates continue to be monitored and improvements have been seen in maternity over the last 2 reporting periods. Across all FFT data positive scores consistently achieve above the national average in Inpatient, A&E outpatients and Maternity.

Work has begun to on board the Trust's FFT survey to **Iwantgreatcare**. This will be conducted as a 12-month pilot to include text messages thus it is expected to increase the number of survey responses received Trust-wide.

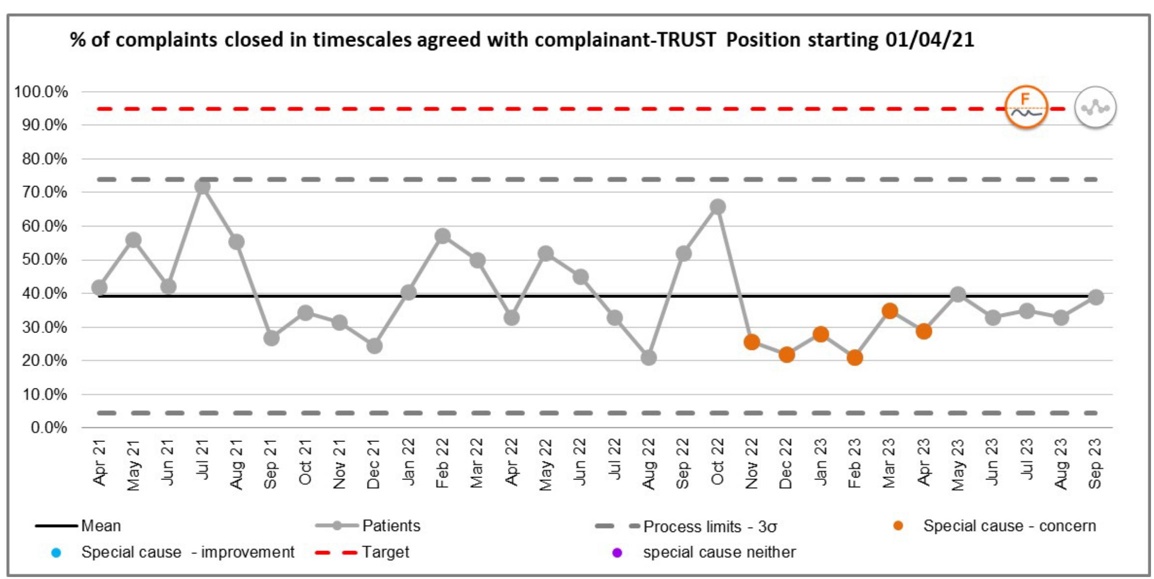
Complaints July 2023

In September 2023, 51 complaints were received a reduction from 65 logged in August. This brings the year to date (2023/2024) total to 327.



Complaints closed in agreed timescale

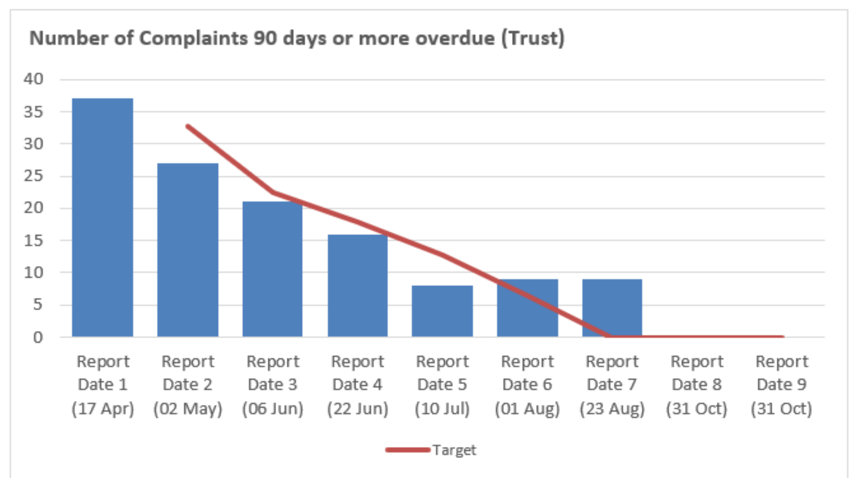
A total of 53 complaints were closed in July 2023 an increase from 48 complaints closed in June 2023, of these 40% met the timeframe for closure.



Trajectories have been agreed with divisions to recover the Trusts position in managing complaints in the agreed timeframe by 31 October 2023.

The agreed trajectories and current performance are highlighted in the following charts:

Number of Complaints 90 Days or more overdue
Target: Zero complaints exceeding three months by 31 August 2023.



There remain two complaints over 90 days however the Chief Nurse has received assurance of the rationale for this.

Conclusion
The Board of Directors is asked to take assurance from this report in relation to the key highlights from the Chief Nurse portfolio in relation to quality, safety, and patient experience.

2311 - C3 MATERNITY & NEONATAL UPDATE

Discussion Item — Lois Mellor, Director of Midwifery — 10:15

10 minutes

REFERENCES

Only PDFs are attached

C3 - Maternity & Neonatal Update.pdf

C3 - Appendix 1 - PMRT Q2 report.pdf

C3 - Appendix 2a - DRI ATAIN Dashboard 2023-24 Q1.xlsx

C3 - Appendix 2b - DBTH ATAIN Dashboard 2023-24 Q2.xlsx

C3 - Appendix 3 - Training needs analysis.pdf

C3 - Appendix 4 - Transitional care Action plan.xlsx

C3 - Appendix 5 - Thematic review of Early Notification cases.pdf

C3 - Appendix 6 - Perinatal Surveillance Q3.pdf

C3 - Glossary of Terms - Maternity.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	28 November 2023	**Agenda Reference:**	**C3**
Report Title:	**Maternity & Neonatal Report**		
Sponsor:	Karen Jessop, Chief Nurse		
Author:	Lois Mellor, Director of Midwifery Laura Churm, Divisional Nurse, Paediatrics		
Appendices:	Appendix 1 - Perinatal Mortality Reviews Summary Report Appendix 2 - Q1 & Q2 Avoiding term admissions into neonatal units (ATAIN) Action plans Appendix 3 - Training Needs Analysis Appendix 4 - Transitional Care Action Plan Appendix 5 - Thematic review of Early Notification cases Appendix 6 - 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 steady. Safety action 8 (training) is still challenging and is proactively being managed. The last training session is on 28th November and this is when compliance with this standard will be evident. This report requires a number of documents to be approved to meet CNST standards, these are listed below:

- The transitional care action plan (Safety Action 3)
- The Q1 & Q2 action plans related to ATAIN (safety action 3)
- The action plan for the use of short term locums (safety action 4)
- The action plan for the engagement of long term locums (safety action 4)
- The action plan to meet the BAPM standards for neonatal nursing workforce (safety action 4)
- The local training need analysis (safety Action 8)

Included in this paper is the details of the thematic analysis undertaken by NHS Resolution on the early notification case from 2017-2023. The response submitted on 13th November demonstrates that the organisation had already undertaken work related to these themes. Full details are included in the paper and appendices.

The service is non-compliant with BAPM nursing requirements but has an action plan in place to meet this requirements. Work is ongoing to improve transitional care for eligible babies, and their families.

Midwifery staffing has increased with 29 newly qualified midwives starting on 16th October 2023, recruitment of midwives is ongoing. The service continues to provide 1:1 care in labour and any red flag events are proactively managed.

Medical staffing remains stable, and consultants have attended in person when required. The service is non-compliant with compensatory rest for medical staff but has an action plan in place to address this. The service has a robust plan in place to ensure that all locums have a certificate of eligibility before working the service.

The service is continuing to make progress with all the national guidance, and where it is non-compliant has action plans in place to meet the recommendations.

Attached are several appendices to read in conjunction with the board paper, please see the table below;

Appendix	
1	Q2 Perinatal Mortality Review Tool (PMRT) Summary report
2	Q1 & Q2 Avoiding term admissions into neonatal units (ATAIN) Action plans
3	The Learning Needs Analysis
4	The action plan for transitional care
5	The Response to the thematic review undertaken by NHS Resolution
6	The Perinatal Surveillance Dashboard

Please also note that the Maternity and Newborn Safety Investigations (MSNI) programme has now come into effect, hosted by the CQC and replacing Health Services Investigation Bureau for maternity/neonates.

Recommendation:	For the Trust Board of Directors to take assurance from the detail provided within this Maternity and neonatal report.			
Action Require:	~~Approval~~	~~Review and discussion/ give guidance~~	**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:	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:	6th October 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

November 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 were two stillbirths in October.

1.2 Neonatal Deaths

There were no neonatal deaths in October.

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

Two cases were closed in October, the draft MSNI report has been received for one case and both cases have been moved to report writing stage.

Enclosed as an attachment is the quarter 2 summary report (Appendix 1).

Table 1 - PMRT

	2020 MBRACCE report	Annual rate at DBTH	Rolling rate for DBTH	Quarter 2 (adjusted)	Quarter 1 (adjusted
Stillbirths	3.33 per 1000	4.45 per 1000	2.64 per 1000	2.53 per 1000	0.91 per 1000
Neonatal deaths	1.53 per 1000	1.81 per 1000	0.66 per 1000	0.84 per 1000	

There were no issues identified by the reviews as relevant to the deaths.

However for learning from PMRT reviews the table 2 below describes the issues identified, and the actions planned.

Table 2 - Identified Learning PMRT

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
The baby had to be transferred elsewhere for the post-mortem	2	No action entered
		No action entered
It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home	1	No action entered
Review of bloods prior to sending home if any are rejected or abnormal for repeat / review	1	WHATS HOT, email and ward briefs to remind staff to review blood results prior to sending patient home
The risk allocation of this mother based on her history at booking was incorrect	1	Education and learning to be shared
The type of care this mother was booked for was inappropriate for her risk allocation at booking	1	No action entered
This mother was not assessed but in retrospect she was high risk and should have been prescribed aspirin	1	Education and learning to be shared
This mother's progress in labour was monitored on a partogram but the partogram was only partially completed	1	WHATS HOT and email reminders for staff to complete the partogram for all losses
This mother's progress in labour was not monitored on a partogram	1	Education and learning to be shared

1.4 CNST Compliance for PMRT

Table 3 - CNST compliance

Requirements	CNST requirement compliance	CNST Trust Compliance
a) All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. For deaths from 30th May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death.	**100%**	**100%**
b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30th May 2023 onwards.	**95%**	**100%**

c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 30th May 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.	**95%**	**100%**
	60%	**66.6%**
d) Quarterly reports should be submitted to the Trust Executive Board from 30th May 2023.		**Q1 submitted and presented** **Q2 for submission after approval in divisional meeting on 10th November**

2. Neonatal Services

Neonatal staffing is 88% recruited with 81% of establishment at work, with 6% maternity leave. The Qualified in Speciality ratio is below the 70% standards at 64% on the Neonatal Unit (NNU). During October we had 84% of shifts resourced within British Association of Perinatal Medicine (BAPM) standards compared to a quarter 2 average of 75% at DRI and 59% at Bassetlaw. The majority of these shifts had the number of registered nurses for clinical care but were missing a supernumerary 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 acknowledged and it was agreed to support the development of a phased business plan to be submitted to Trust Capital Investment Group and included in the divisions business planning requirements for 2024/25. This was reported to Trust Board in October.

The Local Maternity and Neonatal Service (LMNS) and Operational Delivery Network (ODN) will be undated on the action plan and its progress.

Proposed investment for Meeting BAPM standards

Year	Investment	Total funding
2023-2023	increase clinical roles to 25% uplift at SCBU and NNU	67,865.76
2024-2025	Quality roles on SCBU and coordinator at night NNU	217,133.97
2025-2026	24 hour coordinator for SCBU at night	310,252.37
2027-2027	AHP at recommendations	201,056.73
total investment		796,308.84

No new serious incidents or Maternity and Newborn Safety Investigation Programme (MSNI) 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 neonates on both sites. Work to review neonatal consultant cover including planned absences is ongoing in relation to a historic Serious Incident (SI) with a paper going to the Capital Investment Group in November 2023.

2.1 Avoiding Term Admissions into Neonatal Units (ATAIN)

Term admissions to the neonatal unit remain below both the national (6%) and regional (5%) thresholds. An overarching action plan is in place (please see the attached document in appendix 2). This has been submitted in this paper for approval and oversight of the Trust Board. The board level safety champion and non-executive director have oversight of the ATAIN work.

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

Executive summary

Table 4 - MSNI cases

Cases to date	
Total referrals	23
Referrals / cases rejected (1 declined by parents)	6
Total investigations to date	18
Total investigations completed	18
Current active cases	1
Exception reporting	0

In October there was 1 MSNI qualifying incident however the parents declined MSNI referral after counselling. Case referred for awareness however without parental consent MSNI will not investigate. Duty of Candour has been undertaken, including information given about MSNI.

3.1 Reports Received since last report

The service has received one report in draft from MSNI.

3.2 Current investigations

No further cases identified.

3.3 Maternity and Newborns Safety Investigations (MSNI) / 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)

There is one internal investigation that has commenced into a neonatal fractured humerus after a shoulder dystocia and manoeuvres undertaken to deliver the baby.

5. Training Compliance

The service is proactively managing training, with staff allocated to training sessions and individual follow up for anyone who does not attend training. This is monitored by the CNST and Ockenden oversight committee. The Maternity Incentive Scheme has published an amendment to the standards for safety action 8. The requirement to declare compliance has been changed from >90% to > 80% with an action plan to achieve >90% within 12 weeks from 1st December 2023. Currently the trajectories demonstrate that this will be achieved and therefore the risk rating on the risk register has been reviewed and downgraded to 12. The reporting trajectories and tables below still use the 90% metric.

The training position on 31st October 2023 was:

K2 E learning package and Cardiotocograph (CTG) Study Day

Table 5 - K2 & CTG figures

Staff Group	K2 CTG Compliance	Study Day Compliance
90% of Obstetric Consultants	**73.3 % ↑**	**86.6% ↑**
90% of All other Obstetric Doctors including trainees	**75 % →**	**50%→**
90% of Midwives	**84.1% →**	**62.5% ↓**
90% of Bank & NHSP Midwives	**82.9%↓**	**59.5% ↑**

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

Table 6 - PROMPT figures

Staff Group	Prompt Compliance
90% of Obstetric Consultants	**80% ↑**
90% of All other Obstetric Doctors including trainees	**71% ↑**
90% of Midwives including NHSP & agency	**75.34% ↓**
90% of NHSP & agency Midwives	**84.6% ↑**
90% of Maternity Support Workers	**79.71% ↑**
90% of Obstetric Anaesthetic Consultants	**65% ↓**

Newborn Life Support (NLS) Training

Table 7 - NLS figures

Staff Group	NLS Compliance
90% of neonatal consultants or paediatric consultants covering neonatal units	**73%**
90% of neonatal junior doctors	**92%**
90% of neonatal nurses (Band 5 7 above)	**93%**
90% of advances neonatal practitioners (ANNP's)	**100%**
90% of Midwives	**93.3 % ↑**

The local training needs analysis has been included as appendix 3 in this paper for approval by the board. This three year plan sets out how the Core Competency Framework version 2 will be implemented in the maternity and neonatal services.

6. Service User Feedback

The maternity and neonatal voices partnership (MNVP) continue to work with the services to make changes. They work particularly closely with the Equity and Equality lead midwife and local groups.

The Picker (CQC) maternity survey 2022 action plan is progressing, and the results of the 2023 survey have been received but are currently embargoed.

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

None.

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

Work is continuing of the Year 5 CNST standards, with oversight from the CNST and Ockenden Oversight Committee.

The LMNS are holding regular "confirm and challenge" meetings with trusts in relation to progress against achieving CNST year 5, the report from the October visit is awaited. The next visit is planned for 16th November 2023.

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 data from July's submission has been received which is used for the year 5 CNST submission, and the Trust achieved all the standards (5/5).

For safety action 3 enclosed is the action plan (appendix 4) to move forward with transitional care pathways for babies from 34 weeks. Transitional care pathways assist in keeping babies that need additional care with their parent rather than being cared for in a neonatal unit. This action plan needs to be approved by the Trust Board.

For safety action 6 (saving babies lives care bundle version 3) the service is currently on trajectory to be 70% compliant by 1 Feb 2024 and fully compliant by March 2024.

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 and Director of Midwifery have met with the maternity incentive scheme team and agreed a pause in further work / submission until March 2024. This will allow the service to concentrate on year 5 CNST. A meeting has been scheduled for February 2024 to recommence reviewing the year 2 submission. Further to this meeting the Trust has resubmitted the KPMG audit report to the MIS team undertaken in 2019 to provide assurance to the Board regarding the year 2 submission.

Following the Trust's declaration of non-compliance with year 3 CNST a thematic analysis was undertaken by NHS Resolutions of all the cases reported from 2017 to 2023, as part of the early notification scheme (ENS). There were 14 cases reviewed from the 6 years as described in the table below;

Table 8 - ENS case review

Year	No. of cases	Incident rate by birth rate	EN national average rate
2017/18	4	0.08%	0.12%
2018/19	5	0.11%	0.13%
2019/20	2	0.04%	0.1%
2020/21	0	0%	0.06%
2021/22	2	0.04%	0.04%
2022/23	1	0.02%	No data yet

The thematic analysis reviewed 13 cases, where themes for learning and also good practice were identified. Due to the time elapsed following the cases, much work has already been undertaken on many of the themes identified in the recommendations, the details of which can be viewed in appendix 4.

The service has already undertaken much work to address these areas, please see the paper for full details. To complement this work the service has commissioned work from Paul Furey to assist in developing better working relationships and a culture. Also eight members of the senior team have completed the Perinatal Quadrumvirate Culture and leadership Course and are commencing work with the national team on culture.

Finally cross referencing the claims, incidents and complaints with the findings of the thematic review from NHSR confirms that the Trust patient safety incident review plan themes match. This will support the service and aid with learning within the maternity service using this framework going forward.

9. The response requested by NHS resolution on the thematic analysis of the early notification case from 2017 to 2023 has been submitted (appendix 5)

9.1 Board Level Safety Champion

The next safety champion visit is planned 23rd November 2023. Following on from the last visit the following has been addressed:

- A meeting was held to discuss the staff concerns about supporting the newly qualified midwives on 10th October 2023. This was a positive meeting where staff discussed their concerns, and the senior team shared plans in place to support this transition time.

9.2 Culture, Leadership & SCORE survey

The service has received its SCORE survey results and are currently working through them with the national team. The response rate was lower than hoped for at 34%. To be representative of the staff view the lowest response rate is suggested to be 40%. However the service plans to cross reference with the staff survey result as they contain similar questions.

A session is planned for 9th November to go through the results and identify areas that require further exploration. This will be facilitated session by NHSE with the obstetrics, midwifery, business and neonatal representation from the quadrumvirates.

10. Perinatal Surveillance dashboard

Most of the metrics on the surveillance dashboard remain stable (Appendix 6).

Pre term birth rates at Doncaster have increased in month, this will be monitored and if it continues to increase a ‘deep dive’ will be undertaken. There is a clinic already in place for women at risk of preterm birth to provide enhanced ante-natal care.

11. Midwifery staffing

The newly qualified midwives commenced on 16th October and have a comprehensive preceptorship programme with agreed supernumeray and education time. There are a further 2 WTE newly qualified midwives who will commence in January 2024, and 4.2 WTE more experienced midwives commencing in the next couple of month is various roles. The service now has the greatest number of midwives in post since the director of midwifery commenced in post in January 2019. The service will continue to recruit midwives until it has achieved the birthrate plus® recommendations.

The midwifery incentive will cease on 13th November 2023 once the newly qualified midwives have completed their supernumerary time. The staffing levels are proactively managed via weekly roster reviews, and day to day operational management. The service will continue to use NHSP in the first instance or agency midwives to ensure that safe staffing levels are maintained at all times.

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

Doncaster - 100%
Bassetlaw - 100 %

The labour ward coordinator has remained supernumerary 100% on the Bassetlaw site and has not been supernumerary on one occasion on the Doncaster site where mitigating actions were taken to resolve this within a short period .

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 October 2023.

Table 9 Doncaster BR+ © data

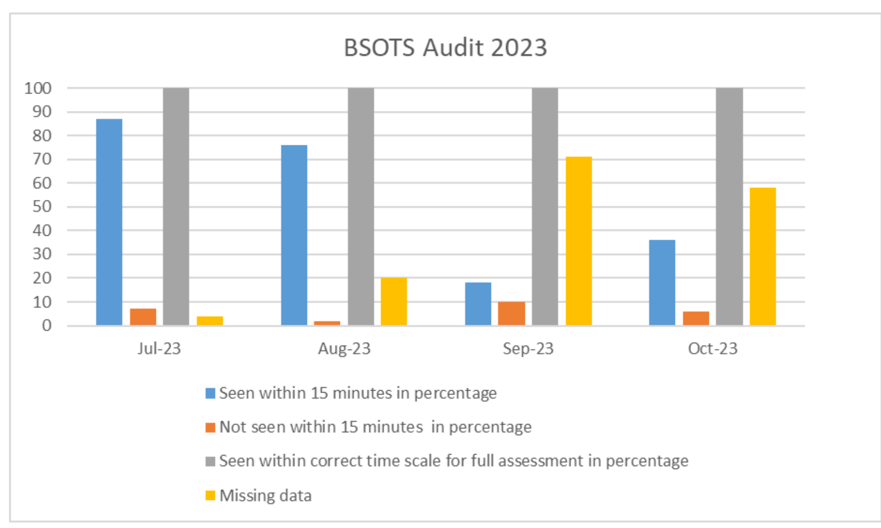
Red Flag	Number of times
Delayed or cancelled critical time activity	6
Delay between admission and commencing induction	2
Coordinator unable to maintain supernumeray status – providing 1:1 care	1
Management Actions taken	
Redeploy staff internally	13
Utilise on call midwife	2
Staff unable to take allocated breaks	1
Unit on divert	11
Escalate to Manager on call	5

Table 10 Bassetlaw BR+ © data

Red Flag	**Number of times**
Delay between admission and commencing induction	4
Management Actions taken	
Redeploy staff internally	4
Unit of divert	1
Escalate to Manager on call	2

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 continues to see 100% of the attendees within the correct timescales set in BSOT guidance. Staffing in triage is managed on the twice daily huddles, to ensure that safe staffing levels are in place. All calls to triage are centralised on the Doncaster site, and families are directed to the most appropriate site for the care they require (Doncaster or Bassetlaw).

12. Medical Workforce

The service has undertaken an audit of short and long term locums used to ensure that they hold the certificate of eligibility. There was one occasion in the six month period where the locum did not possess the certificate. Therefore an action plan has been developed to meet the requirements, this requires board sign off.

An audit of short term locums has been undertaken between February 23 - August 23 and identified there was one episode of non-compliance. In March a waiver was completed for a locum that did not have a certificate of eligibility. It was communicated after the shift had been worked that a waiver cannot be completed. Going forward to address this it has been agreed on the Locum Agency Framework that doctors who do not have 100% compliance cannot be booked. The action plan to address the non-compliance is detailed below:-

Standard	Action	Responsible Individual	Completion date
No waivers for compliance to be submitted to the agency	All doctors booked to work through the agency must be 100 % compliant	Rota Team/Holt Doctors	Ongoing

Ongoing monthly monitoring of compliance is continuing. In September and October there were no episodes of non-compliance.

The Trust Board is asked to note this position and agree the action plan to address any lapses.

An audit of engagement of long term locums has also been undertaken between February 2023 - August 2023 and ongoing monthly monitoring of compliance is continuing.

From this audit it was identified that improvements to the process for booking long term locums need to be made as detailed below:-

Standard	Action	Responsible Individual	Completion date
Discussion with locum doctor re clinical capabilities by consultant lead prior to starting or on appointment	Consultant on call to discuss clinical capabilities with doctor when reporting for shift rather than a discussion prior to booking	Consultant On Call	Ongoing
Supernumerary clinical duties undertaken with appropriate direct supervision	Locum to be booked for day time hours prior to working out of hours when booked for long term bookings	Rota Team	Ongoing

These actions will apply to any new locum bookings from November 2023 onwards. The Trust Board is asked to note this position and agree the action plan.

The standard operating procedure for compensatory rest has been completed and was ratified by the division on 17th October 2023. The service is currently non-compliant with this and an action plan is in place that was shared in October board papers.

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

Weekly rotas for the anaesthetic medical workforce are collated to evidence ongoing compliance with the Anaesthetic Clinical Services Accreditation (ASCA) standard 1.7.2.1. Following a review the Trust meets the relevant British Association of Perinatal medicine (BAPM) national standards of the neonatal medical workforce and asks the Trust Board to formally record this in the minutes.

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.

The Trust Board are also asked to approve the following contained in this report;

- The transitional care action plan (Safety Action 3)
- The Q1 & Q2 action plans related to ATAIN (safety action 3)
- The action plan for the use of short term locums (safety action 4)
- The action plan for the engagement of long term locums (safety action 4)
- The action plan to meet the BAPM standards for neonatal nursing workforce (safety action 4)
- The local training need analysis (safety Action 8)

PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Report of perinatal mortality reviews completed for deaths which occurred in the period:

1/7/2023 to 30/9/2023

1. Introduction

This is a quarterly report produced by the Children and Families Division and will be reported to the Perinatal Mortality and Morbidity Divisional Meeting, the Trust Mortality Governance Committee and the Trust Board. The report details the use of the National Perinatal Mortality Tool (PMRT) in the review of all:-

- Late Fetal losses 22+0 to 23+6
- All antepartum and intrapartum stillbirths from 24+0 onwards
- All neonatal deaths from 22+0 to 28 days after birth
- All post-neonatal deaths where the baby is born alive from 22+0 but dies after 28 days following care in a neonatal unit; the baby may be receiving planned palliative care elsewhere (including at home) when they die.

(Termination of pregnancies (TOP) for abnormality and babies with a birth weight under 500gms if gestation is not known at birth, are excluded.)

In accordance with the requirements of the Clinical Negligence Scheme for Trusts (CNST) – NHS Resolution, all stillbirths and Neonatal deaths eligible for review using the PMRT from 30th May 2023 up to and including the 7th December 2023 will be part of Quarterly Reports submitted to the Trust board and will include details of all deaths reviewed and consequent action plans.

This report also documents whether the required standards within Safety Action standard 1 have been met. These standards have recently been revised and the requirements differ according to when the loss occurred.

The Health Care Safety Investigation Branch (HSIB) will also review cases where a specific criteria has been met following consent from the family. Where the review has been accepted by HSIB this will be highlighted within the quarterly report.

Babies who meet HSIB criteria include all babies born at least 37 completed weeks of gestation, who have one of the following outcomes:

- **Intrapartum stillbirth**: where the baby was thought to be alive at the start of labour but was born with no signs of life.
- **Early neonatal death**: when the baby died within the first week of life (0-6) days of any cause.

The definition of labour used by HSIB is

- Any labour diagnosed by a health professional, including the latent phase of labour at less than 4cm cervical dilatation.

Report Generated by: Rhian Morris
Date report generated: 26/10/2023 09:51

- When the mother called the maternity unit to report any concerns of being in labour, for example (but not limited to) abdominal pains, contractions, or suspected ruptured membranes (waters breaking).
- Induction of labour (when labour is started artificially).

This report focuses on births from 24+0 weeks' gestational age, with the exception of the chapter on mortality rates by gestational age, which includes information on births at 22+0 to 23+6 weeks' gestational age. This avoids the influence of the wide disparity in the classification of babies born before 24+0 weeks' gestational age as a neonatal death or a fetal loss. **All terminations of pregnancy have been excluded from the mortality rates reported.**

2. Trust Stillbirths And Late Fetal Losses From 22 Weeks Gestation

The latest MBRRACE Report for births 2020 gives a national stillbirth rate of 3.33 per 1000, a minimal decrease from the 3.35 figure for 2019 births. This figure is calculated from births at 24 weeks or over, and excluding terminations of pregnancy.

The Trust annual stillbirth rate for 2022 **from 24+0 weeks** of pregnancy and above across both sites is to 4.45 stillbirths per 1,000 births. In numerical values this was 20 stillbirths. During this same period from **22 weeks of pregnancy to full term** there were in addition to the 20 stillbirths there was 1 late fetal loss, and 6 terminations of pregnancy (TOP).

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

During the second quarter of 2023-2024, from 1st July 2023 to 30th September 2023 there has been **3** stillbirths of the 1,184 births across both sites. 792 births being at DRI and 391 Births being at BDGH.

There have been **0** late fetal losses between 22+0-23+6 weeks gestation during this quarter. During the same timescale, there have been **0** MTOP's.

This provides a trust adjusted stillbirth rate of **2.53 per 1000 births for this quarter 2**, from 24 weeks gestation; which is an increase from last quarter (quarter 1 2023-2024 adjusted stillbirth rate of 0.91 per 1000 births).

Combining the figures from Quarters 3 and 4 of 2022-2023 and quarters 1 and 2 of 2023-2024 the rolling adjusted stillbirth rate is **2.64** per 1000 births. This equates to 12 stillbirths from 24 weeks of gestation (total births for this period is 4,546 for both sites). This rate excludes 1 late fetal loss between 22+0 and 23+6 weeks gestation, and 2 MTOP (all between 22+0 and 23+6 gestation) during the same time period.

3. NEONATAL DEATHS

The latest MBRRACE Report for births 2020 gives a national neonatal death rate of 1.53 deaths per 1,000, a reduced rate compared to the 2018 rate of 1.53 per 1000 the previous year. The rate is calculated for births over 24 weeks and includes deaths to 28 days.

Deaths that are included in the Trust rates are those of babies that were born and died within the trust. The Trust annual 2022 stabilised and adjusted rate for 2022 was 1.81 per 1000.

<u>During the second quarter of 2023-2024</u>, from 1st July 2023 to 30th September 2023 there has been 1 Neonatal and post-Neonatal deaths of the 1,184 births across both sites. 792 births being at DRI and 391 Births being at BDGH.

This provides the Trust with a stabilised and adjusted rate for this <u>quarter 2 of 2023-2024</u> of 0.84 per 1,000.

Combining the figures from Quarters 3 and 4 of 2022-2023 and quarters 1 and 2 of 2023-2024 (excluding the deaths under 22+0 and MTOP resulting in NND) <u>the rolling adjusted</u> neonatal and post-neonatal deaths rates of 3 equates to a rate of **0.66** per 1000 births from 24 weeks of gestation (total births for this period is 4,546 for both sites).

MBRRACE is informed of all neonatal deaths from 20 weeks gestation, only those above 22+0 weeks and weighing more than 500g meet the criteria for PMRT review however during this quarter the PMRT members felt the review of two babies that did not meet this criteria was for review, these are not including in the trusts annual or quarterly statistics. The Team felt that because the trust was in front of projected timescales (for those that met the criteria) that there was sufficient time to review these cases.

Requirements	CNST requirement compliance	CNST Trust Compliance
a) All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days. For deaths from 30 May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death.	**100%**	**100%**
b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards.	**95%**	**100%**
c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 30 May 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.	**95%**	**100%**
	60%	**66.6%**
d) Quarterly reports should be submitted to the Trust		**Q1 submitted and presented**

Executive Board from 30 May 2023.		**Q2 for submission after approval in divisional meeting on the 10th November**

The following pages are regarding the details, themes and grading's of the cases discussed through PMRT

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *4*

Summary of reviews**

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in Progress	Reviews Completed ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
3	0	0	3	0

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal death reported	Not supported for Review	Reviews in Progress	Reviews Completed ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
1	0	1	0	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACEUK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Deaths following termination of pregnancy are excluded.

** Post-neonatal deaths can also be reviewed using the PMRT

*** Reviews completed and have report published

**** Cases reviewed when clinically not supported for review

Report Generated by: Rhian Morris
Date report generated: 26/10/2023 09:51

Case ID **(SB)**	Date	Gestation	Antenatal/ Intrapartum	Initial review findings	PMRT and investigation /review outcome
88276		28+4	Antenatal		Care graded: A, B Review Outcome: Discussions taken place around the use of magnesium sulphate and whether this should have been considered in the postnatal period.
88683		29+0	Antenatal		Care Graded: B, B Review Outcome: Inappropriate allocation at booking resulting in aspirin not being prescribed in the antenatal period. This did not affect the outcome. Partogram not utilised
89353		26+1	Antenatal		Care Graded: B, B Review Outcome: Fibroids noted on dating scan, but not referred to CLC at that point. Subsequently referred to CLC with low Hb where growth scans then requested. Bloods not reviewed and actioned in a timely manner.

Case ID **(NND)**	Date	Gestation / age	Initial review findings care until the birth of the baby	Initial review findings of care of the baby	PMRT and investigation /review outcome
89358		Born at 37+2 weeks RIP 18 days old	Planned LSCS, birth weight 2100g. Known complex and multiple congenital abnormalities. ReSPECT form completed		Care graded: To be presented at Nov perinatal meeting. Review outcome:

Social, economic and deprivation data (SB)		Gestational age at birth						
		Unknown	**22-23**	**24-27**	**28-31**	**32-36**	**37+**	**Total**
Age	<18							
	19-25				3			
	26-35							
	36-45							
	46+							
Smoking status	Never smoked				1			
	Non-smoker stopped before conception							
	Non-smoker stopped after conception				1			
	Smoker				1			

Ethnicity	White				2			
	Black							
	Asian				1			
	Chinese/other							
	Mixed							
IMDD	1-4				3			
	5-8							
	8-10							
Employment	Employed				1			
	Not employed				2			
	Homemaker							
	Sick							
Marital status	Married				1			
	Single							
	Cohabiting				2			
English is their first language	Yes				2			
	No				1			
Learning or communication difficulties	Yes							
	No				3			

Social, economic and deprivation data (NND)		Gestational age at birth						
		Unknown	**22-23**	**24-27**	**28-31**	**32-36**	**37+**	**Total**
Age	<18							
	19-25							
	26-35							
	36-45		1					
	46+							

Smoking status	Never smoked		1					
	Non-smoker stopped before conception							
	Non-smoker stopped after conception							
	Smoker							
Ethnicity	White							
	Black							
	Asian		1					
	Chinese/other							
	Mixed							
IMDD	1-4		1					
	5-8							
	8-10							
Employment	Employed		1					
	Not employed							
	Homemaker							
	Sick							
	Not stated							
Marital status	Married		1					
	Single							
	Cohabiting							
English is their first language	Yes							
	No		1					
Learning or communication difficulties	Yes							
	No		1					

Table 1: Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 2)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late Fetal Losses (<24 weeks)	0	0	--	--	--	--	0
Stillbirths total (24+ weeks)	0	0	1	2	0	0	3
Antepartum stillbirths	*0*	*0*	*1*	*2*	*0*	*0*	*3*
Intrapartum stillbirths	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Early neonatal deaths (1-7 days)*	0	0	0	0	0	0	0
Late neonatal deaths (8-28 days)*	0	0	0	0	0	0	0
Post-neonatal deaths (29 days +)*	0	0	0	0	0	0	0
Total deaths reviewed	0	0	1	2	0	0	3
Small for gestational age at birth:							
IUGR identified prenatally and management was appropriate	0	0	0	0	0	0	0
IUGR identified prenatally but not managed appropriately	0	0	0	0	0	0	0
IUGR not identified prenatally	0	0	0	2	0	0	2
Not Applicable	0	0	1	0	0	0	1
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	0	1	2	0	0	3
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Parental perspective of care sought and considered in the review process:							
Yes	0	0	1	2	0	0	3
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Booked for care in-house	0	0	0	0	0	0	0
Mother transferred before birth	0	0	0	0	0	0	0
Baby transferred after birth	0	0	0	0	0	0	0
Neonatal palliative care planned prenatally	0	0	0	0	0	0	0
Neonatal care re-orientated	0	0	0	0	0	0	0

*Neonatal deaths are defined as the death within the first 28 days of birth of a baby born alive at any gestational age; early neonatal deaths are those where death occurs when the baby is 1-7 days old and late neonatal death are those where the baby dies on days 8-28 after birth. Post-neonatal deaths are those deaths occurring from 28 days up to one year after birth

Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 2)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late fetal losses and stillbirths							
Placental histology carried out							
Yes	0	0	1	2	0	0	3
No	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	1	2	0	0	3
Hospital post-mortem declined	0	0	0	1	0	0	1
Hospital post-mortem carried out:							
Full post-mortem	0	0	1	0	0	0	1
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	1	0	0	1
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	0	0	0	0	0	0
No	0	0	0	0	0	0	0
Death discussed with the coroner/procurator fiscal	0	0	0	0	0	0	0
Coroner/procurator fiscal PM performed	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	0	0	0	0	0
Hospital post-mortem declined	0	0	0	0	0	0	0
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive PMpost-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	1	0	0	1
All deaths:							
Post-mortem performed by paediatric/perinatal pathologist*							
Yes	0	0	1	1	0	0	2
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	0	1	2	0	0	3
No	0	0	0	0	0	0	0

*Includes coronial/procurator fiscal post-mortems

Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation

Role	Total Review sessions	Reviews with at least one
Chair	3	100% (3)
Vice Chair	2	66% (2)
Admin/Clerical	4	100% (3)
Bereavement Team	9	100% (3)
Community Midwife	0	0%
External	6	100% (3)
Management Team	7	100% (3)
Midwife	33	100% (3)
Neonatal Nurse	5	66% (2)
Neonatologist	6	66% (2)
Obstetrician	24	100% (3)
Other	5	100% (3)
Risk Manager or Governance Team	20	100% (3)
Safety Champion	1	33% (1)

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths *

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	0	0%
Admin/Clerical	0	0%
Bereavement Team	0	0%
Community Midwife	0	0%
External	0	0%
Management Team	0	0%
Midwife	0	0%
Neonatal Nurse	0	0%
Neonatologist	0	0%
Obstetrician	0	0%
Other	0	0%
Risk Manager or Governance Team	0	0%
Safety Champion	0	0%

*No reviews for relevant criteria during this quarter.

** Table four is yet to be populated as the final report has not been approved by Sheffield teaching hospitals as it is a shared PMRT case where by the baby was born at Sheffield Teaching Hospitals and died at DBTH

Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 2)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0	0	0	1	0	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	1	1	0	0	2
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	1	2	0	0	3
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
NEONATAL AND POST-NEONATAL DEATHS							
Grading of care of the mother and baby up to the point of birth of the baby:							
A - The review group concluded that there were no issues with care identified up the point that the baby was born	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the baby from birth up to the death of the baby:							
A - The review group concluded that there were no issues with care identified from birth up the point that the baby died	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following the death of her baby	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 2)

Timing of death	Cause of death
Late fetal losses	**0 causes of death out of 0 reviews**
Stillbirths	**3 causes of death out of 3 reviews**
	Unknown
	Early onset IUGR and PET
	The cause of death was undetermined
Neonatal deaths	**0 causes of death out of 0 reviews**
Post-neonatal deaths	**0 causes of death out of 0 reviews**

Table 7:Issues raised by the reviews identified as relevant to the deaths reviewed, by the number of deaths affected by each issue* and the actions planned

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned

None – highlighted

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

Report Generated by: Rhian Morris
Date report generated: 26/10/2023 09:51

Table 8: Issues raised by the reviews which are of concern but not directly relevant to the deaths reviewed, by the number of deaths in which this issue was identified* and the actions planned

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
The baby had to be transferred elsewhere for the post-mortem	2	No action entered
		No action entered
It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home	1	No action entered
Review of bloods prior to sending home if any are rejected or abnormal for repeat / review	1	WHATS HOT, email and ward briefs to remind staff to review blood results prior to sending patient home
The risk allocation of this mother based on her history at booking was incorrect	1	Education and learning to be shared
The type of care this mother was booked for was inappropriate for her risk allocation at booking	1	No action entered
This mother was not assessed but in retrospect she was high risk and should have been prescribed aspirin	1	Education and learning to be shared
This mother's progress in labour was monitored on a partogram but the partogram was only partially completed	1	WHATS HOT and email reminders for staff to complete the partogram for all losses
This mother's progress in labour was not monitored on a partogram	1	Education and learning to be shared

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

Table 9: Top 5 contributory factors related to issues identified as relevant to the deaths reviewed, by the frequency of the contributory factor and the issues to which the contributory factors related

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors

None – highlighted

Core Competency Framwework Version 2 Training Needs Analysis

Core Competency Framework TNA

Date of agreement by LMNS each year:

Save new TNA each year, or as per any changes to show any developments

INSERT DATE: (Can attach meeting minutes here)	INSERT DATE: (Can attach meeting minutes here)	INSERT DATE (Can attach meeting minutes here)
Year 1 (INSERT DATE)	Year 2 (INSERT DATE)	Year 3 (INSERT DATE)

Core Competency Module	Minimum standard	Stretch Target - Ambition/Aspiration	Training details			Monitoring system	Trust Compliance %	Mitigation/Action Plan	Predicted staff expenditure perinatal team (WTE/Annum)									
			Year 1	Year 2	Year 3				Attend (Y/N)	Midwives	Attend (Y/N)	Maternity Care Assistants	Attend (Y/N)	Obstetricians	Attend (Y/N)	Anaesthetists	Attend (Y/N)	Theatre Staff
									Total cost/year WTE									
1. Saving babies Lives care bundle	90% attendance – annually for each element with eLfH module every 3 years Training must include learning from incidents, service user feedback and local learning Training must include local guidelines and care pathways E-learning can be appropriate for some elements. Learning must be responsive to local clinical incidents and service user feedback	≥95% attendance Shared learning from incidents across LMS and Buddy LMNS relating to morbidity & mortality. Benchmarking against other organisations with similar clinical profile and national programmes Staff evaluation on quality of training in place with evidence of improvement Service users share their experiences as part of training day Use of positive case examples to learn from Training to be tailored to role and place of work for each element.	Smoking in Pregnancy. Reduced Fetal Movements Governance, 90% Included within PROMPT training and REST days (attach programme). Focus - language and communication	Pre-term 90% Service user Focus: Postive Safety Culture - Area specific plus focus within MDT Training (subject to amendment pending local case reviews/incidents	Scanning, Detection plus Diabeties SBLCB Completion all elements 95% Case review specific -'Tea Trolley Training'. Focus - Live Drills	Training to be added to ESR System compliance matrix. eLfH certificates to be uploaded to ESR and personal file. Monitored via ward managers. Escalated to governance team.		Current systems not reporting accurate compliance with SBLCB elements. To discuss at speciality governance meeting to agree process and recovery action plan. All new starters to be allocted time during induction period. Communicate requirements for training (annual elements) overarching completion of all elements to be completed within 3 years .	Please record data against module elements									
Smoking in Pregnancy	Training must include:- All multidisciplinary staff trained to deliver Very Brief Advice to women and their partners NCSCT e-learning Local opt-out pathways/protocols, advice to give to women and actions to be taken. CO monitoring & discussion of result. Individuals delivering tobacco dependence treatment interventions should be fully trained to NCSCT standards	Smoke-free advisors have evidence-based behavioural training (i.e. CBT/Risk perception) Use of service user case study Every Contact Counts training Evidence of Specialist smoke-free advisors sharing briefings and national publications i.e. Maternal and Neonatal Health Safety Collaborative. Action on Smoking and Health (ASH) briefings for Integrated Care Systems	Maternity Staff trained to deliver Very Brief Advice to women and their partners NCSCT e-learning. https://elearning.ncsct.co.uk/vba REST DAY - Local Learning - Smoking in the population. Local Smoking in pregnancy and SaToD rates and impact on Service Provisions including local prevalence and demographic characteristics and pregnancy.	NCST online Vaping Training for Professionalshttps://elearning.ncsct.co.uk/vaping-stage_1REST Day- NRT, PGD, provisions and local pathways Focus -Audits/ Case review and learning from incidents.	Every contact Counts Training https://portal.e-lfh.org.uk/Component/Details/432821. REST Day - Smoke Free TDA advisors; Case studies and service user feedback Focus - Service user/holistic care. Feedback 15 steps of service user with lived experience	eLfH - training certificates to be uploaded ESR. REST Attendance Register. Team leaders to monitor compliance. Monthly Assurance Reports to Governance. Work Maternity and Education department to devise process for escalation		. If not achiving minimum target, All staff to complete VBA as mandatory training allocated by team leader. Staff not completing this element will be emailed and supported to book a further training day. New Starters to complete as part of preceptorship package. Self- Assessment and self directed learning to be completed by staff unable to attend face to face sessions.	Y	£5,498 0.12	Y	£1,013 0.04	Y	£2,451 0.03	N	£0 0.00	N	£0 0.00
Fetal Growth Restriction	Training must include:- local referral pathways, identification of risk factors and actions to be taken. Evidence of learning from local Trust detection rates and actions implemented Include symphysis fundal height measuring, plotting & interpreting results practical training and assessment, and case reviews from examples of missed cases locally	Use of service user case study Review of trust's detection rates, compared to other similar organisations and national data Audit of compliance against training action plan developed as a result of incidents related to fetal growth restriction	Midwives - Fundal Hight Measurement - assessment to be completed annually plus eLfH . SET days present -Current local pathways and trust detection rates. Obstetric Team Audited and Presented at GROW 2.0 Training	As per yeart 1. Plus case study and learning from incidents Scanning - Requesting and Reviewing doppler studies (online learning to be developed) as per RFM	To be confirmed - Evaluate Action Plans from incidents. To include obsteric Team for Yr one Learning from audits (including Induction of labour)	Monitor via SET day register. To transfer data to ESR - includes fundal height measurement		Compliance not currently reported. Process to cross reference with SET day attendance to be completed for 2023/24. Agree monitoring process to be developed for Yr 2 and Yr 3. If not achieving targets to liaise with LMNS for peer support	Y	£5,498 0.12	N	£0 0.00	Y	£2,451 0.03	N	£0 0.00	N	£0 0.00
Reduced fetal movements	Training must include:- Local pathways/protocols, and advice to give to women and actions to be taken. Evidence of learning from case histories, service user feedback, complaints and local audits	Use of service user case study Audit of compliance against training action plan developed as a result of incidents related to fetal movements	eLfH Additional tea trolley teaching	Face to Face training on REST Day. Update on RCOG RFM Guideline and local pathways. Engage with MNVP for service user feedback/case study triangulated with audits and complaints. Scanning - Requesting and Reviewing doppler studies (online learning to be developed)	Themes and trends via IRM meetings. Physiology, risk assessment and scanning pathways. Scenario based presentation and discussion	ELFH to be monitored by ward managers. Registers to be uploaded to ESR		All midwives to complete E learning to be completed on maternity induction All midwives attend REST day. Clinical educator to monitor. Ward managers to roster teams to study day	Y	£5,498 0.12	N	£0 0.00	Y	£2,451 0.03	N	£0 0.00	N	£0 0.00
Fetal monitoring in labour	See Module 2	See Module 2	K2 Training All elements. Assessment min standard 85% pass	K2 Training All elements. Assessment min standard 85% pass	K2 Training All elements. Assessment min standard 85% pass	Fetal monitoring leads - report compliance through education team and governance		Email all staff. Fetal monitoring leads to submit monthly compliance reports to team leaders.	Please record data in Module 2. Fetal Surveillance in labour (Below)									
Preterm birth	Training must include:- Identification of risk factors, local referral pathways, All elements in alignment with the BAPM/MatNeoSIP optimisation and stabilisation of the preterm infant pathway of care A team-based shared approach to implementation as per local unit policy Risk assessment and management in multiple pregnancy	Evidence of impact using the improvement strategies to optimise preterm birth outcomes Use of clinical simulations Review of outcomes in relation to multiple births & identified improvement(s) Use of service user case study	Face to face training REST day. Local pathways. Speculum Training - Premature labour/SROM (area specific)	eLfH. Include on NALs and PROMPT Focus on Infant Feeding (IFT Training Day)	Review demographic and bespoke training for women at place. Evidence on impact of IOL and emotional/cognitive development of neonate Pre-Term - PNMH and personalised care planning	Speculum Training Competency Register (Area Specific). REST day attendance. System to include eLfH training on ESR		Online teaching and self -declaration with competency assessment	Y	£8,247 0.18	Y	£1,519 0.05	Y	£3,676 0.04	Y	£1,059 0.01	Y	£846 0.02
Diabetes in pregnancy	Training must include:- identification of risk factors and actions to be taken referral through local multidisciplinary pathways including Maternal Medicine Networks and escalation to endocrinology teams Intensified focus on glucose management in line with NHS Long Term Plan & NICE guidance, including Continuous Glucose Monitoring Care of the diabetic woman in labour	Learning from local and national case reviews are disseminated Use of service user case study with diabetes in pregnancy	Diabetes and Endocrinology eLfH https://portal.e-lfh.org.uk/Component/Details/811857 REST Day - local pathways and maternal medicine . Face to Face training for outpatient staff to participate in CGM starts and Education with self Assessment/competency document	Introduction to Obesity https://portal.e-lfh.org.uk/Component/Details/41044 REST Day - Dietician and Diabetic Nurse; Empowering Healthy Lifestyles Feedback from incidents 2023/23 - Need to include Pre-conception Care - optimising subsequent pregnancy	Induction of labour, Care of diabetic women in labour, postnatal period, breastfeeding and the neonate. REST day - Service User Feedback, Case study and Audit Outcomes Training as per evaluation/staff feedback	Speculum Training Competency Register (Area Specific). REST day attendance. System to include eLfH training on ESR		Low compliance due to new standard within SBLB v 3. Consider Development of shared Training (local partner Trust) or LMNS online training resources to be completed by year 2/3 to support stretch targets.	Y	£5,498 0.12	Y	£1,013 0.04	Y	£2,451 0.03	N	£1,059 0.01	N	£0 0.00
2. Fetal monitoring and surveillance (in the antenatal and intrapartum period)	90% attendance Annual Update. All staff will have to pass an annual competency assessment that has been agreed by the local commissioner (CCG) based on the advice of the Clinical Network. Trusts should agree a procedure with their CCG for how to manage staff who fail this assessment. (Pass mark of 85%) 1 full day training in addition to the local emergencies training day Fetal monitoring lead trainers must attend annual specialist training updates outside of their unit Training must:- Be responsive to local clinical incidents, service user feedback and local learning, utilising local case histories. Include use of risk assessment at start of and throughout labour complying with fetal monitoring guidelines. Include antenatal fetal monitoring, intermittent auscultation and electronic fetal monitoring. Be tailored for specific staff groups e.g. Homebirth or birth centre teams Be multi-disciplinary & scenario-based. Include information about using the equipment that is available Include the fetal surveillance of multiple pregnancies Include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMNS.	≥95% attendance ≥95% pass mark/evaluation Use of positive case examples to learn from Shared learning across LMNS & Buddy LMNS. Benchmarking against other organisations with similar clinical profile and national programmes. Evidence of MDT case scenario discussions & shared with wider team to increase accessibility Evidence of improvement following staff evaluation on training when ≤95% feedback is evaluated as good or excellent Lead specialists are in collaboration with the national network of fetal monitoring specialists to support own learning, practice developments & evidence based care Wider training i.e. on neonatal HIE & nervous system physiology Intrapartum midwives attend additional high level training to support fetal monitoring knowledge on the ABC programme when available Independent external evaluation of local training	Annual attendance at face to face training plus K2 and completion of competency assessment. Evidence service user engagement (feedback from MNVP monitoring inlabour/telemetry) To include all elements of fetal monitoring. MDT approach. Weekly OCR training	As per year one. Fetal monitoring leads to attends specialist external training. As per yr 1 plus compulsory attendance at OCR x 1 per year. Evlaution and training	As per year one plus HIE and nervous system physiology Buddy/peer review of training within LMNS	All attendees and completed tarining logged on ESR. K2 E learning and face to face study day is recorded by fetal monitoring lead and non attendees escalated to department mangers and HOMe		E learning (K2 training) to be completed on maternity induction. Face to face training for Dr's impacted by industrial action and roatation All midiwves and doctors to attend on face to face study day. Attandance monitored through governance group	Y	£49,482 1.11	N	£0.00 0.00	Y	£22,054.77 0.24	N	£0.00 0.00	N	£0 0.00
3. Maternity Emergencies and multiprofessional training	90% of each relevant maternity unit staff group has attended an "in-house" MDT training day & include a minimum of 4 maternity emergencies with all scenarios covered over a 3-year period and priorities based on locally identified training needs Antepartum and postpartum haemorrhage Shoulder dystocia Cord prolapse Maternal collapse, escalation and resuscitation Pre-eclampsia/eclampsia severe hypertension Impacted fetal head Uterine rupture Vaginal breech birth Care of the critically ill patient Annual update Training should be face to face (unless in exceptional circumstances such as the Covid Pandemic) Training must:- Include the identification of deteriorating mother/baby and use of MEWS/MEOWS/NEWTT charts as locally relevant Include communication, escalation of care & use of tools such as SBARD Be sensitive and responsive to local safety insights, near misses or HSIB cases. Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan	≥95% attendance Shared learning across LMNS or network Use of positive case examples to learn from Programme of clinical simulations at point of care in variety of settings including community and evidence of learning, actions, feedback & debrief Staff evaluation on quality of training in place with evidence of improvement if ≤95% feedback is evaluated as good or excellent	All relevant staff members to attend training as per the minimum requirements. n locally identified training needs. Correct identification of deterioration of woman and effective escalation and SBAR communication. Year one topics include APH, shoulder dystocia, cord prolapse, maternal collapse, escalation and ABLS, vaginal breech birth, annual update, communication and SBAR, physchological safety and human factors, inequalities, uterine rupture and APH of non english speaking woman in the clinical area	As per year one. - Use of positive case studies to learn from. - Year two include antepartum and postpartum haemorrage, shoulder dystocia, cord prolapse, maternal collapse, pre eclampsia/ eclampsia, impacted fetal head, uterine rupture, vaginal breech and care of the criticall ill patient as prioritised on locally identified needs. - Training will have communication, psychological safety and civility threaded through the day. Community PROMPT to commence in year 2 and continue to year 3.	As per year one and two. - Topics include antepartum and postpartum haemorrage, shoulder dystocia, cord prolapse, maternal collapse, pre eclampsia/ eclampsia, impacted fetal head, uterine rupture, vaginal breech and care of the crititcall ill patient as prioritised on locally identified needs.	Monitored by ESR/OLM registers. E learning is recorded by evidence of certificates and retrospectively added to ESR Managers have 'manager acces's on ESR to see individual staff compliance. All attendance/non attendance on training recorded via ESR and for those who do not attend		Face to face delivery of the training delivered for all new starters to the Trust within 2 months of start dates. Training compliance impacted by industrial access Monitoring compliance CNST oversight	Y	£43,984	Y	£8,104	Y	£19,604	Y	£8,473	Y	£6,770

	Use service user comments or feedback from investigations Maternal & Neonatal outcomes using exemplars from national programmes i.e. National Maternity Perinatal Audit (NMPA); Getting it Right First Time (GIRFT); Healthcare Safety Investigation Branch (HSIB) Include at least one scenario from a learning from excellence case study. Be tailored for specific staff groups e.g. Homebirth or birth centre teams/ maternity support worker (MSW). Include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. Include human factors training. Include at least one of the emergency scenarios to be conducted in the clinical area, ensuring full attendance from the relevant wider multi-professional team. This will enable local system and environmental factors within the clinical setting to be considered, any risks and issues identified and an action plan developed to address these.		Face to face training day with Case studies are developed from locally identified themes include human factors	co production of local training with MNVP /service user feedback community training to be based from local incidents	Attend LMNS learning events evalutate improvement utilising feedback to inform training	training- all are investigated and reported to the line manager in the first instance. Further escalation via divisional management structure and reported via Divisional, Speciality and Educational Governance.		comittee and governance meetings . Regular review of candidate evaluations and faculty delivery of programme		0.98		0.28		0.22		0.08		0.16
4. Equality, Equity and Personalised Care	90% attendance (3 yearly programme of all topics) Training should cover local pathways and key contacts when supporting women & families. Training must include learning from incidents, service user feedback and local learning Must include local guidance, referral procedures and 'red flags' One topic from each list must be covered as a minimum, identified from unit priorities, audit report findings and locally identified learning, involving aspects of care which require reinforcing and national guidance:- List A Ongoing antenatal and intrapartum risk assessment and risk communication Maternal mental health Bereavement Care List B Personalised Care and Support Planning (including plans when in use locally) Informed decision making, enabling choice, consent & human rights Equality & Diversity with cultural competence	≥95% attendance Involving MNVPs/Service Users in coproducing and/or delivering training based on lived experiences. Service user feedback gained from Personalised Care and Support Plans (PCSP) audits are embedded into training Use of positive case examples to learn from Benchmarking against other organisations with similar clinical profile and national programmes Training on learning disabilities & Autism that is maternity specific is embedded in personalised care training Equality & diversity training includes unconscious bias; LGBTQ Risk assessment & risk communication includes genetic risk Staff evaluation on quality of training in place with evidence of improvement where ≤95% feedback is evaluated as good or excellent Yearly training on any subject Stakeholder support i.e. SANDS involved in supporting delivery of training	Rest Day 1) Equity and Equality Lead Midwife; National Reports and EDI agenda, Cultural Bias, Local Data/profile . 2) Maternal Mental Health (PNMH Midwives), Redflags, Pathways Service user feedback, referrals and assessments 3) Bereavement Care (Bereavement Midwives) eLfH. NBCP, Culturally sensitive bereavement care. Feedback from incidents 4) Personalised Care Plans - what good looks like	Rest Day 1) Equity and Equality Lead - Risk Assessment. How inequalities and deprivation can impact on outcomes. (Thresholds) Wider determinents of health 2) Informed decision making - including barriers and how to overcome them (language, mental health, learning difficulties, cultutural needs)	(REST day) Protected Characteritics in maternity care and unconscious bias.	Evidence of eLfH and ESR. Reported to Governance Group. Escalation process tbc		E&E, Low initial compliance due to new standard within Core Competency, however presented during PROMPT. Personalised Care planning - awaiting LMNS online training. Presentation on trust maternity induction day. Monitor compliance monthly (Education reports and Ward assurance). Recovery plan to be agreed if not meeting trajectories for compliance - monitored in speciality governance . Regular review of staff evaluations and self assessment.	Y	£32,988	Y	£3,039	Y	£7,352	Y	£2,118	Y	£846
			LMNS Personalised Care Training. Staff and service user survey (personalised Care Plans)	LMNS Cultural Competency Training. Staff Survey 'Response to findings of inequalities within MBRRACE reports'	Becoming a trauma informed service and protecting human rights in pregnancy and birth (PROMPT)					0.74		0.28		0.08		0.02		0.02
5. Care during Labour and Immediate Postnatal Period	90% attendance (3 yearly programme of all topics) Training must:- Include learning from incidents, audit reviews and investigations, service user feedback and local learning Learning from themes identified in national investigations e.g. HSIB Have a focus on deviation from the norm and escalating concerns Include national training resources within local training e.g., OASI Care Bundle (obstetric anal sphincter injuries), RoBUST Operative Simulation Birth Course, prevention and optimisation of premature birth. . Be tailored for specific staff groups depending on their work location and role e.g. Homebirth or birth centre teams/ MSW Subjects must include:- Management of labour including latent phase VBAC (vaginal birth after caesarean) and uterine rupture GBS (Group B Streptococcis) in labour Management of epidural analgesia and recovery care after general anaesthetic Operative vaginal birth Pelvic Health & Perineal Trauma – prevention of & OASI pathway and PFMT Multiple Pregnancy Infant Feeding ATAIN (Avoiding Term Admissions into Neonatal Units).	>95% attendance of relevant staff group Shared learning across LMNS Use of positive case examples to learn from Benchmarking against other organisations with similar clinical profile and national programmes Staff evaluation on quality of training in place with evidence of improvement where ≤95% feedback is evaluated as good or excellent Use of service user case studies & service users to share their experiences	- management of epidurals in labour - pelvic health and repair of perineal trauma on clinical skills day - Infant Feeding session delivers update on hand expression, how to complete a feeding assessment, postioning and attachement as well as responsive bottle feeding.	-To include OASI in year 2 and 3 - Latent phase in labour training will include learning from incidents, audit reviews and investigations, local learning and service user feedback. - Multiple pregnancy will include learning from incidents, audit reviews and investigations, local learning and service user feedback. - ATTAIN training using national resources	- Shared learning from ATTAIN - GBS (group B Streptococcus) in labour training will include learning from incidents, audit reviews and investigations, local learning and service user feedback. - MNVP to coproduce training based on service user feedback -VBAC and operative vaginal birth will will include learning from incidents, audit reviews and investigations, local learning	Attendance monitored through PDM's, infant feeding team and clinical educators.		Escalated to managers in first instance Managers to ensure midwives and MSW's rostered onto study sessions. Low initial compliance as new core competency, programme for Year 1 (2023/24) commenced prior to publication	Y	£32,988	Y	£6,078	Y	£4,901	Y	£2,118	N	£0
			Infant feeding face to face study day , epidural and recovery after GA, pelvic health	Bespoke study for OASI Care bundle RESt study day Elearning	VBAC, GBS, operative vaginal delivery					0.74		0.21		0.05		0.02		0.00
6. Neonatal Basic Life Support	90% attendance at a neonatal basic life support annual update either as an in-house neonatal basic life support training or Newborn Life Support (NLS) Only registered RC trained instructors should deliver their local NLS courses and the in-house neonatal basic life support annual updates Training must:- Be 'hands-on' and scenario based and tailored to learning from incidents, service user feedback and local learning priorities. Include knowledge and understanding of NLS algorithm. Include recognition of the deterioration of black and brown babies Include recognition of deteriorating newborn, action to be taken and local escalation procedures, and the use of SBARD tool for handovers (or local equivalent). Include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. Include human factors. Be tailored for specific staff groups depending on their work location and role, e.g. Homebirth or birth centre teams/ MSW. Cover scenarios in different environments and must include training on use of the equipment available in those environments to ensure staff are familiar.	≥95% attendance Attendance on separate certified NLS training for maternity staff should be locally decided but this would be the gold standard with updates every 4 years. Evidence of MDT point of care simulation programme, attendance records and learning from them with innovative practices to ensure wide attendance from all staff groups/unsocial shifts/community staff Learning from national investigations & programmes e.g. HSIB & ATAIN Benchmarking against other organisations with similar clinical profile and national programmes Staff evaluation on quality of training in place with evidence of improvement plans where ≤95% feedback is evaluated as good or excellent Use of service user case studies and parents sharing their experiences including the use of positive case examples to learn from.	- All midwives to attend face to face training yearly to include minimum standard - Identified leads to deliver training and access training to support NLS training. - Review staff evalutaions	As per year one. Identify and allocate places on L4 training for locally decided midwives. Engage with service users and utilise personal experience to form part of training .	As per year one and two. Utilise information from national, local and trust HSIB /incidents to inform training requirements. Collaborate with MNVP to form training based on service users experience.	Training is monitored through the clincial educators and CNST oversight committee Department managers to roster staff members who are out of date. ESR updated		Monitored through CNST oversight committee Any team members not booked on course will be automatically booked by ward managers (clinical educators to provide information) Midwives out of date will need to complete to remain in clincial areas where they need to have the NLS skills	Y	£16,494	Y	£3,039	Y	£4,901	Y	£1,059	Y	£846
			Face to face training includes neonatal case scenarios designed to be relevant to the candidates attending the course. MDT of obstetrics, NNU and midwifery deliver simulations in the clinical areas across both sites.	As per year one staff evalutation to be included	Year to include face to face teaching scenarions developend through service user feedback and to include HB examples					0.37		0.11		0.05		0.01		0.02

Department inputs (table 1)		
	Annual Head Count	Annual Mid Point Salary
Midwives	240	£44,671.00
Maternity Care Assistants	69	£28,628.00
Obstetricians	53	£90,161.00
Anaesthetists	20	£103,269.00
Theatre staff	40	£41,257.00

Department Outputs (table 2)			
	Total AnnualCost	Total Annual WTE	Total hours training
Midwives	£206,174	5	38
Maternity Care Assistants	£23,805	1	24
Obstetricians	£72,291	1	30
Anaesthetists	£15,888	0	15
Theatre staff	£9,309	0	11
Total	£327,467		

Workbook and Sheet Passwords All = CCF

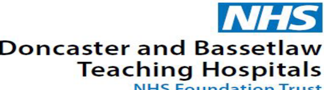
Table 3				
Training Module	Groups	Input Data	Outputs	
		Training Hour(s) per staff member per year (all blended learning to be added as a total)	Total Annual Cost	Annual WTE
1. Saving babies Lives				
Smoking in Pregnancy	Midwives	1	£5,498	0.12
	Maternity Care Assistants	1	£1,013	0.04
	Obstetricians	1	£2,451	0.03
	Anaesthetists	0	£0	0.00
	Theatre staff	0	£0	0.00
Fetal Growth Restriction	Midwives	1	£5,498	0.12
	Maternity Care Assistants	0	£0	0.00
	Obstetricians	1	£2,451	0.03
	Anaesthetists	0	£0	0.00
	Theatre staff	0	£0	0.00
Reduced fetal movements	Midwives	1	£5,498	0.12
	Maternity Care Assistants	0	£0	0.00
	Obstetricians	1	£2,451	0.03
	Anaesthetists	0	£0	0.00
	Theatre staff	0	£0	0.00
Fetal monitoring in labour (this will be the same as below)	Please record data in Module 2. Fetal Surveillance in labour (Below)			
Pre-term birth.	Midwives	1.5	£8,247	0.18
	Maternity Care Assistants	1.5	£1,519	0.05
	Obstetricians	1.5	£3,676	0.04
	Anaesthetists	1	£1,059	0.01
	Theatre staff	1	£846	0.02
Diabetes in pregnancy	Midwives	1	£5,498	0.12
	Maternity Care Assistants	1	£1,013	0.04
	Obstetricians	1	£2,451	0.03
	Anaesthetists	1	£1,059	0.01
	Theatre staff	0	£0	0.00
2. Fetal surveillance in labour	Midwives	9	£49,482	1.11
	Maternity Care Assistants	0	£0	0.00
	Obstetricians	9	£22,055	0.24
	Anaesthetists	0	£0	0.00
	Theatre staff	0	£0	0.00
3. Maternity emergencies	Midwives	8	£43,984	0.98
	Maternity Care Assistants	8	£8,104	0.28
	Obstetricians	8	£19,604	0.22

	Anaesthetists	8	**£8,473**	**0.08**
	Theatre staff	8	**£6,770**	**0.16**
4. Personalised Care	Midwives	6	**£32,988**	**0.74**
	Maternity Care Assistants	3	**£3,039**	**0.11**
	Obstetricians	3	**£7,352**	**0.08**
	Anaesthetists	2	**£2,118**	**0.02**
	Theatre staff	1	**£846**	**0.02**
5. Care during Labour and Immediate PN Period	Midwives	6	**£32,988**	**0.74**
	Maternity Care Assistants	6	**£6,078**	**0.21**
	Obstetricians	2	**£4,901**	**0.05**
	Anaesthetists	2	**£2,118**	**0.02**
	Theatre staff	0	**£0**	**0.00**
6. Neonatal life support	Midwives	3	**£16,494**	**0.37**
	Maternity Care Assistants	3	**£3,039**	**0.11**
	Obstetricians	2	**£4,901**	**0.05**
	Anaesthetists	1	**£1,059**	**0.01**
	Theatre staff	1	**£846**	**0.02**

Department inputs (table 1)		
	Annual Head Count	Annual Mid Point Salary
Neonatologists	52	£44,671.00
Neonatal Nurses	83	£28,628.00

Department Outputs (table 2)			
	Total AnnualCost	Total Annual WTE	Total hours training
Neonatologists	**£9,530**	**0.21**	**8**
Neonatal Nurses	**£9,748**	**0.34**	**8**
Total	**£19,278**		

Table 3				
Training Module	**Groups**	**Input Data**	**Outputs**	
		Training Hour(s) per staff member per year (all blended learning to be added as a total)	**Total Annual Cost**	**Annual WTE**
3. Maternity emergencies	**Neonatologists**	0	**£0**	**0.00**
	Neonatal Nurses	0	**£0**	**0.00**
6. Neonatal life support	**Neonatologists**	8	**£9,530**	**0.21**
	Neonatal Nurses	8	**£9,748**	**0.34**



Thematic review of Early Notification cases for DBTH

1. Background

Following the non-compliance with year 3 CNST a thematic analysis was undertaken by NHS Resolutions of all the cases reported from 2017 to 2023, as part of the early notification scheme. There were 14 cases reviewed from the 6 years as described in the table below;

Year	No. of cases	Incident rate by birth rate	EN national average rate
2017/18	4	0.08%	0.12%
2018/19	5	0.11%	0.13%
2019/20	2	0.04%	0.1%
2020/21	0	0%	0.06%
2021/22	2	0.04%	0.04%
2022/23	1	0.02%	No data yet

13 of the 14 cases were identified for inclusion in the thematic analysis, the 1 case was excluded because it did not meet the early notification criteria. Reviews were undertaken using the clinical records or a HSIB report if it was available.

2. Themes Identified by the review

A. Fetal Monitoring

Recommendation - The Trust should ensure that fetal monitoring in labour remains a priority for ongoing learning in all staff groups

Work already undertaken and ongoing

- Fresh eyes in place and audited
- Twice weekly obstetric case reviews in place for all staff to attend
- Weekly incident review learning sent to all staff
- Annual face to face fetal monitoring study day for all staff
- Annual e learning on K2 fetal monitoring training package in place
- Compliance with training reported to board monthly
- Monthly CNST oversight committee monitoring training compliance
- Training support in place for individuals if required
- Pastoral support / practice development midwives working in clinical areas to support all staff

B. Obstetric Emergencies

Recommendation - The trust should ensure that staff can recognise obstetric emergencies such as fetal bradycardia and cord prolapse based on staff mandatory training (e.g PROMPT)

<u>Work already undertaken and ongoing</u>

- PROMPT training already in place since 2019, using local cases and data to run localised scenarios. All staff attend training annually
- Adhoc unannounced skills drills undertaken in clinical areas with debriefing session afterwards for sharing of learning
- Compliance with training reported to board monthly
- Monthly CNST oversight committee monitoring training compliance
- Training support in place for individuals if required
- Pastoral support / practice development midwives working in clinical areas to support all staff

C. Ante-natal counselling

Recommendation - The trust is to ensure that staff are following national guidance and the Montgomery principles of consent when women are being counselled. Risks should be fully disclosed to women and supporting information provided in a format that they can understand.

<u>Work already undertaken and ongoing</u>

- The Montgomery ruling is included annually in the PROMPT study day together with training about consent
- Birthrights UK training offered Human Rights in maternity care funded and supported by the maternity voices partnership (MNVP)
- Work on going with the MNVP review leaflets, and information given in the maternity services (format, platform and language)
- Rebirth report (RCM) shared with all staff, and discussed at various meetings
- Completion of Personalised care plan audited and finding shared at governance meetings

D. Hyperstimulation

Recommendation - Prior to oxytocin being commenced for induction of labour women should be reviewed by an obstetrician and a holistic assessment performed.

Consideration of additional risk factors such as women receiving an induction of labour whilst attempting vaginal birth after caesarean section should also be considered.

<u>Work already undertaken and ongoing</u>

- VBAC guideline in place, and recently updates
- SOP for use of oxytocin in place and on intranet
- Twice daily multidisciplinary huddles in place
- Twice daily consultant ward rounds for all women in place and attendance audited
- SOP for Consultant ward rounds in place and on the intranet
- SOP for consultant attendance in place

E. Escalation

Recommendation - The trust should ensure that all staff feel able to escalate their concerns and that they are supported in doing this. This should include support for staff escalating concerns regarding fetal monitoring.

The trust should also ensure that junior obstetricians are supported in their decisions by a more senior obstetricians at all times especially when reviewing high risk patients on labour ward.

Work already undertaken and ongoing

- The service has implemented in the RCOG escalation toolkit
- Twice daily consultant ward rounds for all women in place and attendance audited
- SOP for Consultant ward rounds in place and on the intranet
- Guideline on managing differences of opinion on clinical care
- A freedom to speak up guardian visits maternity on a regular basis, and information about raising a concern is on the intranet
- The board level safety champion and non-executive director visit the clinical areas on a bi-monthly basis, on September visits the junior medical staff were prioritised for discussions
- SOP for consultant attendance in place

F. Delay in delivery

Recommendation - The trust is to ensure staff received appropriate training on human factors and that they are aware of confirmation bias whereby staff can think delivery is imminent when in fact an intervention is needed.

Work already undertaken and ongoing

- Human factors training is part of PROMPT study day
- In September 2021 further training given at the perinatal mortality meeting on all types of bias including conformation bias after an HSIB case
- All types of bias were included in the fetal monitoring study day including confirmation bias
- What's Hot newsletter (governance) also included learning about confirmation bias

G. Use of Interpreters

Recommendation - It is best practice to always use an interpreter either face to face or via a telephone interpreting service.

Work already undertaken and ongoing

- Interpreting services available and can be booked in advance for consultations
- Big word (telephone service) available
- Work ongoing with the MNVP and local communities to support

- New guideline going through approval for interpretation services

H. Women not attending appointments

Recommendation - The trust is to ensure that there are escalation plans in place when women miss multiple appointments. This should include the community midwife attending the women's home where necessary.

Work already undertaken and ongoing

- Guideline in place for DNA at appointments this includes community home visits, safeguarding team and health visitors.

3. Good Practice identified

- Shoulder dystocia managed well
- Women appropriately risk assessed in the ante-natal period and growth scans requested in line with national guidance
- Women booked for induction of labour appropriately and in a timely manner

4. Overarching work in the maternity service to support all the recommendations

HSIB Quarterly Review meetings

The service receives quarterly feedback and in October 2021 asked for a thematic analysis of the recommendations from the reports received. This has continued on the review meetings since, and this have informed changes / work to address the themes that have been identified from the HSIB cases.

In October 2021 the themes below were identified:

Context of recommendations

Escalation (4)	Risk assessment(3)	Staffing (3)
• **1903-538 (Mar 2020)** Emergency cascade bleep system is activated in the event of an obstetric emergency. • **2007-2270 (Apr 2021)** & **MI-003610 (Sept 2021)** Escalation process to the obstetric team when a CTG is difficult to interpret/concerns • **MI-003301 (Sept 2021)** Clear guidance to support managing IOL services including triggers to support robust escalation when delays occur	• **1903-538 (Mar 2020)** All mothers who book following a caesarean section to ensure that risks and benefits are discussed and documented • **1903-538 (Mar 2020)** Any mother having had a previous caesarean section has an agreed management plan documented regarding the birth of her baby. • **2010-2579 (Mar 2021)** Staff are supported to undertake a holistic risk assessment, including a CTG for high-risk mothers	• **1901-366 (Sept 2019)** Appropriate staffing levels on the postnatal ward to care for all mothers and babies • **MI-003610 (Sept 2021)** Staffing model enables the labour ward coordinator to remain supernumerary at all times • **MI-003610 (Sept 2021)** Junior staff & newly qualified clinicians have a personalised support plan in place to consolidate their skills and confidence

WWW.HSIB.ORG.UK

Context of recommendations

Clinical Assessment (3)	Clinical Oversight (3)	Fetal Monitoring (3)
• **1901-366 (Sept 2019)** full Breastfeeding assessment prior to discharge & ward handover to include the status and/or outcome of the assessment • **MI-003301 (Sept 2021)** Mothers with cumulative risk factors have an obstetric led individualised discussion about their risks • **MI-003301 (Sept 2021)** Staff are supported to make clinical assessments in real time, & are documented contemporaneously	• **1903-538 (Mar 2020)** Reliable system in place at the antenatal clinic so Mothers are seen at the correct time & by an appropriately experienced clinician • **1912-1573 (Oct 2020)** Mothers - semi-recumbent position when holding baby & are informed of the risks of bed-sharing with their baby when they are excessively tired • **2007-2270 (Apr 2021)** If multiple tasks occur at once, a member of the team maintains the role of a helicopter view' at all times	• **1903-538 (Mar 2020)** Trust guideline and electronic categorisation of the CTG during labour are consistent • **1903-538 (Mar 2020)** Fresh eyes review of a CTG during labour includes a documented assessment of the CTG • **2012-2795 (May 2021)** IA is carried out in line with national guidance ensuring early consideration is given to monitoring a baby's heart rate using CTG when A is not possible.

This informed all the work that has been described above, and this work continues today.

5. <u>Cultural Work and Relationships</u>

Eight members of the team (2 x quadrumvirate) have completed the perinatal Quadrumvirate Culture and Leadership development programme. The service has completed the SCORE survey in September 2023, and are currently working through the results.

All the senior midwifery team, and specialist midwives will have undertaken their Insights profiles and a workshop to understand their preferred styles and how that affects other members of the team.

The service has action plans in place from the staff survey 2022, and plan to use the SCORE survey and staff survey 2023 results together to identify ongoing work.

The organisation has funded training for all the multidisciplinary team around relationships and having difficult conversations. This work is ongoing with regular bite size face to face training sessions.

6. <u>Patent safety incident Response Plan (PSIRF) and the future</u>

The service has cross referenced themes from the incidents, claims and complaints within the service from 2022 and 2023 scorecards. This has been reviewed against the proposed PSIRF to ensure that all the themes are included in the plan going forward (see below);

Claims	**Complaint themes**
Fail / Delay in treatment Fail / Delay in diagnosis Fail in ante natal screening Fail to respond to an abnormal fetal heart rate Intra operative problem	Communication (written & verbal) Care Staff Behaviours / attitudes when in conversation with service user Informed choice / lack of/ issues with documentation being changed Caesarean section Miscellaneous Investigations Medicines Induction of labour Perinatal mental health / bereavement Anaesthetics
Incidents	**PSIRF Draft safety themes**
Postnatal Delivery Oral nutrition Antenatal Sodexo food service issues Images for diagnosis (scans/ x-ray/photo) Test results / reports Communication between staff, teams and departments Capacity issues Red Flag	Access, admission, assessment and transfer of care Communication and documentation Assessing and responding to and escalating the deteriorating patient Medication Recognising and responding to behaviours of concerns Falls Pressure Ulcers Infection prevention and Control (IPC)

The maternity service has been a key stakeholder in the PSIRF implementation group and is involved in the trust development and implementation. All PSIRF plans are being reviewed by the LMNS once completed.

The planned date of commencement of PSIRF is 1st December 2023.

7. Conclusion

The service has a number of work streams that have been implemented, and work that is ongoing. The service continues to proactively seek themes and trends in data that can be used to undertake focussed work. There are systems and processes in place within the service to identify themes and monitor progress on actions using the governance structure.

NE&Y Regional Perinatal Quality Oversight Group Highlight Report

MW to birth ratio : BR+ recommendation 1::28.25		Vacancy rate (MW)	LW co-ordinator supernumerary (%)
Oct	1:24	12% (BR+)	99.9%

LMNS: South Yorkshire and Bassetlaw

Reporting period: October –December 2023 Q3

Overall System RAG:

(Please refer to key next slide)

Maternity unit DBTH – Doncaster

KPI (see slide 4)	Measurement / Target		Doncaster Rate Oct		Nov	Dec
Caesarean Section rate	Elective	<13.2 %	15.5%			
	Emergency	<15.2 %	36.1%			
Preterm birth rate	≤26+6 weeks	0	1			
	≤36+6 weeks	<6%	10.7%			
Massive Obstetric Haemorrhage	≥1.5l	<2.9%	5.2%			
Term admissions to NICU		<6%	3.39%			
3rd & 4th degree tear	SVD (unassist'd)	<2.8%	3.2%	1.7%		
	Instrumental (assisted)	<6.05 %	5.3%			
Right place of birth		95%	99%			
Smoking at time of delivery		<11%	13.2%			
Percentage of women placed on CoC pathway		35%	0%			
Percentage of women on CoC pathway: BAME / areas of deprivation	BAME	75%	0%	0 %		
	Area of deprivation		0%			

Month/Quarter		Red flag alert	Open > 30 days	Unactioned Datix	Maternity Serious Incidents	Maternity Never Events	HSIB cases	Still Births (All / Term / Intrapartum)			HIE cases (2 or3)	Neonatal Deaths Early	Neonatal Deaths Late	Notification to ENS	Maternal Mortality (direct / indirect)	
2022/2023	Oct	42	140	0	1	0	0	2	1	1	0	0	0	0	0	0
	Nov															
	Dec															
	Q3															

Maternity Red Flags (NICE 2015)

		Oct	Nov	Dec
1	Delay in commencing/continuing IOL process	34		
2	Delay in elective work	7		
3	Unable to give 1-1 care in labour	1		
4	Missed/delayed care for > 60 minutes	0		
5	Delay of 30 minutes or more between presentation and triage (LWAU)	0		

NE&Y Regional Perinatal Quality Oversight Group
Highlight Report

LMNS: South Yorkshire and Bassetlaw

Reporting period: October –December 2023 Q3

Overall System RAG:

(Please refer to key next slide)

Maternity unit | DBTH – Bassetlaw

KPI (see slide 4)3.9%	Measurement / Target		Bassetlaw Rate		
			Oct	Nov	Dec
Caesarean Section rate	Elective		11.3%		
	Emergency		33.1%		
Preterm birth rate	≤26+6 weeks	0	0		
	≤36+6 weeks	**<6%**	5.08%		
Massive Obstetric Haemorrhage	**≥1.5l**	<2.9%	6.5%		
Term admissions to NICU		<6%	0.84%		
3rd & 4th degree tear	SVD (unassist'd)	<2.8%	0 / 1.61 %		
	Instrumental (assisted)	<6.06 %	10.5% / 1.61 %		
Right place of birth		95%	100%		
Smoking at time of delivery		<11%	5.6%		
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 / 0	0 / 0

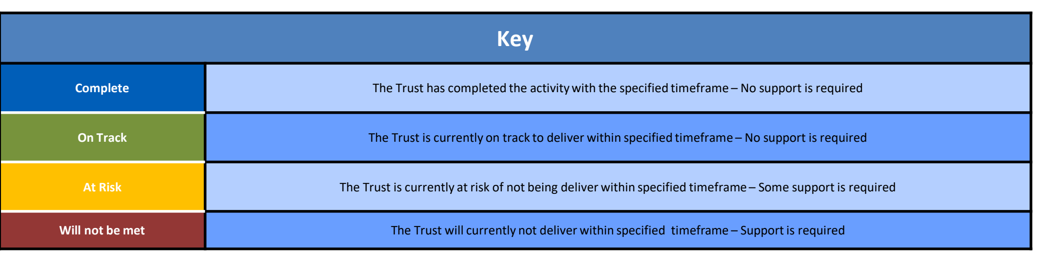
	Month/Quarter	Red flag alert	Open > 30 days	Unactioned Datix	Maternity Serious Incidents	Maternity Never Events	HSIB cases	Still Births (All / Term / Intrapartum)			HIE cases (2 or3)	Neonatal Deaths (Early / Late)		Notification to ENS	Maternal Mortality (direct / indirect)	
2020/2021	Oct	3	**39**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	Nov															
	Dec															

Maternity Red Flags (NICE 2015)

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

Assessed compliance With 10 Steps-to-Safety

		July	Aug	Sept
1	Perinatal review tool			
2	MSDS			
3	ATAIN			
4	Medical Workforce			
5	Midwifery Workforce			
6	SBLCB V3			
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		October			November		December	
		self assessment	LMNS	CNST 50% self assessment				
1	Reducing smoking	60%	0%					
2	Fetal Growth Restriction	85%	65%					
3	Reduced Fetal Movements	100%	50%					
4	Fetal monitoring during labour	60%	20%					
5	Reducing pre-term birth	59%	29%					
6	Diabetes	67%	50%					

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 (80% of Staff)	PROMPT	CTG			
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	October	AUGUST	SEPTEMBER
Freedom to speak up / Whistle blowing themes	None		
Themes from Datix (to include top 5 reported incidents/ frequently occurring)	Weight unexpectedly below the 10th centile PPH Shoulder dystocia Unexpected admission to NNU Staffing		
Themes from Maternity Serious Incidents (Sis)	1 serious Incidents declared in October for maternity iatrogenic fractured humerus in the management of a shoulder dystocia		
Themes arising from Perinatal Mortality Review Tool	October meeting		
Themes / main areas from complaints	Anaesthetic concerns Care delivery Attitude, behaviours and communication of staff		
Listening to women (sources, engagement / activities undertaken) CQC Women's Experience	MNVP attended Governance meeting and shared presentation around the co-production work that has been ongoing Working with audit and guideline midwife		
Evidence of co-production	Guideline production Governance meetings		
Listening to staff (eg activities undertaken, surveys and actions taken as a result)	Face to face staff engagement meetings on CDS Meetings with staff listening to suggestions for improvement within the service 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		

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)

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

2311 - D1 CHAIR'S ASSURANCE LOG - PEOPLE COMMITTEE

Discussion Item | Mark Bailey, Non-Executive Director | 10:25

5 minutes

REFERENCES

Only PDFs are attached

D1 - Chairs Assurance Log - People Committee.pdf

People Committee - Chair's Highlight Report to Trust Board

Subject:	**People Committee**	**Board Date: November 2023**
Prepared By:	Mark Bailey, Committee Chair & Non-executive Director	
Approved By:	People Committee Members	
Presented By:	Mark Bailey Committee Chair & Non-executive Director	
Purpose	The paper summaries the key highlights from the People Committee meeting held on Tuesday 7th November 2023	

Matters of Concern (Moderate, Partial or No Assurance)	**Work Underway / Major actions commissions**
Staff retention – return to work conversations – Moderate Assurance The internal assurance report recently received by and monitored through the Audit & Risk Committee were noted. The 3 medium recommendations agreed by management are to give clear guidance, training on sickness absence management and to agree a Trust wide approach for the recording of return-to-work interviews. Assurance was, however, taken that a high number of people (over 80%) were having return to work interviews. Recruitment time & Occupational Health Capacity Business cases Given the cost pressures for 2023/24, business cases are being revised for Corporate Investment Group in Q3/Q4 and outcomes will determine next steps for actions on recruitment and Occupational Health – risk/issues identified in earlier Chair Assurance logs.	People Strategy - Implementation & effectiveness The Integrated Performance Report (IQPR) dashboard will have additional People success measures incorporated using the outcomes of the staff survey. The indicators will be around the themes: we are compassionate and inclusive; we each have a voice that counts; we are always learning; we are a team; and Staff engagement. National comparisons with other acute providers will also be provided. Education A new DBTH Education Quality Framework (EQF) has been developed to clearly identify our expected education quality standards and future objectives which support the delivery of high-quality learning and education across DBTH. Violence and Prevention Standards - Partial Assurance The Committee took assurance from the report, however further evidence required of engagement on the implementation of the standards with the wider teams. The bi-annual report would return in 6 months, therefore a further update would be shared with the Committee. The Chair and Executive Lead to hold an offline conversation prior to this update for further assurance.
Significant or Full Assurances to Provide	**Decisions Made**
Board Assurance Framework 2023/4 - Significant Assurance Further review and confirmation of the approach and content of the refreshed Board Assurance Framework for People - Strategic Risk 2. People Strategy - Significant Assurance Comprehensive high-level summary of implementation of in-year actions in the strategy and forward view of the delivery plan activity. Linkage to operational performance measures and in year targets. Engagement & Leadership - Significant Assurance Detailed updates on range of actions to improve engagement, involvement, and leadership contributors to the experiences at work of all our people. Strong position in	Revalidation of Doctors The purpose of revalidation is to provide greater assurance to patients and the public, employers and other healthcare professionals that licensed doctors are up-to-date and fit to practise. The People Committee reviewed the annual report for medical revalidation and appraisal for 2022/23 and support the presentation of the Statement of Compliance to the Chief Executive for signature. People Committee Terms of Reference Approval of wording revision to reflect that the Committee work is structured to provide assurance against the 4 themes of the People Strategy.

participation numbers in the 2023 annual staff survey with a month to go. DBTH Way sessions and introduced into leadership programmes. Succession planning roll-out planned. Responses to an externally facilitated organisational-wide survey on health & wellbeing has given assurance that the health & wellbeing offer is having a positive impact on colleagues' wellbeing and their experiences of working at DBTH. Education - Significant Assurance Statutory compliance improvement to 86.5% (amber rating). Planned improvements to data quality, reporting efficiency and recovery action noted. The NHS England annual Self-assessment (SA) report shows compliance in all elements of the education contract. Equality, Diversity and Inclusion - **Significant Assurance** Detailed reports of delivery of actions within the EDI improvement plan and evidence from mandatory reporting, year on year improvements in NHS staff survey results. External validation from RSM UK Consulting acknowledging DBTH as a potential trailblazer organisation under the RACE Code accreditation. Widening Participation - **Significant Assurance** Continued high levels of school engagement, expanding work experience slots and apprenticeships (4.8% of workforce currently) and career outreach events with increased number of entry level roles and pre-employment opportunities. Improvement Projects - **Significant Assurance** Reward and recognition activity to relaunch long service awards, expansion of DBTH Star awards and increased regional and national professional award nominations. Nursing Workforce review & Safe Staffing - **Significant Assurance** Bi-annual establishment assessment report following June 2023 adult inpatient workforce review using Safer Nursing Care Tool and other methods to recognise complexity in care needs and ward layouts. No change to establishment numbers recommended with further focus on skill mix and effective rostering within divisions.	Speaking Up Strategy (Draft) The draft strategy was positively received and will be supported for submission to the Board for approval subject to a review of any additional clarification points from NEDs in the next two weeks. The Chief People Officer and the FTSU Guardian to discuss offline how the strategy links in with the Senior Independent Director role.

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.

2311 - D2 PEOPLE UPDATE

Discussion Item | Zoe Lintin, Chief People Officer | 10:30

10 minutes

REFERENCES

Only PDFs are attached

D2 - People Update.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	28 November 2023	**Agenda Reference:**	**D2**
Report Title:	**People Update**		
Sponsor:	Zoe Lintin, Chief People Officer		
Author:	Zoe Lintin, Chief People Officer		
Appendices:	N/A		

Report Summary

Executive Summary

There is a Board commitment and ambition to improve colleague experience and engagement across DBTH in line with our True North objectives to be in the top 10% in the UK for feedback from our colleagues and learners and to ensure everyone knows their role in achieving the vision.

This paper highlights some of the recent developments at DBTH and nationally, including progress being made against our People Strategy and plans in relation to cultural improvement, colleague experience, supporting our people and workforce development, including:

- National staff survey
- Flexible working
- Succession planning
- Reward and recognition - Long Service Awards
- Digital Staff Passport
- Leadership = new NHS England resources on expectations on line managers

The People Committee receives regular detailed progress reports and there are detailed delivery plans in place to support the People Strategy 2023-27.

Recommendation:	The Board is asked to note the actions being taken, the progress being made and to continue to support the work programmes described.			
Action Require:	~~Approval~~	~~**Review and 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 colleagues 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:	As presented at People Committee in November 2023

Risk register:	Existing workforce-related risks
Regulation:	-
Legal:	-
Resources:	-
Assurance Route	
Previously considered by:	Aspects considered within reports to Executive team, Trust Executive Group and People Committee
Date:	October/November 2023
Any outcomes/next steps	-
Previously circulated reports to supplement this paper:	-

1. Introduction

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

This report provides updates in relation to the following:

- National staff survey – current position with engagement in the 2023 survey and next steps together with national recognition in relation to our 2022 results
- Flexible working – update on this workstream, which is a theme within our People Strategy
- Succession planning – plans to introduce a new approach to succession planning at DBTH, as articulated in our People Strategy
- Reward and recognition – new Long Service Awards programme
- Digital Staff Passport – the Trust's involvement in wave 1 of this national project
- Leadership – new NHS England framework and resources in relation to expectations of line managers in relation to people management

2. National staff survey

2.1 National recognition on 2022 results

In November, the Chief People Officer received a letter from Em Wilkinson-Brice (National Director for People, NHS England) in connection with our 2022 staff survey results. The letter states "I wanted to reach out regarding your organisation's exemplary performance in the NHS Staff Survey 2022."

The letter continues "The 2022 results show you are one of the Trusts that has shown improvement in all 7 elements of the People Promise and the themes of Employee Engagement and Morale. This is a significant achievement, and we would like to celebrate this with you. Please find enclosed a certificate that I hope you can share across your organisation to recognise the hard work of your colleagues to improve staff experience in your organisation."

This communication and the message of thanks will be shared with colleagues through our appropriate channels.

2.2 2023 survey

The 2023 national staff survey went live on 27 September and closes on 24 November 2023. Our plans were successfully enacted prior to this time, to support engagement and encourage participation throughout the survey period, in line with our ethos of embedding a year round cycle of engagement. The spot prizes and vouchers available as a thank you to people for taking the time to participate have proved popular again. These are being allocating randomly and based on trust when confirmation is received from individuals that the survey has been completed.

Our ambition for this year was to strive to exceed our Trust record of a 65% response rate for the 2022 survey, which was one of the highest for acute trusts in the country last year. As at 17 November, our response rate was 65%.

When the survey results are made available next year, we will continue with the approach of engagement sessions and action planning which commenced in 2022 with positive feedback being received from managers and teams about this approach. The People & OD team developed a suite of resources and template documents to support managers with facilitating the engagement sessions and with action planning and these will continue to be available.

There will also continue to be a focus on embedding an approach of communicating improvements and changes made at a Trust-wide and local departmental/divisional level in response to survey feedback, to demonstrate 'you said, we (collectively) did'. The publication date for the national results will be confirmed nearer the time and it is usually in February or March.

2.3 Integrated Quality Performance Report (IQPR)

There was a request at the People Committee to build some national staff survey measures into the IQPR dashboard, in addition to existing metrics, as further indicators of engagement and colleague experience. This aligns with oversight of the ongoing delivery of our new People Strategy 2023-27. The Chief People Officer has discussed and agreed this with the Chief Finance Officer/Director of RIT (as the Executive lead for Informatics).

The following measures have been agreed as the most appropriate ones for inclusion, aligned with our People Strategy:

- We are compassionate and inclusive
- We each have a voice that counts
- We are always learning
- We are a team
- Staff engagement

The intention is the IQPR will include the Trust scores on each of these themes for the most recent survey, together with comparisons with acute providers nationally in-year and our own scores in the previous two years. The data will be updated on an annual basis in line with the publication of the national staff survey results. The request has been discussed with the Informatics team and it is anticipated that these will be included within the IQPR within the next two months.

3. Flexible working

Our commitment to embed a flexible working culture is articulated in our People Strategy and initial engagement events started last Autumn. A well-attended Qi event was held on Flexible Working in June 2023 to seek further engagement and shape the next stages in this project. Several people left their names to say they wanted to continue to be involved in progressing this work, which is encouraging.

The pillars within the Flexible Working workstream are as follows, each with a project lead:

- Policy development and data
- Flexible working options and toolkit
- Systems
- Retire and return/flexi-retirement

In addition, there is a 'Flexible stories and communications' strand which is led by a member of the Communications team and is woven throughout all the pillars, which will identify opportunities to share stories and update the wider organisation on changes as actions progress.

A Steering Group has now been established including the project leads, with the Chief People Officer as the chair to provide support and oversight. Key actions and activities to date include:

- All project leads have been following up with people who have expressed an interest in this work, to increase involvement in the project teams.

- Process and frequently asked questions guidance published in light of the recent changes on partial retirement from the NHS Pension Scheme with further work ongoing.

- Seeking stories to share about colleagues who have successfully retired and returned to work, with a positive impact for them and the service.

- Flexible Working policy has been refreshed and is going through the usual development and approval process. The new policy will be accompanied by a toolkit to support colleagues and managers with the application of the formal policy.

- Self-rostering pilots have commenced, building on learning from other areas where this approach has been in place for some time.

- Action plan built on Monday.com with progress monitored at Steering Group meetings.

- Second Qi session arranged for 27 November 2023.

4. Succession planning

A new succession planning grid template has been designed as part of our ongoing strategic work to introduce more robust talent management processes at the Trust. This template has been completed for the Executive Directors and shared with the Nominations and Remuneration Committee.

A briefing note has been written for use alongside the succession planning template. This new approach is currently being further tested with the Chief People Officer's senior leadership team as a pilot prior to rolling out more widely to divisional and corporate leadership teams in the next two months. The wider talent management approach is in the early design and development phase, drawing on learning from national resources and following discussions with colleagues in other organisations.

5. Reward and recognition – Long Service Awards

Our new Long Service Awards programme has been well received by colleagues and the celebration events are arranged across three dates in December 2023, at external venues close to our Doncaster, Bassetlaw and Montagu sites. Board members have been invited to attend to meet with and pass on their thanks to colleagues for their long service to the Trust and the NHS.

In total, around 250 colleagues are expected to join these recognition events with all guests having between 10 and 50 years NHS service.

6. Digital Staff Passport

The NHS Digital Staff Passport enables employees to move more easily between NHS organisations, reducing duplication of employment checks and some aspects of mandatory training. The Trust is involved in wave 1 of the roll out of the Digital Staff Passport, which initially focuses on:

- Postgraduate doctors in training rotations
- Temporary movements of other staff groups

There is a working group in place at the Trust who are meeting regularly. Small numbers of doctors in rotation are involved in the pilot stage and the plan is for the system functionality to be utilised for the December 2023 rotation. The national scope of this work is fairly limited initially, focusing primarily on doctors in training, and the intention is for this to be scoped to be extended to other staff groups in the future if these initial waves of implementation prove to be successful.

7. Expectations of line managers in relation to people management – NHS England resources

In November 2023, NHS England launched a new suite of resources designed to support the Future of NHS HR and OD report published in November 2021 and the more recent Messenger review. The new framework outlines expectations of line managers in relation to their roles and responsibilities in ensuring their colleagues feel valued, supported and cared for at work and throughout the employee life cycle. The framework is supported by a comprehensive collection of e-booklets, videos and masterclasses.

The Chief People Officer and her senior leadership team are currently reviewing these resources to ensure they are used and communicated in the most effective way at the Trust, to align with our People Strategy, the DBTH Way and our existing local resources. A further update will be provided at the People Committee meeting in January 2024.

8. Recommendations

The Board can be assured that actions are being taken to continue to enhance our approach to colleague experience and workforce development with ongoing cultural improvement linked to our True North ambitions, and that good progress is being made in different workstreams. The Board can also be assured that the People Committee is maintaining regular oversight of the delivery of our People Strategy.

2311 - D3 GUARDIAN OF SAFE WORKING QUARTERLY REPORT

Discussion Item Zoe Lintin, Chief People Officer & Dr Nick Mallaband, Acting Executive Medical Dire

Dr Anna Pryce, Guardian of Safe Working

10 minutes

REFERENCES

Only PDFs are attached

D3 - Guardian of Safe Working Quarterly Report.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	28 November 2023	**Agenda Reference:**	**D3**
Report Title:	**Guardian of Safe Working Quarterly Report**		
Sponsor:	Zoe Lintin, Chief People Officer		
Author:	Dr Anna Pryce, Guardian of Safe Working		
Appendices:	-		

Report Summary

Executive Summary

The number of overall and education-related Exception Reports (ERs) remains low, but there has been a small increase from August 2023 onwards when compared with previous months in 2023. This is despite a more positive outlook in terms of an increase in training posts and a decrease in rota gaps. Over the past 12 months, the majority of Exception Reports have been submitted by Trainees working in General Medicine and in General Surgery. However, since August 2023 there has been a more even spread of ERs across different specialties. The majority of ERs are submitted in relation to additional hours worked, reflecting the high workload of Junior Doctors, often compounded by rota gaps and inadequate locum provision, and unpredictable emergency care. There have been very few recent reports in relation to missed educational opportunities and only 12 over the past year.

The cost of 'locum' cover remained fairly stable over the 7 months to July 2023, despite Junior Doctor strike action. A decrease in 'locum' costs month on month observed from August 2023 onwards coincides with a significant decrease in Junior Doctor rota gaps. With the new intake of Junior Doctors in August, rota vacancies now stand at only 11% overall.

The Board of Directors can be assured that the vast majority of Trainee doctors are able to work safely. Junior Doctors are broadly able to access educational opportunities as envisaged in the 2016 contract, although this remains a challenge where high workload and rota gaps/sickness absence preclude attendance at planned teaching sessions and specialty clinics.

Recommendation:	The Board is asked to note and take assurance from the quarterly report.			
Action Require:	~~Approval~~	**Review and 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 colleagues 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:	New BAF format for July 2023
Risk register:	-
Regulation:	-
Legal:	-
Resources:	-

Assurance Route	
Previously considered by:	N/A
Date:	
Any outcomes/next steps	
Previously circulated reports to supplement this paper:	

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

Author: Dr Anna Pryce, Guardian of Safe Working

Report date: November 2023

Executive summary

The number of overall and education-related Exception Reports (ERs) remains low, but there has been a small increase from August 2023 onwards when compared with previous months in 2023. This is despite a more positive outlook in terms of an increase in training posts and a decrease in rota gaps. Over the past 12 months, the majority of Exception Reports have been submitted by Trainees working in General Medicine and in General Surgery. However, since August 2023 there has been a more even spread of ERs across different specialties. The majority of ERs are submitted in relation to additional hours worked, reflecting the high workload of Junior Doctors, often compounded by rota gaps and inadequate locum provision, and unpredictable emergency care. There have been very few recent reports in relation to missed educational opportunities and only 12 over the past year.

The cost of 'locum' cover remained fairly stable over the 7 months to July 2023, despite Junior Doctor strike action. A decrease in 'locum' costs month on month observed from August 2023 onwards coincides with a significant decrease in Junior Doctor rota gaps. With the new intake of Junior Doctors in August, rota vacancies now stand at only 11% overall.

The Board of Directors can be assured that the vast majority of Trainee doctors are able to work safely. Junior Doctors are broadly able to access educational opportunities as envisaged in the 2016 contract, although this remains a challenge where high workload and rota gaps/sickness absence preclude attendance at planned teaching sessions and specialty clinics.

Introduction

This report sets out the information from the Guardian of Safe Working with regards the 2016 Terms and Conditions for Junior Doctors to assure the Board of the safe working of junior doctors. This report is for the period 1st September 2023 to 31st October 2023, although data is presented for the preceding months for comparison. The Board should receive a quarterly report from the Guardian as per the 2016 contract, which will include:

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

• Details of fines levied against departments with safety issues

• Data on rota gaps, vacancies and locum usage

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

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

Table 1. Number of exception reports by month, 1 November 2022 to 31st October 2023.

Month	Complete	Pending	Total
November 2022	12		12
December 2022	1		1
January 2023	3		3
February 2023	10		10
March 2023	3		3
April 2023	4		4
May 2023	13		13
June 2023	7		7
July 2023	2		2
August 2023	19		19
September 2023	13	1	14
October 2023	13	1	14
Grand Total	**100**	**2**	**102**

There is seasonal variation in Exception Reporting (ER) with the highest number of monthly reports usually occurring during the winter months and also in August. The latter coincides with Foundation Year 1 (FY1) Doctors commencing work. This is likely due to a combination of awareness of exception reporting from Trust induction and adjusting to the demands of their workloads. In August 2023, there was a low proportion of unfilled junior doctor posts, making understaffing an unlikely cause of reporting. The number of reports in August 2023 was high compared with previous months, and this has remained the case in September and October.

Table 2. Number of exception reports by specialty, 1st November 2022 to 31 October 2023.

Specialty	2022-11	2022-12	2023-01	2023-02	2023-03	2023-04	2023-05	2023-06	2023-07	2023-08	2023-09	2023-10	Grand Total
Gastroenterology				7				2					**9**
General medicine	4		1	3	2	1	12	2		7	2		**34**
General surgery	5	1	1							6	2	5	**20**
Geriatric medicine								2					**2**
Renal Medicine												1	**1**
Accident and emergency										2	2	4	**8**
Obstetrics + gynaecology	3					1				1	3	4	**12**
Paediatrics							1	1					**2**
Respiratory Medicine										3	4		**7**
Acute Medicine			1										**1**
Palliative medicine						2							**2**
Vascular Surgery									2				**2**
Ophthalmology											1		**1**
Grand Total	**12**	**1**	**3**	**10**	**2**	**4**	**13**	**7**	**2**	**19**	**14**	**14**	**101**

Over the past 12 months, the majority of ERs have been submitted by Trainees working in General Medicine (34%) and in General Surgery (20%). In the most recent 4 months, there has been a more even distribution of ERs across General Surgery (13), General Medicine (9), O+G (8), A+E (8) and Respiratory Medicine (7). It should be noted that there are far more Trainees working in medical specialties than in any other hospital specialties (73 posts out of a total of 317 posts).

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

Table 3. Reason for submission of Exception Report, November 2022 to end of October 2023.

Additional Hours Worked	65
Change in pattern of work	3
Service Support	16
Educational opportunities	11
Breaks	6
Total	**101**

Over the past 12 months, the majority of ERs were submitted in relation to additional hours worked, reflecting the high workload of Junior Doctors and unpredictable emergency care requiring Juniors to stay late to ensure patient safety.

In the most recent 3 months, since the changeover of Junior Doctors in August, there have been 36 ERs due to additional hours worked, 4 due to missed breaks, 3 in relation to service support, 2 due to missed educational opportunities and 2 due to a change in work pattern.

b) Work schedule reviews

No work schedule reviews were requested within the last quarter.

c) Locum bookings

Locum and bank usage.

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

Table 4. Cost of locum and bank usage, January 2023 to October 2023.

Agency/Internal Bank	(All)

Specialty	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Grand Total
Acute Medicine	£139,787.20	£126,680.81	£105,432.13	£133,772.31	£123,141.13	£148,481.34	£164,054.63	£102,314.92	£85,631.08	£50,104.76	£1,179,400.31
Anaesthetics										£0.00	£0.00
Anaesthetics and Critical Care	£20,255.10	£10,690.16	£10,304.52	£13,241.02	£10,106.24	£11,651.24	£17,755.14	£20,391.42	£18,973.21	£12,103.82	£145,471.87
Anaesthetics and Maternity				£0.00	£0.00				£1,135.62		£1,135.62
Anaesthetics and Theatres	£51,545.23	£2,190.00	£4,183.24	£6,908.65	£1,494.08	£6,404.08		£4,911.38	£13,780.89	£7,102.78	£98,520.33
Cardiology (Medical)	£9,780.10	£8,394.60	£17,345.55	£11,965.85	£10,525.09	£11,680.83	£8,886.04	£2,373.26	£2,166.36	£1,105.00	£84,222.68
Care of the Elderly	£72,508.86	£42,334.82	£49,416.58	£31,485.61	£25,071.26	£32,621.47	£38,246.60	£22,716.50	£25,430.34	£30,503.96	£370,336.00
Clinical Haematology				£1,600.00		£1,200.00	£2,200.00	£2,160.00	£840.00	£1,260.00	£9,260.00
Dermatology	£1,050.00										£1,050.00
Emergency Medicine	£397,959.88	£336,619.09	£326,919.82	£321,077.02	£322,577.65	£268,656.05	£291,299.65	£274,301.56	£265,534.69	£299,320.91	£3,104,266.32
Endocrinology and Diabetes	£33,615.95	£22,780.10	£27,894.09	£19,870.74	£24,174.27	£27,776.78	£26,730.70	£20,359.74	£22,908.00	£18,413.28	£244,523.65
Endoscopy - Medicine							£800.00				£800.00
Endoscopy - Surgical	£3,400.00		£4,000.00	£2,400.00	£2,800.00	£1,600.00	£2,400.00	£400.00	£3,500.00		£20,500.00
ENT	£26,409.39	£25,760.00	£38,857.24	£34,178.12	£29,690.92	£36,022.76	£31,861.06	£31,485.44			£254,264.93
Gastroenterology	£15,603.04	£8,625.12	£2,536.80		£2,205.00	£4,515.20	£20,826.95	£26,785.73	£3,607.50	£3,875.00	£88,580.34
General Medicine	£10,560.94	£4,584.00	£8,841.60	£15,540.83	£11,326.40	£12,867.98	£10,315.20	£6,569.60	£0.00	£4,269.85	£84,876.40
General Surgery	£110,718.41	£95,345.41	£98,072.79	£46,166.69	£26,295.29	£46,909.98	£54,476.31	£45,672.08	£37,680.32	£7,851.01	£569,188.29
Genitourinary Medicine	£910.00										£910.00
Intensive Care				£5,237.96		£1,091.58	£3,021.00	£1,013.61	£650.00	£0.00	£11,014.15
Microbiology (Medical)	£1,600.00	£1,600.00	£3,200.00	£3,200.00	£3,200.00	£1,600.00	£3,200.00		£3,200.00		£20,800.00
Obstetrics and Gynaecology	£126,684.10	£99,794.54	£108,001.65	£122,601.39	£65,439.45	£91,036.23	£108,151.93	£101,629.45	£93,866.80	£53,727.76	£970,933.30
Ophthalmology	£500.00			£270.00							£770.00
Oral and Maxillofacial Surgery	£4,000.00										£4,000.00
Orthopaedic & Trauma for Emed	£22,237.61	£19,001.86	£29,507.77	£21,285.20	£17,218.26	£7,521.71	£8,549.80	£9,976.41	£3,063.80	£1,723.76	£140,086.18
Orthopaedic and Trauma Surgery	£139,781.65	£164,875.03	£208,450.79	£206,489.56	£203,091.83	£152,690.52	£148,465.98	£138,644.03	£76,981.29	£72,813.77	£1,512,284.45

Paediatrics and Neonates	£66,933.38	£87,181.38	£82,282.43	£94,454.22	£85,365.98	£113,034.78	£112,205.10	£88,902.94	£71,172.36	£35,210.02	£836,742.59
Renal Medicine	£13,942.50	£13,924.06	£16,383.90	£1,397.50	£350.00			£9,025.00	£7,766.00	£3,605.00	£66,393.96
Respiratory Medicine	£41,983.73	£38,283.97	£38,624.39	£16,303.30	£22,239.32	£22,506.98	£28,340.06	£14,645.01	£11,839.55	£20,539.35	£255,305.66
Stroke Medicine	£36,180.41	£29,517.76	£29,039.38	£23,130.13	£28,473.54	£39,024.18	£33,709.92	£17,619.34	£13,733.70	£13,340.10	£263,768.46
Urology	£14,284.50	£14,783.12	£25,269.80	£32,486.20	£12,109.10	£19,095.02	£32,491.37	£21,512.08	£29,125.00	£7,425.00	£208,581.19
Vascular Surgery	£0.00	£4,881.60	£9,038.26	£7,390.70	£1,690.00	£8,000.00	£19,022.10	£7,739.50	£19,453.26	£1,750.00	£78,965.42
Haematology							£1,499.58		£850.34	£5,573.11	£7,923.03
Paediatrics					£1,079.20				£0.00		£1,079.20
Breast Surgery		£8,064.00	£12,177.92	£7,248.80							£27,490.72
Diabetes				£1,260.00			£0.00				£1,260.00
Rehabilitation Medicine	£9,526.41	£5,793.84		£2,228.40	£9,804.96	£9,804.96	£9,359.28	£12,981.28			£59,499.13
Rheumatology		£1,200.00				£800.00		£2,769.13		£1,392.13	£6,161.26
Anaesthesia Obs										£1,168.05	£1,168.05
ENT									£16,171.52	£14,109.92	£30,281.44
Infectious Diseases									£5,473.56	£3,823.00	£9,296.56
Grand Total	**£1,371,758**	**£1,172,905**	**£1,255,780**	**£1,183,190**	**£1,039,468**	**£1,076,593**	**£1,177,868**	**£986,899**	**£834,535**	**£672,111**	**£10,771,111**

The cost of ‘locum’ cover has decreased month on month from July 2023 onwards. This coincides with a significant decrease in unfilled training posts from August 2023 onwards.

Table 5. Reason for locum and bank usage, 1 January 2023 to 31 October 2023

Reason	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Grand Total
Additional session Endoscopy	12		15	6	7	4	8	1	11		64
Additional session Outpatients	23	18	9	13	2	6	1	7	2		81
Additional session Theatres	12	11	15	12	8	1	2		2		63
Annual Leave	69	95	151	85	59	34	50	8	18	6	575
Compassionate/Special leave	5	11	4	10	6	4	1	3	5	1	50
Covid Escalation					1						1
Extra Cover	204	170	133	103	116	125	124	91	47	29	1142
Induction	2	7	4	3				27	14		57
Maternity/Pregnancy leave	21	13	7	3	33	49	49	16	3		194
Paternity Leave	8	4	16	13	8	2	3	7	3		64
Restricted Duties	22	25	11	5	7	17	15	26	14	13	155
Seasonal Pressures	45	53	6	3				2			109
Sick	155	146	128	78	99	70	93	88	96	45	998
Sickness - Covid-19	18	4	8	13	15	17	17	21	9	2	124
Study Leave	9	8	7	5		3	2	11	5	3	53
Vacancy	1636	1413	1421	1420	1355	1342	1191	864	827	780	12249
Strike		2	88	111	2	146	195	177	130	49	900
LTFT Trainee gap		13	25	18	21	29	87	51	46	34	324

Post strike cover			1	2		3	2	2			10
Pre strike cover			1	10							11
Grand Total	**2241**	**1993**	**2050**	**1913**	**1739**	**1852**	**1840**	**1402**	**1232**	**962**	**17224**

The majority of locum cover since January 2023 was to provide staffing for rota vacancies (71%). The number of locum shifts covering rota vacancies has, in general, decreased steadily over the past 10 months to a currently low figure of 780 (this is less than half that in January 2023). A comparable number of locum shifts were required for both extra cover (1142) and for sickness absence/covid sickness absence (1122) over the past 10 months.

Junior doctor strike action has resulted in over 900 locum shifts being provided between February 2023 and October 2023. The Junior medical workforce will continue to be affected due to ongoing industrial action, however, there does not appear to be a correlation between Exception Reporting and Junior Doctor strike dates. There is significant annual variation in locum cover required for sickness absence, induction and rota vacancies.

d) Vacancies

Rota vacancies have fluctuated over the course of the year, with the highest number of monthly vacancies occurring in July 2023 (51.2 WTE, or 16% of posts unfilled). The number of rota vacancies increased and remained high from March 2023 until the end of July 2023. With the new intake of Junior Doctors in August, there has been a significant decrease in rota vacancies, and they now stand at only 33.7 WTE (11%). There has been a slight increase in the number of posts unfilled since August 2023. Of the current rota vacancies in October 2023, only 3% of medical specialty posts are unfilled, despite the majority of ERs being submitted by Trainees working in these posts. This reflects the large number of Trainees overall working in Medicine.

In previous years, monthly rota vacancies have varied between 30.9 WTE and 41.6 WTE (in 2022) and between 19.2 WTE to 31.4 WTE (in 2021). Overall, the monthly rota vacancies to date in 2023 exceed those of previous years with a range of 26.8 WTE to 51.2 WTE, with the highest number occurring in July 2023. The number of rota vacancies in August 2023 (26.8 WTE) was significantly lower than in the preceding 6 months.

Table 6. Trainee vacancies by specialty, January 2023 to October 2023.

	VACANCIES (WTE)	Posts	January	February	March	April	May	June	July	August	September	October
Medicine	**Medicine (all sub-specialties)**	**73**	**10.2**	**7.8**	**8.4**	**8.4**	**8.4**	**8.4**	**8.4**	**2.2**	**2.2**	**2.2**
	FY1	**16**	0	0	0	0	0	0	0	0	0	0
	FY2	**2**	1	1	1	1	1	1	1	0.2	0.2	0.2
	CT/ST GPST 1-3	**34**	6.2	4.2	4.4	3.6	3.6	3.6	3.6	0	0	0
	ST3+	**21**	3	2.6	3	3.8	3.8	3.8	3.8	2	2	2
	Emergency Medicine	**28**	**3.2**	**7.4**	**8.2**	**7.2**	**7.2**	**7.2**	**7.2**	**4.2**	**4.2**	**4.7**
	FY1	**5**	0	0	0	0	0	0	0	0.4	0.4	0.4
	FY2	**5**	1.2	1.2	2	1	1	1	1	0.2	0.2	0.2
	CT/ST GPST 1-3	**16**	2	6.2	6.2	6.2	6.2	6.2	6.2	3.6	3.6	3.6
	ST3+	**2**	0	0	0	0	0	0	0	0	0	0.5
	Elderly Medicine	**21**	**2.4**	**2.4**	**2.4**	**4.4**	**3.8**	**3.8**	**3.8**	**0**	**1.8**	**1.8**
	FY1	**2**	0	0	0	1	0.4	0.4	0.4	0	0	0
	FY2 (No FY2 placements)	**0**	0	0	0	0	0	0	0	0	0	0
	CT/ST GPST 1-3	**15**	2.4	2.4	2.4	3.4	3.4	3.4	3.4	0	0	0
	ST3+	**4**	0	0	0	0	0	0	0	0	1.8	1.8
	Renal	**7**	**0.4**	**0.2**	**0**	**0**	**0**	**0**	**0**	**0.2**	**0.2**	**0.2**
	FY1 (No FY1 placements)	**0**	0	0	0	0	0	0	0	0	0	0
	FY2	**6**	0.2	0.2	0	0	0	0	0	0.2	0.2	0.2
	CT/ST GPST 1-3 (No CT/GPST placements)	**0**	0	0	0	0	0	0	0	0	0	0
	ST3+	**1**	0.2	0	0	0	0	0	0	0	0	0

Children & Family	**Obstetrics & Gynaecology**	**26**	**6**	**7.4**	**6.4**	**7.4**	**7.4**	**8.4**	**8.4**	**5.2**	**4.2**	**4.2**
	FY1	**2**	0	0	0	0	0	0	0	0	0	0
	FY2	**1**	0	0	0	0	0	0	0	0	0	0
	CT/ST GPST 1-3	**12**	2.6	4	4	4	4	5	5	1.4	2.4	2.4
	ST3+	**11**	3.4	3.4	2.4	3.4	3.4	3.4	3.4	3.8	1.8	1.8
	Paediatrics	**36**	**4.7**	**4.7**	**9.2**	**9.2**	**9.2**	**9.2**	**9.2**	**4.2**	**6.6**	**6.6**
	FY1	**3**	0	0	1	1	1	1	1	0	0	0
	FY2	**0**	1	1	1	1	1	1	1	0	0	0
	CT/ST GPST 1-3	**21**	1.9	1.9	4.8	4.8	4.8	4.8	4.8	4.2	6.6	6.6
	ST3+	**12**	1.8	1.8	2.4	2.4	2.4	2.4	2.4			
	GU Medicine	**2**	**0**	**0.4**	**0.4**	**0.4**	**0.4**	**0.4**	**0.4**	**0.5**	**0.5**	**0.5**
	FY1 (No FY1 placements)	**0**	0	0	0	0	0	0	0	0	0	0
	FY2	**1**	0	0	0	0	0	0	0	0	0	0
	CT/ST GPST 1-3	**1**	0	0.4	0.4	0.4	0.4	0.4	0.4	0.5	0.5	0.5
	ST3+ (No ST3+ placements)	**0**	0	0	0	0	0	0	0	0	0	0
Surgery & Cancer	**ENT**	**8**	**1.4**	**1.4**	**2.4**	**2.4**	**2.4**	**2.4**	**2.4**	**1**	**1**	**2**
	FY1 (No FY1 placements)	**0**	0	0	0	0	0	0	0	0	0	0
	FY2	**2**	0	0	1	1	1	1	1	0	0	0
	CT/ST GPST 1-3	**3**	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1	1	1
	ST3+	**3**	0	0	0	0	0	0	0	0	0	1
	General Surgery	**21**	**2**	**5**	**4**	**2**	**2**	**2**	**2**	**3**	**3**	**4**
	FY1	**9**	2	2	2	0	0	0	0	0	0	0
	FY2	**1**	0	0	0	0	0	0	0	0	0	0
	CT/ST GPST 1-3	**4**	0	3	2	2	2	2	2	2	2	2
	ST3+	**7**	0	0	0	0	0	0	0	1	1	2
	Ophthalmology	**10**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**

	ST3+	**1**	0	0	0	0	0	0	1	0	0	0
	Urology	**6**	**2.2**	**2.2**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
	FY1	**1**	0	0	0	0	0	0	0	0	0	0
	FY2	**2**	1.2	1.2	0	0	0	0	0	0	0	0
	CT/ST GPST 1-3 (No CT/GPST placements)	**0**	0	0	0	0	0	0	0	0	0	0
	ST3+	**3**	1	1	1	1	1	1	1	1	1	1
	Trauma & Orthopaedics	**10**	**1.2**	**3.2**	**3.2**	**3**	**3**	**3**	**3**	**1**	**2**	**2.2**
	FY1 (No FY1 placements)	**0**	0	0	0	0	0	0	0	0	0	0
	FY2	**1**	0	0	0	0	0	0	0	0	0	0
	CT/ST GPST 1-3	**5**	1	3	3	3	3	3	3	1	2	2
	ST3+	**4**	0.2	0.2	0.2	0	0	0	0	0	0	0.2
	Vascular	**6**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**1**	**1**
	FY1	**2**	0	0	0	0	0	0	0	0	0	0
	FY2 (No FY2 placements)	**0**	0	0	0	0	0	0	0	0	0	0
	CT/ST GPST 1-3	**2**	1	0	0	0	0	0	0	0	0	0
	ST3+	**2**	0	0	0	0	0	0	0	1	1	1
Clinical Specialties	**Anaesthetics**	**14**	**2**	**0.2**	**2**	**2**	**2**	**2**	**2**	**2.1**	**2.1**	**2.1**
	FY1 (No FY1 placements)	**0**	0	0	0	0	0	0	0	0	0	0
	FY2	**0**	0	0	0	0	0	0	0	0	0	0
	CT/ST GPST 1-3	**10**	0.8	0	1	1	1	1	1	0.6	0.6	0.6
	ST3+	**4**	1.2	0.2	1	1	1	1	1	1.5	1.5	1.5
	ICT	**13**	**0.2**	**2.2**	**2.4**	**2.4**	**2.4**	**2.4**	**2.4**	**1.2**	**1.2**	**1.2**
	FY1 (No FY1 placements)	**0**	0	0	0	0	0	0	0	0	0	0
	FY2	**6**	0	0	0	0	0	0	0	0	0	0
	CT/ST GPST 1-3	**4**	0	0	0.2	0.2	0.2	0.2	0.2	1.2	1.2	1.2
	ST3+	**3**	0.2	2.2	2.2	2.2	2.2	2.2	2.2	0	0	0

Total	317	36.9	44.5	50	49.8	49.2	50.2	51.2	26.8	31	33.7

e) **Fines**

No fines have been levied within the last quarter.

Qualitative information

At the most recent Junior Doctor Forum in September the following was discussed:

- The vast majority of ERs were due to workload compounded by rota gaps. There were only 2 reports in relation to missed educational opportunities over the past 4 months, perhaps reflecting the fewer scheduled training sessions towards the end of the academic year.
- Understaffing and unfilled locum shifts contribute to heavy workloads. This results in Junior Doctors missing educational opportunities, having to change their work patterns at short notice, missing breaks and working additional hours.
- The number of training posts has increased, particularly in Medicine, and the proportion of posts filled has also significantly increased. However, these positive changes occurred at the same time as a new cohort of Junior Doctors started work in August. Therefore, rather than seeing a decrease in ERs, there is a paradoxical rise due to increased awareness of reporting and Junior Doctors settling into their new roles.
- It was felt by Trainees that the Trust has a historical and ongoing reputation for very busy out-of-hours shifts and that this was an ongoing barrier to effectively organising locum cover. This reputation appears to be sustained despite positive steps in recruiting junior medical staff.
- In General Medicine and in Emergency Medicine, high workloads, unplanned leave and providing necessary unpredictable emergency care all contributed to Junior Doctors working additional hours in August and September.
- Emergency Medicine has secured additional funding for 10 extra middle-grade doctors. However, it will take time to appoint to these posts.
- In Obstetrics and Gynaecology, it was felt that known understaffing was not adequately addressed and rota gaps remained unfilled, preventing the effective handover of patients towards the end of a shift.
- In Surgical specialties, missed breaks due to high workloads were reported.
- Self-rostering has previously been demonstrated to be very helpful in reducing rota gaps and this is being introduced within the Anaesthetics department.
- Suboptimal Trainee attendance at the JDF and Trainee Management Forum was discussed. Revised guidance to departments has been issued and Trainees should be released to attend these opportunities. However, this has not resulted in a significant improvement in attendance. Trainees who are not scheduled

to be working, who are off post-nights or who feel unable to leave their clinical duties as well as those who are prioritising training are unlikely to attend and to contribute. Further engagement opportunities with Trainees are being explored.

Summary

Ongoing exception reports highlight high workloads for Junior Doctors, especially in Medicine and despite significant improvements in staffing. High workload and understaffing are the usual causes for Junior Doctors being unable to undertake educational opportunities. The huge improvement in unfilled posts observed in August 2023 and the concurrent increase in the total number of training posts will both improve staffing and help to alleviate high workloads in those specialties with historically high numbers of Exception Reports.

The seasonal increase in reports observed as Junior colleagues join the Trust in August has been observed, and this has been sustained in September and October. However, rather than Trainees working in Medicine submitting the majority of ERs, there has been a more even distribution of ERs across General Surgery, General Medicine, Obstetrics and Gynaecology, A+E and Respiratory Medicine. The number of locum shifts worked and the cost of locum cover have substantially improved since August 2023. The current staffing position is favourable for the beginning of the winter.

Engagement

The regional Guardian Forum now takes place twice a year and the last meeting occurred in October 2023. The local quarterly Junior Doctors' Forum (JDF) took place via MS Teams in September 2023, with the next one planned for 30th November. A joint meeting with the Trainee Management Group has been implemented since December 2020. The JDF is open to all trainee Junior Doctors with the aim of improving engagement.

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

- Induction with new FY1s and additional teaching sessions to reinforce the importance of Exception Reporting and addressing any underlying barriers to submitting ERs.
- Working collaboratively with the Freedom to Speak Up Guardian and Trust SuppoRTT Champions, with engagement sessions planned to take place during future Junior Doctor Forums.
- Guardian drop-in sessions in the Junior Doctors Mess, a poster campaign and utilising Toolbox to disseminate information about Exception Reporting and the JDF to junior colleagues.
- Discussion at the September JDF to canvass ideas from Trainees regarding increasing attendance at the JDF, barriers to Exception Reporting and effective ways of disseminating information.

Recommendation

The Board of Directors can be assured that a clear majority of Trainee doctors are able to work safely. General Medicine has been less of a concern since August 2023 with regards high workloads for Junior Doctors and there has been a more recent spread of ERs across different specialties. The number of training posts has increased and the proportion of training posts that have been appointed has increased significantly since August 2023. Overall, a historically low percentage of 11% of posts are currently vacant.

Junior Doctors are broadly able to access educational opportunities as envisaged in the 2016 contract, although this remains a challenge where high workload and rota gaps preclude attendance at educational sessions. This requires local resolution within those affected specialties and Junior Doctors are encouraged to discuss this issue with their Educational Supervisors for additional support.

BREAK 10:50 - 11:00

2311 - E1 CHAIR'S ASSURANCE LOG - FINANCE & PERFORMANCE COMMITTEE

Discussion Item | Mark Day, Non-Executive Director | 11:00

Meeting on 27 November 2023
5 minutes

2311 - E2 FINANCE UPDATE

Information Item | Jon Sargeant, Chief Financial Officer | 11:05

10 minutes

REFERENCES

Only PDFs are attached

E2 - Finance Update - Month 7.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	28 November 2023	**Agenda Reference:**	**E2**
Report Title:	**Finance Update – Month 7 (October) 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 7.
Summary of key issues:	The Trust's reported deficit for month 7 (October 2023) was £0.9m, which was £0.1m favourable to plan and £0.8m favourable to forecast. Year to Date (YTD) the Trust's reported deficit at month 7 was £24.8m, which was £1.3m adverse to plan and £1.0m adverse to forecast. The variance to plan is mainly driven by Elective Recovery Fund (ERF) under performance (£1.7m) and strike costs of (£1.6m), offset by non-recurrent CIP delivery due to pay savings against budget. As at month 7 the Trust's ERF performance was 97%, equating to a £1.7m under-performance against the baseline target value, which includes the original 2% target reduction for industrial action (applied across the year). Pay spend is favourable to plan by c.£1.3m YTD (£0.5m adverse to plan in month), mainly driven by Nursing and Admin staff. Medical staff are overspent by £5.3m, which includes junior doctor strike costs of £1.6m. 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 recharges, pay spend is in line with forecast YTD. Non-pay spend is £4.4m adverse to plan YTD (£0.3m adverse to plan in month), driven by continued overspends related to the phasing of the independent sector usage (£1.6m – where independent sector usage has been front loaded by the Division), drugs (£2.3m) and Medical and Surgical equipment (£0.9m) 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. A recovery plan for improving core productivity has been requested and is being led on by the Chief Operating Officer. Excluding reserves and recharges, non-pay spend is £0.8m adverse to forecast YTD, mainly driven by drug expenditure (£0.6m adverse). A deep dive with escalation meetings with the CFO and Divisions on drug spend will be undertaken over the next month. 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 half 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 and the Trust is asked to improve its Better Payment Practice Code performance (timeliness of payments to suppliers).

Capital

Capital spend in month 7 was £5.3m against a plan of £4.3m giving an in-month over-performance of £1.1m. The YTD position is £15.7m against a plan of £25m showing an under-performance of £9.3m. The main underspends are against Community Diagnostic Centre (CDC) of £1m and Bassetlaw Emergency Village (BEV) of £6.6m. A revised cashflow for both CDC and BEV shows current spend is in line with year-end expectations. The Trust is forecasting to deliver its year end capital plan.

Cash

The cash balance at the end of October was £15.4m (September: £21.6m), meaning cash has increased by £6.2m in the month. This is despite the Trust receiving £6.3m in cash via PDC in the month. The underlying decrease in cash of £12.5m is as a result of c. £3m capital cash spend in excess of depreciation, loan repayments of £0.7m, underlying deficit and a c.£8m reduction in trade creditors.

The Trust has an approved cash drawdown request of £14.9m for Quarter 3, with £7.2m of this due to come in in November. 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 £3.3m of savings versus the plan submitted to NHSE of £2.6m and therefore is £0.8m favourable to plan. YTD the Trust has delivered £11.1m of savings versus the plan submitted to NHSE of £9.2m and is therefore favourable to plan by £1.9m. Whilst the Trust is ahead of plan at this point, the phasing of the CIP programme has started to increase in Q2 and will significantly increase in Q3. Significant work is underway to identify further opportunities to meet the full year target of £22.1m.

Income and & Expenditure Forecast and National Funding Update

A verbal update with regards to changes in national funding and year end forecast submissions will be provided to the Board following the ICB submission on the 22nd November.

Recommendation:	The Board is asked to note: • The Trust's deficit YTD at month 7 (October 2023) was £24.8m, which was £1.3m adverse to plan and £1.0m adverse to forecast.				
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 7 – October 2023

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

M7 October 2023

1. Income and Expenditure vs. Budget

Performance Indicator	Monthly Performance Actual £'000	Monthly Variance to budget £'000		Monthly Variance to forecast £'000		YTD Performance Actual £'000	YTD Variance to budget £'000		YTD Variance to forecast £'000	
Income	(45,538)	(889)	F	(576)	F	(313,882)	(1,361)	F	(105)	F
Pay	29,580	454	A	(19)	F	214,689	(1,268)	F	125	A
Non Pay	16,263	339	A	(79)	F	120,650	4,437	A	1,345	A
Financing Costs	623	39	A	(168)	F	3,626	(455)	F	(365)	F
(Profit)/Loss on Asset Disposals	0	0	A	0	A	0	0	A	0	A
(Surplus)/Deficit for the period	**928**	**(57)**	**F**	**(841)**	**F**	**25,083**	**1,353**	**A**	**1,000**	**A**
Adj. for donated assets	(41)	(7)	F	0	A	(288)	(49)	F	0	A
Adjusted (Surplus)/Deficit for the purposes of system achievement	**887**	**(64)**	**F**	**(841)**	**F**	**24,795**	**1,304**	**A**	**1,000**	**A**

Key

Income: Over-achieved F; Under-achieved A

F = Favourable A = Adve

Expenditure: Underspent F; Overspent A

2. CIPs

Performance Indicator	Monthly Performance Plan £'000	Monthly Performance Actual £'000		YTD Performance Plan £'000	YTD Performance Actual £'000		Annual Plan £'000
Local / Unidentified	951	2,873	F	4,209	7,893	F	9,130
Cross Cutting - Pay - Job Plans / Agency	867	316	A	2,167	2,593	F	6,500
Cross Cutting - Elective - Theatres/OP/Diagnostics/LOS	365	126	A	1,472	391	A	3,250
Cross Cutting - Procurement	69	(21)	A	329	164	A	720
Cross Cutting - Major Contracts	121	19	A	469	72	A	1,000
Cross Cutting - RPA	56	0	A	222	0	A	500
Cross Cutting - Corp Pay/Benefits from PLACE	125	7	A	375	7	A	1,000
Total CIP	**2,553**	**3,320**	**F**	**9,244**	**11,120**	**F**	**22,100**

3. Statement of Financial Position

	Opening balance £'000	Closing balance £'000	Movement £'000
Non Current Assets	**295,075**	**301,108**	**6,033**
Current Assets	79,601	**53,604**	**-25,997**
Current Liabilities	-112,917	**-92,352**	**20,565**
Non Current liabilities	-16,014	**-16,373**	**-359**
Total Assets Employed	**245,745**	**245,987**	**242**
Total Tax Payers Equity	**-245,745**	**-245,987**	**-242**

4. Other

Performance Indicator	Monthly Performance Plan £'000	Monthly Performance Actual £'000	YTD Performance Plan £'000	YTD Performance Actual £'000	Annual Plan £'000
Cash Balance		15,366		15,366	1,900
Capital Expenditure	4,280	5,333	24,968	15,672	65,051

5. Workforce

	Funded WTE	Substantive WTE	Bank WTE	Agency WTE	Total worked WTE
Current Month	6,860.33	5,963.41	388.09	146.70	6,498.20
Previous Month	6,828.17	5,945.80	371.73	147.13	6,464.66
Movement	32.16	17.61	16.36	-0.43	33.54

1. Month 7 Financial Position Highlights

Income and Expenditure

The Trust's reported deficit for month 7 (October 2023) was £0.9m, which was £0.1m favourable to plan and £0.8m favourable to forecast. Year to Date (YTD) the Trust's reported deficit at month 7 was £24.8m, which was £1.3m adverse to plan and £1.0m adverse to forecast. The variance to plan is mainly driven by Elective Recovery Fund (ERF) under performance (£1.7m) and strike costs of (£1.6m), offset by non-recurrent CIP delivery due to pay savings against budget.

As at month 7 the Trust's ERF performance was 97%, equating to a £1.7m under-performance against the baseline target value, which includes the original 2% target reduction for industrial action (applied across the year).

Pay spend is favourable to plan by c.£1.3m YTD (£0.5m adverse to plan in month), mainly driven by Nursing and Admin staff. Medical staff are overspent by £5.3m, which includes junior doctor strike costs of £1.6m. 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 recharges, pay spend is in line with forecast YTD.

Non-pay spend is £4.4m adverse to plan YTD (£0.3m adverse to plan in month), driven by continued overspends related to the phasing of the independent sector usage (£1.6m – where independent sector usage has been front loaded by the Division), drugs (£2.3m) and Medical and Surgical equipment (£0.9m) 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. A recovery plan for improving core productivity has been requested and is being led on by the Chief Operating Officer. Excluding reserves and recharges, non-pay spend is £0.8m adverse to forecast YTD, mainly driven by drug expenditure (£0.6m adverse). A deep dive with escalation meetings with the CFO and Divisions on drug spend will be undertaken over the next month.

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 half 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 and the Trust is asked to improve its Better Payment Practice Code performance (timeliness of payments to suppliers).

Capital

Capital spend in month 7 was £5.3m against a plan of £4.3m giving an in-month over-performance of £1.1m. The YTD position is £15.7m against a plan of £25m showing an under-performance of £9.3m. The main underspends are against Community Diagnostic Centre (CDC) of £1m and Bassetlaw Emergency Village (BEV) of £6.6m. A revised cashflow for both CDC and BEV shows current spend is in line with year-end expectations. The Trust is forecasting to deliver its year end capital plan.

Cash

The cash balance at the end of October was £15.4m (September: £21.6m), meaning cash has increased by £6.2m in the month. This is despite the Trust receiving £6.3m in cash via PDC in the month. The underlying decrease in cash of £12.5m is as a result of c. £3m capital cash spend in excess of depreciation, loan repayments of £0.7m, underlying deficit and a c.£8m reduction in trade creditors.

The Trust has an approved cash drawdown request of £14.9m for Quarter 3, with £7.2m of this due to come in in November. 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 £3.3m of savings versus the plan submitted to NHSE of £2.6m and therefore is £0.8m favourable to plan. YTD the Trust has delivered £11.1m of savings versus the plan submitted to NHSE of £9.2m and is therefore favourable to plan by £1.9m. Whilst the Trust is ahead of plan at this point, the phasing of the CIP programme has started to increase in Q2 and will significantly increase in Q3. Significant work is underway to identify further opportunities to meet the full year target of £22.1m.

Income and & Expenditure Forecast and National Funding Update

A verbal update with regards to changes in national funding and year end forecast submissions will be provided to the Board following the ICB submission on the 22nd November.

2. Recommendation

The Board is asked to note:

The Trust's deficit YTD at month 7 (October 2023) was £24.8m, which was £1.3m adverse to plan and £1.0m adverse to forecast.

2311 - E3 DIRECTORATE OF RECOVERY, INNOVATION & TRANSFORMATION UPDATE

Discussion Item | Jon Sargeant, Director of Recovery, Innovation & Transformation | 11

10 minutes

REFERENCES

Only PDFs are attached

E3 - Recovery, Innovation & Transformation Update.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	28 November 2023	**Agenda Reference:**	**E3**
Report Title:	Recovery, Innovation & Transformation Update		
Sponsor:	Jon Sargeant, CFO & Director Recovery, Innovation & Transformation (RIT)		
Author:	Kirsty Edmondson-Jones, Director of Innovation & Infrastructure		
Appendices:	None		

Executive Summary	
Purpose of report:	To provide an update on the progress by the Recovery, Innovation and Transformation Directorate.
Summary of key issues:	This report provides an update on the work of the RIT Directorate including: • Quality Improvement & Innovation • Capital inc Complex Schemes • Green Plan • Health Inequalities • PMO/Tenders • Performance/Transformation/POSM.
Recommendation:	The Board is asked to note and take assurance from this report.

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

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

Implications	
Board assurance framework:	
Corporate risk register:	
Regulation:	None
Legal:	None
Resources:	None

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

1. INTRODUCTION

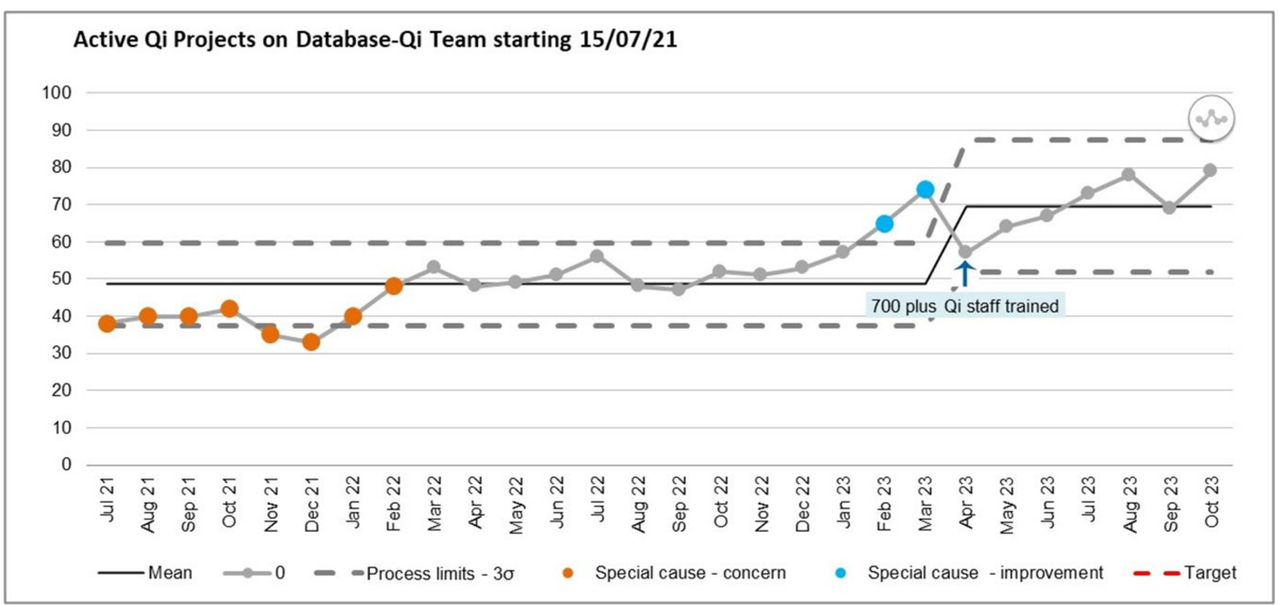
This paper outlines the progress with the work of the RIT since the last update. Updates are provided relating to the Green Plan and Health Inequalities Strategy development progress, alongside Quality Improvement and Innovation, PMO and contracts. This includes details of a Board of Director Qii workshop held on 31st October which is aimed to equip NED's with level 1 equivalent knowledge and be a base for the level 2 Qii training that Executive Team members will undergo during the remainder of 2023/24.

Work on complex capital schemes continues at pace with updates provided for Bassetlaw Emergency Village and Montagu Elective Orthopaedic Hub (MEOC) progressing well and to programme.

2. QUALITY IMPROVEMENT & INNOVATION

Since April 2023 the team have engaged in Qii conversations with **902 people** (including training) and across **21** new teams / projects.

There are currently **79 active Qi projects** registered on the DBTH Qi database.



The team are currently scoping **10** projects, have **6** projects in the planning and design phase, **three** in delivery and **11** have been completed. In addition there are 15 new requests for support.

CIP support

Letters to all SROs of CIP programmes have been sent out to clarify support required for the programmes listed below, whilst also reviewing with SROs of major CIP programs if additional Qii support is required.

- Agency & sickness management
- Job plans
- Procurement
- Theatre productivity
- Outpatient productivity
- Diagnostic productivity
- UEC / LoS
- Corporate pay
- Benefits from Doncaster place
- RPA
- Major contracts
- Data assurance
- Workforce
- Infrastructure

NHS Impact – Base line & Self-assessment

The initial response to the NHS impact self-assessment was presented in the September TEG paper. There is no longer a requirement to send a response centrally, however the NHS impact board request that all Acute providers undertake the circulated self-assessment to inform of current position and then to identify action plans to strengthen the embedding of the NHS impact elements.

The five principles of the NHS impact are:

1. Building a shred Purpose and vision,
2. Investing in People and culture,
3. Developing leadership behaviours,
4. Building improvement capability and capacity; and
5. Embedding improvement into management systems and processes.

A shorter baseline assessment coordinated by the ICBS was submitted at the end of August 2023. Updates on major programmes of work that improvement are supporting are outlined in further detail below:

Patient Safety Incident Response Framework (PSIRF)

Initial implementation group meetings are being held, project managed by the PMO team, with all current state mapping and work on future state being completed. The thematic analysis is being undertaken by the project team to identify main areas of focus.

Support for ED / AMU / Medicine

Three Strands of work are currently taking place:

1. ED front door triage – working with ED & FCMS – test of change planned October
2. ED / AMU – communication – 4 'direct referral' routes test of change being extended to capture more information.
3. Triage within ED – planning meetings set up.

Job Planning

The initial problem statement and top-level process is done with a second meeting with CDs being held on the 12th September 2023.

Diagnostics

Involved with Diagnostic Steering group and picking up required Qii actions for support.

Patient Tracking system – pathway mapping

Five patient pathways have been mapped identifying system tracking points and clinical review points confirmed.

Place and System support

Co facilitation of MEED collaborative held in Rotherham New York stadium on the 8th September 2023 as well as the facilitation of Doncaster place pain referral models at the Civic offices in Doncaster on the 14th September 2023. A further session on lived experience session was facilitated on the 25th October 2023 and audiology pathway and lived experience groups being planned in November 2023.

Stock Rotation (non-clinical stock)

After the recent CQC findings of out of date stock on some wards, a Qii project has been set up as part of the response. The Qii team have visited 26 areas and collated responses from 51 people on the process before the main event held on 23rd October which only three participants attended. However, a representative from Nursing, Inventory Management and Housekeeping were present so the project was able to move forward. A follow up event is being planned.

Improvement Report outs

Next report out dates planned:

- Thursday 16th December 2023 – 12:30 -14:00
- Thursday 18th January 2024 – 12:30 – 14:00

Training / Awareness

- **44 Qi Level 1** accredited to date this financial year (year target =60)
- **7 Qi Level 2** accredited to date this financial year (now 44 overall trained within the divisions)
- **332 Qi general awareness** this financial year
- June Qii drop in session DRI, July drop in session MMH held, September drop in BDGH held.

Quality improvement and innovation strategy

The previous Qii strategy was due to be refreshed after 2022. A draft Qii Strategy has been aligned to incorporate the newly published NHS Impact (published 19th April 2023). The Qii Strategy was presented to TEG paper in November.

3. CAPITAL INC. COMPLEX SCHEMES

DRI Update

The programme of activities to develop our initial thinking regarding options for redevelopment of East Ward Block(EWB) in order to present a bid in response to opportunities from the Autumn Statement are on target.

Options have been reviewed and the Preferred Way Forward is to refurbish the East Ward Block in two stages and to build a four-storey decant facility to enable this. This is the only viable option due to engineering constraints associated with the configuration of the building but is also supported by the logistics associated with multiple service moves under other options and the fact that this option is the fastest to deliver.

Initial costings which show the Preferred Way Forward at £340 million have been through a first revision process which indicates a cost of £289 million which is within the indicative funding envelope of circa £300 million. Given that the total funding envelope is not known the project team has developed a number of sub options which can be drawn upon to deliver a range of bids up to £300 million.

A board paper summarising the bid proposal is included for final approval to the Confidential Board in readiness for the bid submission.

Bassetlaw Emergency Village (BEV)

The BEV scheme received approval on the 27th June with the MOU and cash approvals being agreed and signed on the 30th June. The BEV interior design work is progressing well and includes detailed designs for the CAU and ED areas which are now being discussed with staff stakeholder groups. Work is still ongoing to programme the decant, mobilisation and operationalisation of the BEV once built, and the second phase of the scheme which is to refurbish the existing ED areas. A further phase will be to establish an SDEC, although funding for this falls outside of the BEV project.

Key activities completed:

- Newbuild: Roofing panels approaching completion on Gl.K
- Newbuild: Substructure masonry completed and area backfilled for superstructure to commence.
- Refurb: Window removal and replacement commenced.
- Refurb: masonry amendments between BDG47 & newbuild continue.

- Substation: Generator slab steelwork commenced.
- Substation: Internal fitout commenced including ceilings and temporary doors installed.
- External: Traffic management still in place & surveys underway to find alternative hydrant break in point

BECV: Roofing progress. Panels nearly completed	Refurb: Window removal & reinstall commened. Plasterboard loaded out.

Montague Elective Orthopaedic Centre (MEOC)

Progress towards the MEOC facility being available from 8th January 2024 is still on target with recruitment of staff forming the main barrier to opening on that date. Plan B options are developing but the likelihood that any one option will support opening on time, other than insourcing, seems remote. Progress with "Winter Pressures" options indicates that transfers of staff from host trusts are likely to be limited. The solution to opening as planned is therefore going to be a hybrid of core recruitment, insourcing, potentially a small number of host trust staff transfers and possibly agency and locum staff.

Financial analysis indicates that any option which allows full opening of MEOC will deliver a surplus albeit lower than would have been achieved through core recruitment alone due to additional costs associated with interim resourcing measures. Discussions with insourcing companies are being undertaken.

Management arrangements for MEOC once operational have been included in this report based on the agreed position at business case stage. Discussions with COOs highlight that the earlier an operational leader is appointed the better in order to drive forward the transition to opening and business as usual.

Critical path items remain on track but discussions with Clinical Leads and Operational Leads from across the three partner trusts indicate that there is a concern with regard to timelines. Planning for opening needs to commence at least eight weeks in advance of 8th January 2024 and Plan B options must be agreed in time for patients to be booked with confidence. There is also a risk that having reached agreement for the initial theatre rota a delayed opening date would leave surgeons without lists to perform. A decision on resourcing was made prior to the 13th November 2023 and the clinicians were informed.

Risk items continue to reduce across most areas as the facility heads towards opening. The key areas of risk remain recruitment and IT & Digital.

Communications and engagement continues at pace with arrangements in place for tours, visits, surveys and presentation to Overview & Scrutiny Committees. Branding for MEOC has been developed and public voting on the logo for MEOC has been undertaken.

4. GREEN PLAN

Green Theatres

Surgery is one of the most carbon intensive functions within the NHS. A recent review looking at the carbon footprint of surgery estimated that a single operation can generate up to 814kg of CO_2e (the equivalent to

driving over 2,000 miles in an average petrol car). Operating theatres are also 3 to 6 times more energy intensive than other clinical spaces and generate 21% - 30% of all hospital waste[1].

This means that operating theatres provide one of the best opportunities for improved sustainability within DBTH. One of the Trust's Green Champions, Lisa Quean (Sterile Services Manager), recently completed an MBA programme, focusing on the topic of improved sustainability within theatres for her dissertation. Lisa now plans to use her research as part of a project to improve sustainability within theatres at DBTH, focusing initially on waste reduction. The project is currently going through the scoping phase and further updates on progress will be provided in future reports.

Sustainable Development Assessment Tool (SDAT)

The Sustainable Development Assessment Tool (SDAT) is a comprehensive self-assessment tool that provides a holistic view of the Trust's current position against a range of different sustainability measures. The tool was used to establish a baseline of the Trust's position when the Green Plan was developed in 2021. The scores and improvement targets can be seen within the Green Plan and on the 'Plan on a Page' displayed below.

Figure 1: Green Plan on a Page

Work is now underway to repeat the assessment to measure the progress achieved so far. However, as a number of the key responsible managers who contributed to the initial assessment have now left the Trust, the tool is currently being updated to reflect the new structure within the organisation. Once this piece of work is complete, responsible managers will be contacted by the Trust's sustainability consultants, Inenco Consulting Group, for an update on the current position. Inenco will brief managers where necessary and provide adequate support to simplify this process. The SDAT update is expected to be complete early in the New Year and the results from the assessment will be shared in a future report.

Heat from Waste Proposal

The NHS has an ambitious target to achieve net zero for directly controlled emissions by 2040. One of the most significant challenges in meeting this target is the decarbonisation of heat. In simple terms, this means that NHS organisations must look for engineering solutions that provide hot water and heating without using fossil fuels such as natural gas. This is particularly challenging in older estates, such as the Trust's, as low carbon heating solutions typically generate lower levels of heat compared to conventional systems, which makes it difficult to achieve satisfactory internal temperatures in buildings with high heat losses. The Trust therefore needs to develop a long term heat decarbonisation plan (HDP) to understand the changes necessary to achieve this aim.

Estates & Facilities are, however, also now in talks with the energy supplier SSE regarding a proposal for the construction of a 'waste to heat' plant in Doncaster. If the project goes ahead, the plant will use waste to generate heat to supply a district heat network, with the potential for Doncaster Royal Infirmary to become a customer. At this stage the proposal is in the very early stages and further work is required to assess the feasibility, but if the proposal goes ahead it is anticipated that the plant could be supplying heat to customers by as early as 2028.

[1]*Net Zero Elective Theatre Recovery, Greener NHS*

5. HEALTH INEQUALITIES

Strategy

We have completed the final version of the DBTH Tackling Health Inequalities Strategy and produced an Operational Action Plan which sits alongside the strategy document. We presented the strategy and action plan to F&P on 30th October and it has been recommended for approval to the Board. A separate paper is included on the agenda for this item.

Communications

We have been continuing to progress the comms work. We are working on plans to enhance the current comms for health inequalities (improve content to website on the HIVE) and explore other options/opportunities for comms (including how we share events/info from our Place leads, use of DBTH social media channels, developing videos to tell stories to bring to life the issues of health inequalities). This is ongoing work and a core element of the strategy going forwards. We will continue to meet every 2 months.

Education/Training

We are continuing to plan how to adapt/improve/develop health inequalities training for DBTH staff. We have mapped the types of training that might be required and for which staff and are still reviewing what training packages already exist and how/if we can tap into those. We have been approached to input into the Foundation Doctors training and have booked in specific Public Health/Health Inequalities seminars with both Foundation Year 1 and 2 doctors. There are other links that we are exploring with the Director of Education. We have also made links with the Qi team and are working to embed health inequalities into Qi training opportunities.

MEOC

A meeting was held on the 17th October looking at the health inequalities impact of MEOC. There were attendees from all three Trusts. We are still developing a data specification so we can evaluate the health inequalities impact of MEOC and are looking to do some modelling work prior to MEOC opening to try to understand what the impact on health inequalities might be. We are also supporting the involvement of patients to understand if there are any access and/or environment issues that need to be accounted for.

We are exploring options for funding this evaluation including the use of capital funds, existing capacity, and potentially a future business case.

6. PMO/TENDERS

Performance, overview and support meetings

Discussions over the last month have focussed on the following areas:

Children and Families

- **Successes –** Continued strong performance on elective recovery and job planning
- **Issue –** Further assurance required on cancer recovery plan for division specifically around the faster diagnostic standard **Next steps –** COO to review action plan developed by division
- **Issue –** Significant spend on agency medical staff specifically relating to "double running" trainee grades with agency due to seniority **Next steps –** Further information to be provided and reviewed by MD / DoF
- **Issue –** SDEC activity within Gynaecology not recorded correctly **Next steps –** General manager to provide plan to rectify with continued support from information business partner team

Medicine

- **Successes –** Continued strong performance on elective recovery and across several key quality metrics.
- Issue – Challenges with job planning engagement. Next steps – Acting Medical Director to provide CDs with a template letter to be used as basis of comms with consultants
- Issue – Challenges with resources within division to support clinical validation activity. Next Steps – GM to estimate resources required to address
- Issue ––Decision needed if Junior Doctor Premiums for Strike Shifts going to continue Next Steps – To be picked up by executives outside of POSM

UEC

- **Successes –** Continued hard work by the teams despite high ED demand to try and sustain improvement in flow
- Issue – Significant CIP gap and delays in non-recurrent schemes being quantified Next steps – FBP to cost up and action to understand overall position in division
- Issue – Significant agency spend above budget Next steps – Further investigation to be done by DDON, CD and finance team.

Surgery (shortened meeting due to SMT availability)

- **Successes –** Maximising usage of the Independent sector and endoscopy DM01 performance
- Successes – Position on medium term trauma capacity agreed (32 lists)
- Issue – Division require clarity on cost pressures Next steps – COO to review and feedback to division within the week
- Issue – Division is an outlier for job plan completion with some specialities having no signed off versions Next steps – Trajectory to be developed (interdependency to CD recruitment noted)
- **Issue –** Some specialities not achieving Faster diagnosis standard **Next steps –** Division to provide an action plan and trajectory for specific tumour sites and endoscopy
- **Issue** – Audiology complaints letter out of date and still references COVID **Next steps** – Document to be refreshed

Clinical specialities

- **Successes –** High performance in some DM01 modalities and high level of CIP identified.

- Issue – Significant gaps in biochemist team and LOCUM has given backword Next steps – Further mitigating actions to be developed by division
- Issue – Irefer deployment for consultants paused Next steps – SRO to review process to agree pause and evaluate whether this should be reinstated / current bypass rates
- Issue – A number of significant areas of over-spend identified Next steps – Detailed review of anaesthetics / imaging pay and Abbott contract
- **Issue –** Further clarity needed on impact on SYB Pathology transfer and internal plan to manage **Next steps –** Further clarity on business case to be requested

A key issue shared across the majority of divisions was the status of the winter plan and when this would be shared with teams.

Transformation Programme Update

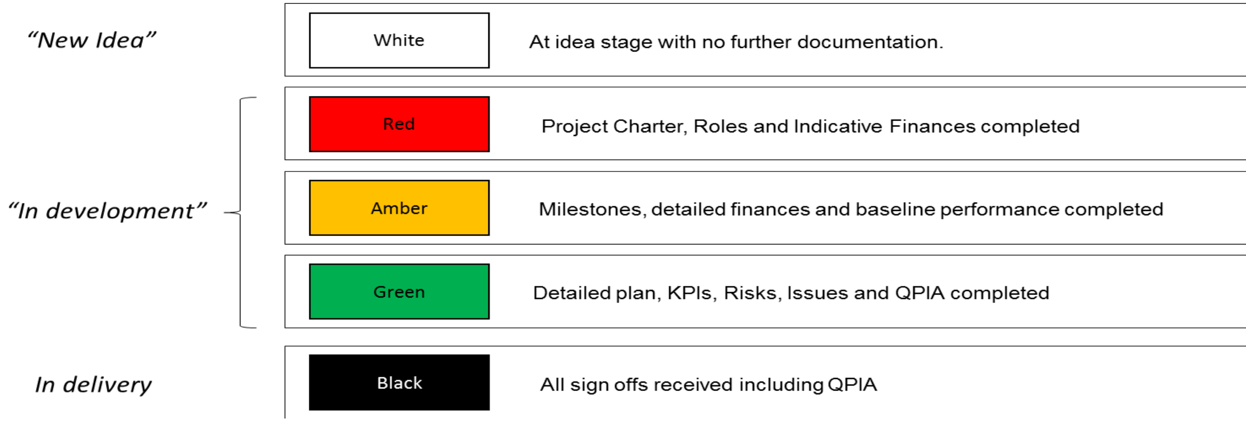
The Transformation Programme incorporates several workstreams which as a whole aim to improve quality, access, people and financial performance. The onus of each work-stream varies with some focussed on delivering significant financial efficiencies whereas others do not have a financial target. The programme is governed by a monthly Transformation Board Meeting which receives Workstream Highlight Reports and / or CIP updates signed off by each senior responsible officer. This paper will review on an exception basis progress, successes and areas of escalation.

RAG Rating of CIP Plans (as at Month 6 September 2023/24)

The table below shows the RAG rating of the £22.1m CIP plan to date broken down by workstream:

Workstream	Black	Green	Amber	Red	White	Unidentified	Total
Cross Cutting - Agency & Sickness Management	4,002,253	-	-	1,997,747	-	-	**6,000,000**
Cross Cutting - Job Plans	70,256	-	-	-	-	429,744	**500,000**
Cross Cutting - Procurement	430,144	-	-	-	-	289,856	**720,000**
Cross Cutting - Theatre Productivity	199,302	-	-		-	300,698	**500,000**
Cross Cutting - Outpatient Productivity	417,126	-	-	-	-	82,874	**500,000**
Cross Cutting - Diagnostic Productivity	-	-	-	-	-	750,000	**750,000**
Cross Cutting - LOS	253,654	-	-	-	-	1,246,346	**1,500,000**
Cross Cutting - Corporate Pay	250,000	250,000	-	-	-	-	**500,000**
Cross Cutting - Benefits from Doncaster PLACE	-	-	-	-	-	500,000	**500,000**
Cross Cutting - RPA	-	-	-	-	-	500,000	**500,000**
Cross Cutting - Major Contracts	897,550	476,867	65,665	-	-	-	**1,440,082**
Local	6,779,586	-	90,148	-	-	-	**6,869,734**
Unidentified	-	-	-	-	-	1,820,184	**1,820,184**
Total	**13,299,871**	**726,867**	**155,813**	**1,997,747**	**-**	**5,919,702**	**22,100,000**

Planning RAG definitions:



Transformation Highlight Reports

Monthly Workstream Highlight Reports are completed for each meeting, identifying achievements in month, key actions for the coming month and highlighting any risks / concerns and items for escalation. Each Highlight Report is also RAG rated as to the assurance of CIP Delivery, the robustness of the plan and delivery to date of the plan after assessing completion dates of tasks and milestones.

Workstream	SRO	CIP	Forecast v Target	Plan	Delivery
Agency & Sickness Management	Zoe Lintin	Medium		Low	Medium
Workforce Job Planning	Tim Noble	High	£70k vs £500k	Medium	High
Theatre Productivity	Denise Smith	High	£199k vs £500k	Low	Medium
Diagnostic Productivity	Denise Smith	High	£0k vs £750k	Low	Low
LOS	Denise Smith	High	£254k vs £1.5m	Medium/High	Medium/High
UEC	Denise Smith			Medium/High	Medium/High
Data Assurance	Andrew Pope			Medium	Medium
Benefits from PLACE		High	£0k vs £500k		
RPA	Andrew Pope	High	£0k vs £500k		

The following RAG ratings are applied:

PLANS:

Low	tasks and milestones have >90% nominated leads and timescales
Medium	tasks and milestones have 76%-89% nominated leads and timescales
High	tasks & milestones not identified &/or have <75% nominated leads and timescales

DELIVERY:

Low	plan is in line with original timescales
Medium	plan is behind original timescales, but this will not adversely impact the delivery of key objectives and benefits.
High	plan is significantly behind original timescales, and this will adversely impact on delivery of key objectives and benefits.

Business Case Support

A number of business cases are being supported and are progressing through the governance approval process. These include:

- **Hydrotherapy** – Business case complete submitted for September CIG. Charitable Funds Committee December 2023 – case being refined and submitted.
- **Estates Management** – draft business case complete, due to November CIG
- **Robotic Surgery** – working group continues, case drafted. Estates walk round undertaken and survey of theatres. Justification for Robot choice collated.
- **Stroke Rehab/Music Therapy pilot** – Music therapy case approved at September CIG to progress to next Charitable Funds Committee (December 2023). Main Rehab Suite case awaiting estates plans and costs and finalisation for December CIG.

- **2nd CT scanner at Bassetlaw** – Meeting held 16th August 2023 confirmed Location 2 option and choice reflected in draft business case together with location map. Finances needed reviewing and delayed CIG to November.
- **SDEC Extension of Hours** Refinement of case before submission to F&P Committee and move to new template.
- **Discharge Lounge extended hours** Case preparation underway for November CIG or chairs action if possible.
- **Audiology** – fortnightly working group being held with internal and external stakeholders. Preferred Way forward agreed mid-August and commissioners now working up timeline for procurement of lower complexity service, however slight pause due to benchmarking against Sherwood and Barnsley to see if changes options (led by Bassetlaw Place). New PWF to be defined early October 2023. DBTH continuing service improvements and refining patient criteria and referral processes with commissioners. Positive PCN conversations undertaken
- **Pain Management** Initial scope given – Andrew Potts/Heather Jackson. QI event held 14.9.23, various stakeholders attended and positive feedback. Service User QI Event to be held October 2023. Rehab Direct conversations commence. 1:1 with internal service representatives undertaken and internal QI elements agreed.

2311 - E4 OPERATIONAL PERFORMANCE UPDATE

Discussion Item | Denise Smith, Chief Operating Officer | 11:25

10 minutes

REFERENCES

Only PDFs are attached

E4 - Operational Performance Update.pdf

	Report Cover Page		
Meeting Title:	**Board of Directors**		
Meeting Date:	28 November 202	**Agenda Reference:**	**E4**
Report Title:	**Operational Performance Update**		
Sponsor:	Denise Smith, Chief Operating Officer		
Author:	Suzanne Stubbs, Deputy Chief Operating Officer		
Appendices:			

Report Summary

Executive Summary:

Emergency Care Access

- **4 hours:** In September 2023, there were 16,373 attendances to the Trust Emergency Department (ED), of these 5,006 patients were in the Department over four hours before admission, discharge, or transfer. Performance was 69.42% against a standard of 76%
- **12 hours:** In September 2023, there were 585 patients in ED > 12 hours from arrival (3.57% of attendances).
- **Ambulance handover:** within 15 minutes improved from 55.30% in August 2023 to 55.61% in September; within 30 minutes improved from 81.45% in August 2023 to 83.3% in September; within 60 minutes improved from 93.86 in August 2023 to 95.36% in September

Diagnostics

- In September, 67.67% of patients had their diagnostic test within 6 weeks of referral, an improvement compared to 61.45% in August.

Elective Care

- **78 week waits:** There were 27 patients waiting over 78 weeks in September, a reduction of one compared to August. The majority of patients waiting over 78 weeks are in ENT (19) and Orthopaedics (5).
- **65 week waits:** There were 283 patients waiting over 65 weeks at the end of September, a reduction compared to 299 in August although the Trust remains off track against trajectory.

Cancer waiting times

- **Faster Diagnosis Standard:** In August 2023, the Trust achieved 79.2% against the standard of 75%.
- **31-day from diagnosis to first definitive treatment (all cancers):** In August 2023, the Trust achieved 94.5% against the standard of 96%. Out of a total of 127 first treatments, 7 patients were not treated within 31 days. Out of the 7 breaches, 4 of these were in Dermatology.
- **62-day wait from referral from urgent referral to first definitive treatment for cancer:** In August 2023, the Trust achieved 71.4% against the standard of 85%. This is an improvement from the July position of 70.1%. Out of the 7 breaches, 4 of these were in Dermatology.
-

Recommendation:	The Trust Board of Directors is asked to NOTE the report.			
Action Required:	~~Approval~~	~~Review and discussion / give guidance~~	**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:	No changes made
Risk register:	
Regulation:	
Legal:	
Resources:	

Assurance Route	
Previously considered by:	Finance and Performance Committee
Date:	28 November 2023
Any outcomes / next steps	None
Previously circulated reports to supplement this paper	

1. Introduction

This paper details Trust performance against the national access standards, summarises the key factors driving any underperformance, the actions in place to improve performance and any risks to delivery. Benchmarking data is provided where available.

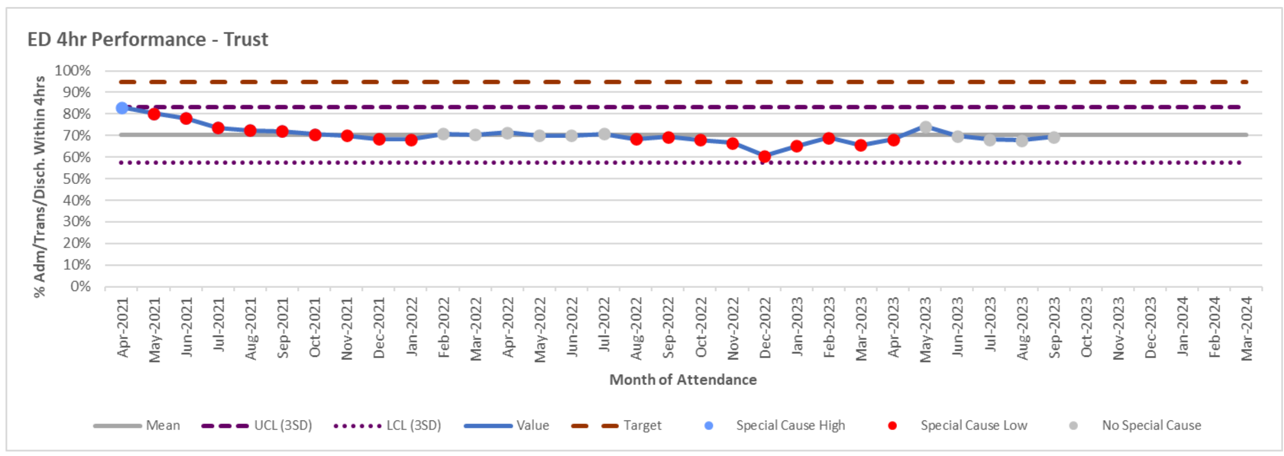
2. Background

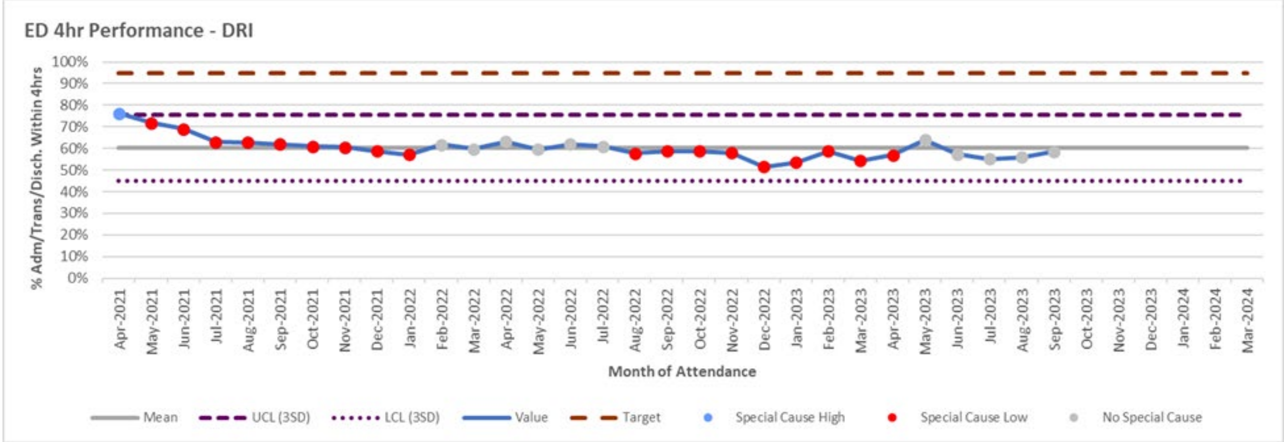
The NHS Standard Contract (2023/24) sets out the national quality requirements; these include waiting times for urgent and emergency care, diagnostics, elective care and cancer services.

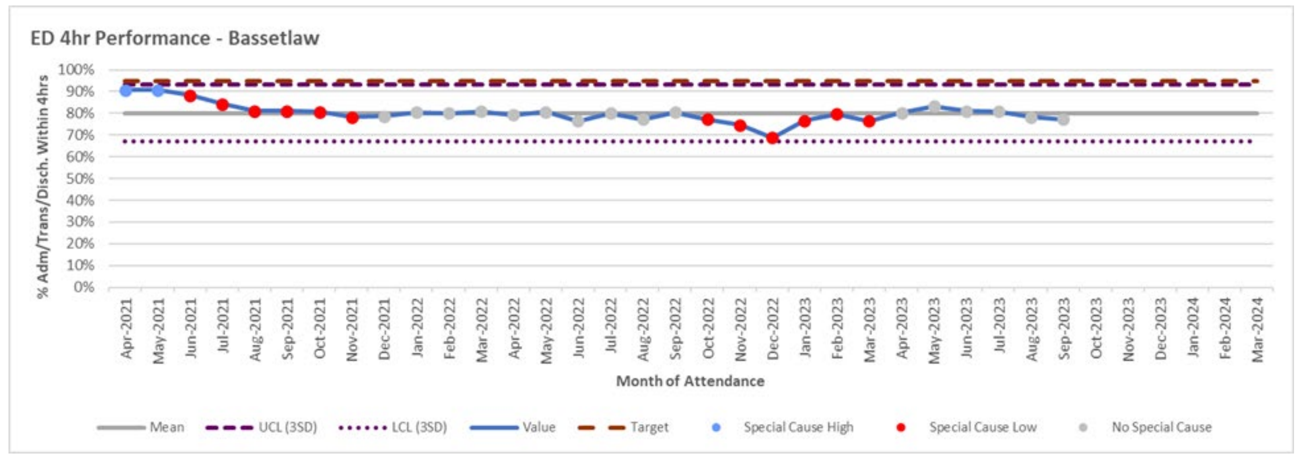
The NHS Priorities and Operational Planning Guidance summarises the national objectives for 2023/24, these include waiting time standards for urgent and emergency care, diagnostics, elective care and cancer services.

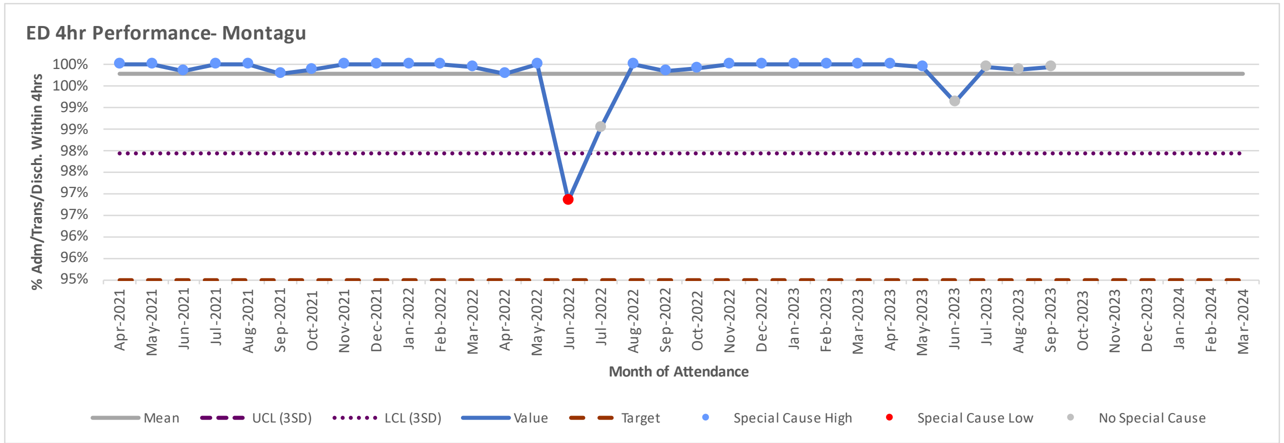
3. Emergency Care

3.1 Emergency access within 4 hours









Performance summary:

Trust: In September 2023, there were 16,373 attendances to the Trust Emergency Department (ED), of these 5,006 patients were in the Department over four hours before admission, discharge, or transfer. Performance was 69.42% against a standard of 76%

Bassetlaw: In September 2023 there were 5,140 attendances to BDGH ED, of these 1,166 patients were in the Department over four hours before admission, discharge, or transfer. Performance was 77.32%.

Doncaster: In September 2023 there were 9,258 attendances to DRI ED, of these 3,839 patients were in the Department over four hours before admission, discharge, or transfer. Performance was 58.53%.

Mexborough: In September 2023 there were 1,975 attendances to Montagu Minor Injuries Unit, of these 1 patient was in the Department over four hours before admission, discharge, or transfer. Performance was 99.95%.

Key issues (new issues in red):

- Waiting for assessment in ED continues to be the main reason patients wait longer than 4 hours in September 2023 (62.58%, of breaches) with the second highest cause being the delay in patients leaving the department to be admitted to a bed (16% of breaches).
- Multiple factors are causing delays associated with waiting for assessment; including a change in skill mix of the medical and nursing workforce due to newly recruited staff following a period of high vacancies and agency usage and multiple processes in patient pathways on arrival.
- Reduced streaming: streaming to alternative disposition including the urgent treatment centre was 13.39% in September 2023, and remains below the ambition of 20%.

- Staffing challenges due to consultant and junior doctor industrial action also affected performance in September 2023.

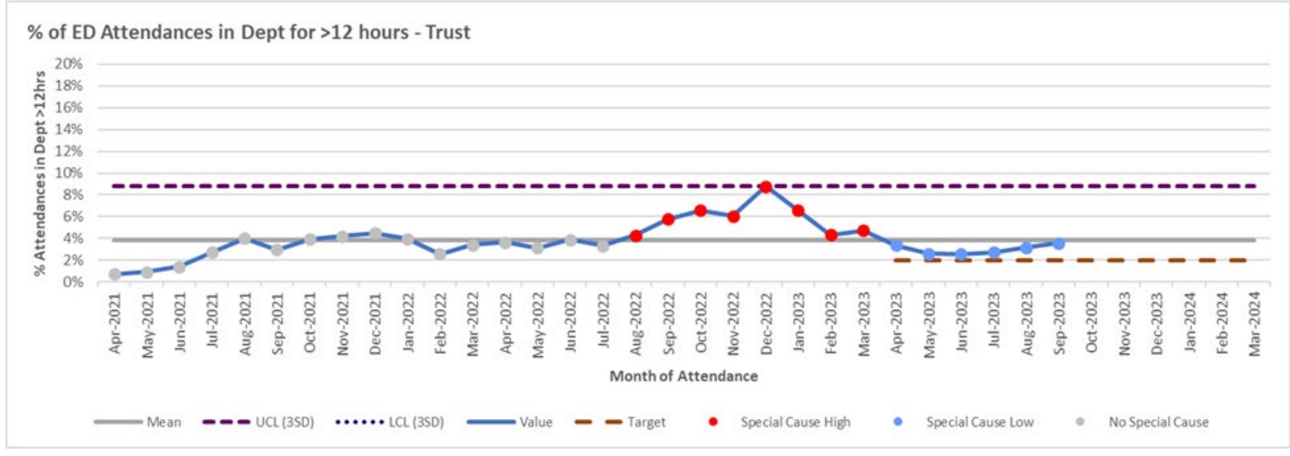
Key actions (new actions in green):

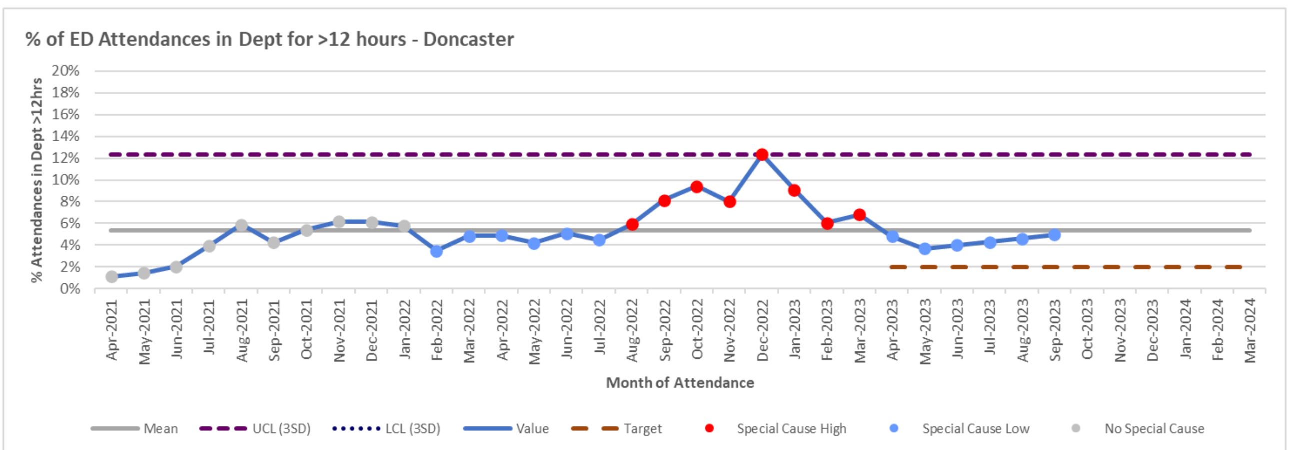
- Mitigation is in place to reduce the delays, where possible, through 2 hourly board rounds led by the Emergency Consultant in Charge and Nurse in Charge. This allows the team to be reallocated across the department according to demand, and 'surge' senior staffing in areas where a surge in activity occurs.
- A key priority in the UEC improvement programme is the redesign of the front door to ensure a streamlined, simple and consistent offer to patients.

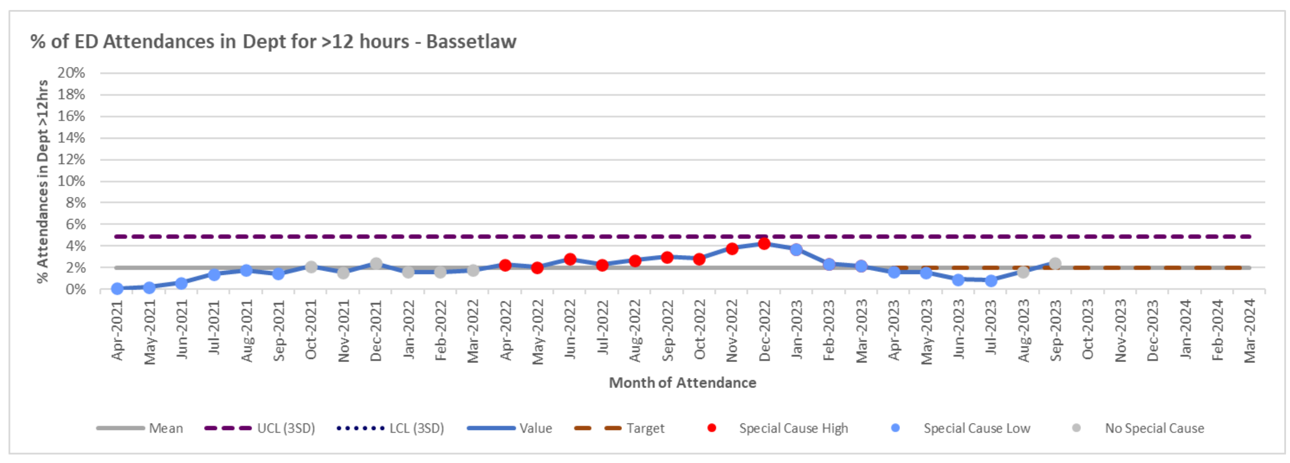
Key risks to delivery:

- Recruitment, retention and training of ED workforce to ensure the department achieves the level of skill required to see and treat patients in a timely manner.
- Continued periods of industrial action
- Delays to the delivery of the UEC improvement programme

3.2 Emergency access within 12 hours







Performance summary:

Trust: In September 2023, there were 585 patients in ED > 12 hours from arrival (3.57% of attendances).

Bassetlaw: In September 2023, there were 125 patients in ED > 12 hours from arrival at Bassetlaw ED (2.43% of attendances)

Doncaster: In September 2023, there were 460 patients in ED > 12 hours from arrival to Doncaster ED (4.97% of attendances)

Mexborough: In September 2023, there were 0 (zero) patients in ED > 12 hours from arrival to Montague Minor Injuries Department (0% of attendances).

Key issues (new issues in red):

- 39% of patients waiting over 12 hours in ED were waiting for a medical bed.
- Time to see an ED doctor and time taken for a review by ED doctor are the next two contributing factors on performance.
- 15.2% of patients in ED > 12 hours were admitted and 2.7% were discharged

Key actions (new actions in green):

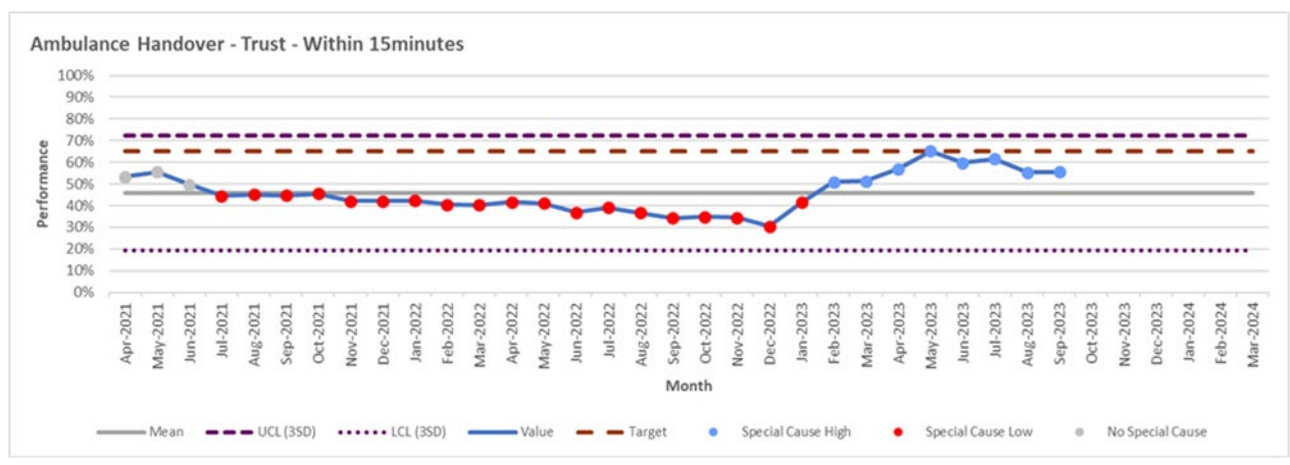
- Increase in patient flow team in ED, to support timely requests and reviews of tests, support discharges from the department and to link with assessment areas.
- A review of roles and responsibilities between Emergency Department and Acute Medical Unit has taken place to ensure patients move to assessment units in a timely manner rather than wait for assessment in ED.
- The UEC improvement programme will include improvement initiatives for ward / board rounds and discharge processes across key wards.

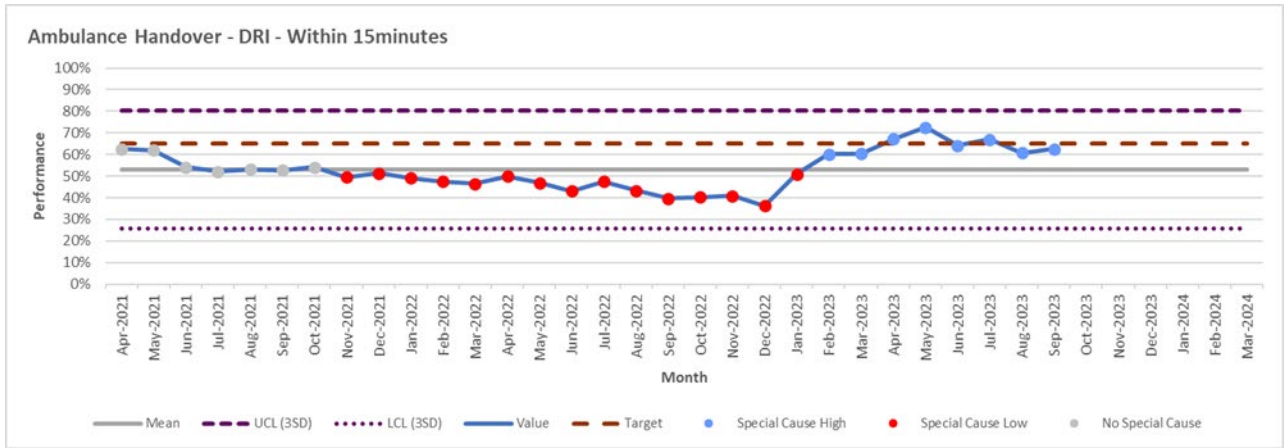
Key risks to delivery:

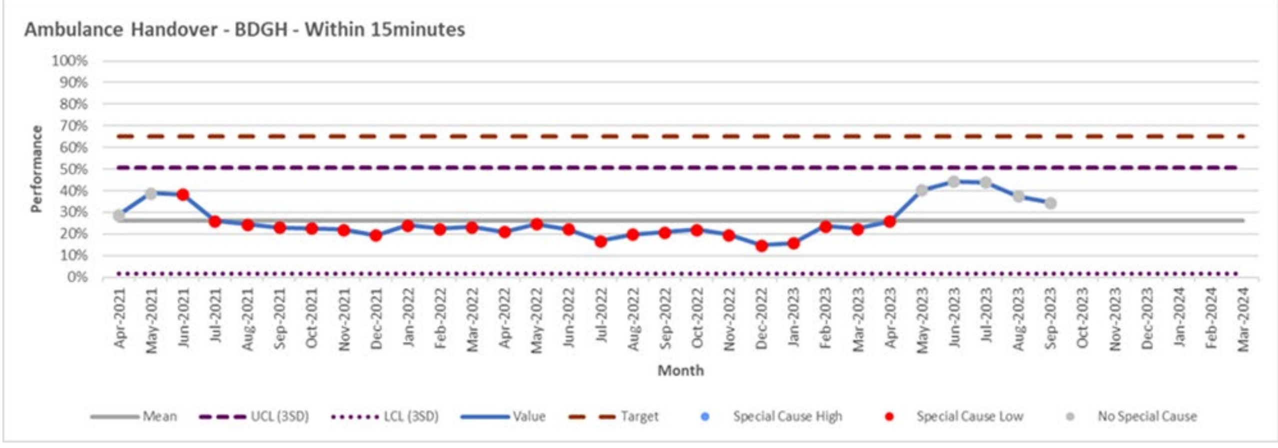
- Continued periods of industrial action
- Delays to the delivery of the UEC improvement programme

3.3 Ambulance handover

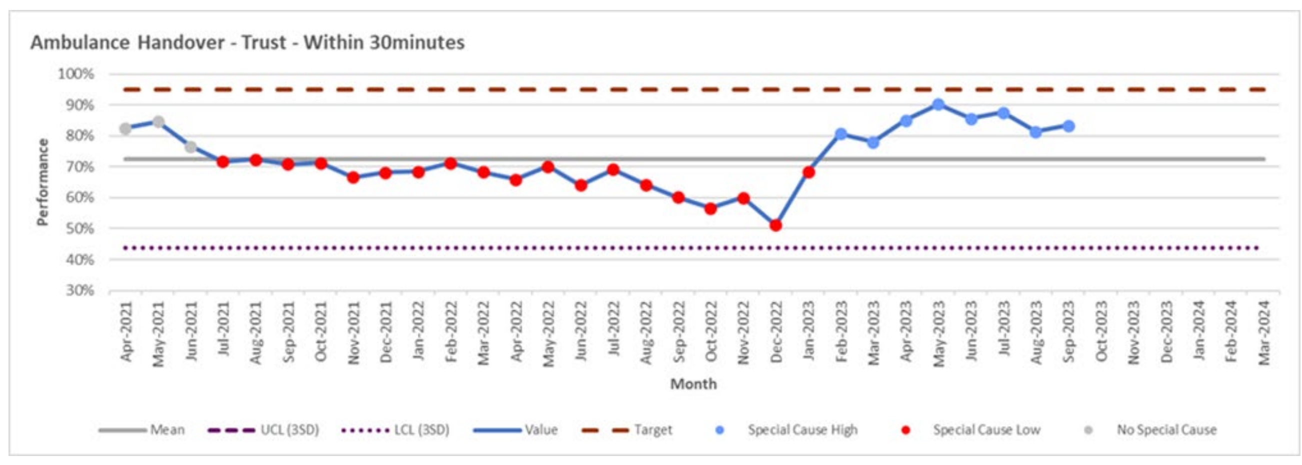
Within 15 minutes

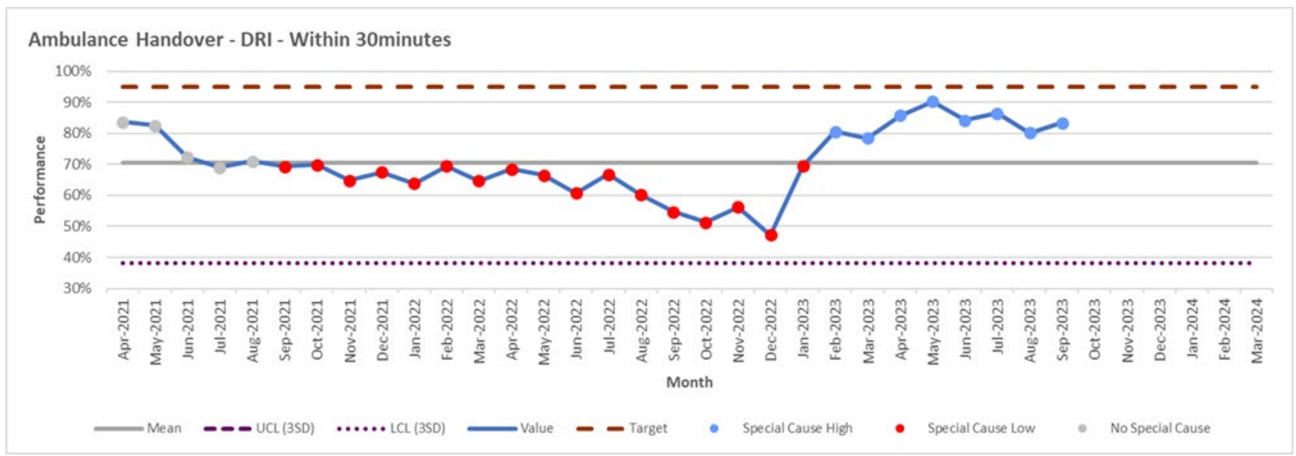


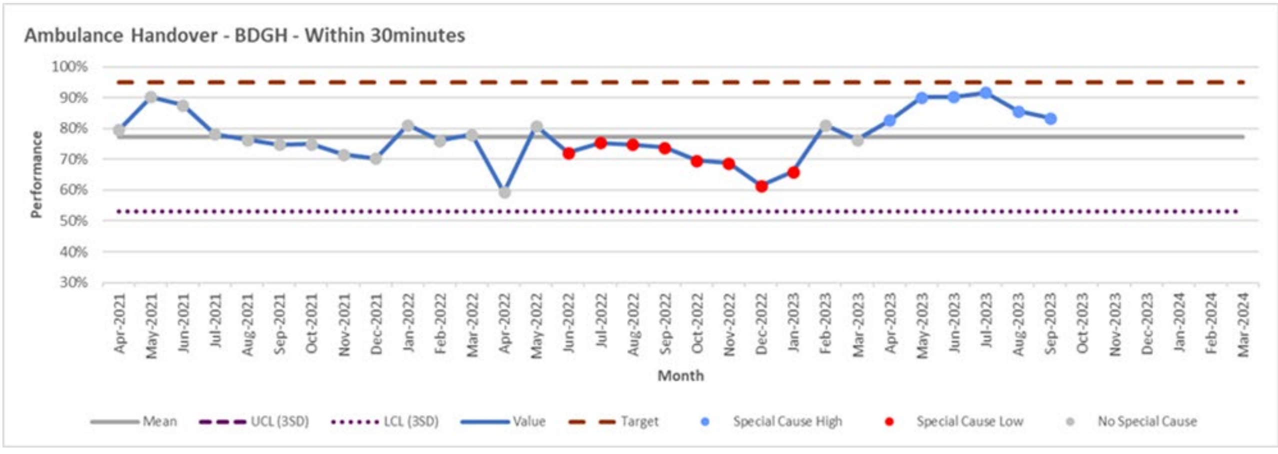




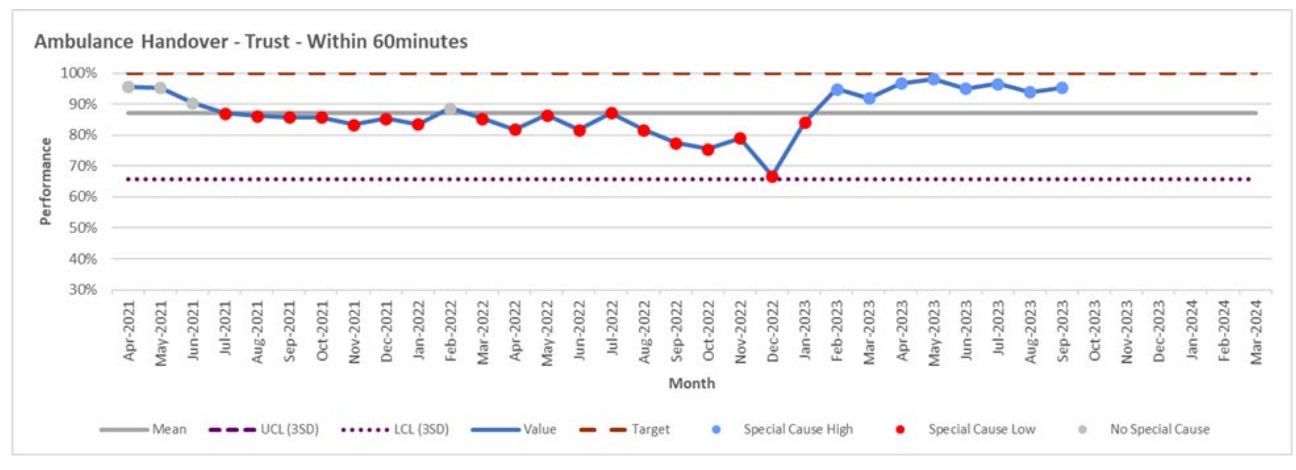
Within 30 minutes

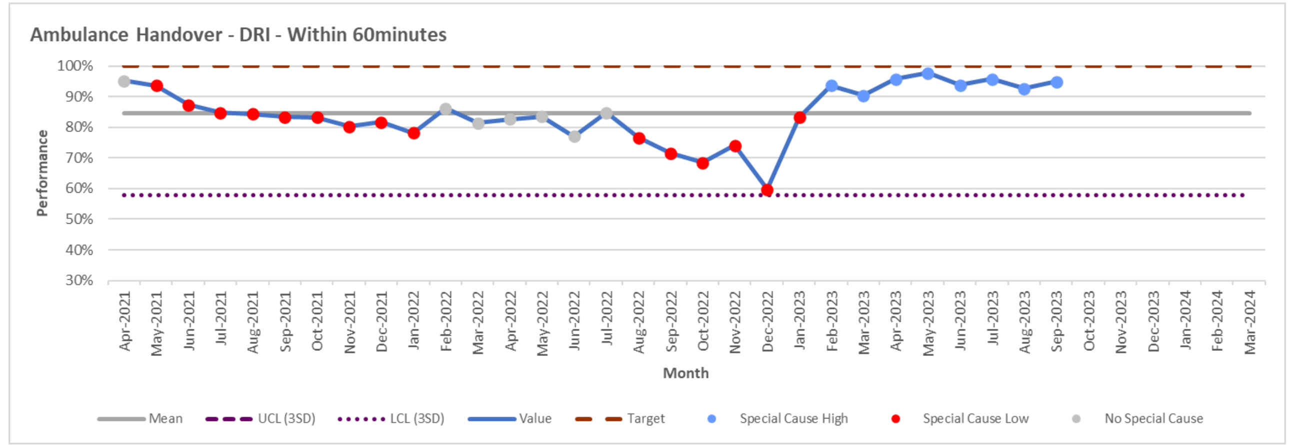


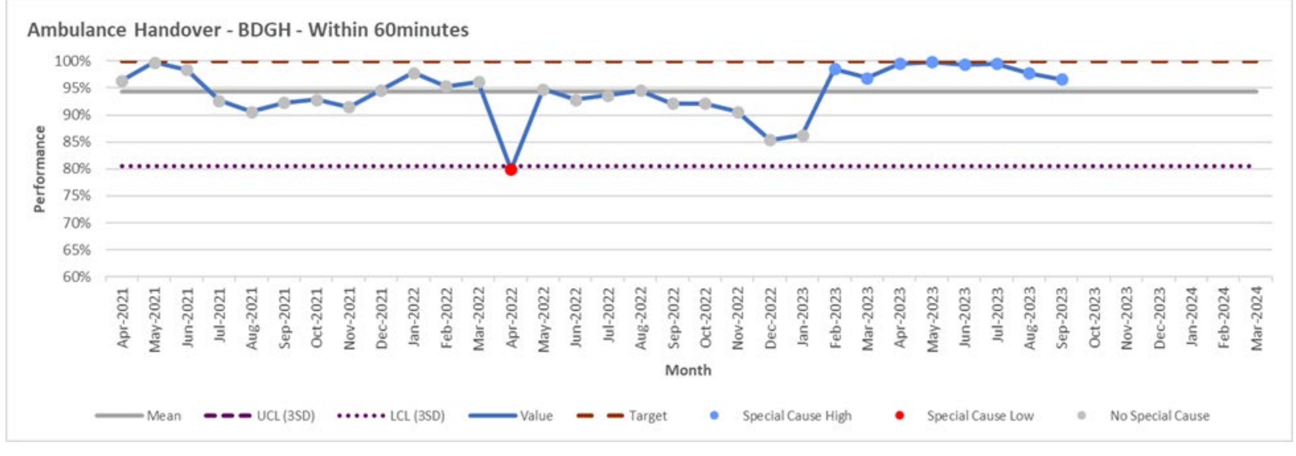




Within 60 mintues







Performance Summary:

Ambulance handover within 15 minutes improved from 55.30% in August 2023 to 55.61% in September.

Ambulance handover within 30 minutes improved from 81.45% in August 2023 to 83.3% in September.

Ambulance handover within 60 minutes improved from 93.86 in August 2023 to 95.36% in September.

Key issues (new issues in red):

- The performance analysis shows the impact on ambulance delays are at times when the department is over capacity.
- Bassetlaw's lack of capacity to off load ambulances is a limiting factor in turnaround times as well as continuing delays in crews pinning out.

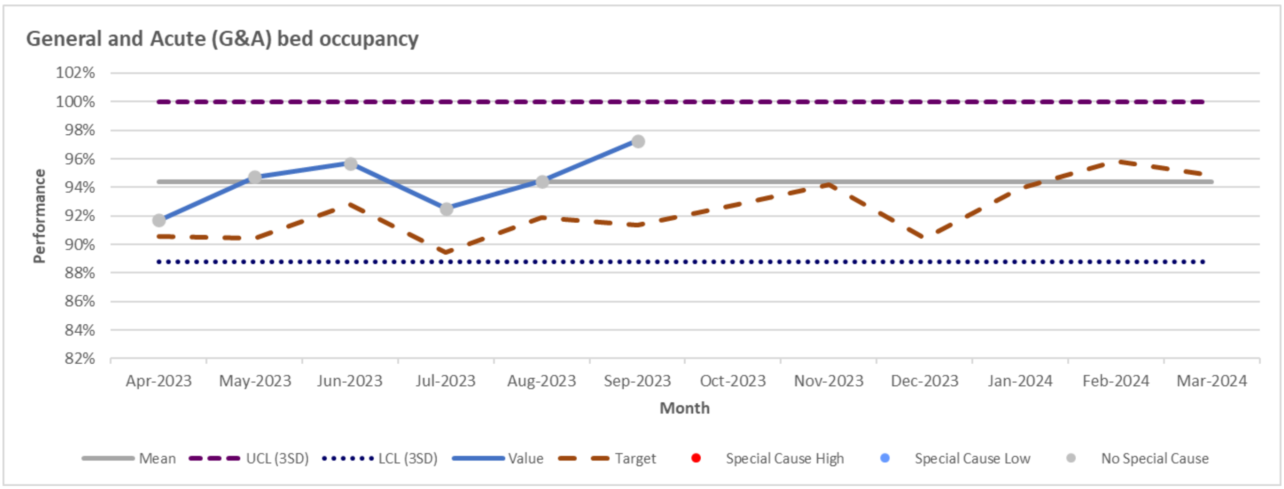
Key actions (new actions in green):

- The Early Senior Assessment model is embedded at Doncaster, which allows the patients waiting to be triaged and prioritised at time of delay.
- Collaborative working with YAS and the Trust continues, an Ambulance Resilience Co-ordinator is now in post and is based at DRI in hours 7 days a week.
- Work continues to embed the Early Senior Assessment model at Bassetlaw to increase handover capacity in the department.
- Direct ambulance to SDEC / UTC pathways are now in place at Doncaster and Bassetlaw.

Key risks to delivery:

- Continued periods of industrial action
- Delays to the delivery of the UEC improvement programme

3.4 General and Acute (G&A) bed occupancy



Performance summary:

In September, bed occupancy was 97.3%, an increase from 94.4% in August. This is above trajectory.

Key issues (new issues in red):

- Low numbers of patients on virtual wards
- Delays in supported discharges due to lack of capacity and process delays.

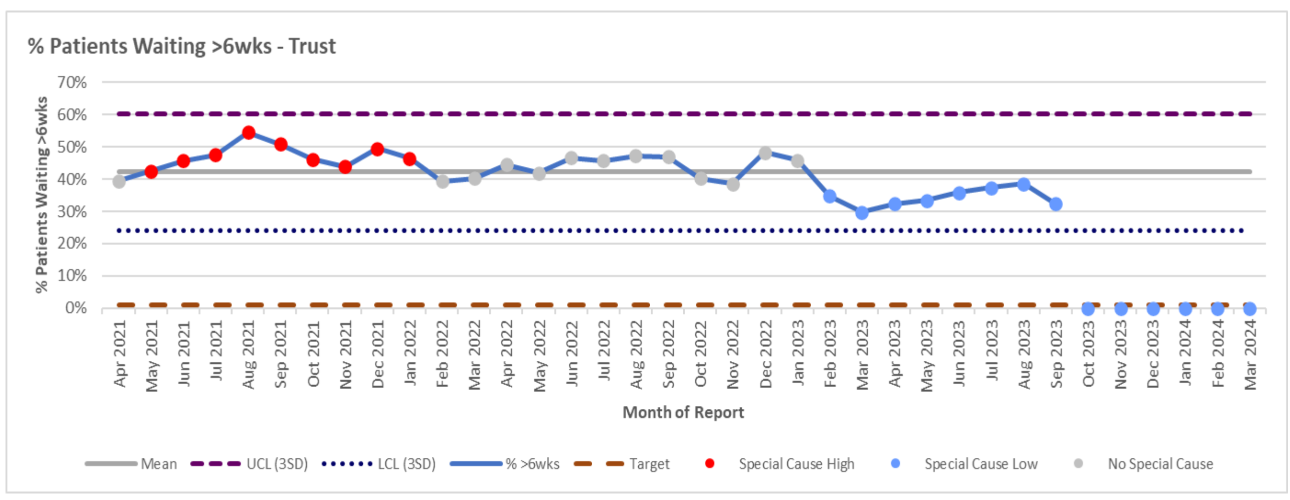
Key actions (new actions in green):

- Joint virtual ward meeting structure with RDASH, chaired by Deputy Chief Operating Officer
- Capacity and demand review looking at gaps in service and capacity in social care workforce

Key risks to delivery:

- Under utilisation of virtual ward capacity
- Delays to discharge for patients on discharge pathways 1 – 3

4. Diagnostic waiting times



	Apr 2023			May 2023			Jun 2023			Jul 2023			Aug 2023			Sep 2023		
	WL	>6wks	%>6wks	WL	>6wks	%>6wks	WL	>6wks	%>6wks	WL	>6wks	%>6wks	WL	>6wks	%>6wks	WL	>6wks	%>6wks
Magnetic Resonance Imaging	2,881	1,201	41.7%	3,279	1,424	43.4%	3,663	1,679	45.8%	3,577	1,721	48.1%	3,683	1,815	49.3%	3,683	1,140	31.0%
Computed Tomography	2,297	74	3.2%	2,830	395	14.0%	3,207	880	27.4%	3,179	1,203	37.8%	3,203	1,508	47.1%	3,203	695	21.7%
Non-Obstetric Ultrasound	2,095	249	11.9%	2,003	182	9.1%	2,271	86	3.8%	2,451	44	1.8%	3,055	38	1.2%	3,055	209	6.8%
Barium Enema	0	0		0	0		0	0		0	0		0	0		0	0	
Dexa Scan	972	552	56.8%	952	566	59.5%	909	490	53.9%	798	361	45.2%	842	415	49.3%	842	429	51.0%
Audiology - Audiology Assessments	1,860	1,521	81.8%	1,888	1,496	79.2%	1,921	1,648	85.8%	1,856	1,659	89.4%	2,082	1,745	83.8%	2,082	1,876	90.1%
Cardiology - Echocardiography	396	49	12.4%	395	70	17.7%	371	22	5.9%	367	11	3.0%	324	15	4.6%	324	21	6.5%
Cardiology - Electrophysiology	0	0		0	0		0	0		0	0		0	0		0	0	
Neurophysiology - Peripheral Neurophysiology	201	31	15.4%	209	52	24.9%	229	83	36.2%	229	63	27.5%	178	56	31.5%	178	19	10.7%
Respiratory Physiology - Sleep Studies	33	0	0.0%	19	0	0.0%	24	0	0.0%	25	1	4.0%	32	3	9.4%	32	4	12.5%
Urodynamics - Pressures & Flows*	62	9	14.5%	60	11	18.3%	63	10	15.9%	81	14	17.3%	96	10	10.4%	96	33	34.4%
Colonoscopy	335	70	20.9%	298	35	11.7%	331	8	2.4%	326	0	0.0%	300	0	0.0%	300	0	0.0%
Flexi Sigmoidoscopy	149	44	29.5%	112	18	16.1%	110	3	2.7%	113	1	0.9%	95	0	0.0%	95	0	0.0%
Cystoscopy	418	15	3.6%	386	13	3.4%	361	30	8.3%	349	17	4.9%	394	14	3.6%	394	17	4.3%
Gastroscopy	517	136	26.3%	416	35	8.4%	327	2	0.6%	281	1	0.4%	290	0	0.0%	290	0	0.0%
Total	**12,216**	**3,951**	**32.3%**	**12,847**	**4,297**	**33.4%**	**13,787**	**4,941**	**35.8%**	**13,632**	**5,096**	**37.4%**	**14,574**	**5,619**	**38.6%**	**13,744**	**5,619**	**40.9%**

Performance summary:

In September, 67.67% of patients had their diagnostic test within 6 weeks of referral, an improvement compared to 61.45% in August.

There were three modalities with the 100% DM01 performance in September (Gastroscopy, Flexi-sigmoidoscopy and Colonoscopy), the second consecutive month this has been achieved.

The lowest performing modalities in September were Audiology (15.2%) and Dexa (48.6%).

Key issues (new issues in red):

- Sustained high demand for CT scans
- Workforce gaps in Echocardiography
- Endoscopy (gastroscopy) activity has reduced due to strike days / sickness/consultant vacancies.

Key actions (new actions in green):

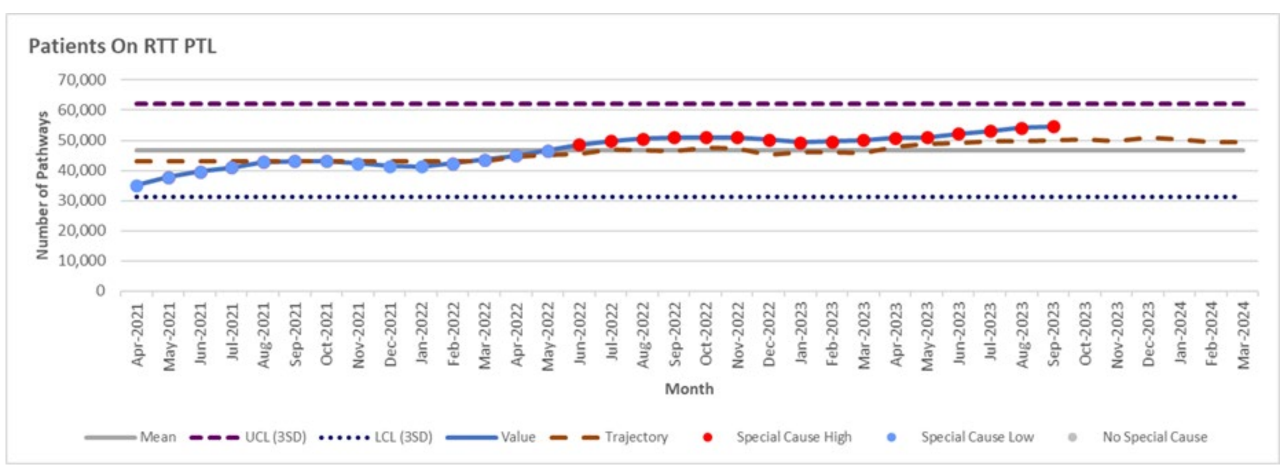
- A diagnostic improvement programme is in place, two of the key priorities are demand management of CT in line with clinical guidelines and effective utilisation of all diagnostic capacity.
- iRefer, a software tool designed to support appropriate imaging investigations, has gone live in CT.

Key risks to delivery:

- Continued periods of industrial action
- Continued high demand in some modalities

5. Elective Care

5.1 18 weeks referral to treatment



Top five specialties (number of pathways in most recent month)

	Apr 2023			May 2023			Jun 2023			Jul 2023			Aug 2023			Sep 2023		
Specialty	Total	18wks +	%18wks+	Total	18wks +	%18wks+	Total	18wks +	%18wks+	Total	18wks +	%18wks+	Total	18wks +	%18wks+	Total	18wks +	%18wks+
T&O	8,054	3,518	43.7%	8,037	3,364	41.9%	8,122	3,373	41.5%	8,312	3,429	41.3%	8,424	3,463	41.1%	8,438	3,521	41.7%
ENT	6,118	2,698	44.1%	5,976	2,729	45.7%	6,199	2,906	46.9%	6,262	3,037	48.5%	6,401	3,242	50.6%	6,477	3,474	53.6%
X02 Other - Medical S	5,010	1,204	24.0%	4,962	1,200	24.2%	4,969	1,350	27.2%	4,892	1,487	30.4%	4,802	1,589	33.1%	4,853	1,721	35.5%
Dermatology	3,753	1,192	31.8%	3,867	1,163	30.1%	4,112	1,347	32.8%	4,230	1,375	32.5%	4,540	1,463	32.2%	4,701	1,549	33.0%
Gynaecology	4,165	1,398	33.6%	4,377	1,338	30.6%	4,494	1,451	32.3%	4,635	1,607	34.7%	4,645	1,785	38.4%	4,601	1,925	41.8%

Top five specialties (% total pathways 18wks or over in most recent month – standard 8%)

	Apr 2023			May 2023			Jun 2023			Jul 2023			Aug 2023			Sep 2023		
Specialty	Total	18wks +	%18wks+	Total	18wks +	%18wks+	Total	18wks +	%18wks+	Total	18wks +	%18wks+	Total	18wks +	%18wks+	Total	18wks +	%18wks+
ENT	6,118	2,698	44.1%	5,976	2,729	45.7%	6,199	2,906	46.9%	6,262	3,037	48.5%	6,401	3,242	50.6%	6,477	3,474	53.6%
X06 Other - Other Serv	620	368	59.4%	600	321	53.5%	629	340	54.1%	664	355	53.5%	682	346	50.7%	687	367	53.4%
Oral Surgery	2,982	1,260	42.3%	3,054	1,291	42.3%	3,109	1,354	43.6%	3,065	1,376	44.9%	2,952	1,361	46.1%	2,933	1,368	46.6%
Thoracic Medicine	1,093	236	21.6%	1,035	205	19.8%	1,149	307	26.7%	1,160	400	34.5%	1,324	533	40.3%	1,432	600	41.9%
Gynaecology	4,165	1,398	33.6%	4,377	1,338	30.6%	4,494	1,451	32.3%	4,635	1,607	34.7%	4,645	1,785	38.4%	4,601	1,925	41.8%

Performance summary:

Trust level performance for September was 61.47%, a deterioration from 62.77% in August.

The number of incomplete pathways in September (54,680) has increased from August.

The number of admitted clock stops in September (1,365) is slightly lower than the number in August (1,391) and slightly lower than the average of previous months this calendar year (av. Jan – Aug: 1,387 per month)

but this average is skewed slightly by an exceptionally high number of admitted clock stops in March (1,613; range of other months: 1,205 – 1,458).

The number of non-admitted clock stops in September (8,476) is broadly in line with August (8,513) and the average of the other months in 2023 (av Jan – Aug: 8,500).

The number of new RTT periods in September (12,040) was 513 fewer than the total in August (12,553) and was the third lowest monthly total in 2023 (range Jan-Aug: 10,940-13,734 new periods per month).

Key issues (new issues in red):

- Reduced elective activity due to continued industrial action

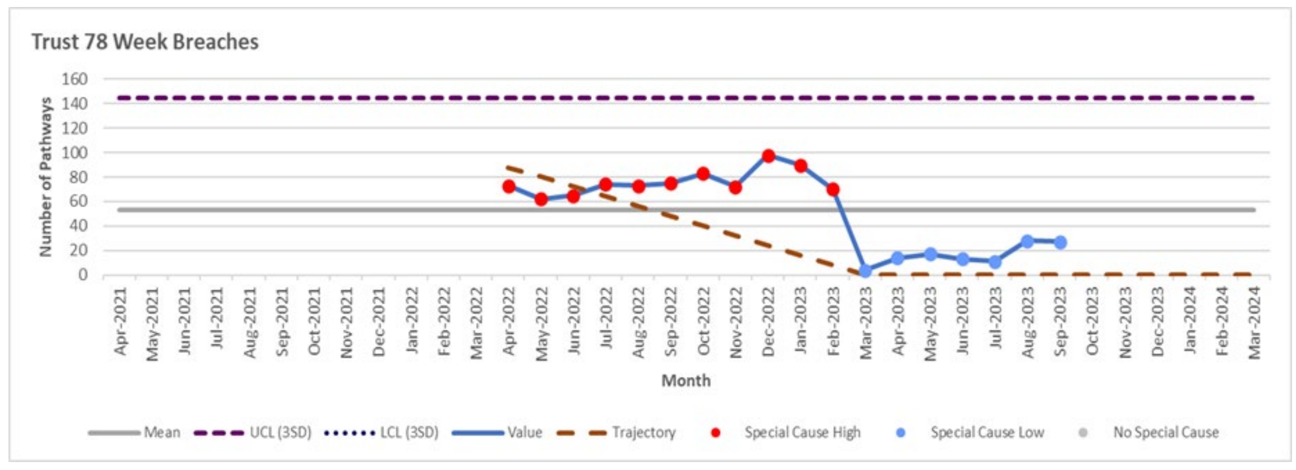
Key actions (new actions in green):

- Outpatient improvement programme in place, one of the key priorities is to reduce the 'did not attend' rates
- Continued recruitment to the validation team to support timely validation of the waiting list

Key risks to delivery:

- Continued periods of industrial action

5.2 Waits over 78 weeks for incomplete pathways



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022/23	73	62	65	74	73	75	83	72	98	90	70	4
2023/24	14	17	13	11	28	27						

Top five specialties (number of 78wk breaches in most recent month)

	Apr 2023			May 2023			Jun 2023			Jul 2023			Aug 2023			Sep 2023		
Specialty	Without Dec. to Admit	With Dec. to Admit	Total	Without Dec. to Admit	With Dec. to Admit	Total	Without Dec. to Admit	With Dec. to Admit	Total	Without Dec. to Admit	With Dec. to Admit	Total	Without Dec. to Admit	With Dec. to Admit	Total	Without Dec. to Admit	With Dec. to Admit	Total
ENT	1	4	5	0	5	5	0	4	4	0	6	6	1	20	21	1	18	19
T&O	0	6	6	1	6	7	0	5	5	0	4	4	1	4	5	2	3	5
Dermatology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2
Oral Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	1	1

Performance summary:

There were 27 patients waiting over 78 weeks in September, a reduction of one compared to August. The majority of patients waiting over 78 weeks are in ENT (19) and Orthopaedics (5).

Key issues (new issues in red):

- Lack of capacity in Rhinology services in ENT and mutual aid not available
- National issue with lack of corneal transplant materials, patient selection is being directed by NHSBTS.
- Continued periods of industrial action

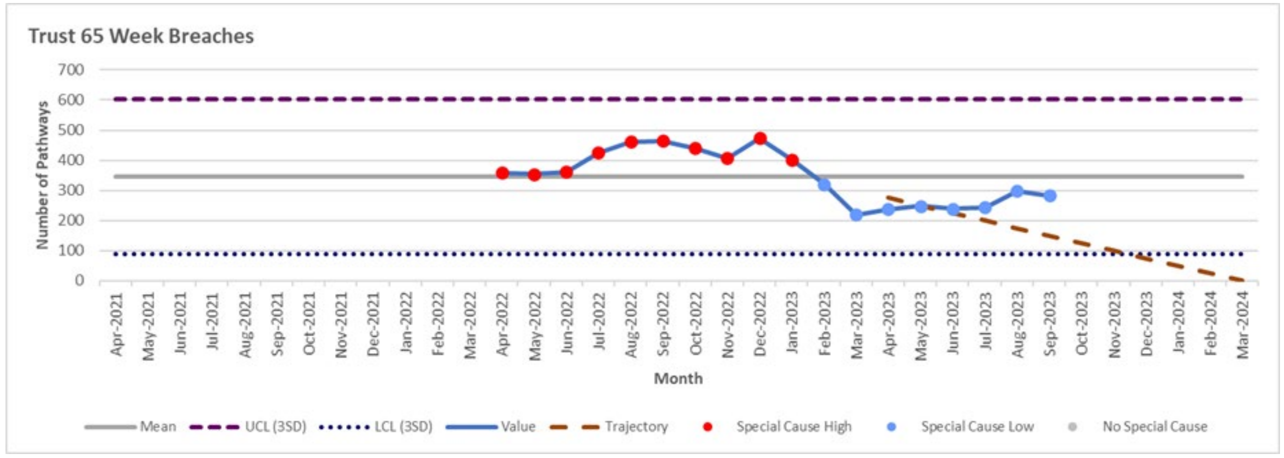
Key actions (new actions in green):

- Additional internal capacity secured for Rhinology

Key risks to delivery:

- Continued periods of industrial action
- Under delivery of the activity plan

5.3 Waits over 65 weeks for incomplete pathways



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021/22												
2022/23	359	354	362	425	462	464	441	407	473	403	321	220
2023/24	238	248	239	244	299	283						

Top five specialties (number of 65wk breaches in most recent month)

	Apr 2023			May 2023			Jun 2023			Jul 2023			Aug 2023			Sep 2023		
Specialty	Without Dec. to Admit	With Dec. to Admit	Total	Without Dec. to Admit	With Dec. to Admit	Total	Without Dec. to Admit	With Dec. to Admit	Total	Without Dec. to Admit	With Dec. to Admit	Total	Without Dec. to Admit	With Dec. to Admit	Total	Without Dec. to Admit	With Dec. to Admit	Total
T&O	21	149	170	18	151	169	15	151	166	20	146	166	17	176	193	18	158	176
ENT	7	32	39	6	45	51	3	37	40	6	39	45	19	45	64	36	43	79
Urology	4	1	5	0	4	4	7	1	8	13	3	16	15	2	17	8	1	9
Ophthalmology	3	3	6	9	1	10	3	5	8	2	5	7	0	5	5	3	2	5
Gynaecology	7	3	10	5	3	8	3	2	5	1	0	1	4	2	6	2	2	4

Performance summary:

There were 283 patients waiting over 65 weeks at the end of September, a reduction compared to 299 in August although the Trust remains off track against trajectory.

Key issues (new issues in red):

- Lack of capacity in Rhinology services in ENT and mutual aid is not available
- National issue with lack of corneal transplant materials, patient selection is being directed by NHSBTS.
- Continued periods of industrial action

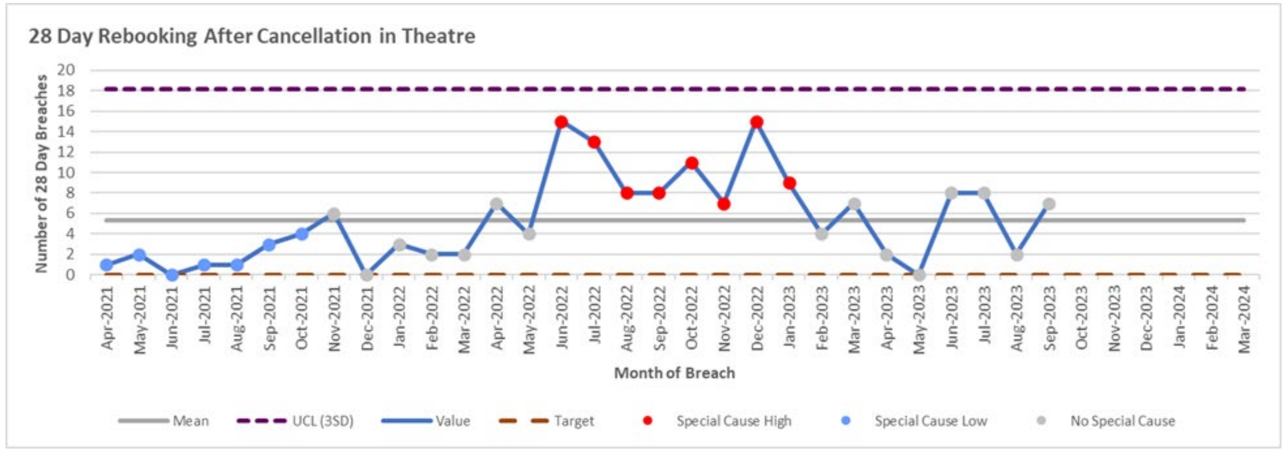
Key actions (new actions in green):

- Additional internal capacity secured for Rhinology

Key risks to delivery:

- Continued periods of industrial action
- Under delivery of the activity plan

5.4 Breaches of the 28 day guarantee



Performance summary:

There were 7 breaches of the 28-day guarantee in September 2023 compared to 2 in the August.

Key issues (new issues in red):

None identified

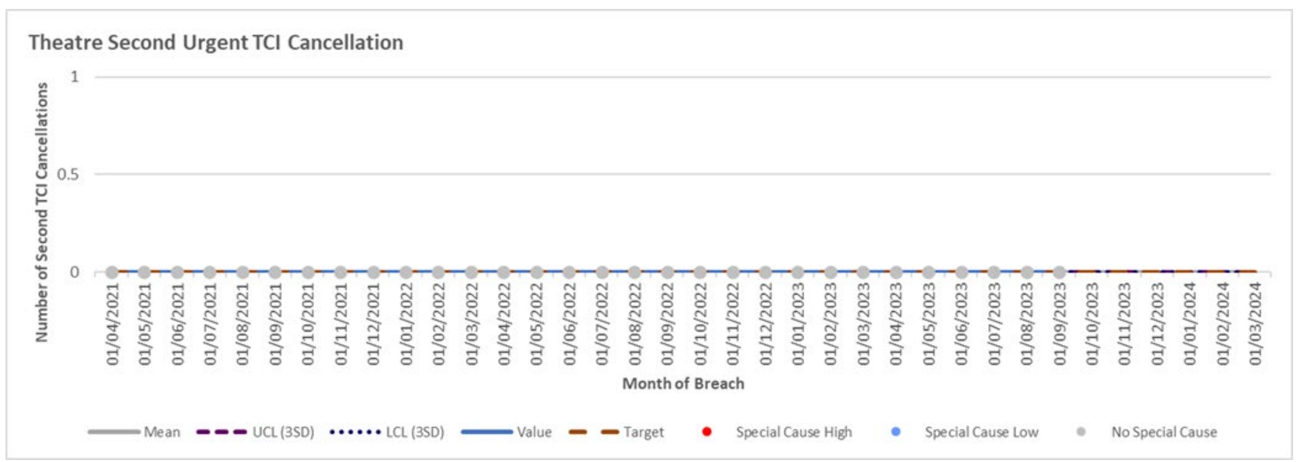
Key actions (new actions in green):

- Improved oversight of re-booking of patients within 28 days of a cancellation.

Key risks to delivery:

- Continued periods of industrial action

5.5 Urgent operations cancelled for a second time

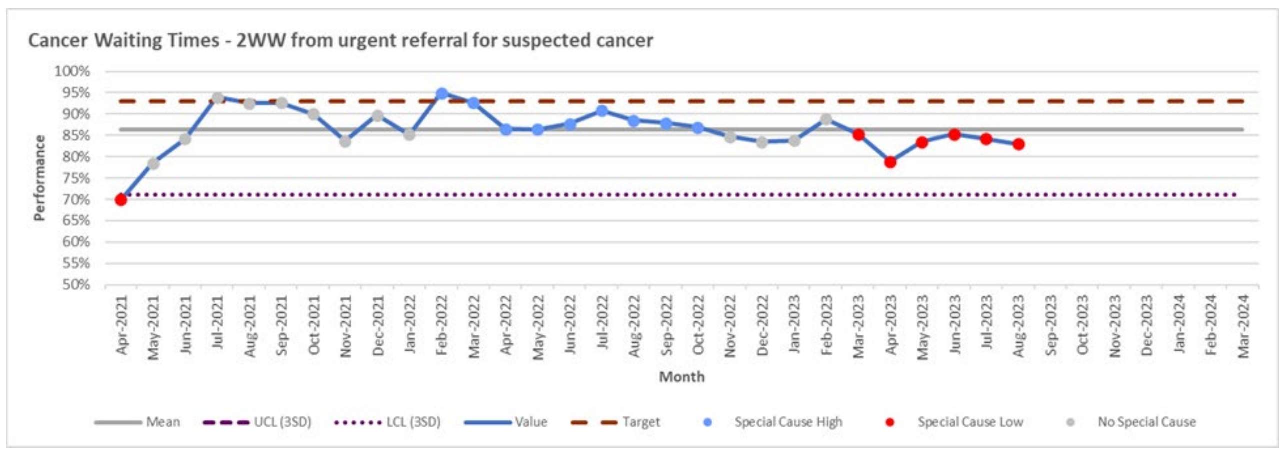


Performance summary:

There were zero urgent operations cancelled in September 2023 for a second time (no breaches year to date).

6. Cancer Waiting Times

6.1 2-week wait from urgent referral for suspected cancer to first outpatient attendance



Performance summary:

In August, the Trust achieved 83% against the standard of 93%. Out of 1,747 attendances, 297 patients were not seen within 14 days.

Key issues (new issues in red):

- Continuing industrial action in September
- Increased demand into Dermatology, 500 2 week wait referrals received

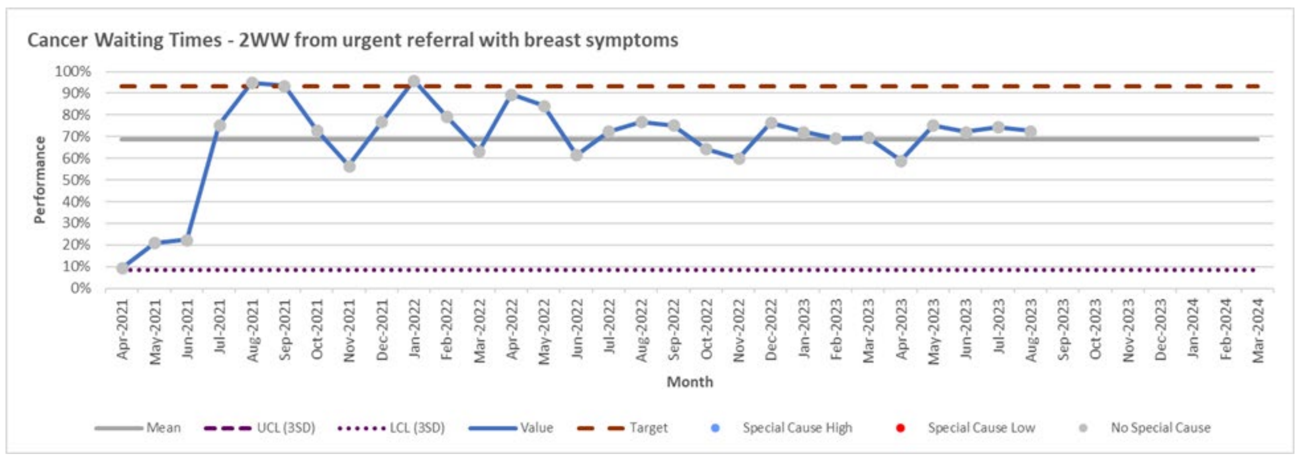
Key actions (new actions in green):

- No new actions

Key risks to delivery:

- Increase in referrals
- Diagnostic capacity

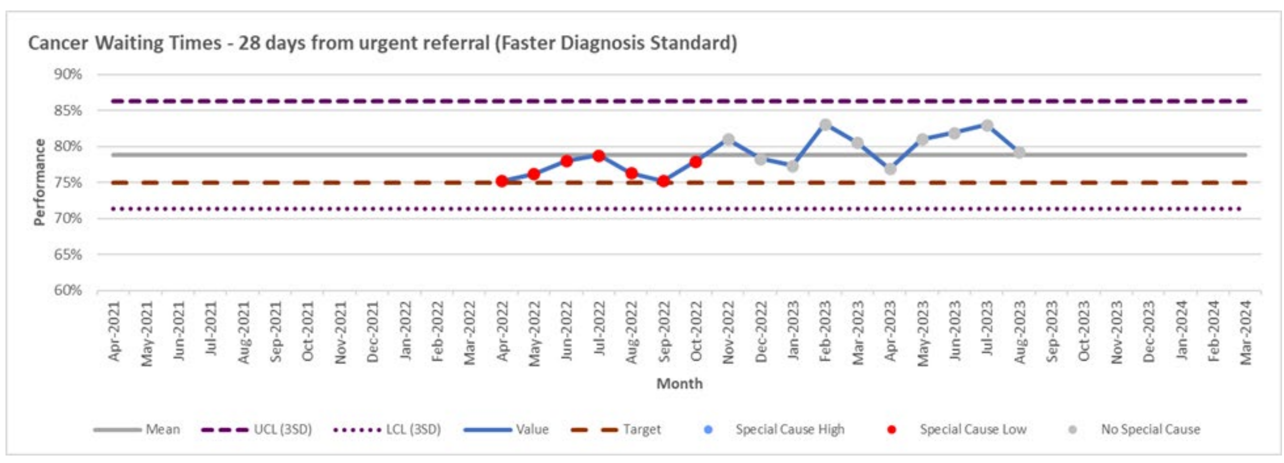
6.2 2-week wait from urgent referral with breast symptoms (where cancer was not initially suspected) to first outpatient attendance



Performance summary:

In August 2023, the Trust achieved 72.6% against the standard of 93%. Out of a total of 84 attendances, 23 patients were not seen within 14 days.

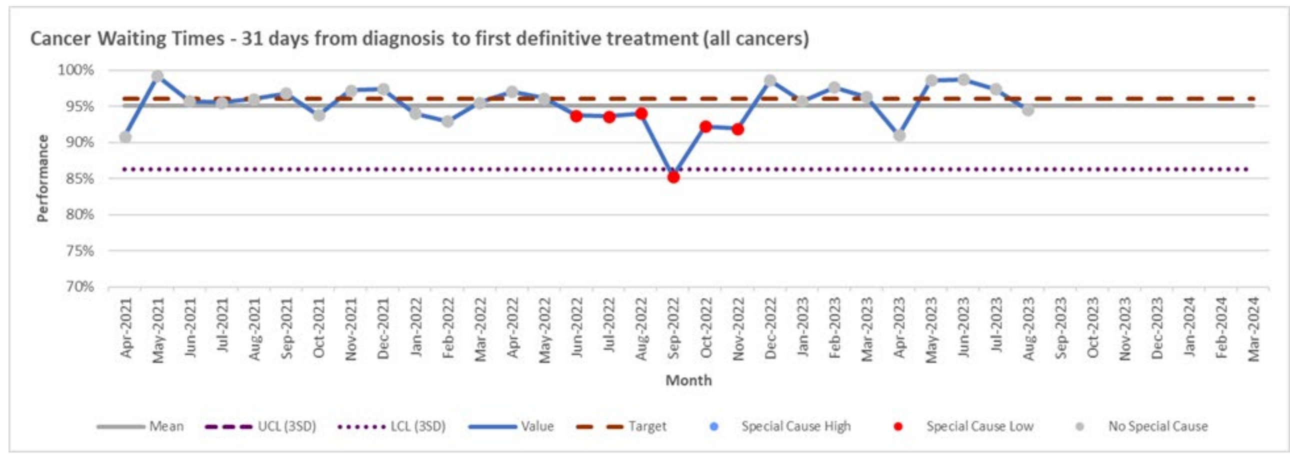
6.3 28 days from urgent referral to receiving a communication of diagnosis for cancer or ruling out of cancer



Performance summary:

In August 2023, the Trust achieved 79.2% against the standard of 75%.

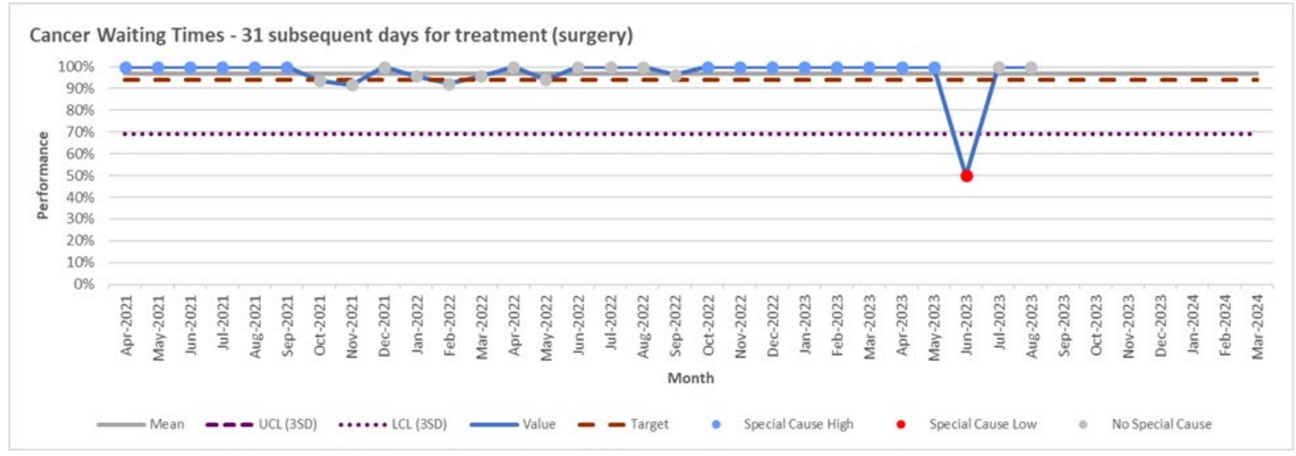
6.4 31-day from diagnosis to first definitive treatment (all cancers)



Performance summary:

In August 2023, the Trust achieved 94.5% against the standard of 96%. Out of a total of 127 first treatments, 7 patients were not treated within 31 days. Out of the 7 breaches, 4 of these were in Dermatology.

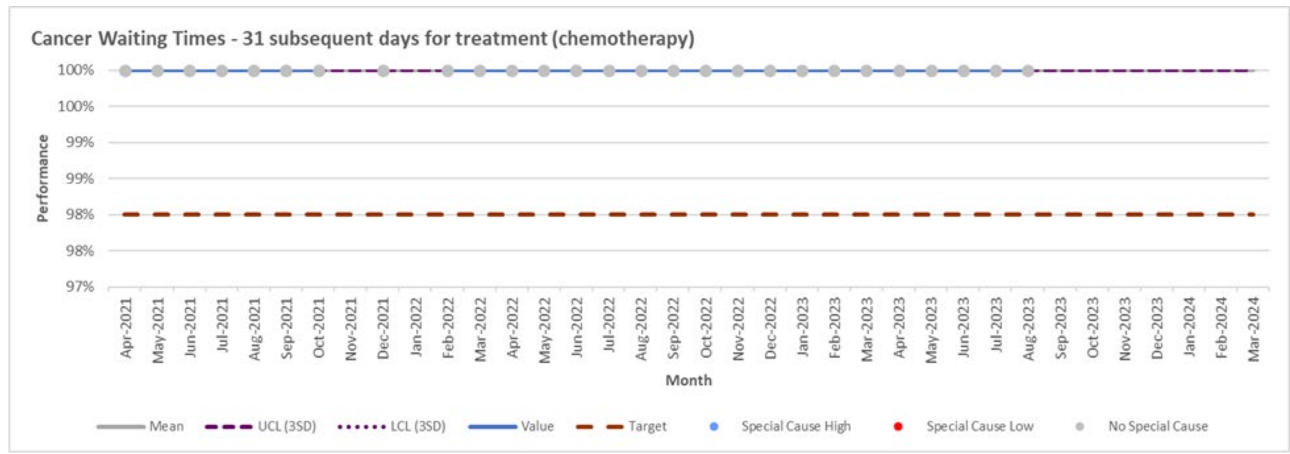
6.5 31-day for subsequent treatment (surgery)



Performance summary:

The standard has been met for August 2023 at 100%.

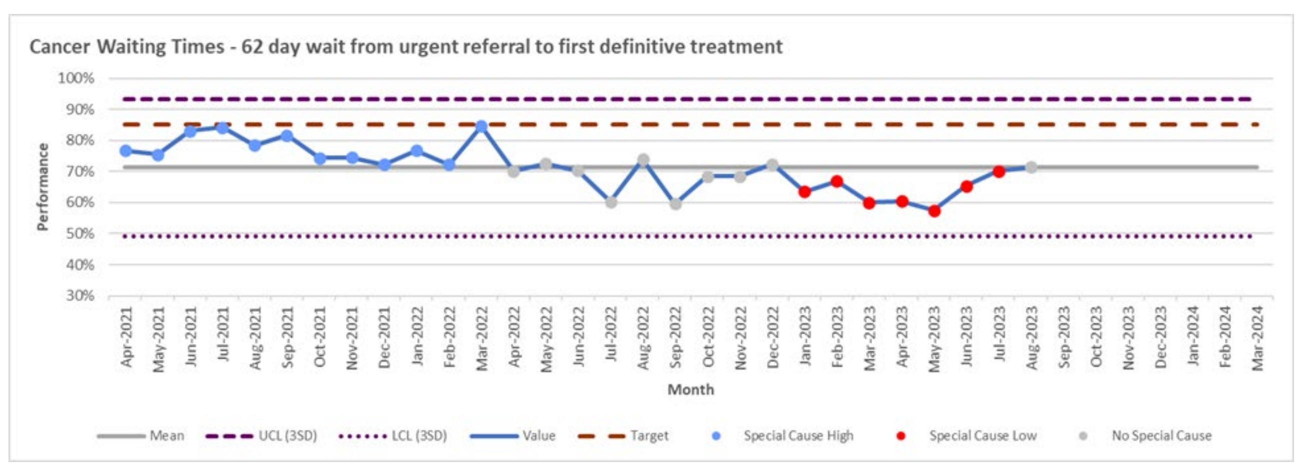
6.6 31-day for subsequent treatment (chemotherapy)



Performance summary:

The standard has been met for August 2023 (100%).

6.7 62 day wait from referral from urgent referral to first definitive treatment for cancer



Performance summary:

In August 2023, the Trust achieved 71.4% against the standard of 85%. This is an improvement from the July position of 70.1%. Out of the 7 breaches, 4 of these were in Dermatology.

Key issues (new issues in red):

- Complexity of patient management and diagnostics
- Tertiary Centre capacity for first and subsequent clinical Oncology treatments
- Patient choice of treatment option due to long waiting times for radical surgical treatment at the Tertiary Centre (Prostate Cancer)

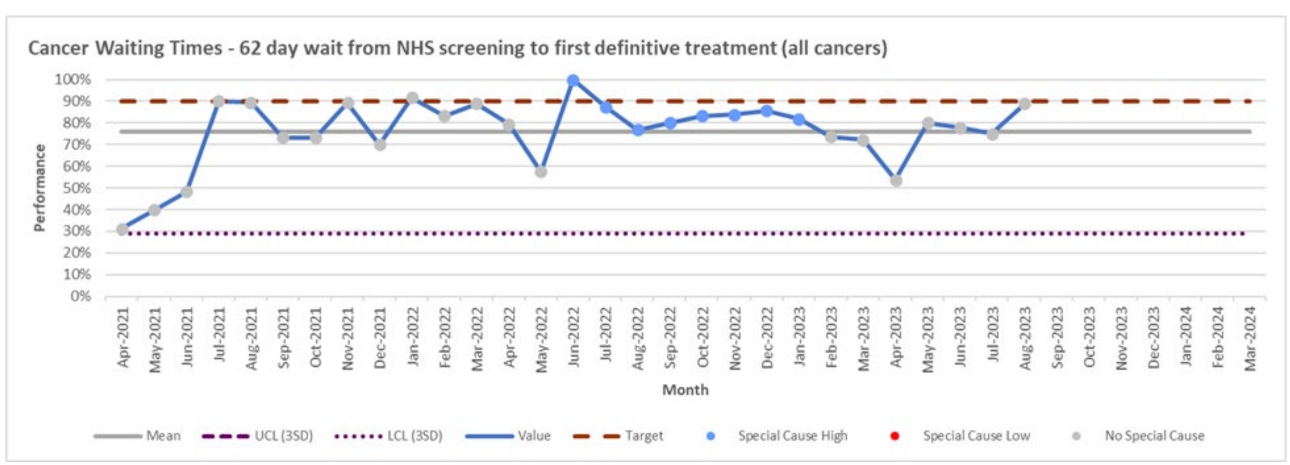
Key actions (new actions in green):

- Deep Dive work has commenced across the Cancer Alliance looking to the Prostate pathway, which includes radical surgery.
- Deep Dive work into Gynaecology pathways

Key risks to delivery:

- Diagnostic capacity
- Non-surgical Oncology capacity
- Surgical capacity at the tertiary provider

6.8 62-day from referral from an NHS screening service to first definitive treatment (all cancers)



Performance summary:

Performance has improved in August 2023; the Trust achieved 88.9% against the standard of 90%.

There was one patient, from the Bowel Screening Programme, where the standard was not met.

Key issues (new issues in red):

None identified

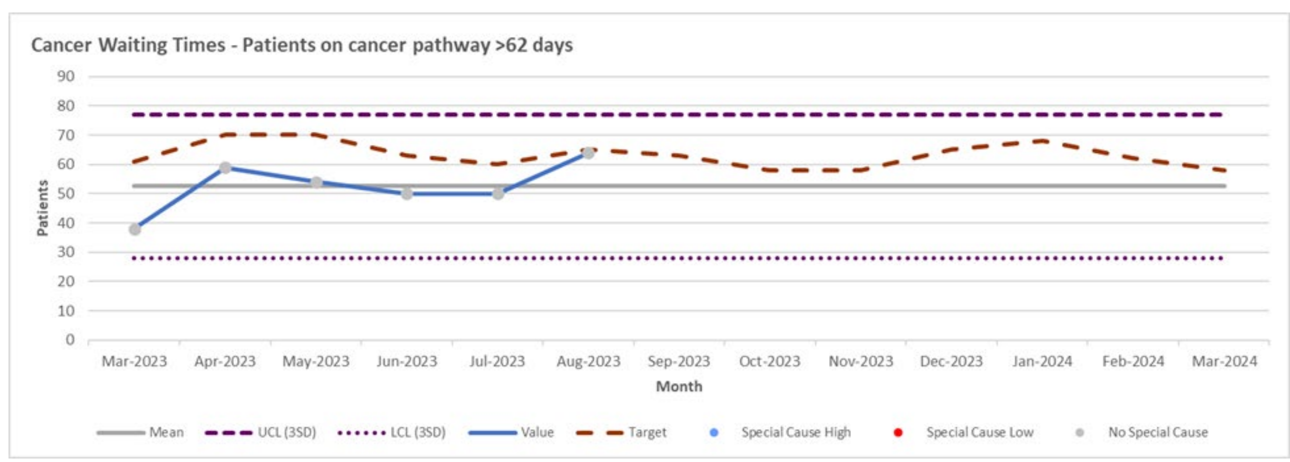
Key actions (new actions in green):

None identified

Key risks to delivery:

- Diagnostic capacity

6.9 Patients on a cancer pathway > 62 days



Performance summary:

There were 64 patients on a cancer pathway > 62 days in August, against the trajectory of 65 patients.

Key issues (new issues in red):

- Continued periods of industrial action
- Turnaround times for histology
- Patient choice during the summer

Key actions (new actions in green):

There are no new actions at present.

Key risks to delivery:

- Diagnostic capacity
- Continued industrial action

7. Recommendations

The Trust Board of Directors is asked to NOTE the report.

2311 - E5 SAME DAY EMERGENCY CARE BUSINESS CASE

Decision Item | Denise Smith, Chief Operating Officer | 11:35

10 minutes
Executive summary only - Business case paper has been reviewed at F&P on 27 November 2023, there will be an update for the Board from the Chief Operating Officer and supported by Mark Day, Chair of F&P Committee.

REFERENCES

Only PDFs are attached

E5 - SDEC Extended Opening Hours Board Nov 23.pdf

Report Cover Page			
Meeting Title:	Trust Board		
Meeting Date:	28 November 2023	**Agenda Reference:**	E5
Report Title:	Same Day Emergency Care (SDEC) Extended Hours Business Case		
Sponsor:	Denise Smith, Chief Operating Officer		
Author:	Clare Ainsley, Head of Planning and Service Developments		
Appendices:			

Executive Summary	
Purpose of report:	The Same Day Emergency Care (SDEC) Extended Hours Business Case was approved in principle at the Corporate Investment Group in September 2023 and a deep dive review being undertaken on behalf of the Board at the Finance and Performance Committee (F&P) 27 November 2023. Recommendations from the F&P Committee will then be presented to the Board for approval.
Executive Summary	The business case being presented to Finance & Performance Committee (F&P) on 27 November 2023 outlines the benefits of extending the opening hours of the medical same-day emergency care (SDEC) service at Doncaster Royal Infirmary (DRI). Currently, the facility operates during standard business hours, limiting its availability to patients who require urgent care outside of those hours. Extending the service's opening hours would provide patients with greater access to emergency care and alleviate pressure on other healthcare services. Additionally, it has the potential to support increased patient volume; thus reducing the bed occupancy rate across Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH). The case is in line with the NHS Long Term Plan and the NHS Operational Planning and Priorities Framework 23/24. The Trust have applied for and secured £711,868 of NHSE funding to support the expansion of the medical same-day emergency care operating hours. The initial gap to be covered is *£96,962.* Doncaster Place have confirmed that this funding is recurrent, and conversations are underway with NHSE to increase the funding There will be a deep dive review of the case at F&P Committee on 27 November 2023. The recommendations of the review will then be presented to the Board for approval by the Chief Operating Officer, supported by Mark Day, Chair of F&P Committee.
Recommendation:	Board to approve the recommendations on the case as a result of a deep dive review by the Finance and Performance Committee held on 27 November.

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 our vision*	*Team DBTH feels valued and feedback from staff and learners is in the top 10% in the UK*	*The Trust is in recurrent surplus to invest in improving patient care*

Implications			
Board assurance framework:			
Corporate risk register:			
Regulation:	None		
Legal:	None		
Resources:	None		
Assurance Route			
Previously considered by:	Corporate Investment Group approval given September 2023		
Date:	**September 2023**	**Decision:**	Approved
Next Steps:	Finance and Performance Committee approval 27 November 2023		
Previously circulated reports to supplement this paper:			

2311 - E6 WINTER PLANS

Decision Item | Denise Smith, Chief Operarting Officer | 11:45

10 minutes

REFERENCES

Only PDFs are attached

E6 - Winter Plans.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	28 November 2023	**Agenda Reference:**	**E6**
Report Title:	**Winter Plan Schemes 2023/24**		
Sponsor:	Denise Smith, Chief Operating Officer		
Author:	Suzanne Stubbs, Deputy Chief Operating Officer		
Appendices:			
Purpose of report:	This paper details the final winter plan schemes, requiring additional investment, for 2023/24.		
Summary:	Winter planning workshops were held in the summer with Divisional and Corporate teams to develop the long list of proposed winter plan schemes for 2023/24. Further prioritisation of these schemes has been undertaken and a confirm and challenge session, with the Deputy Chief Operating Officer, Deputy Director of Finance and Deputy Chief Nurse, has been completed. The following are the final winter plan schemes for 2023/24 that require additional funding: • Additional patient transport for the overnight period • Additional registered nursing support to the Same Day Emergency Care (Surgery) • Additional Acute Medicine Consultant support to in reach to the Emergency Department • Extended opening of the Trauma Ambulatory Care Unit • Additional Paediatric Registrar at the weekend • Additional junior doctor support to the medical wards at Doncaster Royal Infirmary • Phased opening of the remaining Bassetlaw bed base on B floor to 24 beds in December 2023 and 28 in January 2024.		

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

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

Implications	
Board assurance framework:	No changes made
Corporate risk register:	
Regulation:	
Legal:	

<table>
<tr><td colspan="2">Resources:</td><td colspan="3"></td></tr>
<tr><td colspan="5">Assurance Route</td></tr>
<tr><td colspan="3">Previously considered by:</td><td colspan="2">Executive Team November 2023</td></tr>
<tr><td>Date:</td><td>22/11/23</td><td>Decision:</td><td colspan="2"></td></tr>
<tr><td colspan="2">Next Steps:</td><td colspan="3"></td></tr>
<tr><td colspan="2">Previously circulated reports to supplement this paper:</td><td colspan="3"></td></tr>
</table>

1. Introduction

This report details the final winter plan schemes, requiring investment, for 2023/24.

2. Background

Earlier this year, NHS England published the Urgent and Emergency Care Recovery Plan, underpinned by an extensive programme of work to deliver improvements across urgent and emergency care ahead of winter. This plan, along with the NHS's primary care and elective recovery plans, and the broader strategic and operational plans and priorities for the NHS, provides a firm basis for preparing for the 2023/24 winter period.

The 2023/24 winter plan is comprised of the following core elements:

- High-impact priority interventions drawn from the UEC recovery plan that we know lead to a safe and effective service to patients. All systems will be asked to deliver these.
- Clear roles and responsibilities for each part of the system so that both shared and individual organisational accountability is clear.
- Returns from systems on system-level resilience and surge planning, to avoid systems becoming overwhelmed at times of peak demand and a narrative return against key lines of enquiry.

All the interventions over winter should contribute towards the two key ambitions for UEC performance of:

(i) 76% of patients being admitted, transferred, or discharged within four hours by March 2024, with further improvement in 2024/25.
(ii) Ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24

3. Winter plan schemes 2023/24

Winter planning workshops were held in the summer with Divisional and Corporate teams to develop the long list of proposed winter plan schemes for 2023/24. Further prioritisation of these schemes has been undertaken and a confirm and challenge session, with the Deputy Chief Operating Officer, Deputy Director of Finance and Deputy Chief Nurse, has been completed.

The following are the final winter plan schemes for 2023/24 that require additional funding:

- Additional patient transport for the overnight period
- Additional registered nursing support to the Same Day Emergency Care (Surgery)
- Additional Acute Medicine Consultant support to in reach to the Emergency Department
- Extended opening of the Trauma Ambulatory Care Unit
- Additional Paediatric Registrar at the weekend
- Additional junior doctor support to the medical wards at Doncaster Royal Infirmary
- Phased opening of the remaining Bassetlaw bed base on B floor to 24 beds in December 2023 and 28 in January 2024.

The detail of these schemes, together with the benefits and costs are detailed at Appendix A.

It is proposed that all schemes commence in December 2023 and remain in place until the end of March 2024.

The total cost of all schemes is £671,102.

It is noted that the following additional capacity has already been invested in during 2023/24:

- **Clinical Site Team** for Doncaster and Bassetlaw, providing senior clinical oversight of the sites over a 24/7 period. The Clinical Site Team has a key role in maintaining patient flow from the Emergency Department through to Discharge and ensuring robust escalation arrangements are in place.

- The **Discharge Lounges** at Doncaster and Bassetlaw have increased capacity and extended opening hours, this enables early discharges from the wards and supports patient flow from the Emergency Department and Assessment units.

- The **medicine inpatient bed base** at Doncaster Royal Infirmary has been increased through the opening of ward 22 (17 beds) and a further 8 escalation beds across a number of wards.

In addition, the Finance and Performance Committee will receive a business case in November 2023 for the expansion of the Same Day Emergency Care Unit (Medicine) at Doncaster Royal Infirmary. This will extend the opening hours of the unit, meeting national planning requirements and reduce the demand for inpatient beds as more patients can be managed on a same day emergency care basis.

4. Summary

The schemes identified for winter 2023/24 will provide the necessary increase in capacity to manage the forecast peaks in demand through winter and maintain patient flow.

5. Recommendations

The Finance and Performance Committee is asked to APPROVE the winter plan schemes for 2023/24.

Appendix A Winter Plan Schemes 2023 / 24

Scheme	Description	Benefits	Operational Dates	Pay costs (per month)	Non-pay costs (per month)	Total Cost
Patient Transport	2 x additional crews overnight (18.00-02.00 and 20.00-04.00)	Support discharges from the Emergency Department and Discharge Lounge overnight, thereby avoiding overnight stays in ED or unavoidable admissions.	Dec 23 - Mar 24	21,005		84,020
Acute Medicine	Additional Consultant (9am – 1pm) to provide in reach to the Emergency Department	Support in reach to the Emergency Department to reduce time to Acute Medicine review and support admission avoidance	Dec 23 - Mar 24	6,346		25,384
Same Day Emergency Care (Surgery)	Additional Registered Nurse (Band 5), 10am - 8pm, 7 days, in SDEC (Surgery)	Increase capacity in SDEC (Surgery) which will enable more timely flow out of the ED and support admission avoidance in surgery	Dec 23 - Mar 24	9,796		39,184
Trauma	Trauma Ambulatory Care Unit to remain open 7 days a week (7am - 8pm)	Increase trauma assessment capacity during the forecast peaks in trauma demand, enabling more timely flow out of the ED	Dec 23 - Mar 24	6,679		26,716
Paediatrics	Additional Registrar cover (1pm - 11pm) at the weekend	Increased senior medical capacity during the weekend period to support timely assessment of children during the forecast peaks in demand and minimise avoidable admissions	Dec 23 - Mar 24	8,656		34,624
Medical Wards	Additional junior doctor (9am - 5pm) to support medical wards at Doncaster	Increase junior doctor capacity on the medical wards to ensure essential ward tasks are completed to improve pre-noon discharges	Dec 23 - Mar 24	5,457		21,828
Bassetlaw bed base	Phased increase in, and reconfiguration, of the bed base on B floor to maintain elective activity and provide additional medical beds (phase I to open to 24 beds in December, phase II to open to 28 beds in January 23). ESSU opening hours are increased	Expansion of the bed base provides a phased increase in medical beds to support the forecast peaks in demand for emergency admissions. Reconfiguration of the floor supports the maintenance of the elective activity programme during the winter period.	Dec 23 - Mar 24	Phase 1 = 88,460 Phase 2 = 108,311	Phase 1 = 10,570 Phase 2 = 12,332	439,346
					Total	**671,102**

2311 - F STRATEGY

2311 - F1 HEALTH INEQUALITIES STRATEGY

Decision Item | Jon Sargeant, Chief Financial Officer | 11:55

Dr Kirsty Edmondson-Jones, Director of Innovation & Infrastructure
Dr Kelly Mackenzie, Public Health Consultant
10 minutes

REFERENCES

Only PDFs are attached

F1 - Health Inequalities Strategy.pdf

Report Cover Page				
Meeting Title:	**Board of Directors**			
Meeting Date:	28 November 2023	**Agenda Reference:**	**F1**	
Report Title:	**DBTH Tackling Health Inequalities Strategy 2023-2028**			
Sponsor:	Kirsty Edmondson-Jones, Director of Innovation and Infrastructure			
Author:	Kelly Mackenzie, Consultant in Public Health			
Appendices:	DBTH Tackling Health Inequalities Strategy 2023-2028 – Final DBTH Tackling Health Inequalities Action Plan 2023-2028 – Final DBTH Tackling Health Inequalities “Plan on a Page” 2023-2028 – Final			

Report Summary

Executive Summary

Purpose of the report:
Enclosed within this report are three documents in their final versions: (1) DBTH Tackling Health Inequalities Strategy, (2) the associated action plan, and (3) the “Plan on a Page”. The documents are presented here for approval. To note, the documents still need to be formatted by the comms team so that they are visually consistent with other DBTH strategies. The documents presented here are the final versions in terms of content.

Summary of key issues:
- To present and gain approval for the final version of the DBTH Tackling Health Inequalities Strategy 2023-2028, associated action plan and “Plan on a Page”.

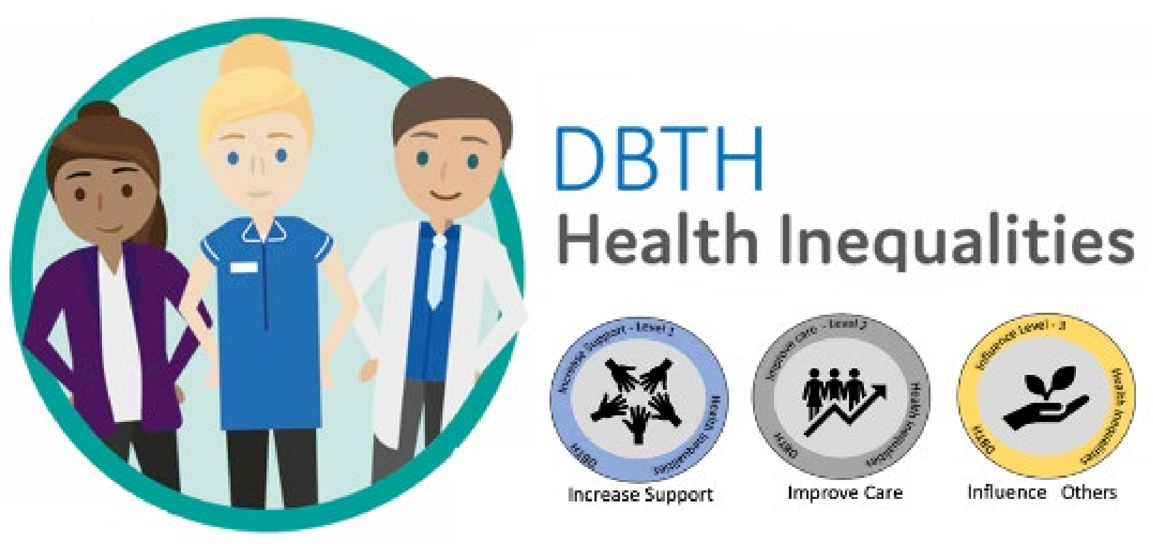
Recommendation:	Members are asked to receive this report and approve the documents enclosed within it.			
Action Required:	Approval	~~Discussion~~	~~Take assurance~~	~~Information only~~
Link to True North Objectives:	**TN SA1:** ***To provide outstanding care and improve patient experience***	**TN SA2:** *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:	None
Risk register:	N/A
Regulation:	There are 8 CQC Key Lines of Enquiry Measures relating to health inequalities. The strategy document presented in this paper will support the

	provision of evidence that we are meeting these Key Lines of Enquiry Measures.
Legal:	Tackling health inequalities is mandated in the Health and Social Care Act 2022 – "…considerations also need to be given to the effects [of decisions] in relation to health inequalities. This applies to ICBs, NHS England and foundation trusts, and trust in England (the relevant bodies)." The strategy document presented in this paper will support the provision of evidence that we are taking action to tackle health inequalities.
Resources:	None

Assurance Route	
Previously considered by:	F&P
Date:	30/10/2023
Any outcomes/next steps	F&P Committee recommended the strategy and action plan for approval up to the Trust Board.
Previously circulated reports to supplement this paper:	DBTH Tackling Health Inequalities Strategy 2023-2028 (F&P Committee 30/10/2023) Draft DBTH Tackling Health Inequalities Strategy and "Plan on a Page" (F&P Committee 24/07/2023)



DBTH Tackling Health Inequalities Strategy 2023-2028

Foreword

[INSERT Something from Richard Parker / Suzy Brain England / Kirsty Edmondson-Jones]

Executive Summary

Health inequalities are "avoidable, unfair and systematic differences in health between different groups of people". They mean that some population groups have significantly worse health experiences and outcomes than others. These differences can be due to a range of factors including a person's social, economic and environmental circumstances – and we know that greater deprivation in any of these factors is associated with an increased risk of becoming ill earlier and dying younger. People with certain characteristics, such as certain ethnicities, sexual orientation, age, and disabilities, also have a lower chance of living a long and healthy life compared to others. This is often due to the exclusion from society that people with these characteristics face.

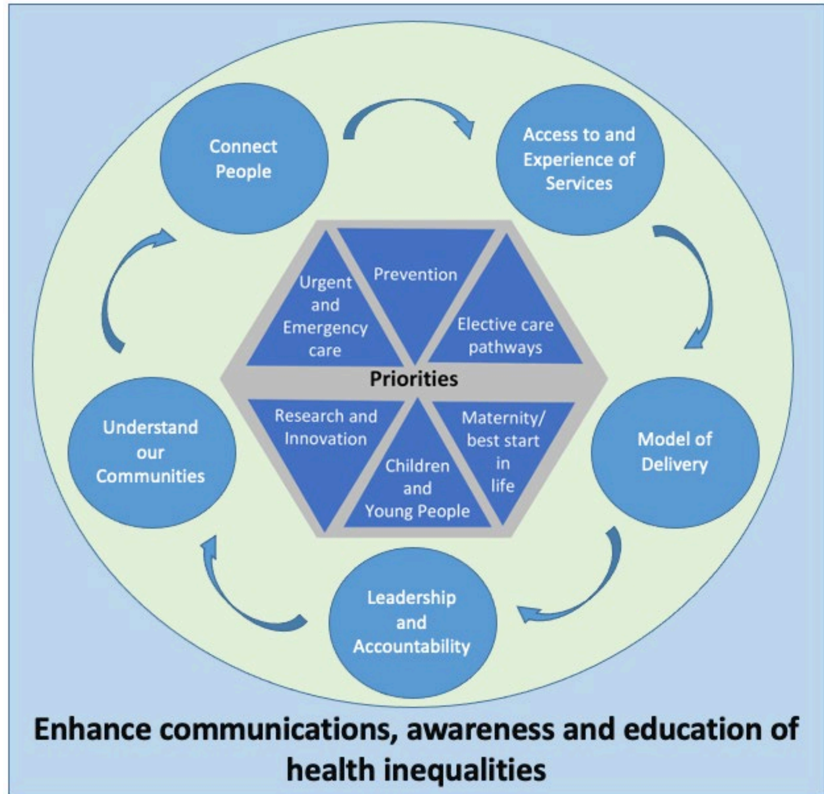
At Doncaster and Bassetlaw Teaching Hospitals Foundation Trust (DBTH) we want to do all we can to tackle unfair health inequalities so have developed this strategy with the aim to embed the reduction of health inequalities in everything we do to ensure equitable access and excellent experience, thereby providing optimal outcomes for our patients and the communities that we serve. In order to achieve this aim, our strategy has set out 6 priority areas of focus which include:

1. Prevention
2. Elective care pathways / recovery
3. Urgent and emergency care pathways
4. Maternity and best start in life
5. Children and young people
6. Research and innovation

The 6 priority areas are underpinned by 1 base and 5 pillars. The base provides the foundation to the delivery of this strategy and refers to enhancing our communications, awareness and education of health inequalities for our people, our patients and our local communities. The 5 pillars encompass behaviours, models of practice and a general ethos/culture shift which when implemented will support all the work across all 6 priority areas. These pillars include:

1. Understanding our communities – to ensure accurate, complete and timely access to population health data in conjunction with community voices to better understand the health inequalities and where to focus our action.
2. Connecting people – to work closely with partners and build on existing relationships, networks, and trust. This will ensure work is aligned and supported and will prevent silo-working allowing health inequalities to be addressed using a whole system approach.
3. Model of delivery – to move towards a more needs-led, compassionate social model of care and to use co-production to improve existing services and/or develop new services based on the needs of our communities.

4. Access to and experience of services – to focus on the Core20PLUS5, ensuring targeted support is provided for the Core20 and PLUS groups, including inclusion health groups, particularly (but not exclusively) across the 5 service areas for adults and children and young people.
5. Leadership and accountability – strong leadership and clear accountability and governance structures will support a culture shift and help to embed heath inequalities in everything we do, acknowledging that our staff may also be experiencing health inequalities.



DBTH's Tackling Health Inequalities Strategy: 1 Base, 5 Pillars and 6 Priority Areas

To support the delivery of our strategy, we have also provided a 3-tier framework. The framework outlines work that we can do to tackle health inequalities by: 1) increasing support/developing new services, 2) improving our existing services, and 3) influencing the wider determinants of health in our Anchor Institution role. This framework will support teams, services, and divisions to guide thinking/act as a prompt for action.

We have also developed an associated action plan which outlines our planned areas of work, associated key performance indicators and anticipated timeframes for completion.

DBTH's 3-tier framework for improving health and tackling health inequalities (adapted with permission from Barnsley's Integrated Care Partnership framework)

Tier 1: Increase Support

The first layer of action is to increase engagement, opportunities, services and support to address the key drivers of health inequalities for people in need and making every contact count.

To ensure people have access to support that prevents them getting sick and reduces the drivers of inequality in their life, we need our teams (both clinical and non-clinical) across the Trust to be discussing health inequalities, to highlight where gaps in knowledge may be and/or to identify potential areas for improvement.

Tier 2: Improve Care

The second layer of action is to improve all health and care services in such a way that they are targeted to greatest need and reduce inequalities in care.

To ensure that DBTH does all that it can to provide care and support to those with the greatest need first, teams / services should consider reframing the phrase "hard to reach groups" to instead answer the question "why are our services often hardest to access for the people who need them most?"

Tier 3: Influence Others

The third layer is to influence those differences in health which are linked to things like housing conditions, the quality of green spaces and clean air, education and income, i.e., the wider determinants of health, by becoming the best anchor institution we can be and advocating for health equity across all sectors.

To ensure that due consideration is given to the impact that the Trust has on health and wellbeing by means other than the services it delivers, which can lead to huge impacts and far-reaching benefits.

Key Terms

Some key terms are (Office for Health Improvement and Disparities, 2021):

Health Inequalities: Avoidable differences in health outcomes between groups or populations – such as differences in how long we live, or the age at which we get preventable diseases or health conditions.

Equality: We want everyone to have equally good health. However, the term 'equality' is sometimes used to describe equal treatment or access for everyone regardless of need or outcome.

Equity: We want fair outcomes for everyone. What is important is addressing avoidable or remediable differences in health between groups of people. To achieve health equity, some groups may need more or different support or resources to achieve the same outcomes. Ideally, the barriers to good health would be removed for everyone, so adjustments wouldn't be required – however, this is not always possible.

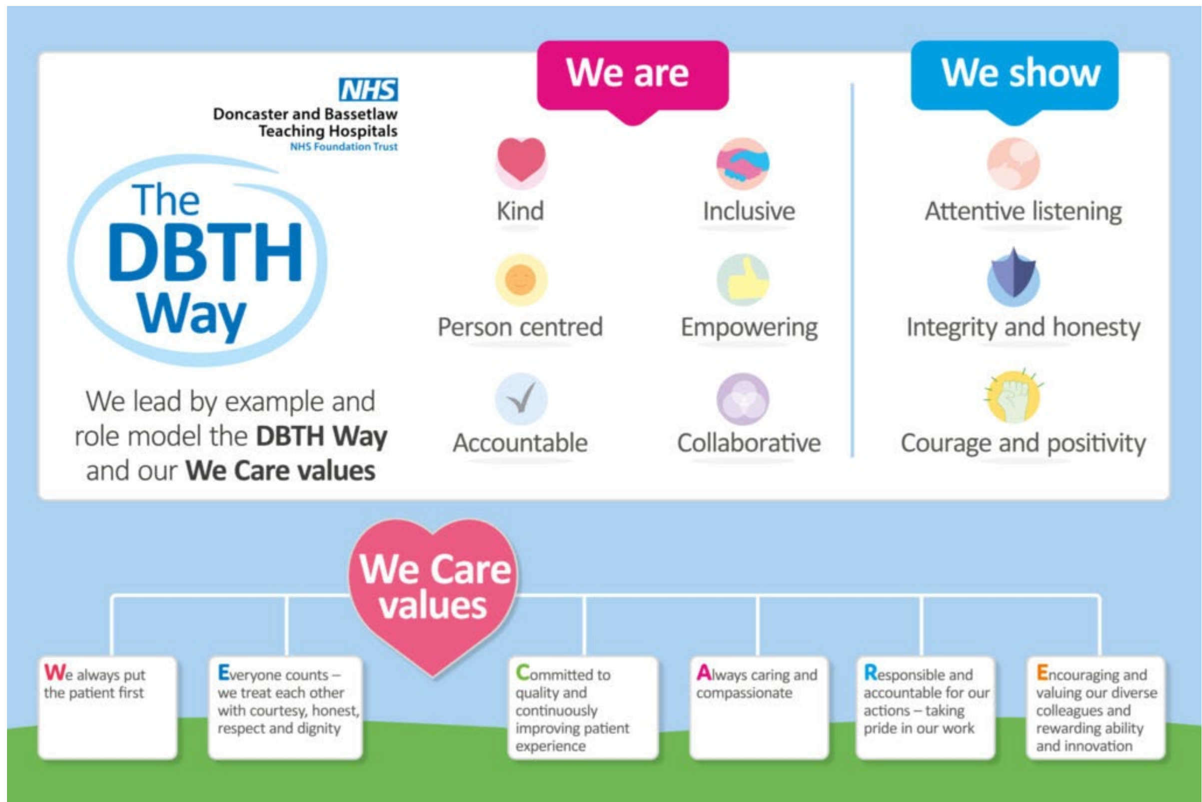
Access: Ensuring everyone can access services equitably (that is according to need) is a key priority for the NHS. To achieve this, consideration needs to be given to access to information, services and support. Central to this is enabling people to access the right service at the right time for them, reducing variation in the avoidable use of urgent support such as accident and emergency services through better access to preventative care.

Introduction

Welcome to DBTH's new Tackling Health Inequalities Strategy!

At Doncaster and Bassetlaw Teaching Hospital Foundation Trust (DBTH), we have the vision of being "the safest Trust in England, outstanding in all we do". The Tackling Health Inequalities Strategy described in this document is aligned to this vision and to the True North objectives of the Trust (to provide outstanding care and improve patient experience; everybody knows their role in achieving the vision; feedback from colleagues and learners is in the top 10% in the UK; the Trust is in recurrent surplus to invest in improving patient care).

This strategy also aligns closely to the DBTH Way and our We Care values. Leading by example and role modelling the DBTH Way and our We Care values will provide an appropriate ethos and a supportive environment for health inequalities work to be undertaken more effectively.



What are Health Inequalities?

Health inequalities are "avoidable, unfair and systematic differences in health between different groups of people" (The Kings Fund, 2022). They mean that some population groups have significantly worse health experiences and outcomes than others. These differences can be due to a range of factors including a person's social, economic and environmental circumstances – and we know that greater deprivation in any of these factors is associated with an increased risk of becoming ill earlier and dying younger (Box 1). People with certain characteristics, such as certain ethnicities, sexual orientation, age and disabilities, also have a lower chance of living a long and healthy life compared to others. This is often due to the exclusion from society that people with these characteristics face.

Box 1: Comparing life expectancy in Doncaster and Bassetlaw between the most and least deprived communities

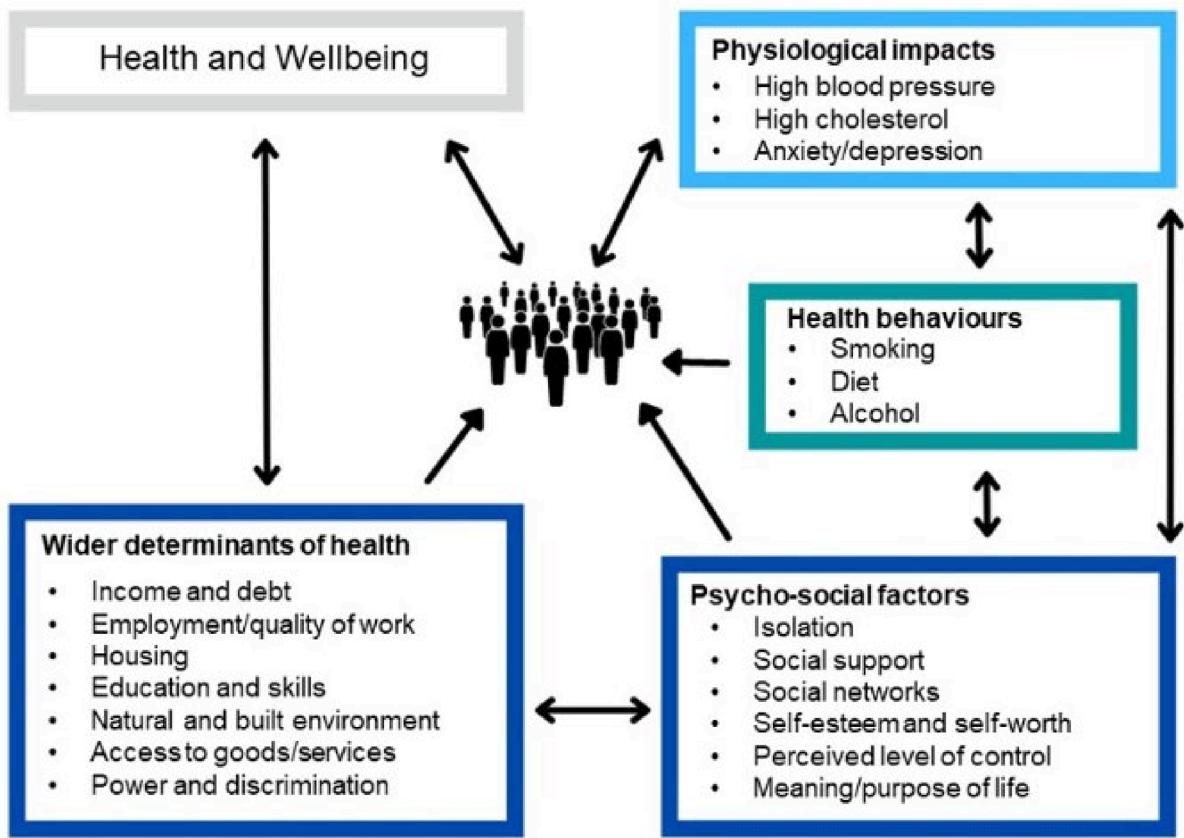
In Doncaster: men living in the most deprived areas die on average 10 years earlier than men living in the least deprived areas; for women this difference is 8 years.

In Bassetlaw: men living in the most deprived areas die on average almost 8 years earlier than men living in the least deprived areas; for women this difference is 6 years.

A wide range of factors influence our ability to be healthy. These factors often overlap with each other and are often outside the control of individuals themselves.

Figure 1 below demonstrates the complex interplay between the wider determinants of health (e.g., income, housing, built environment, education), psychosocial factors (e.g., isolation and social support), health behaviours (e.g., smoking, drinking alcohol), and the resulting physiological impacts (e.g., high blood pressure, anxiety and depression).

Figure 1: System map of the causes of health inequalities (Office for Health Improvement and Disparities, 2022)



Why do we need to tackle Health Inequalities?

Addressing health inequalities is a matter of social justice - some have less health than others and that is largely to do with structural factors not individual choices. It is unfair that just by virtue of someone's ethnic background or place of birth they should experience poorer health.

In addition, these avoidable differences in health pose a huge cost to societal, economic and health systems. Health inequalities contribute to increased demand for healthcare – as investment and action in the cost-effective approaches to maintain health and wellbeing

shrinks, the need for less cost-effective diagnostic and treatment services grows. When wider costs are factored in, such as loss of workforce productivity, the overall economic burden of preventable and premature illness is staggering – around £31 billion a year in lost productivity and between £20 and £32 billion a year in lost tax revenue and benefit payments (Public Health England, 2021). What does this mean for the NHS? The higher burden of disease experienced by women living in the most deprived neighbourhoods costs the NHS 22% more per person than women living in the least deprived neighbourhoods, despite having shorter life expectancy (or £400 per person per year in secondary care costs). For men, this figure is 16% per person (or an additional £300 per person per year in secondary care costs). This results in an additional spend of £4.8 billion per year, almost 20% of the total hospital budget (Asaria M, 2016), without taking into account additional costs, including social care provision.

Health is therefore a major determinant of economic performance and prosperity. Consequently, taking action on health inequalities:

- improves the quality of lives of individuals
- reduces cost to the NHS and social care system of treating and caring for people with preventable conditions
- benefits the wider economy (Marmot, 2010).

Much of the way our national and local systems have been set-up has inadvertently contributed to the increase in health inequalities – we therefore need to do things differently. Figure 2 demonstrates the difference between equality and equity. By treating people *equally*, e.g., offering an NHS which is free at the point of use to all (or providing everyone with the same sized box to see the ball game, as per the first image in Figure 2), we are assuming everyone has the same ability to access our services. In reality, some groups have significant barriers to accessing healthcare, such as physical disabilities, poor mental health, language or cultural barriers, mistrust of healthcare systems, inability to pay for transport to get to hospitals, other more significant life priorities, e.g., caring responsibilities, work, finances etc. By treating everyone equally, we are contributing to the widening of health inequalities as we're not taking into account these systemic barriers – those who can, will access health services and get better health outcomes as a result; those who can't, will be left with worsening health issues.

Instead, if we offer more targeted supports for those who need it, i.e., if we treat people *equitably* based on their needs, then we can help to ensure equal access (or providing the right number of boxes to each person to ensure they can see the ball game equally well, as per the second image in Figure 2), which in turn will help to reduce health inequalities.

The third image in Figure 2 is where we should aspire to be – the systemic barriers (in this case the wooden fence) have been removed so no extra supports are needed as everyone can see the ball game equally well already. It is predominantly national level shifts in policy and infrastructure change that are needed to remove the systemic barriers and address the

cause of the inequalities, however, there are lots of things we can do locally which will make a difference. This strategy therefore highlight's DBTH's commitment to tackling health inequalities and lays out the key areas of focus for DBTH for the next 5 years.

Figure 2: Equality versus equity explained

EQUALITY VERSUS EQUITY

In the first image, it is assumed that everyone will benefit from the same supports. They are being treated equally.

In the second image, individuals are given different supports to make it possible for them to have equal access to the game. They are being treated equitably.

In the third image, all three can see the game without any supports or accommodations because the cause of the inequity was addressed. The systemic barrier has been removed.

Health Inequalities in Doncaster and Bassetlaw

Table 1 presents a few key figures which demonstrate the extent of some of the health inequalities facing people from Doncaster and Bassetlaw. To summarise:

- Over 40% of the Doncaster population and 21% of the Bassetlaw population are living in the 2 most deprived Index of Multiple Deprivation (IMD) deciles nationally, i.e., the "Core 20".
- 1 in 3 children and young people in Doncaster and 1 in 6 in Bassetlaw are living in poverty.
- In terms of life expectancy for males and females, both Doncaster and Bassetlaw are lower than the national average.
- The difference in life expectancy from the most to the least deprived areas in Doncaster is almost 11 years for males and 8 years for females. For Bassetlaw, the differences in life expectancy from the most to least deprived is almost 9 years for

males and 7 years for females. Just to put that into context – a man from the most deprived area of Doncaster is living on average 11 years less than a man from the least deprived area. Similarly, a man living in the most deprived area of Bassetlaw is living on average 9 years less than a man from the least deprived area.

- Healthy life expectancy for males and females in both Doncaster and Nottinghamshire (LA-level data so not available for Bassetlaw) is lower than the England average and if we just pull out the data here for females in Doncaster, we can see that the amount of time females are living in good health (i.e. their healthy life expectancy) is 56 years, but their average life expectancy is 81 years. This means that they are living for on average 25 years in poor health and during that time, will likely be accessing a range of health services.

Table 1: Data demonstrating some of the health inequalities in Doncaster and Bassetlaw (Office for Health Improvement and Disparities, Fingertips, Public Health Data 2018-20)

	Doncaster	Bassetlaw
% living in IMD Decile 1 (most deprived)	25.0%	8.0%
% living in IMD Deciles 1 & 2 (Core20)	41.3%	21.4%
% children (<16y) in low-income families	22.6%	16.0%
Life expectancy (LE) males (78.7y England)	77.8y	78.9y
LE females (82.7y England)	81.0y	82.0y
Diff in LE from least to most deprived males	10.0y	7.6y
Diff in LE from least to most deprived females	8.2y	5.8y
Healthy life expectancy males (63.1y England)	57.4y	62.0y
Healthy life expectancy females (63.9y England)	56.1y	61.9y

We also need to remember that many of our people are our patients. We therefore need to consider health inequalities that our people face too.

Our Strategy

Our Tackling Health Inequalities Strategy 2023-2028 has been developed in alignment with various other national and local plans/strategies. By aligning our strategy with others, we will ensure that we are not producing a "standalone" strategy, but one that is working alongside and with our partners across the system. This will mean that work is not duplicated and where relevant we can collaborate, share resources (human and financial), and provide support when needed. Other plans and strategies we have considered during the development of our strategy include:

- The NHS Long Term Plan, which clearly sets out commitments for action that the NHS needs to take on improving prevention and tackling health inequalities
- NHS England's "Tackling inequalities in healthcare access, experience, and outcomes: Actionable Insights"
- Core20PLUS5 – a national framework for addressing healthcare inequalities
- NHS South Yorkshire Integrated Care Board (ICB) NHS Joint Forward Plan for South Yorkshire
- NHS Nottingham and Nottinghamshire ICB NHS Joint Forward Plan
- Doncaster 1 Plan 2023/24
- Bassetlaw Place Plan

It's worth highlighting the detail relating to the Core20PLUS5 framework as we will draw on this throughout our strategy.

Figure 3 depicts the Core20PLUS5 framework for adults. The "Core20" refers to the most deprived 20% of the *national* population as identified by the Index of Multiple Deprivation (IMD). The key word there is *national*. For clarity, the IMD score ranks small geographical areas from most to least deprived. It then groups them together into 10 equal groups (or deciles) – from 1 (most deprived) to 10 (least deprived). The 20% most deprived areas nationally are therefore those in deciles 1 and 2. However, in Doncaster, for example, 41% of our population fall into the 2 most deprived deciles nationally (as shown in Table 1 above).

The "PLUS" refers to chosen population groups experiencing poorer than average health access, experience and/or outcomes who may not be captured in the Core20 alone and would benefit from a tailored healthcare approach. See appendix 1 for a list of "PLUS" groups (please note, this is not an exhaustive list). "PLUS" groups can include people with a protected characteristic, people in socio-economically deprived populations, people from specific geographies (the places where we live), e.g., urban/rural/coastal locations, and inclusion health and vulnerable groups, e.g., Gypsy, Roma, Traveller communities, people experiencing homelessness, offenders, sex workers. When individuals, groups or communities face more than one of these issues (intersectionality), then the risk of health inequalities is further increased.

The "5" refers to 5 key clinical areas of health inequalities and includes:

1. Maternity services
2. Severe mental illness
3. Chronic respiratory disease
4. Early cancer diagnosis
5. Hypertension case-finding

Finally, smoking cessation has been identified as something that would impact all 5 key clinical areas.

Figure 3: Core20PLUS5 framework for adults (Nov 2021)

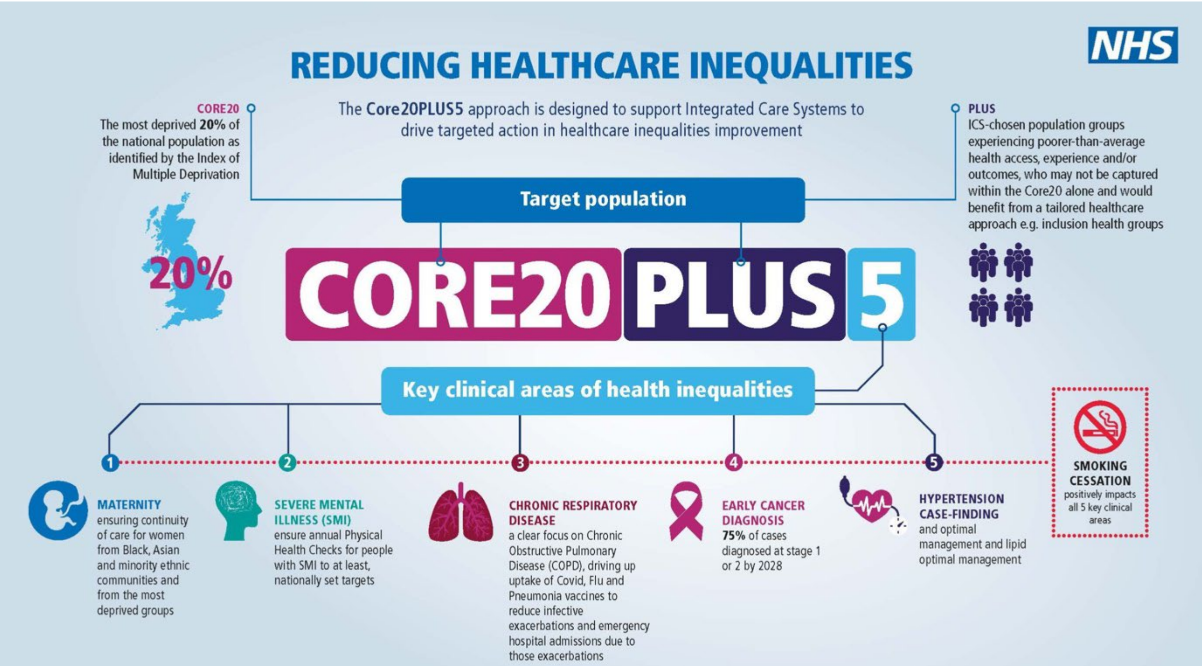
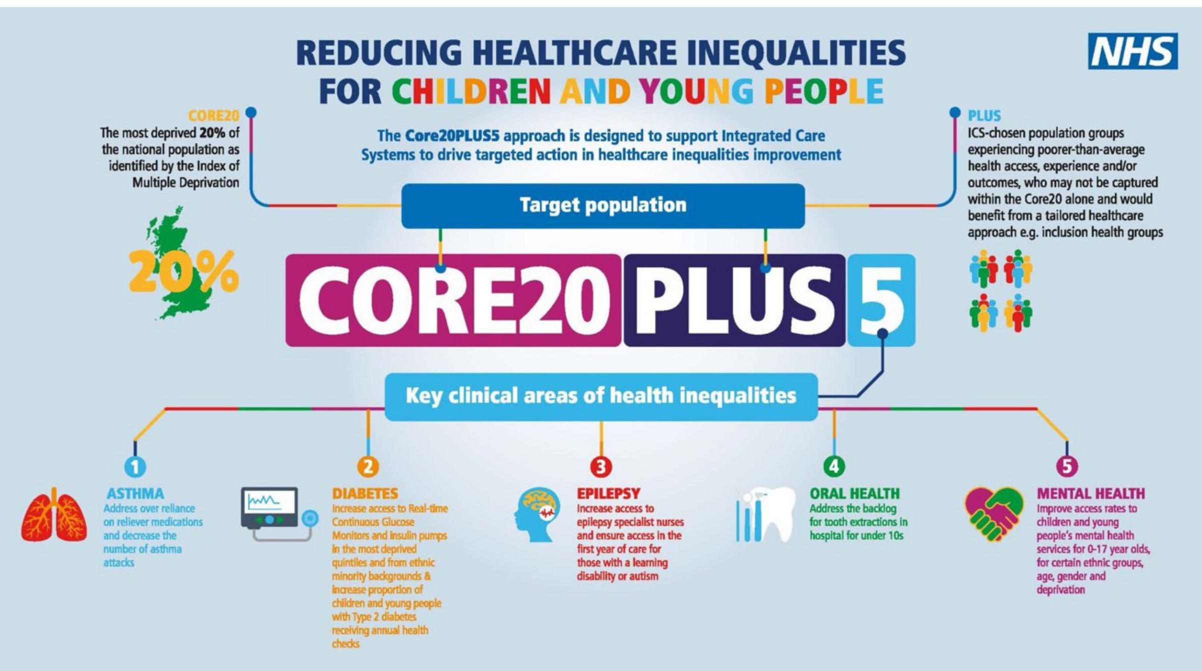


Figure 4 shows the Core20PPLUS5 framework for children and young people. The "Core20PLUS" elements are the same as for the adults (although we may wish to focus on different "PLUS" groups than those for adults), but the 5 key clinical are different, and include:

1. Asthma
2. Diabetes
3. Epilepsy
4. Oral health
5. Mental health

Figure 4: Core20PLUS5 framework for children and young people (Nov 2022)



We have also reviewed some of our own strategies/plans and feel that our Tackling Health Inequalities Strategy has clear links with DBTH's:

- **Quality Improvement and Innovation (Qii) Strategy 2023-2028** – The Qii Strategy has directly referenced our Tackling Health Inequalities Strategy and identified the synergies between the two. In particular, there are synergies between the co-production and leadership elements of the Qii Strategy and our 5 pillars (details to follow). Furthermore, health inequalities training is being included within Qii training to ensure that health inequalities are considered during any improvement initiative. We also intend to use Qii approaches to support health inequalities-specific improvement initiatives.

- **DBTH Green Plan 2022** – There are direct links between the actions identified as part of the Green Plan and health inequalities. For example, decarbonisation decreases air pollution. The health consequences of air pollution disproportionally effect people from lower socioeconomic backgrounds, so reductions in carbon supports the reduction in health inequalities. There is also a clear focus on improving access to preventative health advice in the Green Plan, acknowledging that prevention of ill health will reduce service demand, which in turn will reduce the Trust's carbon emissions. Both the sustainability and health inequalities work also feeds into the Anchor Institution agenda, and supports DBTH in being a "good" Anchor Institute.

- **People Strategy 2023-2027** – There are several elements of the People Strategy that link into/complement our Tackling Health Inequalities Strategy, particularly when considering that many of our people are also our patients, so we need include tackling health inequalities for our people as well as our patients. Some of the elements that link to our strategy include: the focus on Just culture; education (90% compliance on SET training – questions relating to health inequalities is included within the SET training); the Equality, Diversity and Inclusion (EDI) work which involves embedding an inclusive culture, representative of the communities we serve, and enhancing our inclusive recruitment practices and in addition we are supporting the delivery of the health inequalities actions within the EDI Improvement Plan; workforce planning and development (apprenticeships), anchor institution and widening participation activities through access to education and employment opportunities.

- **Nursing, Midwifery and Allied Health Professionals Quality Strategy 2023-2027** – There are clear links to Strategic Theme 2, Patient Experience, particularly embedding patient involvement and co-design into our organisations policies and procedures and holding community engagement events to gain insights from groups who are seldom heard and/or affected by health inequalities, and links to the Accessible Information Standard. There are also links to Strategic Theme 3, Clinical Effectiveness, where health inequalities could be embedded into the Qii methodology to improve care. Finally, Strategic Theme 5, Care of our Most Vulnerable Patients, which specifically highlights reducing health inequalities by promoting equitable access to healthcare.

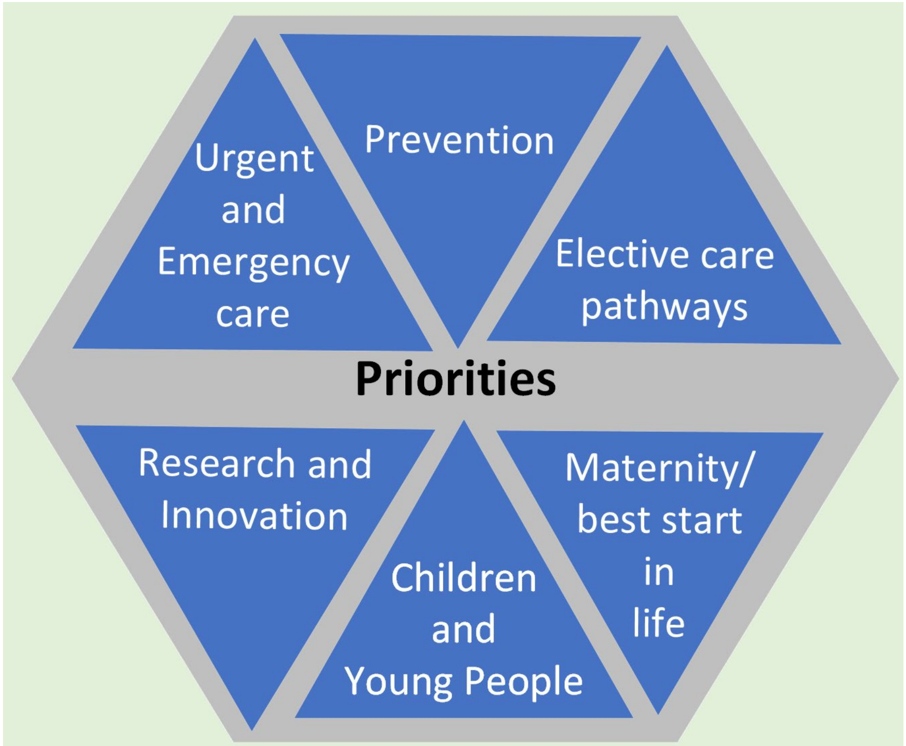
- **Research and Innovation (R&I) Strategy 2023-2028** – This strategy has tackling health inequalities as a cross-cutting theme throughout. The aim is to ensure that the research and innovation undertaken at DBTH will consider the impact on health inequalities across the research / innovation pipeline, from design to delivery and through to adoption. An area of strategic priority for the R&I Strategy relates to improving patient outcomes throughout prevention, early diagnosis and better management of cardiovascular and respiratory diseases and cancer. This links into the prevention agenda and the Core20PLUS5 framework.

Our strategy has also been developed through engagement with DBTH colleagues and leaders and is in support of our True North objectives and our strategic aim to be “the safest Trust in England, outstanding in all we do”. This is an ambitious strategy, designed to challenge, promote innovation, and support action.

The strategy will be supported by an action plan, which will provide details of what we will be doing to tackle health inequalities across six priority areas of focus over the course of the next 5 years.

The **aim** of our strategy is to embed the reduction of health inequalities in everything we do to ensure equitable access and excellent experience, thereby providing optimal outcomes for our patients and the communities that we serve.

There are **6 key priority areas** our strategy focuses on:



There is a great deal of existing work already going on within many of these priority areas. The health inequalities team intends to support and provide advice and expertise to these existing areas of work, to ensure that tackling health inequalities is embedded within the work. We can also support the development of specific initiatives to reduce health inequalities.

1. Prevention

Primary prevention of ill health means taking action to reduce the incidence of disease and health problems within the population by intervening before there is evidence of injury or disease. This can be achieved via universal measures that reduce risks and their causes, e.g., anti-smoking campaigns/smoke-free hospital messages, or by targeting high-risk groups e.g., vaccinations.

Secondary prevention means systematically detecting the early stages of disease and intervening before full symptoms develop, e.g., taking measures to reduce high blood

pressure and cholesterol to prevent the development of cardiovascular disease or screening for cervical cancer.

Tertiary prevention means trying to reduce the impact of an ongoing illness or injury that has lasting effects. This can be done by helping people manage long-term, often complex health problems and injuries to improve as much as possible their ability to function, their quality of life and their life expectancy. For example, supporting patients with asthma to stop smoking.

Within the priority area of prevention, there are several strands which we will focus on from a health inequalities perspective and these include (in alignment with the Core20PLUS5):

1. Smoking cessation (QUIT Programme)
2. Alcohol and substance misuse services
3. Cardiovascular disease – with a focus hypertension case-finding and interventions to optimise blood pressure and lipid optimal management
4. Chronic respiratory disease – particularly focusing on Chronic Obstructive Pulmonary Disease (COPD) to drive uptake of COVID, flu and pneumonia vaccinations to reduce frequency of infective exacerbations and emergency hospital admissions due to those exacerbations
5. Early cancer diagnosis – with a focus on meeting the target set by NHS England of 75% of cases to be diagnosed at stage 1 or 2 by 2028
6. Vaccinations – can we support, for example, the delivery of the MMR vaccine to improve uptake in young children (if presenting to our services) to reduce the rates of measles?

Prevention is also a thread running through all the other priority areas.

2. Elective care pathways / elective recovery

There are national targets that we need to meet regarding elective recovery. However, we must be mindful, that whilst striving towards meeting these targets, we do not want to further exacerbate the already widening health inequalities. A letter from Sir James Mackay (National Director of Elective Recovery, NHS England) to all acute trusts on 23rd May 2023 states, “Systems are expected to outline health inequality actions put in place and the evidence and impact of the interventions as part of their planning returns. Disaggregated elective recovery data should support the development of these plans”. Therefore, elective recovery work needs to have the reduction of health inequalities embedded within it and be supported by accurate, complete, and timely disaggregated data (broken down by, as a minimum, age, gender, ethnicity and level of deprivation (IMD score)) so the impact on health inequalities can be monitored and evidenced. The health inequalities team can help and support existing work focused on elective recovery to ensure it is adequately considering the impact on health inequalities and putting in place mechanisms to support the reduction of health inequalities.

As part of the elective recovery, and a key priority of the Trust Board, is to reduce "Did Not Attend" (DNA) and "Was Not Brought" (WBA) rates. For context, as a Trust our DNA/WNB rates across all services sit above 9% each month, by reducing this number we could expect to see an increase in productivity, improved patient experience and reduced waiting lists. By developing an understanding of why some people DNA and by taking a health inequalities perspective, we could both reduce DNA/WNB rates and reduce health inequalities simultaneously. For example, it may be that for some people, the cost of public transport / a taxi is prohibitive and means they are unable to attend appointments. One potential solution to this would be to arrange suitable transport to targeted groups of patients for whom this would mean they could attend an appointment.

One particular issue to highlight when considering the reduction in DNA rates is the impact of digital exclusion (and inclusion for that matter). For example, one potential solution to reducing DNA rates may be to send every patient a reminder text message or email a few days before their scheduled appointment. However, this excludes those who do not have access to digital forms of communication, e.g., the elderly, or those living in poverty, thereby could in and of itself result in the widening of health inequalities. Conversely, people experiencing homelessness are not able to easily receive letters and hence often rely on digital forms of communication. This is why any such interventions need to always consider the impact on health inequalities.

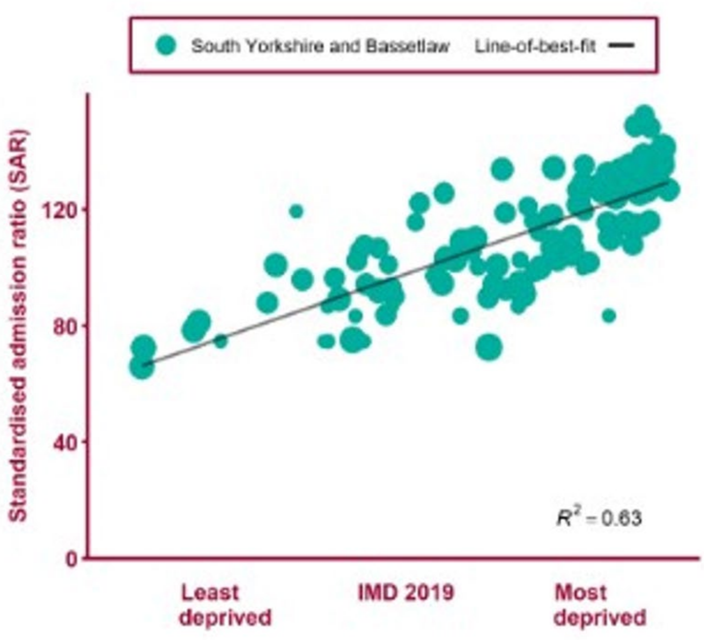
There's also an opportunity to link in with the prevention priority area by considering "waiting well" initiatives. This could focus on patients who may be deemed "high-risk" of worsening health whilst waiting for an appointment/procedure.

It should be noted that any proposed changes to the elective care pathways will need close consultation and collaboration with our primary care colleagues, as well as ICB partners to ensure that there are no unintended consequences in other parts of the system or duplication of efforts.

3. Urgent and emergency care (UEC)

We know that health inequalities are impacting our UEC services and our UEC services are impacting health inequalities. Figure 5 demonstrates the relationship between emergency admissions and deprivation. The graph shows emergency admissions for all causes from 2013/14 to 2017/18 for South Yorkshire and Bassetlaw and highlights the fact that those from the most deprived areas are more likely to require emergency admission than those in the least deprived areas. Therefore, the health inequalities team will work with and support teams working on UEC pathways to ensure that we understand the current situation by obtaining accurate and timely disaggregated data (broken down by, as a minimum, age, ethnicity and IMD score), so that targeted improvements can be made.

Figure 5: Graph showing relationship between emergency admissions and deprivation (provided by South Yorkshire ICB (when it was still SY & Bassetlaw ICB))



Another more focussed initiative to incorporate into UEC pathways are "Making Every Contact Count (MECC)", so when patients present to our emergency departments, we have mechanisms in place to address other issues that they may be facing, e.g., lifestyle interventions (smoking cessation, alcohol and substance misuse, physical activity etc), vaccination/screening catch-up, housing, finances, mental wellbeing. This could be in the form of simple signposting to different services or could incorporate the hosting of additional services, e.g., having a Citizens Advice presence within the department.

Targeting high intensity users, many of whom will likely be experiencing significant health inequalities, is another important strand of work within this priority area. British Red Cross research found that people who frequently attend A&E make up less than 1% of England's population but more than 16% of A&E attendances, 29% of ambulance journeys, and 26% of hospital admissions. Furthermore, the mortality rate among people aged 30-50 who frequently attend A&E is 7.5 times higher than among this age group in the general population and it is estimated that high intensity use of A&E services costs the NHS £2.5 billion per year (British Red Cross Research, *Nowhere else to turn*, Nov 2021). We will need to initially understand more about our high intensity users by analysing disaggregated data, to allow us to consider what initiatives we could implement to support these patients and support demand management in UEC. We can use data from ECIST (Emergency Care Improvement Support Team) to support this work.

4. Maternity and best start in life

In line with the Core20PLUS5 framework and the South Yorkshire Local Maternity and Neonatal System (LMNS) Equity and Equality Plan 2022-2027 (which can be found here: https://syics.co.uk/lmns), we will support our maternity department to: improve equity for mothers and babies from Black, Asian, Mixed and minority ethnic backgrounds and those from the most deprived areas, and improve race equality for staff from minority ethnic backgrounds.

There are also some specific actions identified in the LMNS Plan, which the health inequalities team will further advise on and support. These actions include:

- Minimising the additional risk of COVID-19 to pregnant women and birthing people from ethnic minority backgrounds and their babies.
- The use of personalised care and support plans following an initial assessment about the person's health and wellbeing needs.
- Access to accurate and reliable data relating to ethnicity and postcode.
- The development of maternal medicine networks, ensuring every pregnant woman and birthing person with medical problems has access to specialist advice and care.
- The use of midwifery continuity of care (MCoC) models which ensure that pregnant women and birthing people receive dedicated support from the same midwifery team throughout their pregnancy – this should be rolled out in a targeted way, prioritising those from Black, Asian, Mixed and minority ethnic backgrounds and those from the most deprived areas.
- Improving health – diabetes prevention programme, maternal mental health services, smoke-free pregnancy support, improving breastfeeding rates.
- Family support – antenatal care for pregnant women with complex social factors (e.g., drug or alcohol use, domestic abuse, migrants, asylum seekers or refugees), establishing community hubs in the areas of greatest need, addressing social determinants of health.

5. Children and young people (CYP)

For this priority area, we will be guided by the Core20PLUS5 framework. As outlined above, the "PLUS" groups for children and young people may be different to those we wish to use for adults. We therefore need to spend some time reviewing the data and consulting with colleagues and patients to understand which "PLUS" groups may be most relevant for us to

focus on. For example, we may want to particularly consider children and young people with learning disabilities or neurodiversity, or children living in poverty.

The health inequalities team will work with the various paediatric teams to look at the 5 clinical areas (as per the Core20PLUS5):

1. **Asthma** – address the over-reliance on reliever medications and decrease the number of asthma attacks.
2. **Diabetes** – increase access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds; and increase proportion of those with Type 2 diabetes receiving recommended NICE care processes.
3. **Epilepsy** – increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism.
4. **Oral health** – address the backlog in tooth extractions due to decay for children admitted as inpatients in hospital, aged 10 years and under.
5. **Mental health** – improve access rates to children and young people's mental health services for 0–17-year-olds, for certain ethnic groups, age, gender, and deprivation. For DBTH, this will have a particular focus on improving access to our Attention Deficit Hyperactivity Disorder (ADHD) and Autistic Spectrum Disorder (ASD) services and how we work with RDaSH.

Although the initial focus will be on addressing the specific points from the Core20PLUS5 framework (as described above) we do not want to be constrained by these, and therefore we will take the opportunity to understand what issues are facing our patients and the communities we serve (using quantitative data as well as community voices). This will result in a more tailored, bespoke approach, ensuring we are tackling those health inequalities that are most important to our patients.

We will work closely with the CYP Alliance as well as our ICB and local authority partners to ensure that we are aligned with their work, not duplicating any existing work, and to develop some innovative solutions.

6. Research and innovation (R&I) opportunities

The DBTH Research and Innovation Strategy 2023-2028 has tackling health inequalities as a cross-cutting theme throughout. The aim is to ensure that the research and innovation undertaken at DBTH will consider the impact on health inequalities across the research / innovation pipeline, from design to delivery and through to adoption. The health inequalities team will work closely with the R&I team to support this work and provide advice and expertise when required.

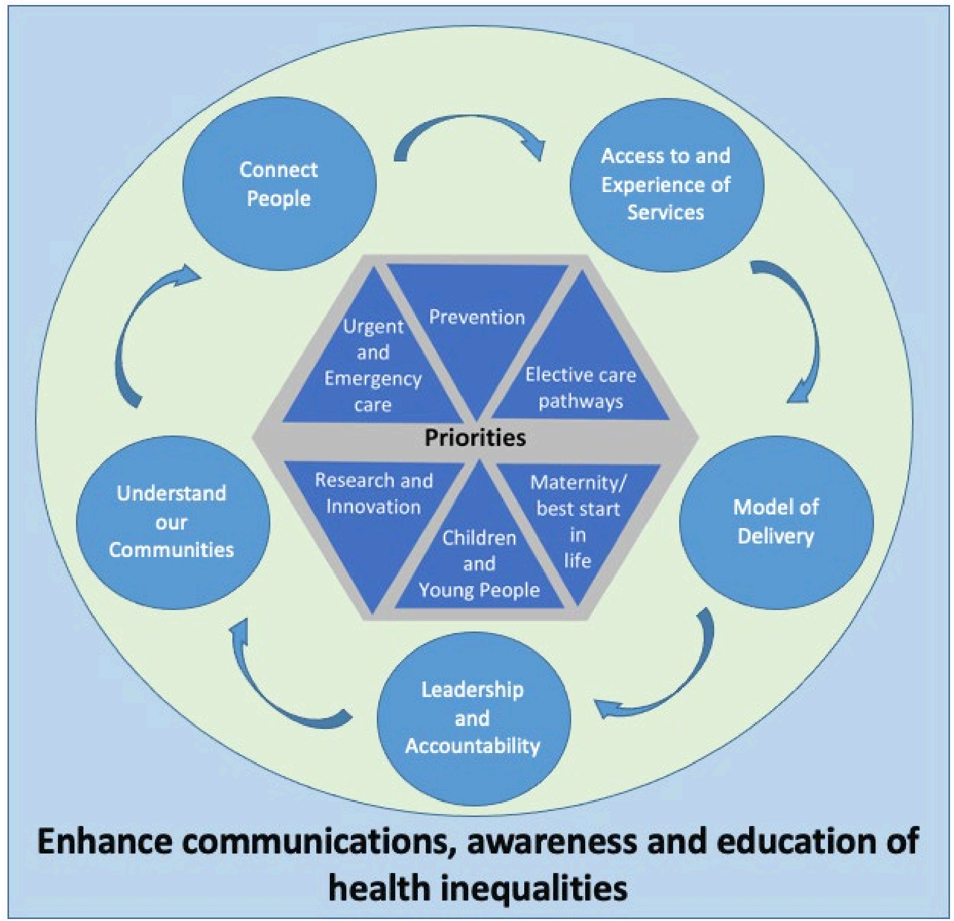
An area of strategic priority for the R&I Strategy relates to improving patient outcomes throughout prevention, early diagnosis and better management of cardiovascular and respiratory diseases and cancer. This is in alignment with our priority area of prevention and links to the Core20PLUS5 framework. The R&I team intend to support, promote, and roll out prevention initiatives, in addition to maximising research opportunities to better understand the challenges to prevention of these diseases specific to our local population. There is an opportunity here to develop future research and innovation proposals which specifically focus on tackling health inequalities. We can use the knowledge we gain from the other priority areas to help inform this. Moreover, we could review existing research projects to see if there are any opportunities for a focus on health inequalities. For example, we could use knowledge gained from the maternity and best start in life priority area, to help identify pertinent research questions from the BaBi-D research project.

Enablers to delivering this strategy

The 6 priority areas are underpinned by 1 base and 5 pillars (see Figure 6 below). The base provides the foundation to the delivery of this strategy and refers to enhancing our communications, awareness, and education of health inequalities for our people, our patients and our local communities. There is currently a lack of awareness and understanding about what health inequalities are. Unless our staff understand what health inequalities are and the impact they have on the care patients receive and their outcomes, they will not be able to support us in developing solutions. We therefore intend to develop a training package (encompassing a range of formats, e.g., presentations, e-learning modules, webinars etc) accessible to all our staff, as tackling health inequalities is everybody's responsibility. Furthermore, we intend to support the development of networks amongst our people to champion the importance of tackling health inequalities, which will in turn support the sustainability of this work. This focus on education and training of our people and the development of networks links in with DBTH's People Strategy 2023-2027.

The 5 pillars encompass behaviours, models of practice and a general ethos/culture shift which when implemented will support all the work across all 6 priority areas. These pillars include: understanding our communities, connecting people, model of delivery, access to and experience of services, and leadership and accountability.

Figure 6: DBTH's Tackling Health Inequalities Strategy 2023-2028 – 1 Base, 5 Pillars, 6 Priority Areas



Pillar 1: Understanding our communities

To ensure accurate, complete and timely access to population health data (DBTH service-level data and other relevant data, e.g., from Joint Strategic Needs Assessments) in conjunction with community voices to better understand the health inequalities and where to focus our action.

Pillar 2: Connecting people

To work closely with partners and build on existing relationships, networks and trust. This will ensure work is aligned and supported and will prevent silo-working allowing health inequalities to be addressed using a whole system approach.

Pillar 3: Model of delivery

- To move towards a more needs-led, compassionate social model of care.
- To use co-production to improve existing services and/or develop new services based on the needs of our communities.

Pillar 4: Access to and experience of services

> To focus on the Core20PLUS5, ensuring targeted support is provided for the Core20 and PLUS groups, including inclusion health groups, particularly (but not exclusively) across the 5 service areas for adults and children and young people.

Pillar 5: Leadership and accountability

> Strong leadership and clear accountability and governance structures will support a culture shift and help to embed heath inequalities in everything we do, acknowledging that our staff may also be experiencing health inequalities.

How are we going to deliver this strategy?

The strategy will be delivered by using the enablers described above and a three-tier framework for improving health and reducing health inequalities (see Figure 7 below, adapted with permission from Barnsley's Integrated Care Partnership three-tier framework). The framework outlines work that we can do to tackle health inequalities by: 1) increasing support/developing new services, 2) improving our existing services, and 3) influencing the wider determinants of health in our Anchor Institution role. To support teams/services implementing the framework, there are a series of associated questions for each tier to guide thinking/to act as prompts for action. These questions are included as an appendix below (see Appendix 2).

In addition, as the "base" of our strategy is focused on training, education, and awareness, we intend to develop four levels of training, which link back to the three-tier framework (see Figure 8 below) and have included relevant Key Performance Indicators for information on the right-hand side of the figure (this detail is also within the associated action plan).

Finally, the Health Inequalities Team will work with the Quality Improvement and Innovation (Qii) Team to ensure that a Qii approach is embedded within our programmes of work where appropriate and to support teams/divisions to use a Qii approach when undertaking any "tackling health inequalities" projects. To such end, we have developed a Health Inequalities Toolkit, with Qii methodology and the three-tier framework described above embedded within it.

Figure 7: DBTH's 3-tier framework for improving health and tackling health inequalities (adapted with permission from Barnsley's Integrated Care Partnership framework)

Tier 1: Increase Support

The first layer of action is to increase engagement, opportunities, services and support to address the key drivers of health inequalities for people in need and making every contact count.

To ensure people have access to support that prevents them getting sick and reduces the drivers of inequality in their life, we need our teams (both clinical and non-clinical) across the Trust to be discussing health inequalities, to highlight where gaps in knowledge may be and/or to identify potential areas for improvement.

Tier 2: Improve Care

The second layer of action is to improve all health and care services in such a way that they are targeted to greatest need and reduce inequalities in care.

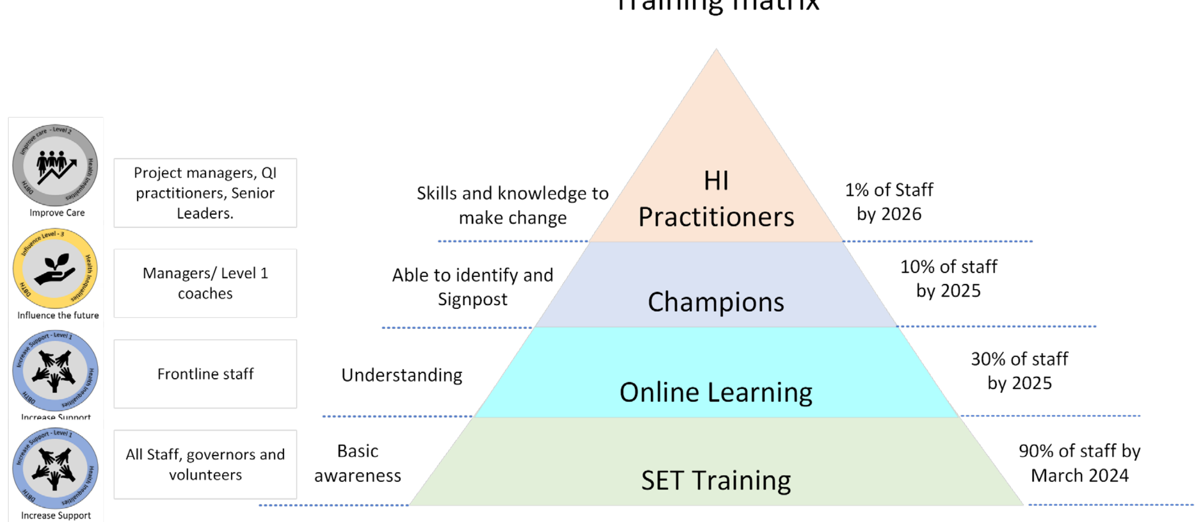
To ensure that DBTH does all that it can to provide care and support to those with the greatest need first, teams / services should consider reframing the phrase "hard to reach groups" to instead answer the question "why are our services often hardest to access for the people who need them most?"

Tier 3: Influence Others

The third layer is to influence those differences in health which are linked to things like housing conditions, the quality of green spaces and clean air, education and income, i.e., the wider determinants of health, by becoming the best anchor institution we can be and advocating for health equity across all sectors.

To ensure that due consideration is given to the impact that the Trust has on health and wellbeing by means other than the services it delivers, which can lead to huge impacts and far-reaching benefits.

Figure 8: Training matrix



Key Performance Indicators

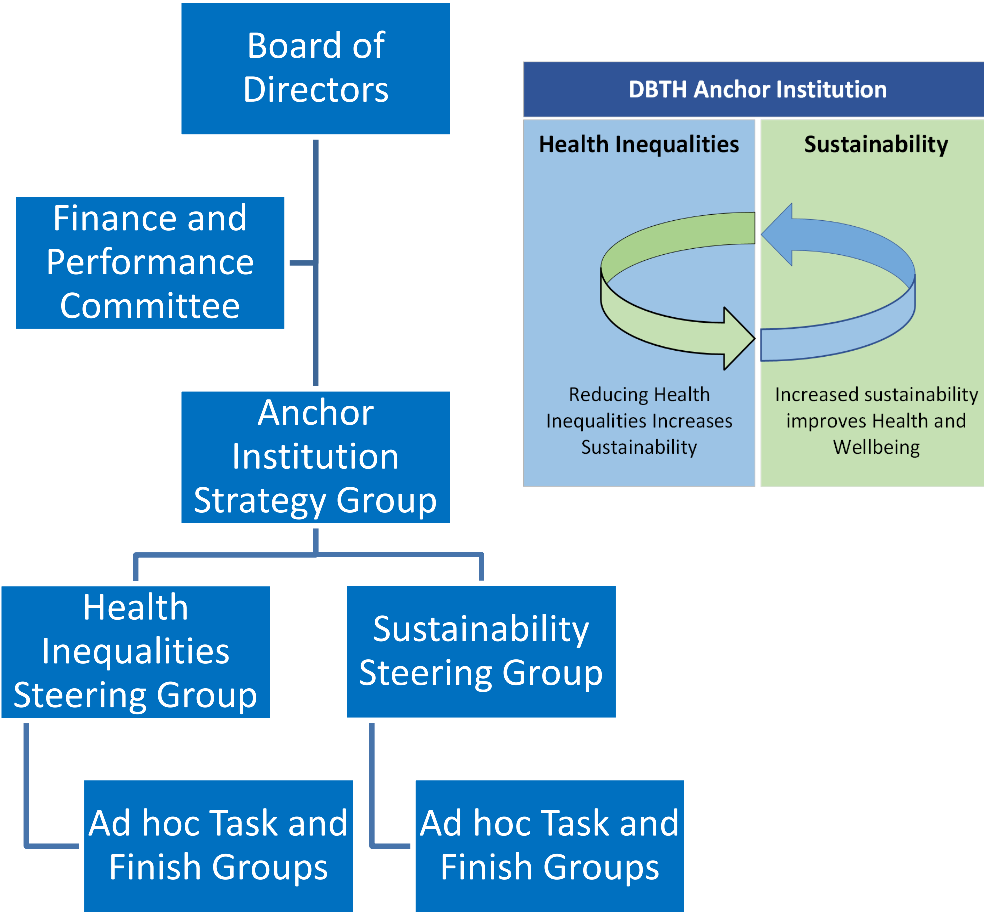
Evaluation and monitoring of performance against this strategy will be coordinated by the Health Inequalities Team, working in close partnership with relevant clinical and corporate colleagues. A five-year operational plan has been developed to accompany the strategy and will be the framework for which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

Governance Structure

The progress of DBTH Health Inequalities programme is monitored via quarterly reporting to the Finance and Performance Committee, with biannual updates to the Board of Directors.

The Health Inequalities and Sustainability programmes of work have come together under the umbrella of the Anchor Institution Strategy Group. There will then be a more operational Health Inequalities Steering Group and some specific task and finish groups the latter of which will be formed to deliver the priorities outlined on a time restricted basis (see Figure 9 below for details).

Figure 9: DBTH governance structure for health inequalities



References

Asaria M, D. T. (2016). The costs of inequality: whole-population modelling study of lifetime inpatient hospital costs in the English National Health Service by level of neighbourhood deprivation. *Journal of Epidemiology and Community Health*, 990.

Corben, S. (2023, February 2). *Blog - How the NHS estate can help reduce health inequalities*. Retrieved from NHS England: https://www.england.nhs.uk/blog/how-the-nhs-estate-can-help-reduce-health-inequalities/

Marmot, M. (2010). *Fair society, healthy lives: the Marmot Review: strategic review of health inequalities in England post-2010.* London: The Marmot Review.

Office for Health Improvement and Disparities. (2021, October 1). *Health disparities and health inequaltities: applying All Our Health.* Retrieved from GOV.UK: https://www.gov.uk/government/publications/health-disparities-and-health-inequalities-applying-all-our-health/health-disparities-and-health-inequalities-applying-all-our-health

Office for Health Improvement and Disparities. (2022, October 11). *Health disparities and health inequalities: applying All Our Health.* Retrieved from GOV.UK: https://www.gov.uk/government/publications/health-disparities-and-health-inequalities-applying-all-our-health/health-disparities-and-health-inequalities-applying-all-our-health

Public Health England. (2021). *Inclusive and sustainable economies: leaving no one behind.* Retrieved from GOV.UK: https://www.gov.uk/government/publications/inclusive-and-sustainable-economies-leaving-no-one-behind/inclusive-and-sustainable-economies-leaving-no-one-behind-executive-summary

The Kings Fund. (2022, June 17). *What are health inequalities?* Retrieved from https://www.kingsfund.org.uk/publications/what-are-health-inequalities

Appendix 1: List of all potential “PLUS” groups

Protected characteristics

- Age
- Sex
- Gender reassignment
- Disability: includes physical impairments, learning disability, sensory impairments, mental health conditions, long-term medical conditions
- Marriage and civil partnership
- Pregnancy and maternity: women before and after childbirth / breastfeeding
- Race and ethnicity
- Religion and belief
- Sexual orientation

Socioeconomic status / Geography

- People living in:
  - Deprived areas
  - Remote / rural / coastal locations
  - Overcrowded conditions
  - Areas with low levels of social connectedness
  - Poor quality housing
  - Prisons
  - Homeless people or those experiencing homelessness
- People with limited income due to:
  - Unemployment / inability to work
  - Employed on low incomes
- People with poor literacy or health literacy

Inclusion health and vulnerable groups

- Individuals who are known to be / have:
  - Clinically extremely vulnerable
  - A long-term health condition
  - Approaching end-of-life
  - Addiction / substance misuse problems
  - Living with or recovering from mental health problems including dementia
  - Serious mental illness
  - Learning disabilities and/or neurodiversity
  - Sensory impairment (e.g., vision or hearing)
  - Looked after or accommodated children and young people
  - Carers: paid / unpaid (including family members)
  - Those involved in the criminal justice system (offenders in prison, on probation, ex-offenders)
  - Gypsy, Roma, Traveller communities
  - Sex workers
  - Vulnerable migrants
  - Asylum seekers
  - Modern slavery victims
  - Veterans

Appendix 2: Questions to support the three-tier framework

Below are some key questions to consider within each tier, which can help us address some of the key issues.

Tier 1: Increase Support

The first layer of action is to increase engagement, opportunities, services and support to address the key drivers of health inequalities for people in need and making every contact count.

To ensure people have access to support that prevents them getting sick and reduces the drivers of inequality in their life, we need our teams (both clinical and non-clinical) across the Trust to be discussing health inequalities, to highlight where gaps in knowledge may be and/or to identify potential areas for improvement.

- What could you introduce that doesn't already exist to strengthen prevention and/or reduce inequalities for your people / patients?
- Historically, which areas or services have historically been prioritised less than others resulting in inequalities?
- Do you have enough information about the drivers and causes of poor health and inequalities in your population and service users?
- Can you give examples of underlying assumptions you have about what is needed in your area or service?
- How effectively joined up and person-centred are the services that strengthen prevention and reduce inequalities?
- What engagement or resource commitments would help to sustainably reduce inequalities?

Tier 2: Improve Care

The second layer of action is to improve all health and care services in such a way that they are targeted to greatest need and reduce inequalities in care.

To ensure that DBTH does all that it can to provide care and support to those with the greatest need first, teams / services should consider reframing the phrase "hard to reach groups" to instead answer the question "why are our services often hardest to access for the people who need them most?"

- Do we plan and prioritise our services based on existing demand or population need?
- Are there disparities between need and service use in certain communities and populations?
- Do we measure inequalities in service use and activity and consider narrowing gaps as a performance target?
- Which populations and communities have not been the focus of support for our services?
- Do some populations have easier / better access to our information and communications than others?
- What training for staff would build on their existing understanding of wider risks to peoples' health and wellbeing?
- How can we increase and co-produce engagement with excluded populations and those at greatest risk to encourage use of services earlier?
- How can we improve peoples' awareness of their own needs and build health literacy and expectations in the people at greatest risk?

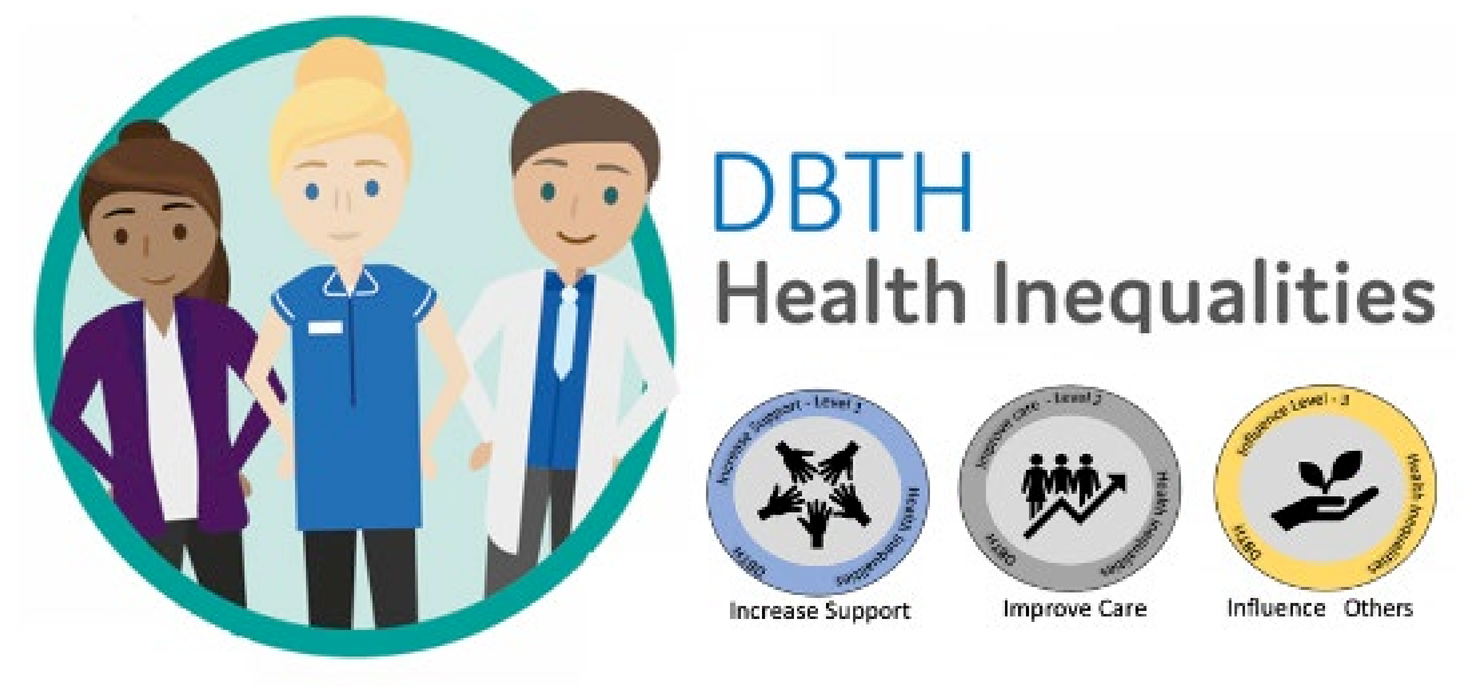
- What opportunities are there for providing services in different locations that may improve access to priority groups?

Tier 3: Influence Others

The third layer is to influence those differences in health which are linked to things like housing conditions, the quality of green spaces and clean air, education and income, i.e., the wider determinants of health, by becoming the best anchor institution we can be and advocating for health equity across all sectors.

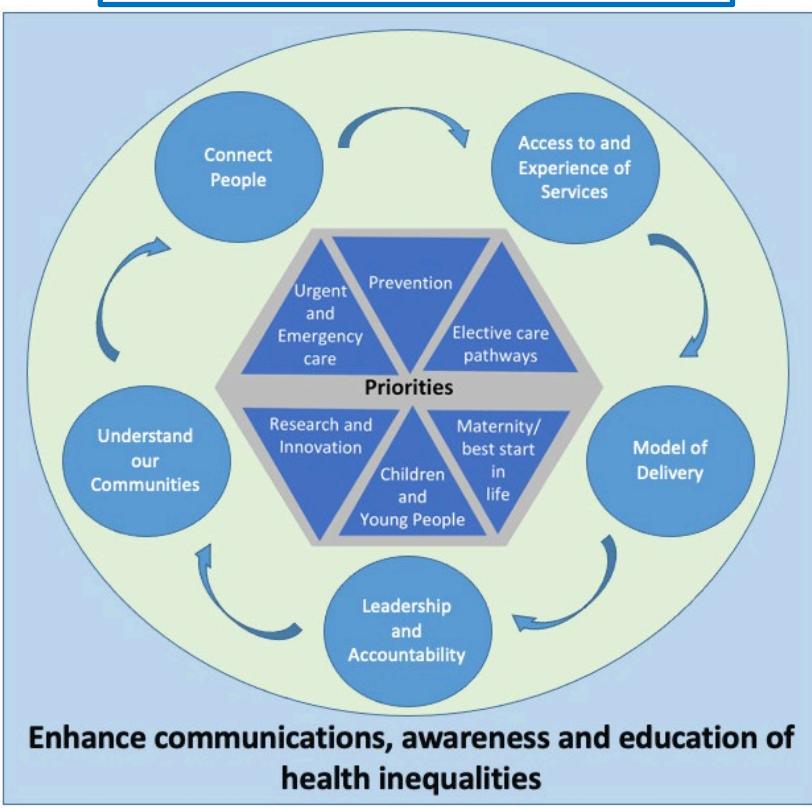
To ensure that due consideration is given to the impact that the Trust has on health and wellbeing by means other than the services it delivers, which can lead to huge impacts and far-reaching benefits.

- What are our values and how do they permeate everything that we do?
- What is our impact on the climate and environment and how do we maximise benefit?
    - How much waste do we produce and how can we manage it?
    - How can we reduce emissions from travel and transport?
    - How can we help to generate green, resilient and sustainable utilities (e.g. energy, water)?
    - How can we use the most sustainable technologies (health and otherwise)?
- What is our impact on the local economy and how can we maximise benefit?
    - How can we procure and spend more locally and regionally?
    - How can we generate local production and supply of what we need?
    - How can we make local supply economically viable through scale?
- What is our impact on communities and society locally and regionally?
    - How can we engage with communities to ensure we are equitable?
    - How can we share and distribute responsibility and power?
    - How can our facilities, estates and assets provide social value?
    - How can we create social mobility through recruitment and staff development?
    - How can we support make Doncaster and Bassetlaw the best place to be born?
    - How can we strengthen education and equal opportunity in Doncaster and Bassetlaw?
    - How can we make DBTH the best place to work?
- What is our impact through our influence on our partners, our suppliers, other sectors and through our reach into wider policy and development?



DBTH Tackling Health Inequalities Action Plan 2023-2028

DBTH's Tackling Health Inequalities Strategy:
1 Base, 5 Pillars and 6 Priority Areas



DBTH's 3-tier framework for improving health and tackling health inequalities (adapted with permission from Barnsley's Integrated Care Partnership framework)

Tier 1: Increase Support

The first layer of action is to increase engagement, opportunities, services and support to address the key drivers of health inequalities for people in need and making every contact count.

To ensure people have access to support that prevents them getting sick and reduces the drivers of inequality in their life, we need our teams (both clinical and non-clinical) across the Trust to be discussing health inequalities, to highlight where gaps in knowledge may be and/or to identify potential areas for improvement.

Tier 2: Improve Care

The second layer of action is to improve all health and care services in such a way that they are targeted to greatest need and reduce inequalities in care.

To ensure that DBTH does all that it can to provide care and support to those with the greatest need first, teams / services should consider reframing the phrase "hard to reach groups" to instead answer the question "why are our services often hardest to access for the people who need them most?"

Tier 3: Influence Others

The third layer is to influence those differences in health which are linked to things like housing conditions, the quality of green spaces and clean air, education and income, i.e., the wider determinants of health, by becoming the best anchor institution we can be and advocating for health equity across all sectors.

To ensure that due consideration is given to the impact that the Trust has on health and wellbeing by means other than the services it delivers, which can lead to huge impacts and far-reaching benefits.

The Year 1 (2023/24) action plan refers to the "base" i.e., enhancing communications, awareness, and education of health inequalities, and the first of our pillars, "understanding our communities". We haven't provided specific actions relating to the other four pillars as they are threads throughout our priority area actions.

In the Year 1 action plan below, timescales have been colour-coded: red = not commenced; amber = work is underway/ongoing; green = work is completed

Detailed Action Plan for Year 1 (2023/24)

	Action		KPIs / Measures	Timeframes	Tier	Links to:
Base: Enhance communications, awareness, and education of health inequalities	1	Set-up a Health Inequalities Communications Task and Finish Group and develop the Health Inequalities Comms Plan	• Set-up of T&F Group	Completed	Increase Support	NHS Long Term Plan Core20PLUS5
			• Development of Comms Plan	By end Dec 2023		
	2	Develop and deliver a Health Inequalities Training package targeting four-levels: 1. Basic health inequalities training for all our people – incorporated into SET training 2. Understanding of health inequalities using the national e-learning package (targeting frontline staff) – roll-out package 3. Training-up champions to identify health inequalities and signpost others (targeting managers / Level 1 Qi coaches) – develop training package 4. Enhanced training of health inequalities skills and knowledge to support and/or make changes (targeting project managers, Qi practitioners, senior leaders) – scope out a training outline	• 90% staff completion in line with SET training target	By end Mar 2024	Increase Support	NHS Long Term Plan Core20PLUS5
			• Plan roll-out of level 2 training	By end Mar 2024		
			• Have an outline of a level 3 training package	By end Mar 2024		
			• Have an outline of a level 4 training package	By end Mar 2024		

	3	Incorporate health inequalities training into relevant existing training/teaching opportunities, e.g., Foundation Doctors training, new staff induction, schools/colleges teaching (linked in with education team)	• Incorporate health inequalities training into existing training packages	Ongoing	Improve Care	NHS Long Term Plan Core20PLUS5
			• Include into Foundation Doctors training	By end Mar 2024	Influence Others	
	4	Embed tackling health inequalities / consideration of the impact on health inequalities into all policies, procedures, and processes, including but not limited to: Monday.com, QPIA, business case templates, strategies	• Reference health inequalities in all policies, procedures, and processes	Ongoing	Increase Support	NHS Long Term Plan Core20PLUS5
	5	Conduct an audit of all projects across the Trust to understand what work is currently going on across the Trust that falls under understanding or tackling health inequalities Raise awareness of this work to support the understanding of other teams/services/divisions of what can be achieved	• Complete the audit	By end Mar 2024	Improve Care	NHS Long Term Plan Core20PLUS5
			• Promote some examples at our strategy launch event	By end Mar 2024		

	6	Develop, pilot and roll-out a health inequalities toolkit to support teams/services/divisions to identify health inequalities and plan service improvement initiatives	• Develop, pilot and roll-out a health inequalities toolkit	Ongoing	Increase Support Improve Care	NHS Long Term Plan Core20PLUS5
Pillar 1: Understand our communities	7	To work with our information analysts to: • Incorporate a health inequalities tab onto the existing DERICK dashboards • Support the development of a health inequalities DERICK dashboard	• Have a HI tab on 2 DERICK dashboards	By end Mar 2024	Improve Care	Doncaster 1 Plan Bassetlaw Place Plan
			• Have a HI dashboard	By end Mar 2024		
	8	To work closely with our patient experience and engagement team to ensure we incorporate the patient voices/stories into all our workstreams. To achieve this we will: • Schedule regular meetings between the Health Inequalities team and the Patient Experience and Engagement lead • Invite Patient Experience and Engagement lead to all health inequalities meetings and task and finish groups	• Book in monthly meetings	Completed	Improve Care	Doncaster 1 Plan Bassetlaw Place Plan
			• Invite Patient Experience and Engagement lead to all HI meetings and T&F groups	Ongoing		

Priority Area	**Action**		**KPIs / Measures**	**Timeframes**	**Tier**	**Links to:**
Prevention	9	Work closely with the Healthy Hospitals Programme Team to support the QUIT (tobacco	• Healthy Hospitals Programme Manager to collect and report data to	Ongoing		NHS Long Term Plan

		control) programme ensuring the following data are collected and reported: • Proportion of patients admitted who are screened for tobacco addiction • Number of patients provided with Nicotine Replacement Therapy (NRT) and specialist stop smoking advice • Number of staff members provided with NRT and specialist stop smoking advice	our Health Inequalities Steering Group on a quarterly basis so we can identify issues and support improvements in the service		Improve Care	Core20PLUS5
	10	Support the ICB in the development an Alcohol Care Team (ACT) for DBTH (underway) Ensure relevant data are collected to evidence the impact of this service (e.g., number of patients screened throughout the Trust, number of referrals to the ACT, number of patients commencing medically assisted alcohol withdrawal, number of referrals to community alcohol services, and disaggregate these data by age, gender, ethnicity, and level of deprivation)	• Participate in meetings regarding the development of this new service	Ongoing – ICB timescales	Increase Support	NHS Long Term Plan
			• Advocate for appropriate data collection and evaluation	Ongoing – ICB timescales		
Elective Care Pathways / Recovery	11	Undertake a project to understand “Did Not Attend” (DNA) and “Was Not Brought” (WNB) data, disaggregating it by age, gender, ethnicity and level of deprivation – to identify inequalities particularly in relation to the “Core20”, ethnic	• Project to be scoped out	By end Dec 2023		Doncaster 1 Plan Core20PLUS5

		minority groups, and where possible, “PLUS” groups Undertake some patient engagement (as appropriate) to understand why they may DNA Provide a set of recommendations for service improvement (to be incorporated into future years’ action plans) considering the impact on digital inclusion and exclusion and involving engagement with partners to consider the whole care pathway	• Work with our information analysts to ensure relevant data is accessible and timely	By end Dec 2023	Improve Care	
			• Data analysis completed	By end Mar 2024		
	12	Review Access Policy with health inequalities lens Provide a set of recommendations for service improvement (to be incorporated into future years’ action plans) considering the impact on digital inclusion and exclusion and involving engagement with partners to consider the whole care pathway	• Access Policy reviewed	By end Mar 2024	Improve Care	Doncaster 1 Plan Core20PLUS5
	13	Ensure tackling health inequalities is embedded within the new MEOC policies, procedures, and plans. To do this we will: • Set-up an MEOC Health Inequalities Working Group with representatives from the three Acute Trusts (Barnsley, Rotherham and Doncaster and Bassetlaw) • Understand the potential impacts of MEOC on health inequalities via modelling work to compare/identify discrepancies between	• Set-up MEOC Health Inequalities Working Group	Completed		Doncaster 1 Plan Core20PLUS5
			• Undertake modelling work in conjunction with colleagues at The Rotherham Foundation Trust	By end Mar 2024		

		patients who are likely to be eligible for MEOC and those who are not • Develop a plan for evaluating the impact of MEOC on health inequalities going forwards and ensure patient engagement and experience is incorporated into the plans			Increase Support	
			• Develop evaluation plan	By end Mar 2024		
Urgent and Emergency Care (UEC)	14	Provide support to ensure processes are in place to analyse our baseline UEC activity by age, gender, level of deprivation and ethnicity – to identify inequalities particularly in relation to the "Core20", ethnic minority groups, and where possible "PLUS" groups and the impact on access, experience and outcomes Provide a set of recommendations for service improvement (to be incorporated into future years' action plans) considering the impact on digital inclusion and exclusion and involving engagement with partners to consider the whole care pathway	• Work with our information analysts to ensure relevant data is accessible and timely	By end Mar 2024	Increase Support	Doncaster 1 Plan Bassetlaw Place Plan Core20PLUS5
	15	Undertake a project to understand health inequalities relating to high intensity users of UEC pathways Review data disaggregated by age, gender, ethnicity and level of deprivation – to identify inequalities particularly in relation to the "Core20", ethnic minority groups, and where	• Project to be scoped out	By end Mar 2024		NHS Long Term Plan Core20PLUS5

		possible "PLUS" groups (ECIST data may support this work) Provide a set of recommendations for service improvement (to be incorporated into future years' action plans) considering the impact on digital inclusion and exclusion and involving engagement with partners to consider the whole care pathway	• Work with our information analysts to ensure relevant data is accessible and timely	By end Mar 2024	Increase Support	
Maternity and Best Start in Life	16	Health inequalities team to build relationships with DBTH's Women and Children's Division, plus relevant partners at the ICBs, local authorities, and primary care networks, attending relevant meetings, e.g., Local Maternity and Neonatal System (LMNS) meetings for both South Yorkshire and Nottinghamshire Relationship building will be an essential starting point to support future work in this priority area (to be outlined into future years' action plans)	• Network, build relationships and attend relevant meetings	Ongoing	Increase Support	Doncaster 1 Plan LMNS Plans Core20PLUS5
Children and Young People (CYP)	17	Health inequalities team to build relationships with DBTH's Women and Children's Division, plus relevant partners at the ICBs, local authorities, and primary care networks, attending relevant meetings, e.g., CYP Alliance meetings Relationship building will be an essential starting point to support future work in this	• Network, build relationships and attend relevant meetings	Ongoing	Increase Support	Doncaster 1 Plan Bassetlaw Place Plan Core20PLUS5

		priority area (to be outlined into future years' action plans)				
Research and Innovation (R&I)	18	Health inequalities team to attend DBTH's Research and Innovation Team (RIT) meetings so we are sited on current research programmes and have an opportunity to influence and/or advocate for the consideration of health inequalities	• Attend RIT meetings	Ongoing	Improve Care	NHS Long Term Plan Core20PLUS5
	19	In line with the R&I Team's priority regarding improving patient outcomes throughout prevention, early diagnosis and better management of cardiovascular and respiratory diseases and cancer (which is in alignment with our priority area of prevention and the Core20PLUS5) – we plan to work with the R&I Team to develop research proposals which have a focus on tackling health inequalities	• Develop and lead on research bids focused on tackling health inequalities	Ongoing	Increase Support	NHS Long Term Plan Core20PLUS5

Reactive work	Action		KPIs / Measures	Timeframes	Tier	Links to:
	20	To undertake/support reactive work that has an impact on health inequalities or has the potential to reduce health inequalities	• Undertake/support this work as required	Ongoing	Improve Care	

Action Plan Outline for Years 2-5

	Year 2 (2024/25) Actions	Year 3 (2025/26) Actions	Year 4 (2026/27) Actions	Year 5 (2027/28) Actions
Base: Enhance communications, awareness, and education of health inequalities	Implement comms plan (ongoing)	→	→	→
	Develop and deliver a Health Inequalities Training Package – 30% staff achieved level 2 and 10% staff achieved level 3 training	Develop and deliver a Health Inequalities Training Package – 1% staff achieved level 4 training	Deliver a Health Inequalities Training Package (ongoing)	Deliver a Health Inequalities Training Package (ongoing)
	Incorporate health inequalities training into existing training packages as appropriate	→	→	→
	Embed health inequalities into all procedures, policies, and processes	→	→	→
	Roll-out our health inequalities toolkit to teams / services / divisions	→	→	→
Pillar 1: Understand our communities	Work with information analysts to have HI tab on a further 6 (total 8) DERICK dashboards	Work with information analysts to have HI tab on a further 8 (total 16) DERICK dashboards	Work with information analysts to have HI tab on a further 10 (total 26) DERICK dashboards	Work with information analysts to have HI tab on a further 10 (total 36) DERICK dashboards
	Continue to work closely with patient experience and engagement lead	→	→	→
Priority Action: Prevention	Continue to support QUIT programme	→	→	→
	Continue to support the ACT service	→	→	→
	Work with the Health and Wellbeing Team to review the	→		

	"Knowing Your Numbers" initiative available for our people – ensuring relevant data is collected to identify health inequalities / evidence the impact on health inequalities (linked to hypertension case-finding / lipid and blood pressure optimisation as per Core20PLUS5)			
	Early cancer diagnosis: Health inequalities team to attend both Bassetlaw and Doncaster "Timely Presentation" meetings to support early cancer diagnosis (as per Core20PLUS5) and support any proposed initiatives	Monitor ethnicity and most deprived decile proportions in usage of cancer services to provide a set of recommendations to inform service improvement with the aim of meeting the target set by NHS England of 75% of cases to be diagnosed at stage 1 or 2 by 2028 (as per Core20PLUS5): • Review proportion of cancer referrals by age, gender, ethnicity and deprivation decile • Review proportion of cancers diagnosed at stages 1 or 2 by age, gender, ethnicity and deprivation decile • Review urgent two-week cancer referral performance by age, gender, ethnicity and deprivation decile	Early cancer diagnosis: • Ensure recommendations are implemented • Evaluate implemented recommendations as appropriate	→

		• Review percentage of patients starting cancer treatment within 62 days of GP referral by age, gender, ethnicity and deprivation decile		
		Undertake a project to drive uptake of COVID, flu and pneumonia vaccinations for patients and our people with Chronic Obstructive Pulmonary Disease (as per Core20PLUS5)		
		Undertake a project to "Make Every Contact Count" (MECC) in terms of improving vaccination uptake for CYP and adults		
				Review substance misuse service offer to understand the impact on health inequalities and establish if there are any recommendations for service improvement
Priority Action: Elective Care Pathways / Recovery	DNA/WNB project: • Undertake patient engagement work • Provide a set of recommendations for service improvement	DNA/WNB project: • Ensure recommendations are implemented • Evaluate implemented recommendations as appropriate		
	Access Policy review: • Provide a set of recommendations for service improvement	Access Policy review: • Evaluate implemented recommendations as appropriate		

	• Ensure recommendations are implemented			
	MEOC evaluation: • Undertake evaluation to establish impact on health inequalities • Provide a set of recommendations based on the evaluation	MEOC evaluation: • Ensure recommendations are implemented • Evaluate implemented recommendations as appropriate	→	
	Identify and reduce health inequalities within our elective waiting lists/outpatient referrals: • Analyse all elective waiting lists by age, gender, level of deprivation, and ethnicity to understand the impact on health inequalities • Review proportion of patients meeting the 18-week Referral to Treatment waiting time standard by age, gender, ethnicity, and deprivation decile • Review proportion of patients on the Referral to Treatment pathway who have been waiting for 52 weeks or more by age, gender, ethnicity, and deprivation decile	Identify and reduce health inequalities within our elective waiting lists: • Develop a set of recommendations to reduce health inequalities within our elective waiting lists • Consider the use of waiting list prioritisation tools (e.g., HEARTT (Health Equity and Referral to Treatment) Tool) • Consider waiting well opportunities • Implement these recommendations	Identify and reduce health inequalities within our elective waiting lists: • Evaluate implemented recommendations as appropriate	→

Priority Action: Urgent and Emergency Care	UEC pathways: • Analyse our baseline UEC data disaggregated by age, gender, ethnicity, and level of deprivation to identify health inequalities in UEC access, experience and outcomes • Review proportion of emergency department (ED) attendances by age, gender, ethnicity, and deprivation decile • Review acuity of ED presentations by age, gender, ethnicity, and deprivation decile • Provide a set of recommendations for service improvement	UEC pathways: • Ensure recommendations are implemented • Evaluate implemented recommendations as appropriate	→	
	High intensity users project: • Analyse our baseline UEC data disaggregated by age, gender, ethnicity and level of deprivation for high intensity users • Provide a set of recommendations for service improvement	High intensity users project: • Ensure recommendations are implemented • Evaluate implemented recommendations as appropriate	→	
			Review MECC opportunities / initiatives within the EDs	→

Priority Action: Maternity and Best Start in Life	Identify and reduce health inequalities within our maternity services: Work with maternity teams (in particular the Health Inequalities Midwife) to identify health inequalities in our maternity services in relation to access, experience, and outcomes – to do this we will: • Review data submitted to the Maternity Services Data Set (MSDS) that contains valid postcode of mother at booking to then determine deprivation decile • Review data submitted to MSDS that includes a valid ethnic category	Identify and reduce health inequalities within our maternity services: • Develop a set of recommendations to reduce health inequalities within our maternity services • Implement these recommendations	Identify and reduce health inequalities within our maternity services: • Evaluate implemented recommendations as appropriate	→
			Work with maternity teams to support specific health inequalities projects relating to: • Continuity of care • The use of personalised care and support plans • Improving health • Family support	→
Priority Action: Children and Young People	Identify and reduce health inequalities within our paediatric services in relation to the Core20PLUS5 clinical areas (asthma, diabetes, oral health,	Identify and reduce health inequalities within our paediatric services: • Implement these recommendations (in	→	→

	mental health and wellbeing, and epilepsy): Work with children's teams to identify health inequalities in our paediatric services in relation to access, experience, and outcomes, to do this we will: • Analyse our baseline data disaggregated by age, gender, ethnicity, and level of deprivation • Develop a set of recommendations to reduce health inequalities within our paediatric services (with particular reference to the Core20PLUS5 clinical areas)	relation to the Core20PLUS5 clinical areas) • Evaluate implemented recommendations as appropriate		
Priority Action: Research and Innovation	Continued attendance at RIT meetings to influence / advocate for the consideration of health inequalities within research projects	→	→	→
	Develop and lead on research bids focused on tackling health inequalities	→	→	→
Reactive Work	Undertake / support reactive work as required	→	→	→

DBTH Tackling Health Inequalities Strategy 2023-2028 Plan on a Page

<table>
<tr><td>Aim</td><td colspan="5">To embed the reduction of health inequalities in everything we do to ensure equitable access and excellent experience, thereby providing optimal outcomes for our patients and the communities that we serve.</td></tr>
<tr><td rowspan="6">6 Priority Areas</td><td colspan="5">1. Prevention
• Smoking (QUIT Programme), alcohol and substance misuse services
• CVD, chronic respiratory disease and early cancer diagnosis (as per Core20PLUS5)
• Vaccinations</td></tr>
<tr><td colspan="5">2. Elective care pathways / elective recovery
• Tackle elective recovery and address DNAs with a health inequalities lens – focus on using disaggregated data to monitor
• Address the issue of digital exclusion and inclusion
• Consider “waiting well” initiatives (links to prevention above)</td></tr>
<tr><td colspan="5">3. Urgent and emergency care pathways
• Review pathways with a health inequalities lens
• Make every contact count
• Target high intensity users</td></tr>
<tr><td colspan="5">4. Maternity and best start in life
• Ensure continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups (as per Core20PLUS5)
• Determine how to link into the best start in life agenda</td></tr>
<tr><td colspan="5">5. Children and young people
• Consider which children and young people “PLUS” groups we should focus on
• Focus on the 5 key clinical areas of health inequalities (as per Core20PLUS5) which include: asthma, diabetes, epilepsy, oral health and mental health</td></tr>
<tr><td colspan="5">6. Research and innovation opportunities
• Ensure tackling health inequalities is considered in all research and innovation applications / initiatives
• Seek opportunities for future research and innovation specifically focused on reducing health inequalities</td></tr>
<tr><td rowspan="2">5 Pillars</td><td>Understand our communities</td><td>Connecting people</td><td>Model of delivery</td><td>Access to and experience of services</td><td>Leadership and accountability</td></tr>
<tr><td>To ensure accurate, complete and timely access to population health data (DBTH service-level data and other relevant data, e.g., from JSNA) along with community voices to better understand the health inequalities and where to focus our action.</td><td>To work closely with partners and build on existing relationships, networks and trust. This will ensure work is aligned and supported and will prevent silo-working allowing health inequalities to be addressed using a whole system approach.</td><td>To move towards a more needs-led, compassionate social model of care. To focus on prevention and making every contact count. To use co-production to improve existing services and/or develop new services based on the needs of our communities.</td><td>To focus on the Core20PLUS5, ensuring targeted support is provided for the Core20 and PLUS groups, including inclusion health groups, particularly (but not exclusively) across the 5 service areas for both adults and children and young people.</td><td>Strong leadership and clear accountability and governance structures will support a culture shift and help to embed heath inequalities in everything we do, acknowledging that our staff may also be experiencing health inequalities.</td></tr>
<tr><td>1 Base</td><td colspan="5">Enhancing our communications, awareness and education of health inequalities for our people, our patients and our local communities</td></tr>
</table>

2311 - G GOVERNANCE & ASSURANCE

2311 - G1 ANNUAL EMERGENCY PREPAREDNESS, RESILIENCE & RESPONSE CORE STANDARDS COMPLIANCE

Decision Item   Denise Smith, Chief Operating Officer   12:05

10 minutes

REFERENCES

Only PDFs are attached

- G1 - Annual Emergency Preparedness, Resilience & Response Core Standards Compliance.pdf
- G1 - Appendix A DBTH Final Submission 21 November 23.pdf
- G1 - Appendix B DBTH Assurance Assurance Process Statement of Compliance 2023-24.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	28 November 2023	**Agenda Reference:**	**G1**
Report Title:	**Emergency Preparedness Resilience and Response (EPRR) annual assurance process for 2023/24**		
Sponsor:	Denise Smith, Chief Operating Officer		
Author:	Denise Smith, Chief Operating Officer		
Appendices:	Appendix A DBTH Final Self-Assessment Appendix B Accountable Emergency Officer signed statement of compliance		

Report Summary

Executive Summary:

This report sets out the

- Emergency preparedness, resilience and response (EPRR) annual assurance process for 2023/24
- Trust final self-assessment submission against the EPRR Core Standards, as part of the Annual assurance process for 2023/2
- Accountable Emergency Officer signed statement of compliance

The Trust final self-assessment (Appendix A) and Accountable Emergency Officer statement of compliance (Appendix B) was submitted on 21 November 2023. This showed a final self-assessment of fully compliant in 19 of the 62 core standards and partially compliant in 43 of the 62 core standards, giving 31% compliance and overall assessment of non-compliant.

Recommendation:	The Trust Board of Directors is asked to receive this report for assurance.			
Action Require:	~~Approval~~	~~Review and discussion/ give guidance~~	**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:	No changes made
Risk register:	No changes made
Regulation:	
Legal:	The Civil Contingencies Act 2004

Resources:	Not applicable
Assurance Route	
Previously considered by:	Trust Executive Team
Date:	22 November 2023
Any outcomes / next steps	To be shared with Trust Board of Directors in November 2023
Previously circulated reports to supplement this paper	

1. Introduction

This report sets out the

- Emergency preparedness, resilience and response (EPRR) annual assurance process for 2023/24
- Trust final self-assessment submission against the EPRR Core Standards, as part of the Annual assurance process for 2023/2
- Accountable Emergency Officer signed statement of compliance

2. Background

The Trust has a responsibility for developing and monitoring compliance with the mandatory obligations within the Civil Contingencies Act (2004) and ensuring compliance with the National Guidance set out in the NHS England Emergency Planning Resilience and Response (EPRR) Framework (2015).

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

NHS England has an annual statutory requirement to formally assure its own and the NHS in England's readiness to respond to emergencies. To do this, NHS England asks commissioners and providers of NHS-funded care to complete an EPRR annual assurance process.

3. Annual assurance process for 2023 / 24

The Trust is asked to undertake a self-assessment against the individual core standards and rate the compliance for each. The compliance level for each standard is defined as follows:

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

In addition, there is an annual deep dive, for 2023/24 this focusses on EPRR responder training.

The timetable for the 2023/24 process is summarised below:

- By 29 September 2023 Self-assessment and submission of evidence
- By 27 October 2023 Primary review and request any additional evidence
- By 24 November 2023 LHRP and RHRP assurance completed
- By 31 December 2023 Report to Trust Board and submission to national team

4. Organisational assurance rating

The overall organisation assurance rating is based on the percentage of core standards the organisation assesses itself as being 'fully compliant' with, the criteria for each overall rating is as follows:

Organisational rating	Criteria
Fully	The organisation is fully compliant against **100%** of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against **89% - 99%** of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against **77% - 88%** of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to **76%** of the relevant NHS EPRR Core Standards

5. Trust self-assessment

The Trust initial self-assessment showed the Trust as fully compliant in 41 of the 62 core standards and partially compliant in 21 of the 62 core standards; this gave 66% compliance and overall assessment of non-compliant.

Following the primary review, by the regional EPRR team, the Trust provided additional evidence against 14 of the core standards, where the regional team had challenged the Trust self-assessment.

The final outcome letter of the regional EPRR assurance check and challenge process accepted the Trust challenge and additional evidence in 6 of the core standards.

The Trust final self-assessment (Appendix A) and Accountable Emergency Officer statement of compliance (Appendix B) was submitted on 21 November 2023. This showed a final self-assessment of fully compliant in 19 of the 62 core standards and partially compliant in 43 of the 62 core standards, giving 31% compliance and overall assessment of non-compliant.

6. Summary and next steps

The Trust has submitted the final self-assessment and awaits the final position to be shared by the regional EPRR team by the 24 November 2023.

7. Recommendations

The Trust Board of Directors is asked to receive the final self-assessment and statement of compliance for assurance.

Ref	Domain	Standard name	Standard Detail	Organisational Evidence: Trust Information	Organisational Evidence	DBTH Final Self Assessment	Action to be taken	Lead	Timescale
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Denise Smith, Chief Operating Officer, is the Accountable Emergency Officer (AEO) and an Executive Director on the Trust Board. The role of the AEO is described in the Chief Operating Office job description and EPRR policy. The AEO is a member of the Local Health Resilience Partnership (LHRP). The Deputy Chief Operating Officer deputises for the Chief Operating Office across the full portfolio, including EPRR. The Deputy Chief Executive main duties and responsibilities includes Business Continuity and Emergency Preparedness. The AEO has signed off the mass casualty dispersal figures on behalf of the organisation.	COO Job Description (updated copy uploaded for secondary submission) Letter from Chief Executive confirming that COO is the AEO (uploaded for secondary submission) Deputy Chief Executive Job Description Organisational Structure Chart EPRR Policy Casualty Dispersal figures	Fully Compliant	N/A	N/A	N/A
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	The Trust has an overarching EPRR Policy. This describes the roles and responsibilities of those individuals within EPRR (AEO, EPRR Lead, Business Continuity leads). The Policy outlines the governance processes for EPRR including oversight groups. The Policy is aligned to the organisation's Policy on Policies includes a review schedule and version control. The EPRR Policy is written to support the achievement of the Trust's strategic objectives. The Policy sets out the processes and owners for Training & Exercising. The Policy aligns to the Trust's Business Continuity Strategy and Policy. The Policy includes CBRNe training and expertise requirements.	EPRR Policy	Partially Compliant	Review and update the Trust's EPRR Policy	Chief Operating Officer	30 September 2024
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	The Trust reports annually to a public meeting of the Board of Directors on its Core Standards compliance. The Trust's Annual Report and Accounts includes a statement of EPRR compliance with the Core Standards. The Audit and Risk Committee, a sub-Committee of the Board, receives a bi-annual EPRR report (i) Annual Assurance Report (ii) Annual report of the previous year and forward work plan for the next year. The EPRR Steering Group reports to the Trust Executive Group and provides assurance to the Audit and Risk Committee.	ARC Work plan ARC Report - July 2023 Annual Report and Accounts	Partially Compliant	EPRR Policy to be updated - to include the reporting arrangements to the Trust's Board of Directors (Public meeting). The Accountable Emergency Officer will provide an EPRR Report to the Trust's Board of Directors (Public meeting) on an annual basis. The Trust will include a statement regarding readiness and preparation in the Annual Report.	Chief Operating Officer	30 September 2024
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	The Trust has an annual EPRR work plan, this is based on the core standards. Governance arrangements have been revised in 2023/24 to ensure oversight of delivery against the work plan is monitored by the EPRR Steering Group and a monthly report will be provided to the Trust Executive Committee from Q4. The Annual Report provided to the Audit and Risk Committee provides assurance of delivery against the annual work plan.	EPRR Policy ARC Report - July 2023	Fully Compliant	N/A	N/A	N/A

Ref	Domain	Standard name	Standard Detail	Trust Information	Organisational Evidence	DBTH Final Self Assessment	Action to be taken	Lead	Timescale
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	The EPRR Policy details the Trust roles and responsibilities. This does not currently detail the resources available. The AEO report to the Audit and Risk Committee notes the EPRR establishment is appropriate. The description of resources assigned to EPRR is detailed in the Policy and there is evidence of an assessment by the organisation of the work vs available resource (capacity v capability) The EPRR Steering Group is accountable to the Trust Executive Group and assurance is provided to Trust Board via the Audit and Risk Committee	EPRR Policy	Partially Compliant	Review of EPRR capacity and capability	Chief Operating Officer	30 September 2024
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	The Trust has a clear process for identifying lessons from incidents and exercises. The process is documented within the EPRR Policy. Debrief information is shared with Partners - including the ICB - to enable system wide learning.	EPRR Policy IA Debrief Reports CBRNe Report to EPRR Steering Group	Partially Compliant	Review and revise the processes for capturing learning from incidents and exercises	Chief Operating Officer	30 September 2024
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	The Trust's Risk Management Policy outlines how risks are assessed and frequency for review. The Trust's Risk Management Policy includes tolerance and risk appetite, and outlines scoring and escalation procedures. The EPRR Policy requires the Trust to regularly review risks to the organisation and its critical functions. The TOR for the EPRR Steering Group require a facilitation of EPRR and business continuity risk assessments to identify key risks and assist in risk mitigation. Trust Business Continuity processes commence with an assessment of risk. The Trust is a member of LHRP where the Regional risk register is reviewed. A Risk Assessment for CBRNe is in place.	Risk Management Policy EPRR Policy TOR of EPRR Steering Group CBRNE Risk Assessment	Partially Compliant	Review and revise the process for assessing EPRR risks	Chief Operating Officer	30 September 2024
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	The Trust's Risk management policy describes the recording, monitoring and escalation of risks, the responsibility for management of risks and the governance arrangements. The Trust's Risk Management Policy includes tolerance and risk appetite, and outlines scoring and escalation procedures. The Trust's Risk Management Policy outlines the responsibility for the Trust's Business Resilience Group (now named the EPRR Steering Group) 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. The EPRR Policy requires the Trust to regularly review risks to the organisation and its critical functions. The TOR for the EPRR Steering Group require a facilitation of EPRR and business continuity risk assessments to identify key risks and assist in risk mitigation. Changes to risk registers are tracked and an audit trail is available.	Risk Management Policy EPRR Policy TOR for EPRR Steering Group CBRNE Risk Assessment	Partially Compliant	Review and revise the method of reporting, monitoring, communicating and escalating EPRR risks (internally and external)	Chief Operating Officer	30 September 2024

Ref	Domain	Standard name	Standard Detail	Organisational Evidence		DBTH Final Self Assessment	Action to be taken	Lead	Timescale
				Trust Information					
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Local Plans The EPO has information links with partner peers and discusses updates to plans and policies on a regular basis (this is likely to be picked up more formally when regular HRSG meetings are in place). Formal consultation with partner organisations takes place as appropriate (eg YAS and EMAS for CBRNe), (Public Health for Pandemic policies). System Plans Partners have been planning to work together on the production of a system wide plan for pandemics (WIP). Relevant plans are shared with colleagues and included on joint working agendas (eg Doncaster Joint Health Emergency Planning Group, South Yorkshire LRF Business Continuity Group, Notts Emergency Planning Delivery Group, LHRP). Changes resulting from consultation are captured in the minutes of meetings. System plans are shared on Resilience Direct.	None submitted	Partially Compliant	Work with the ICB to determine processes for collaborative planning, to consider: - formal consultation routes; - records of consultation.	Chief Operating Officer	30 September 2024
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	The Trust has in place: - Major Incident Plan - HAZMAT / CBRN plan - Business Continuity Plan - Severe Weather Plan - Corporate Business Continuity Plan for Disruption to Road Fuel Supply - Pandemic (Influenza) Plan The Major Incident Plan outlines the role of the organisation in an incident and detail its Command, Control, Coordination & Communication structures - across all sites. Plans outline the authorisation for invocation, procedures on activation and alerting - and for stand-down, debriefing and recovery of any incident.	Major Incident Plan Communications Plan Strategic Commander Action Card Tactical Commander Action Card Bronze Commander Action Card	Partially Compliant	Review and update the Trust's Major Incident Policy.	Chief Operating Officer	30 September 2024
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Severe Weather Plan. Linked to SYLRF Plan. Tested with partners via table top exercises in June 2019, in 2021 and in 2022 (flooding and heatwave). Heatwave protocols within Medical and Estates teams. 4 x 4 Service agreement in place. Weather warnings shared with senior DBTH staff in line as received, and included in weekend plan.	Adverse Weather Plan 4x4 agreement Email re: adverse weather Weekend Plan email	Partially Compliant	Review and update the Trust's Adverse Weather Plan.	Chief Operating Officer	30 September 2024
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Public Health DMBC lead. DBTH IPC policies are in place for the prevention and management and incident outbreaks. Options are included for tailoring at the time of an incident, once circumstances are known. Trainer and ED staff trained in Ebola - Standard Infection Prevention and Control Precautions Policy. Monkey pox - action cards developed - following guidance. FFP3 - the Trust is reviewing the arrangements that were in place during COVID-19 Infection Prevention and Control Policy in place in the organisation	IPC Polices Training Records Action Cards FFP3 Training Records	Partially Compliant	Review and revise the Trust plans to respond to an infectious diseases outbreak	Chief Operating Officer	30 September 2024

Ref	Domain	Standard name	Standard Detail	Organisational Evidence - Trust Information	Organisational Evidence	DBTH Final Self Assessment	Action to be taken	Lead	Timescale
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Public Health DMBC lead. Pandemic Flu Plan (2020) links to SYLRF plan and National Policy - signed off through Business Continuity Steering Group and Policy Approval and Compliance Group. Previous version of plan tested in October 2019 in multi agency exercise (Doncaster CCG - Doncaster Met Council - Trust). Command structure included in Major incident plan. Organisation has pandemic response arrangements which detail how the organisation will respond during a pandemic including the requirement to undertake situation reporting.	Pandemic Flu Plan	Partially Compliant	Review and revise the Trust plans to respond to a new and emerging pandemic	Chief Operating Officer	30 September 2024
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Public Health DMBC lead. Pandemic Flu Plan (2020) links to SYLRF plan and National Policy - signed off through Business Continuity Steering Group and Policy Approval and Compliance Group. Previous version of plan tested in October 2019 in multi agency exercise (Doncaster CCG - Doncaster Met Council - Trust). Command structure included in Major incident plan. Organisation has pandemic response arrangements which detail how the organisation will respond during a pandemic including the requirement to undertake situation reporting.	CBRNe / HAZXMAT Plan CBRNe PGDs Pharmacy Department action card	Partially Compliant	Review and revise the Trust plans to support an incident requiring countermeasures or mass countermeasure deployment	Chief Operating Officer	30 September 2024
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Mass casualty arrangements are included in the Trust's Major Incident Plan. National Mass Casualty Framework shared with BRSG (now EPRR Steering Group) members. Yorkshire & Humber patient dispersal plan. Meeting with South Yorkshire Police (28 September 2022) re: identification of patients within ED. Included walk around of ED and agreed protocols for working together. The Trust has purchased an electronic patient tracking system (requires roll out - covered in evacuation - see standard 16 below).	Major Incident Policy - Appendix 2 Yorkshire and Humber dispersal Plan	Partially Compliant	Review and revise the Trust plans to respond to incidents with mass casualties	Chief Operating Officer	30 September 2024

Ref	Domain	Standard name	Standard Detail	Organisational Evidence – Trust Information	Organisational Evidence	DBTH Final Self Assessment	Action to be taken	Lead	Timescale
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	The Trust's Evacuation and Shelter plan reflects the latest guidance - overarching plan (approved by Health and Safety Committee) for each site in conjunction with DMBC rest centres. Evacuation strategies in place across Trust Buildings (Adam Hunt Know it Solutions). The Trust's plan includes processes for the activation of the evacuation or shelter arrangements building on fire procedures, and follows incremental processes. Equipment and procedures are in place for the movement of patients on site and triage processes are in place for patients. Plans link to transportation arrangements. Plans detail arrangements to provide shelter for patients awaiting transport. Building Evacuation plans include the ability to shelter in situ. The Trust's Evacuation and Shelter plan references the role of, and liaison with, partner emergency services. The Trust's Major Incident Plan includes the Roles of Emergency Services and Partner Organisations. Plans include processes to evacuate specialist services and patients (eg ITU patients). Training on evacuation is provided to the Clinical Site Team,	Major Incident Plan Evacuation and Shelter Plan East Ward Block Fire Evacuation Strategy (example - these are available for each Trust Block) Level 7, Ward 22 Evacuation Plan / Action Card (example - these are available for all wards) Way Finding plans (x5) - evacuation routes	Partially Compliant	Update the Trust's Evacuation and Shelter Plan - this will be informed by the work on the Trust's Estate risks, and will include information on: - receiving patients; - the Trust's Patient Triage system for Evacuation; - Exercising. Roll out the Trust's Patient Triage System for Evacuation.	Chief Operating Officer	30 September 2024
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Security Policy including Bomb Threat in place - includes Lockdown. Electronic door policy in place. Lockdown arrangements are subject to regular testing for the ED. ED Managers have been trained in lockdown. Lockdown plans established for each clinical/corporate area - training delivered by the staff responsible for managing that area.	Security policy Electronic door policy Evidence to show that training has been offered to relevant teams Any evidence of training (ie you stated that the Matron has received training Any evidence of exercising Records of door checks / logging of issues	Partially Compliant	Review and revise the Trust plans to control access and egress in the event of an incident	Chief Operating Officer	30 September 2024
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Carbon Steeple Operational Plan in place. Multiple visits (to both Doncaster and Bassetlaw areas) during 2022/23 - staff aware of policy and actions required. Procedures in place for highlighting VIP visits in a restricted manner.	Carbon Steeple Plan Email highlighting VIP visit Concordat Prisoner Plan (uploaded for secondary submission)	Partially Compliant	Complete system review of Prisoner Plan Review arrangements in place to respond and manage 'Protected Individuals', including VIPs, High Profile Patients and Visitors to the Site, incorporating arrangements for admission into the Trust's bed base (if required), ongoing management of any Media, IG and Security considerations.	Chief Operating Officer	30 September 2024
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Mass Casualty and Mortuary Plans led by SY and Notts LRFs. The Trust's Major Incident Plan includes information on Mortuary Capacity. DBTH contributions as appropriate through partner working groups and consultation. Manual patient records system used in the event of a Major Incident. In mass casualty incidents the deceased are sent to Medico facility in Sheffield.	Major Incident Policy	Partially Compliant	Review multi agency arrangements for excess deaths and mass fatalities to understand Trust role in the event of an incident	Chief Operating Officer	30 September 2024

Ref	Domain	Standard name	Standard Detail	Organisational Evidence: Trust Information	Organisational Evidence	DBTH Final Self Assessment	Action to be taken	Lead	Timescale
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	The Trust has a single point of contact for its on call which operates 24/7 (switchboard). On call arrangements are tested, have the ability to receive all alerts and can be escalate quickly. Supporting information is available to on call personnel - with core procedures and contact numbers being provided to members on a weekly basis in a weekend plan. On call staff are provided with ad-hoc information on alerts and have access to all required Trust policies and procedures.	EPRR Policy On-Call manager contact list Weekend Plan Email Weather Alert Email Communications Test results / report	Partially Compliant	Develop and publish an On-Call Policy and handbook	Chief Operating Officer	30 September 2024
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	A TNA for staff is included in the EPRR Policy. Training includes National and Local sessions. Records of training for on call staff are retrained.	EPRR Policy Slide Pack - Major Incident Training for Senior Managers Training records	Partially Compliant	Develop and deliver Trust training plan for on call staff	Chief Operating Officer	30 September 2024
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	A training needs analysis - covering all staff involved with EPRR - is available, The TNA for Strategic and Tactical Commanders (within the EPRR Policy) is inclusive of the requirements set out in the MOS/NOS. The TNA for Strategic and Tactical Commanders identify the courses and frequency required to achieve the competencies required.1 year Training materials include aims and objectives to allow for effectiveness review. Records of training are retained by the EPRR Team.	EPRR Policy TNA Training Records Slides for Major Incident Training for Senior Managers	Partially Compliant	Undertake TNA for all staff involved in EPRR and ensure all relevant staff are fully trained	Chief Operating Officer	30 September 2024
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	An exercise and testing programme is available. Business continuity exercises test all levels of the organisations Business Continuity Plan. Exercises are relevant to local risks and include key stakeholders, including response staff. Exercise records of attendance are maintained by the organisation. Exercises have an aim and objectives and have been measured against these for effectiveness as part of the post exercise report. Tests of specific equipment used to support response are regularly undertaken regularly.	ARC Report on EPRR (includes plan for 2023/24) Communications Test Reports - (in and out of hours) Partner organisations (eg LRF) can provide records of DBTH attendance at joint exercises	Partially Compliant	Develop and delivery annual exercising programme to test incident response arrangements	Chief Operating Officer	30 September 2024
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Training for responder staff is given on a regular basis and training records are retained.	TNA Training Records	Partially Compliant	Incorporate EPRR training records into staff corporate training records	Chief People Officer	30 September 2024
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	EPRR Training is provided to Managers with Strategic and Tactical roles, and to colleagues joining the Trust through the Foundations of Care Training Programme. Clinical Site Team members are included in ICC awareness training and are offered courses to raise their awareness of Partnership working.	TNA Training Records	Partially Compliant	Incorporate EPRR awareness into staff induction programmes	Chief Operating Officer	30 September 2024

Ref	Domain	Standard name	Standard Detail	Trust Information	Organisational Evidence	DBTH Final Self Assessment	Action to be taken	Lead	Timescale
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	The Trust's Major Incident Plan provides information on the ICCs. Documents to describe: - Staffing roles for the ICC; - Establishment; - Processes; - Layout. Are available in hard copy format within the ICC, and electronically on the shared B:\. Action cards for responders with roles in the ICC are available in hard copy format, and electronically on the shared B:\. The ICCs have equipment to enable virtual operations. The ICCs have resilient phones and power. Inventory lists of equipment within each ICC are available and stocktakes are undertaken. Electronic equipment is tested regularly and IT updates are run on a regular basis.	Major Incident Plan Responder Action cards ICC Documents: - Agenda Template – Battle Rhythm Meeting - Bed State Template - Guidance for Incident Control Room Members - JESIP Aide Memoire - Joint Decision Model Guidance - Major Incident Control Room Attendance Sheet - Major Incident Control Room Message Template - Procedure for Determining an Emergency or Significant Service Disruption -H6 - SYLRF Information Sharing Protocol - Telephone Message Template - TV Set-Up Instructions	Fully Compliant	N/A	N/A	N/A
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Organisations plans are available to response staff in electronic and hard copy (on the shared B:\). Weekend Plans (send weekly) remind Senior colleagues of the location of key documentation.	Weekend Plan Email Pictures of hard copy documents held in the ICC (uploaded for secondary submission) Screen shot of documents available on One Drive (uploaded for secondary submission)	Fully Compliant	N/A	N/A	N/A
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	The Trust's approach to Business Continuity and Business Continuity Incidents is contained in the Trust's Business Continuity Strategy and Policy. NB linked to BC Core Standards (domain 9)	Major Incident Plan Business Continuity Strategy and Policy	Partially Compliant	Review and revise the Trust's Business Continuity Strategy and Policy.	Chief Operating Officer	30 September 2024

Ref	Domain	Standard name	Standard Detail	Trust Information	Organisational Evidence	DBTH Final Self Assessment	Action to be taken	Lead	Timescale
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	The Trust has a number of trained loggists and recent work has increased the number available. Initial and refresher training is offered to all loggists (including SMOCs) - training records are held by EPRR staff. 'Working with your loggist' training available on You Tube - for Senior Managers (referenced in Major Incident Training for Senior Managers) Log books meet the required legal standard. Incident log books and required stationery items for logging are retained in each ICC and are available electronically on the shared B: Personal log books are available to all managers on call and are available electronically on the shared B:\ A record of loggist contact details, including distance from DRI and travel time are retained - available in hard copy in the ICCs and electronically on the Trust's B:\ Training for Managers to work with Loggists is available. Loggists are included in the call out communication tests and during exercising.	Incident log template Personal log template Loggist contact list Communications test report	Partially Compliant	Ensure all relevant staff are aware of the need to maintain personal records and decision logs (to the required standard) and store appropriately Ensure arrangements are in place to provide 24 hour access to trained loggists	Chief Operating Officer	30 September 2024
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Processes are in place for Sitrep reporting - tested and exercised continually during 2022 / 23 incidents - with regular reporting to the ICB and NHSE/I. The major incident board in the ICC at DRI provides the standard formats for SBAR and, METHANE reports. Internal Sitrep reporting to ICR included in guidance to Staff. Sitrep reporting dependent on incident requirements and can be impacted by requesting organisation (format and timing) - eg ICB.	SITREP Template for Reporting to ICR	Partially Compliant	Review and revise the process for receiving, completing, authorising and submitting SitReps during incidents	Chief Operating Officer	30 September 2024
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Guidance available to relevant staff - hard copy and electronically. Led by Major Incident Clinical lead Jonathan Allen. Awareness training provided for key Clinicians.	Photographs to show the documents available on 'SharePoint', the Hive, and via an MS Teams Channel (which all Critical Care Consultants and Matrons have access to) - (uploaded for secondary submission) Photograph of hard copy held in ICC (uploaded for secondary submission)	Fully Compliant	N/A	N/A	N/A
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Provided in CBRNe training (provided to ED staff and other relevant staff by CBRNe Lead).	Photographs uploaded to evidence (uploaded for secondary submission) The hard copy file in situ Staff member accessing the O drive QR code	Fully Compliant	N/A	N/A	N/A

Ref	Domain	Standard name	Standard Detail	Trust Information	Organisational Evidence	DBTH Final Self Assessment	Action to be taken	Lead	Timescale
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Roles for the communication team are clearly defined in the Trust's plan. Action cards clearly detail the responsibilities and actions associated with the communications role. The Trust's Plan clearly indicates how communications fits into the wider response structures of the organisation. Pre-prepared standardised communication messages are available in the organisations incident response plans/arrangements. There are processes to inform staff, patients and stakeholders of the declaration of incidents (through multiple channels). Those needing communications training are identified in the Training Needs Analysis (TNA). Clear plan and criteria for who requires communications training,. Plans are clear on the role of the ICB and NHS England regional communications teams in responding to incidents. Processes allow for the logging of media requests and tracking of the responses given. Informal 24/7 on-call arrangements are in place - essential numbers are logged with Switchboard and Site Teams. Plans are clear on what information cannot be shared in	Media and Public Relations Policy Communications and Engagement Strategy (under review) Major Incident Action Cards Switchboard Call Out Tests TNA Communications Presentation, including: Log of communications requests and weekly briefings	Partially Compliant	Review and revise the alignment of the Trust communication planning for EPRR	Chief Operating Officer	30 September 2024
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	Roles for the communication team are clearly defined in the Trust's plan. Pre-prepared standardised communication messages are available and developed as per the Trust's incident response plans/arrangements Role within multiagency communications are clear. Weekly meetings with ICS colleagues and monthly NHSE briefings and catch-ups (policy of 'no surprises' followed). Informal on-call arrangements maintained between Director and Deputy as required, drawing on the rest of the team as needed. Plans and internal work flows articulate sign of procedures, with executive team sighted or nominated deputy. Plans are clear on what information cannot be shared in response. Communications activities informed by local, regional and national campaigns.	Example of Communications sign off - email Major Incident Plan Media and Public Relations Policy Communications and Engagement Strategy (under review) Communications Presentation	Partially Compliant	Develop a Trust plan for communication during incidents	Chief People Officer	30 September 2024

Ref	Domain	Standard name	Standard Detail	Organisational Evidence: Trust Information	Organisational Evidence	DBTH Final Self Assessment	Action to be taken	Lead	Timescale
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	The Trust engages in warning and informing with organisations and participates in communication structures for coordinated messages. There are established and well-used communications platforms, which span informal and formal channels, with resilience from organisation's internal network. Regularly maintained mailing lists and contacts are retained, with emergency contact list maintained within internal network folders – this includes key stakeholders. Key notice boards within the Trust outlined and regularly maintained. Channels have been developed to communicate with inpatients and families, with cascade from colleagues. The Annual Report is developed and published by the Communications Team each year. 24/7 on-call cover is provided. .	Annual Report. Major Incident Plan Media and Public Relations Policy Action Cards Communications presentation including: Google analytics Additional evidence uploaded for secondary submission: - Statement on Media Training at DBTH; - Communications Team Emergency Response Plan; - Communications Team Emergency Response Sheet; - Template Responsive Communications Plan; - Email advising of high number of Facebook contacts.	Fully Compliant	N/A	N/A	N/A
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Arrangements are in place and outlined for dealing with media, with pre-approved messages developed as per incident, and signed-off by Executive Team or nominated deputy. Arrangements for establishment of media reception centre are outlined in Media policy and Major Incident policy. Media monitoring roles are contained within Job Descriptions. Media training has been provided for Trust Executive and leaders, with a plan to update and refresh in 2024. All messages are signed off by an Executive Team member or nominated deputy. Regular media briefings are provided for all leaders in the Trust. The Trust's Media Policy clearly outlines usage of social media, and regularly briefings undertaken during incident to ensure good grip and control.	Major Incident Plan Media and Public Relations Policy Communications Presentation Action Cards	Partially Compliant	Review and revise Trust plans for rapid and structured communications related to EPRR	Chief People Officer	30 September 2024
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	The Accountable Emergency Officer is a member of the LHRP.	None submitted	Partially Compliant	Accountable Emergency Officer, or designated deputy, to attend LHRP meetings	Chief Operating Officer	30 September 2024

Ref	Domain	Standard name	Standard Detail	Organisational Evidence: Trust Information	Organisational Evidence	DBTH Final Self Assessment	Action to be taken	Lead	Timescale
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	The NHS structure is represented within South Yorkshire LRF by both NHS England and the NHS South Yorkshire Integrated Care Board. This arrangement is confirmed within the LRF Constitution. These two organisations are invited to, and attend, the LRF Strategic Meeting, and the tactical level Business Management Group meeting. They are also called out to, and attend, any Strategic or Tactical Coordinating Groups called in response to a multiagency major incident. Where incidents are relevant to specific NHS Trusts (eg a water mains burst near their site), they are also invited. NHS Trusts are invited to LRF sub-groups where relevant eg Business Continuity Group, Warn & Inform Group. There is also a standing invitation to LRF exercises. • Clear governance arrangements for the Local Resilience Forum are documented in Policy LRF Constitution. • The Emergency Planning Officer is a member of the LRF's Business Continuity Sub Group. Attendance during 2022/23 has been difficult as meetings have fallen outside of the post holders contracted hours. To work around this the Emergency Planning Officer has an open dialogue with the LRF Secretariat and provides comments on the agenda and any papers for inclusion in the meetings. • The Emergency Planning Officer attended exercise	Minutes of meetings held by LRF Policy LRF Constitution Policy LRF Constitution Attendance records at LRF exercise	Fully Compliant	N/A	N/A	N/A
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Established mutual aid agreements - via local Resilience Managers, DMBC, Public Health, SYP and local acute Trusts. During major incidents regional coordination and aid is managed by NHSE teams - no signed agreements required. Regional divert policies are in place. - NHSEI – Escalation and Mutual Aid Plan - South Yorkshire and Bassetlaw Maternity Escalation Policy and OPEL Framework; - DRI Maternity Services Escalation Plan and Suspension of Services Guidance.	NHS England North East and Yorkshire Region – Incident Management South Yorkshire and Bassetlaw Maternity Escalation Policy and OPEL Framework DRI Maternity Services Escalation Plan and Suspension of Services Guidance	Partially Compliant	Work with the ICB to ensure that the Trust applies, and supports all Mutual Aid arrangements as appropriate.	Chief Operating Officer	30 September 2024
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	The ICB leads on sharing protocols. • Documented and signed information sharing protocol; • Evidence relevant guidance has been considered, eg Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004.	None submitted	Partially Compliant	Work with the ICB to ensure that the Trust applies, and supports all arrangements for Information Sharing as appropriate.	Chief Operating Officer	30 September 2024
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	The Trust has a Business Continuity Policy Statement and a Business Continuity Policy in place. The Statement and Policy outline the Trust's strategic intent for the business continuity programme and defines approach to business continuity. The Statement is signed by the AEO and the Policy is approved by the Board of Directors.	EPRR policy Business Continuity Policy Business Continuity Policy Statement	Fully Compliant	N/A	N/A	N/A

Ref	Domain	Standard name	Standard Detail	Trust Information	Organisational Evidence	DBTH Final Self Assessment	Action to be taken	Lead	Timescale
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	The Trust's Business Continuity Policy has been refreshed to outline: Introduction The Policy Statement Roles & Responsibilities Maintenance & Continual Improvement Audit and Review Reporting Structure Related Policies, Standards & Guidance Documents Glossary Equality Impact Assessment BCMS Reporting Structure	EPRR policy Business Continuity Policy Business Continuity Policy Statement	Partially Compliant	Review and update the Trust's Business Continuity Policy.	Chief Operating Officer	30 September 2024
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The Trust's Business Continuity Policy has been refreshed to outline: Introduction The Policy Statement Roles & Responsibilities +F8 Audit and Review Reporting Structure Related Policies, Standards & Guidance Documents Glossary Equality Impact Assessment BCMS Reporting Structure The Trust's Responsive Business Continuity Checklist assists managers in ensuring that they have considered business continuity risks for their service(s), impacted by a reduction or loss of: STAFF SITE SERVICES SUPPLIES and that - should a risk come to fruition - a list of considerations required for a rapid response is available, supported by accessible information.	Business Continuity Policy Responsive Business Continuity Checklist	Partially Compliant	Refresh Business Continuity Processes in light of the updated guidance.	Chief Operating Officer	30 September 2024
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	The Trust's Responsive Business Continuity Checklist assists managers in ensuring that they have considered business continuity risks for their service(s), impacted by a reduction or loss of: STAFF SITE SERVICES SUPPLIES and that - should a risk come to fruition - a list of considerations required for a rapid response is available, supported by accessible information.	Responsive Business Continuity Checklist	Partially Compliant	Ensure business continuity plans are in place for the management of incidents	Chief Operating Officer	30 September 2024
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	EPRR Plan includes BC exercises. Trust carried out IT BC scenario exercises during 2023.	ARC Report - including EPRR Work plan IT BC Exercise Reports	Partially Compliant	Undertake exercises to test BCPs - locally and Trust wide.	Chief Operating Officer	30 September 2024
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	The Trust is DSPT compliant - evidenced by annual submission.	Organisational Status at dsptoolkit.nhs.uk	Fully Compliant	N/A	N/A	N/A

Ref	Domain	Standard name	Standard Detail	Organisational Evidence: Trust Information	Organisational Evidence	DBTH Final Self Assessment	Action to be taken	Lead	Timescale
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	The BMS reporting structure is included in the Trust's Business Continuity Policy.	Business Continuity Policy	Partially Compliant	Include KPIs and Business Continuity update in the Annual EPRR report to the Audit Committee and Board.	Chief Operating Officer	30 September 2024
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Audit and review processes are included in the Trust's Business Continuity Policy. The Trust has an annual internal audit plan, signed off by the Audit and Risk Committee	Business Continuity Policy	Partially Compliant	Include the audit and review of Business Continuity in the Annual EPRR report to the Audit Committee and Board.	Chief Operating Officer	30 September 2024
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Maintenance and continual improvement is included in the Trust's Business Continuity Policy.	Business Continuity Policy	Partially Compliant	Include the maintenance and continual improvement of BC in annual EPRR report to the Audit Committee and Board.	Chief Operating Officer	30 September 2024
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	The Trust's Procurement Team leads on ensuring that Providers have suitable business continuity processes in place. Where relevant a supplier framework is used. Evaluation of business continuity processes is undertaken as part of tender processes.	None submitted	Partially Compliant	Review and revise the systems to assess the BC plans of commissioned services and suppliers	Director of Finance	30 September 2024
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Governance arrangements for the management of Hazmat/CBRN response are clearly documented in the HAZMAT and CBRNe Plan. Named roles are available for those responsible for planning, training, equipment checks and maintenance CBRNe Lead. Roles are clearly documented and defined in the HAZMAT/CBRNE plan. Frequency of maintenance/testing/training is also documented. CBRN reports and action plans arising from Ambulance Audits are provided to the Trust's BRSG. Acute Specific: Training is provided for decontamination personnel.	CBRNE / HAZMAT Plan Report to BRSG Meeting (4 July 2023)	Partially Compliant	Review the Governance arrangements for HAZMAT and CBRNe.	Chief Operating Officer	30 September 2024
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	A risk assessment is in place outlining potential impacts to the organisation (staff, estates, infrastructure). The HAZMAT/CBRNE plan clearly identifies that risk assessments are available and where to find them. Governance arrangements for Hazmat/CBRN are included in the EPRR Policy. Safe systems of work (eg arrangements for managing waste) are in the plan / on action cards. The relevant contact details are also available in the plan and on the action cards. Risk assessments include any impact on BAU and outline actions taken to mitigate these (eg decontamination structures impacting on ambulance access and any associated cordons). Risk assessments take account of multiple locations/sites across the organisation. Acute Specific: Risk assessment identifies and recommends staff who should not work with contaminated patients. Exclusions can also be found on staff training log and action cards.	CBRNE / HAZMAT Plan EPRR Policy (uploaded to standard 1) Risk Assessment on Staff Impacts. BAU and Multiple Locations Action cards	Fully Compliant	N/A	N/A	N/A

Ref	Domain	Standard name	Standard Detail	Trust Information	Organisational Evidence	DBTH Final Self Assessment	Action to be taken	Lead	Timescale
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Plans and action cards identify where advice can be sought. Advice for ongoing treatment is included in the Plan and on action cards. Staff training, and the Plan and action cards include familiarisation of the numbers to be used and where to locate them - including TOXBASE, National Poisons Information Service (NPIS), UK Health Security Agency (UKHSA), and Emergency Coordination of Scientific Advice (ECOSA). Plans clearly detail the decision making process upon receipt of advice - ie implement advice per BAU hierarchy / disseminate relevant information.	CBRNE / HAZMAT Plan Action cards	Fully Compliant	N/A	N/A	N/A
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	The Plan is up to date, has been aligned to the risk assessment and expands beyond IOR principles. The Plan outlines command and control arrangements for organisation and/or responding department. Ambulance services audit the Trust - including a review of the Plan (consider that they have been 'consulted on' as they provide information for inclusion). The processes for the decontamination structures (replacement of tents, cordons etc) are included in the Plan, and on action cards. The Plan identifies where non contaminated patients are managed. Decision making processes for wet vs dry decontamination are clear - a flow chart and action cards are available. Triggering of other organisational plans (eg Lockdown) is included in the CBRNe Plan. Decontamination doesn't stop the receipt of non contaminated patients. Clear process are available for the management of waste - bagged clothing etc / contaminated water.	CBRNE / HAZMAT Plan Procedures for response (tent set up, safe working). Link to training video Risk assessment Learning outcomes Action cards Wet/dry flow chart IOR Advice sheet- dry decon TNA with CBRN roles Exercise and Testing reports Debriefing certificate Respirex evidence of suit replenishments/recertification	Fully Compliant	N/A	N/A	N/A

Ref	Domain	Standard name	Standard Detail	Trust Information	Organisational Evidence	DBTH Final Self Assessment	Action to be taken	Lead	Timescale
59	Hazmat/CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Arrangements are in place to outline safe systems of work in decontamination. Decontamination processes describe how to manage self presenters. The Plan and action cards outline step by step arrangements to meet the requirement to decontaminate the minimum of 4 patients per hour. The process to establish the tent is included in the Plan and action cards, with responsibilities clearly detailed and agreed as part of planning. A call out system is in place for the continual provision of decontamination over an extended period - including handover and management of teams. The Nurse in Charge is responsible for assigning decontamination roles to Staff and for handing out action cards. An assessment of localised needs and resources has been undertaken. Itinerary is available and resources are checked on a monthly basis. The Trust's Plans align to local capacity in ambulance services and fire services but doesn't rely on these services for provision.	CBRNE / HAZMAT Plan Action cards Sample analysis TNA Itinerary	Fully Compliant	N/A	N/A	N/A
60	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	The organisation maintains inventories of the equipment held for a HAZMAT/CBRN response and these are checked on a monthly basis. Equipment is aligned to the risk assessment for the organisation. Conveyors are available for the management of non ambulant or collapsed patients with instructions for use (both sites). Instructions (action cards) are available in different languages. All equipment is non-perishable aside from the suits and tents which are under contract. Equipment checks are undertaken by the CBRNe Lead / Estates. Plans are in place to escalate issues to the ICB - per any EPRR issue.	CBRNE / HAZMAT Plan Equipment lists and inventories, including date of last check Equipment checklists and frequency established Financial forecasts/part of resource updates to Boards SOPs for any specialist equipment Centralised and local records maintained on equipment Multiple Language patient instruction Coveryor system evidence- photo/invoice Risk assessment Action cards	Fully Compliant	N/A	N/A	N/A

Ref	Domain	Standard name	Standard Detail	Organisational Evidence Trust Information		DBTH Final Self Assessment	Action to be taken	Lead	Timescale
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident, where applicable. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Monthly checks are in place for Ram Genes / suit services are on contract. Repair and service contracts are in place for tents and suits. Is there a contract for BH tent? Ramgenes are calibrated each year. CBRNe Lead / Estates responsible for equipment checks. CBRNe Audits - by the Ambulance Services - are undertaken on an annual basis (provides oversight of checks). Processes are the same for all sites under management of the organisation. If a CBRNe incident – the Business Continuity for use equipment is outlined in the Plan. If the BC incident is due to loss of storage area, the Trust would replace all damaged equipment. Procurement check the BC Plans of suppliers (Respirex etc). The procedures for the disposal of equipment are included in the Plan / waste management processes are in place.	CBRNE / HAZMAT Plan Risk assessment Ram-gene servicing documentation Action cards Maintenance records- Tent PAT test- itinerary	Fully Compliant	N/A	N/A	N/A
62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Clear procedures are in place for waste disposal methods for equipment used which cannot be decontaminated. Procedure for waste materials as a result of operating your decontamination processes (to include safe storage) are in place. Procedures for the management of waste water provisions, ensuring any disposal down sewerage is authorised by Environment Agency and Water Companies, are in place. Waste water procedures are checked with water companies. Procedures are included in the Plan to retain / protect materials which need to be held as evidence such as clothing etc. Bags are available for the retention of clothing. Acute Specific: Waste disposal procedures are in place.	CBRNE / HAZMAT Plan CBRNe response arrangements Action cards - chain of custody	Fully Compliant	N/A	N/A	N/A

Ref	Domain	Standard name	Standard Detail	Trust Information	Organisational Evidence	DBTH Final Self Assessment	Action to be taken	Lead	Timescale
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	The Training Needs Analysis identifies the number of trainers required for HAZMAT/CBRN training. The Training Needs Analysis/Risk assessment identifies the number of staff overall to be trained. Audits check that the minimum standards established for HAZMAT/CBRN training are covered. Training records for trainers are maintained on OLM. Records for all staff training which has been undertaken - to ensure that staff are up to date - are maintained on OLM. The training programme in place has monthly dates - to ensure that sufficient slots are available for the number of staff to be trained. The TNA identifies the staff roles to be trained in CBRNe.	CBRNE / HAZMAT Plan Training needs analysis EPRR policy or training policy/programme. Training records - OLM report Personal Development Portfolio for trainers Learning outcomes Room Bookings/allocated training dates Trainer certificates	Fully Compliant	N/A	N/A	N/A
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	There is a training programme for staff with response duties for HAZMAT/CBRN - Clinical staff, receptionists, flow support, housekeepers and porters. The training uses the actual suit and tent types used at the Trust. Training required has been determined from the TNA. The materials used in training outline arrangements for safe systems of work. Non-Responder Staff are provided with information to advise of general HAZMAT / CBRNe awareness (including IOR) - articles are included in Buzz. There is a designated page on the trust intranet designated to CBRNE with advice for non responders. The Training Needs Analysis has established the number of staff to be trained in any given role. A knowledge check at the end of CBRNe training / an examination at the end of PRPS training determines the effectiveness of training provided. Numbers of staff trained are reported to the BRSG meeting. . Acute Specific: Materials for training include use of dry and wet decontamination, FFP3, PRPS and RAM Gene use. Training is tailored for staff in different roles as appropriate (per TNA).	CBRNE / HAZMAT Plan Training needs assessment Training materials Training records Reports on training uptake Training evaluations Training Needs Analysis EPRR policy or training policy/programme Training records Staff groups identified in records (uploaded for secondary submission)	Partially Compliant	Undertake risk assessment to identify all staff who are likely to come into contact with potentially contaminated patients Ensure identified staff are sufficiently trained in IOR principles and isolation	Chief Operating Officer	30 September 2024

Ref	Domain	Standard name	Standard Detail	Trust Information	Organisational Evidence	DBTH Final Self Assessment	Action to be taken	Lead	Timescale
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	The organisation provides information (action cards) and training to aid staff in determining the right PPE to use in each situation. The organisation has ready supplies of PPE in accordance with the potential lists above - a monthly stocktake is undertaken. The TNA identifies which staff are required to use which PPE and training provides clear instruction on its use. The organisation monitors the availability of staff trained to respond ensuring 24/7 coverage. Expected numbers of immediately deployable staff in any type of PPE has been established as part of TNA. Safe systems of work are documented (action cards) alongside communication cascades to prevent unprotected staff exposure - training on this takes place. Regular bank staff are trained/ad-hoc are not. Live and exercise/training equipment is clearly labelled and held separately to the live equipment - so easily distinguished. Training equipment is locked away in a separate unit to operational equipment. Acute Specific: Plans are clear that a high uptake of training is expected across all relevant teams by the organisation.	CBRNE / HAZMAT Plan Report to BRSG Meeting (4 July 2023) Training needs assessment Equipment inventories Fit testing schedules and training schedules/programme Training records, training reporting and evaluation Monitoring of uptake/trained numbers and corrective action plans CBRNe or other response plan documenting availability	Partially Compliant	Ensure staff have access to and are trained in the use of appropriate PPE Ensure arrangements are in place to maintain stock levels of PRPS and FFP3 (or equivalent)	Chief Operating Officer	30 September 2024
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	The EPRR training and exercising programme includes exercises for response to HAZMAT/CBRNe. An exercise was undertaken at BH in May 2023 / an exercise is planned for DRI in August 2023. Exercises cover all types of response for the organisation (IOR, Wet decontamination etc). The exercise programme is adequate to allow all relevant staff to be exercised. Should any issues with equipment be identified through training and exercising, they would be included in the report / with an action to rectify as appropriate. Post exercise reports are written - including lessons and action plans. These are reported to the BRSG meeting to allow for action tracking. Reporting on exercise outcomes is in place - through BRSG (escalated as appropriate to TEG / ARC). Acute Specific: Exercises include wet decontamination, the use of suits and safe systems of work.	CBRNE / HAZMAT Plan Exercise schedule (separate or with main schedule) Post exercise reports Improvement plans Action monitoring and ownership as part of wider learning processes	Fully Compliant	N/A	N/A	N/A

North East & Yorkshire Emergency Preparedness, Resilience and Response (EPRR) Assurance 2023-2024

STATEMENT OF COMPLIANCE

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

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

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Non-compliant (from the four options in the table below) against the core standards.

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

I confirm that the above level of compliance with the core standards has been agreed by the organisation's Accountable Emergency Officer (AEO) pending submission to the Board / governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

D Smm

Date signed: 21 November 2023

2311 - G2 QUALITY & EFFECTIVENESS COMMITTEE TERMS OF REFERENCE

Decision Item | Fiona Dunn, Director Corporate Affairs / Company Secretary | 12:.15

5 minutes

REFERENCES

Only PDFs are attached

G2 - Quality & Effectiveness Committee Terms of Reference.pdf

Quality and Effectiveness Committee

Draft Terms of Reference

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

Delegated authority	The Committee is a Committee of the Board and holds those powers specifically delegated to it by the Board and set out in these terms of reference. The Committee is authorised to investigate any activity within its terms of reference. It is further authorised to seek any information it requires from any employee of the Trust and all employees are directed to co-operate with any request made by the Committee. The Committee may make a request to the executive for legal or independent professional advice and request the attendance of external advisers with relevant experience and expertise if it considers this necessary. The Committee will operate at a strategic level as the executive is responsible for the day to day delivery of Trust services and management of its workforce.
Duties and work programme	(1) To review reports relevant to the Committee that relate to the following matters: - the Trust wide quality objectives as part of the Nursing, Midwifery & Allied Health Professionals Quality Strategy 2023-27, - the clinical risk management framework and any controls and assurances against relevant clinical risks on the Board Assurance Framework, - the effectiveness of clinical governance, clinical risk management, clinical audit and effectiveness and clinical control, - maternity safety accountabilities, - promoting an honest and open reporting culture, - disclosure statements (in particular the Quality Report and Declarations of Compliance made to NHSE), prior to endorsement by the Board, - the CQC Essential Standards of Quality and Safety as part of the internal assurance process, - compliance with licensing standards of the Care Quality Commission, - any improvement reviews/notices from the Care Quality Commission and other external assessors, - clinical data and patient identifiable information to ensure that it is in accordance with the Caldicott Guidelines and relevant legislation and guidance, - adverse clinical incidents, complaints and litigation and examples of good practice and learning, and trend analysis - the QPIA process for Efficiency and Effectiveness Improvement Plans, - infection control, - mortality, - comments, compliments and complaints.

	(2) Through the Clinical Governance Committee, the Committee will obtain assurance that clinical governance strategies and plans are embedded and that the clinical governance function is adequately resourced and has appropriate staffing. (3) To undertake thematic reviews and deep dives into quality and governance related issues. (4) To ensure that the Trust has reliable, up-to-date information about what it is like being a patient experiencing care administered by the Trust. (5) To approve terms of reference and membership of reporting sub-Committees and oversee the work of those sub-Committees.
Chairing arrangements	The chair will be nominated from among the non-executive members of the Committee. The vice-chair will be nominated from the other two NEDs on the committee.
Membership	• Three members, appointed by the Board from amongst the Non-executive Directors (other than the Chairman of the Trust). • Executive Medical Director * • Chief Nurse * * Deputies to attend in the absence of the Chief Nurse and/or the Executive Medical Director. Membership is restricted to executive and non-executive directors only.
In attendance	• Director Corporate Affairs /Company Secretary • Director of Midwifery • Director of Allied Health Professionals • Associate Medical Director for Clinical Safety • Clinical Governance and Professional Standards Co-ordinator • Corporate Governance Officer (Minutes) • Other Trust staff as appropriate / requested • Two governor observers
Secretary	Corporate Governance Officer.
Voting	Matters will generally be decided by way of consensus. Where it is necessary to decide matters by a vote then each member will have one vote. The Chair will have a casting vote.
Quorum	Three members, one of which must be an executive member, including the chair or vice-chair.

Frequency of meetings	Once every two months.	
Papers	Papers will be distributed a minimum of three clear working days in advance of the meeting, but ideally a week before.	
Permanency	The Committee is a permanent Committee.	
Sub-Committees	Clinical Governance Committee Patient Experience & Involvement Committee	
Date agreed by the Committee:		3 October 2023
Date approved by the Board of Directors:		
Review date:		October 2024

2311 - G3 PEOPLE COMMITTEE TERMS OF REFERENCE

Decision Item | Fiona Dunn, Director Corporate Affairs / Company Secretary | 12:20

REFERENCES

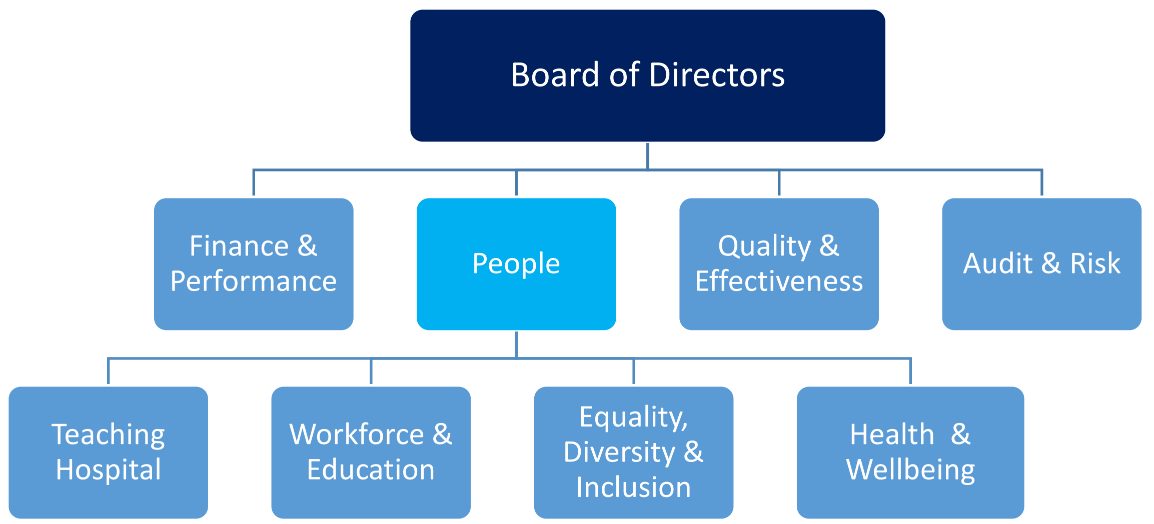
Only PDFs are attached

G3 - People Committee Terms of Reference.pdf

People Committee

Terms of Reference

<table>
<tr><td>Name</td><td>People Committee (“the Committee”)</td></tr>
<tr><td>Purpose</td><td>The Committee will carry out its duties as an assurance Committee of the Board of Directors (”the Board”) in reviewing systems of control and governance specifically in relation to people matters; specifically, although not limited to, the delivery of the People Strategy, including:
The delivery of the People and Organisational Development services and the Education and Research services, to achieve outcomes within the four themes of the People Strategy:
Looking After Our People – including health and wellbeing, staff and learner surveys, Just Culture, flexible working, appraisals, retention, Education and Research.
Belonging in Team DBTH – including leadership and team development, organisational and cultural development, equality, diversity and inclusion, reward and recognition and speaking up.
Growing for the Future – including recruitment and induction, workforce planning and development, career development, talent management and succession planning, anchor institution and education.
New Ways of Working and Delivering Care – including digital and people systems, education, and temporary workforce.
The work of the committee is aligned to these four themes of the DBTH People Strategy.
It is supported by the Audit and Risk Committee which provides the oversight arm of the Board, reviewing adequacy and effectiveness of controls.
The work of the Committee is aligned to the Trust’s Strategic Objectives and is organised to provide assurance on the progress towards the True North Objectives:
To provide outstanding care and improve patient experience.
Everybody knows their role in achieving the vision.
Feedback from our people and learners in top 10% in UK.
In recurrent surplus to invest in improving patient care.</td></tr>
<tr><td>Responsible to</td><td>The Board. The Chair of the Committee is responsible for reporting assurance to the Board on those matters covered by these terms of reference through a regular written report. The minutes of the Committee shall also be submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the Board of Governors or may require executive action. The Committee will present a written annual report to the Board summarising the work carried out during the financial year and outlining its work plan for the future year.</td></tr>
</table>

Relationship to other Committees	The Committee will receive information and assurances from the Trust's internal management and operational Committees as required. This includes the Workforce and Education Committee, EDI Committee, Health and Wellbeing Committee and Teaching Hospital Board as shown below. 
Delegated authority	The Committee is a Committee of the Board and holds those powers specifically delegated to it by the Board and set out in these terms of reference. The Committee is authorised to investigate any activity within its terms of reference. It is further authorised to seek any information it requires from any employee of the Trust and all employees are directed to co-operate with any request made by the Committee. The Committee may make a request to the executive for legal or independent professional advice and request the attendance of external advisers with relevant experience and expertise if it considers this necessary. The Committee will operate at a strategic level as the executive is responsible for the day-to-day delivery of Trust services and management of its workforce.
Duties and work programme	- To review reports relevant to the Committee that relate to the following matters: - The delivery of the DBTH People Strategy and relevant national priorities. - Promoting an honest, open, and just culture through Speaking Up and Equality, Diversity and Inclusion fora. - The CQC Essential Standards of Well Led as part of the internal assurance process. - Workforce and recruitment plans. - People metrics through the iQPR and supporting reports. - Our people and learner engagement, experience, and retention. - Organisational development plans. - Leadership and team development. - Training, education and development, delivery and learning outcomes. - Health and Wellbeing. - Any specific risks in the Board Assurance Framework relevant to the Committee. - Employee relations.

	- HR systems and processes. - Provide assurance to the Board in respect of their delivery. - To consider and review any items identified by, or escalated to the Committee relating to Enabling Strategies that are monitored through the corporate objectives and reported to the Board of Directors. - Through the various sub committees the People Committee will ensure that the People Strategy is being delivered across the Trust and that workforce plans are in place to deliver the services across the Trust. - To undertake thematic reviews and deep dives into workforce related issues. - To ensure that the Trust has reliable, up-to-date information about what it is like being a member of Team DBTH and a learner within the Trust. - To approve terms of reference and membership of reporting sub-Committees and oversee the work of those sub-Committees. There may be occasions when business of the meeting may need to be completed by the membership only.
Chairing arrangements	The chair and vice chair will be nominated from among the non-executive members of the Committee.
Membership	• Minimum of three members, appointed by the Board from amongst the Non-executive Directors (other than the Chairman of the Trust). • Chief People Officer • Chief Nurse • Executive Medical Director
In attendance	• Director of Education & Research • Deputy Director of People & Organisational Development • Head of Organisational Development, EDI, and Wellbeing • Director of Corporate Affairs/Company Secretary • Corporate Governance Officer (Minutes) • Other Trust colleagues as appropriate / requested • Three Governor (Observers) ideally from each constituent part of the Council of Governors.
Secretary	Director of Corporate Affairs/Company Secretary (supported by Corporate Governance Officer).
Voting	Matters will generally be decided by way of consensus. Where it is necessary to decide matters by a vote then each member will have one vote. The Chair will have a casting vote.
Quorum	Three members, including the chair or vice-chair.

Frequency of meetings	Bi-Monthly.
Papers	Papers will be distributed a minimum of three clear working days in advance of the meeting, but ideally a week before.
Permanency	The Committee is a permanent Committee.
Sub-Committees	• Workforce & Education committee • Teaching Hospital Board • Equality, Diversity & Inclusion Committee • Health and Wellbeing Committee. • Freedom to Speak up Forum

Date agreed by the Committee:	November 2023
Date approved by the Board of Directors:	
Review date:	November 2024

2311 - H INFORMATION ITEMS

12:25

2311 - H1 CHAIR AND NEDS REPORT

Information Item

Suzy Brain England OBE, Chair of the Board

to follow

REFERENCES

Only PDFs are attached

H1 - Chair & Non-executive Directors' Board Report.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	28 November 2023	**Agenda Reference:**	**H1**
Report Title:	**Chair and Non-executive Directors' Board Report**		
Sponsor:	Suzy Brain England, Chair of the Board		
Author:	Suzy Brain England, Chair of the Board		
Appendices:	N/A		

Report Summary
This report is for information only and provides an update on the Chair and Non-executive Directors' activities since September 2023's board meeting.

Recommendation:	The Board is asked to **note** the contents of this report.			
Action Required:	~~Approval~~	~~Review and discussion/ give guidance~~	~~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 colleagues 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**	**Nottingham & Nottinghamshire ICS**
	~~Yes~~ /~~No~~/ NA	**~~Yes~~ /~~No~~/ NA**

Implications	
Board assurance framework:	
Risk register:	
Regulation:	
Legal:	
Resources:	

Assurance Route	
Previously considered by:	
Date:	
Any outcomes/next steps	
Previously circulated reports to supplement this paper:	

Chair's Report

Annual Members Meting

On 28 September 2023, the Trust's pre-recorded Annual Members Meeting was broadcast via YouTube, shared via the Trust's Facebook and website and available to view here. As in previous years the online meeting received a significant number of views, in excess of 5,000, which has served to broaden the Trust's reach across its members and local communities. I welcomed the Chief Executive, Chief Financial Officer and Lead Governor, Lynne Schuller to provide an overview of Trust business during the period 1 April 2022 to 31 March 2023. The update included the response to Covid-19, operational activity, financial performance, developments at a local, regional and national level and an insight into the role of governors, including recent governor elections and public engagement. Senior colleagues closed the meeting responding to questions received from governors and members of the public.

Governors

The Trust welcomed newly elected and re-elected governors in September 2023, who were invited to a governor induction with me, the Chief Executive and Director of Corporate Affairs. Since this time governors have also been asked to express an interest in observing Board Committees and taking up membership of the Council of Governors Nominations & Remuneration Committee.

Immediately prior to the Annual Members Meeting, the Council of Governors met and received the external auditors' annual report, in which an unqualified opinion on the trust's financial statements was provided.

A full Council of Governors meeting took place on 9 November, where Non-executive Directors provided feedback as Board Committee Chairs on major works, decisions, positive assurance and matters of concern in relation to the business of the Audit & Risk, Finance & Performance, Quality & Effectiveness, People and Charitable Funds Committees and me and the Chief Executive shared an update on Trust activities.

Governors also had the opportunity to attend a governor briefing led by the Chief Operating Officer on 2023/24 Access Standards and a system wide South Yorkshire Acute Federation governor event.

1:1s & Introductory Meetings

In addition to my regular meetings with the Chief Executive, I have taken part in one-to-one discussions with the Non-executive Directors, the Lead and Deputy Lead Governor and Company Secretary. I have met with the recently appointed Deputy Chief Executive, the Divisional Nurse and Divisional Director for Urgent & Emergency Care and Divisional Nurse for Surgery.

NHS Providers

At the beginning of the month, I was delighted to welcome NHS Providers' Chief Executive, Sir Julian Hartley to the Trust. Members of the Board and senior colleagues met Sir Julian to provide an insight into life at DBTH, including the challenges faced due to the ageing infrastructure.

I also attended NHS Providers' Annual Conference and Exhibition in Liverpool on 14-15 November, where a number of keynote speeches, panel discussions, interactive breakouts and networking opportunities took place to focus on the key issues facing provider sector leaders. I was invited as a guest of the Director of Policy & Strategy, Miriam Deakin to the conference dinner.

Other Meetings

Since my last report I have chaired October's Board meeting and attended the board workshop to consider the introduction of NHS Impact and the Trust's approach to quality improvement and innovation.

I have chaired a meeting of the Board of Directors Nomination & Remuneration Committee and attended a meeting of the Charitable Funds Committee and the Charitable Fund Trustees.

I have also attended meetings of the South Yorkshire Chairs and Nottingham and Nottinghamshire system meetings to support collaborative working and along with the Chief Executive, have met with the Chair and Chief Executive of South Yorkshire Integrated Care Board.

As a group of non-executives, we came together to consider working practices, how we receive assurance and ways of working better together; committing to regular monthly development time to focus efforts on supporting the Trust achieve its strategic objectives.

Alongside my fellow Board members, I participated in a CQC focus group and prepared for and engaged with the inspection team as part of the well-led review.

Finally, at what is always a highlight of the Trust's calendar, it was my pleasure to join colleagues at the annual Star Awards. Listening to inspirational stories of colleagues who go above and beyond to make a real difference to patient care and supporting each other on a learning journey, and I look forward to seeing more great achievements throughout the year!

Non-executive Director's (NEDs) Report

Kath Smart

Since the last report, Kath has attended her corporate meetings; Finance and Performance Committee including an additional deep dive into Cost Improvement Plans, Board of Directors and Board development sessions and presented to the Council of Governors. She also attended the Governor briefing on Access Standards.

Alongside Board colleagues, Kath spent time in September and October in preparation for the Trust's CQC Well Led Review and attended the NED CQC Focus Group, as well as having her individual interview as Audit Committee Chair.

In preparation for October's Audit and Risk Committee, Kath worked with the Corporate team to develop the agenda and also met with internal auditors, 360 Assurance. She met with the Director of Corporate Affairs to input into the development of the Trust Risk register and framing of the new assurance levels and attended the NED Time out Session.

She represented non-executive directors at the second cohort of the Board Delegate Programme to answer questions on the role of a non-executive and presented to NHS Cadets (aged 14-18 years) on the role of leadership in the NHS. She also had the opportunity to look round the newly developing Mexborough Elective Orthopaedic Centre. During September Kath attended the Qii Team report out and heard from the QUIT Team (Stop Smoking Team) and a corporate Qi project aimed at reducing on the day cancellations for surgery.

Her ward visits over this period have included visits to Ward 32 (Renal & Haemodialysis) with the Chief Nurse, DRI Emergency Department (including Childrens, Minor Injuries Unit and the Urgent Treatment Centre) with the Deputy Chief Executive and to Bassetlaw Radiology Department with the Director of Recovery, Innovation & Transformation.

Finally, Kath attended the annual Star Awards which was a great opportunity to hear and see the success stories and achievements of individuals and teams in DBTH.

Emyr Jones

Since his last report Emyr Jones has participated in his designated Board and Committee meetings, including cost improvement plan and clinical audit deep dives, governor briefing, board development and the Quality & Effectiveness Committee pre-meet.

Emyr has met with the Director of Allied Health Professionals, Acting Medical Director and supported the visit of NHS Providers' Chief Executive, Sir Julian Hartley.

He has visited dental, oral maxillofacial and podiatry at Montagu with the Chief Operating Officer.

In respect of additional learning, he has attended an event focused on delivery of the NHS Impact Framework, Patient Safety Incident Response Framework and attended NHS Providers Annual Conference and Exhibition.

Along with fellow non-executive directors Emyr has participated in a non-executive development session, CQC focus group and as the Deputy Chair of the Quality & Effectiveness Committee has been interviewed as part of the CQC well-led review.

Mark Day

Since the last Board report Mark has chaired two regular meetings of the Finance & Performance Committee and an additional meeting to scrutinise the Trust's Cost Improvement Plan. In accordance with the normal meeting cycle, he has also participated in an Audit & Risk and People Committee meeting, and the October Board meeting, which was followed by a Board Development Session.

In common with other directors, significant time was devoted to preparing for, and participating in, the CQC well-led review.

Other activities have included a Non-Executive Director Development Session, a discussion with the Chief People Office on Remuneration Committee matters, an additional Charitable Funds Committee meeting, and chairing a grievance hearing related to employment matters.

Senior Independent Director and Designated Member duties have required significantly more input than in previous periods dealing with a number of matters which, although important individually, are not currently indicative of a wider trend.

Mark has not attended site visits during the period, as one session was cancelled due to a colleague's absence and he had to absent himself from another, due to a family illness.

Jo Gander

Since the last report Jo has chaired October's Quality and Effectiveness Committee, participated in the clinical audit deep dive and led the pre-meet for December's Quality & Effectiveness Committee meeting. She has attended the Audit & Risk Committee, governor briefing on Access Standards and the non-executive Team event.

She has attended ward and departmental visits with the Chief People Officer and Deputy Chief Executive, which included Wards 16 and 17 at Doncaster Royal Infirmary and Medical/Diagnostic Imaging and outpatients at Montagu. She has also met on a bi-monthly basis with the Chief Nurse and had an introductory meeting with the Deputy Chief Executive.

From a training perspective, Jo attended the Quality Improvement Board Development Session, NHS Impact - 'Harnessing the Powers of Quality Improvement to Address Inequalities' webinar and senior management development sessions on enforcement, interviews under caution and recruitment and appeals panel training. She has attended NHS Providers Board Development Programme for effective chairs and NHS England Patient Safety Incident Response Framework for Non- executive Directors.

Jo has attended a CQC preparatory meeting and interview. In maternity she has attended Safety Champion visits and meetings, a context meeting linked to cultural development work and the quarterly Doncaster & Bassetlaw Maternity Voices Partnership meeting. Jo has chaired two consultant interview panels successfully recruiting for a Consultant in Stroke Medicine and Diabetes and Endocrine Medicine.

Lucy Nickson

Since September, Lucy has been on site at Doncaster Royal Infirmary for non-executive director development time and has visited Montagu Minor injuries Unit.

She has spent time with the Chief People Officer and the Health and Well-being team and has planned time to observe some of the day-to-day wellbeing activities with staff on site. Lucy has also attended a national Wellbeing Guardian conversation event.

Alongside other non-executive colleagues Lucy was involved in a series of meetings which supported the CQC well-led inspection. Lucy has continued to meet with the Deputy Chief Executive as part of buddying arrangements.

Lucy has attended her regular corporate meetings, including the Quality & Effectiveness, People, Nomination & Remuneration and Charitable Funds Committees. She has also attended the Council of Governors meetings and is supporting the Trust with an ongoing grievance procedure.

Hazel Brand

Early October was dominated by the CQC Well-led inspection, when Hazel joined other non-executives for a preparatory session and then a forum with inspectors to answer a range of questions put by them. Hazel continued to attend Board committees (Quality & Effectiveness, People, Nominations & Renumerations) and governor briefings during the period in question. She attended a Bassetlaw Place Based Partnership 'accelerator' workshop, along with other staff and governor representatives from numerous organisations and aims to co-design Bassetlaw Place Based Partnership's plan and future developments.

As part of continuing development Hazel attended NHS Providers' workshop on effective challenge, and webinars on the Model Health System and with the National Guardian for Freedom to Speak Up. This focused on overcoming the barriers to speaking up, which was the focus of DBTH's Speaking Up month in October.

Over this time period, Hazel has chaired meetings associated with the Charitable Funds Committee as trustees look to improve the focus of fund-raising and governance, ensuring that donations are put to best (and

appropriate) use. This will be further explored at the next meeting in December.

She attended the DBTH Stars Annual Awards evening and was most impressed by the caliber of shortlisted nominations and the spread of award winners across the hospitals and roles within them.

2311 - H2 CHIEF EXECUTIVE'S REPORT

Information Item Richard Parker OBE, Chief Executive

REFERENCES

Only PDFs are attached

H2 - Chief Executive's Report.pdf

Chief Executive's Report
November 2023

Drive-thru blood testing service to cease operations this week

The drive-thru Phlebotomy service, provided by NHS South Yorkshire – Doncaster Place and delivered by colleagues at Doncaster and Bassetlaw Teaching Hospitals (DBTH), at the Eco-Power Stadium will cease operations as of 4pm on Friday 24 November 2023.

The inception of this service dates to the early months of 2020 and the unprecedented challenges brought about by the COVID-19 pandemic. In response for the need, at that time, for safe, minimal contact medical services, the temporary drive-thru Phlebotomy service was introduced, allowing patients to have their blood samples collected without entering hospital and general practice and community services and to comply with the guidance at that time.

From the 27 November 2023, phlebotomy provision returns to the pre pandemic arrangements with hospital Phlebotomy services consolidated within the Outpatients area of Doncaster Royal Infirmary (in addition to services at Bassetlaw and Montagu hospitals), whilst blood testing will continue to be delivered in the community at GP practices.

This change is part of larger strategic, operational, and budgetary decisions, and signals a return, largely, to business as usual for the local NHS, following the pandemic.

Importantly, all GP practices in the borough have continued to provide blood test appointments throughout the pandemic for those patients who preferred, or otherwise needed to have this done closer to home. This remains the case, although many GP practices are only able to offer these appointments in the morning due to the collection and processing of these samples afterwards.

Prior to the cessation of the drive through service, patients under the direct care of DBTH requiring blood tests have received correspondence from the Trust, highlighting alternative arrangements, while all individuals attending the drive-thru have been made aware of the change.

Patients are also reminded that if they have to come to hospital for blood tests, the Park and Ride is available, just off of Leger Way, which offers regular shuttles to Doncaster Royal Infirmary.

If individuals have any questions or concerns, please raise these directly at https://syics.co.uk/contact-us

X-ray service at Retford Hospital reopens

The service was temporarily closed in 2020 due to challenges posed by the pandemic and was reinstated this month (November) to provide essential healthcare support to the local community.

The X-ray service at Retford Hospital operates as a convenient walk-in facility following GP referral, offering services from Monday to Friday, between 9am and 4:30pm. This development is set to benefit the residents of Retford and wider patients within Bassetlaw, eliminating the need to travel to the Trust's main acute sites in Worksop and Doncaster for routine X-rays.

Recently, the facility has also undergone significant improvements, including the installation of state-of-the-art equipment. In addition to this, the ultrasound room has been refurbished, having been replaced following funding from NHS England in 2022.

As such, the X-ray service at Retford Hospital will now offer a full range of routine scans, such as chest, abdomen, and limb X-rays, ensuring comprehensive diagnostic capabilities for the local community.

Since its reopening on November 1 2023, the X-ray service at Retford Hospital has already welcomed 100 patients.

Retford Hospital will continue to accommodate non-obstetric examinations for outpatients and primary care referrals by appointment only.

Across the Trust's three main hospital sites in Doncaster, Bassetlaw and Montagu, we carry out over 460,000 medical imaging examinations each year, supported by over 290 colleagues in the department including Radiologists, Radiographers, Nurses, Clerical staff, and Service Assistants.

Mexborough Elective Orthopaedic Centre of Excellence (MEOC) nearing completion

The Mexborough Elective Orthopaedic Centre of Excellence (MEOC), a ground-breaking collaboration between our Trust, Barnsley Hospital NHS Foundation Trust (BH), and The Rotherham Hospital Foundation Trust (TRFT), continues to gather momentum, with the facility due to be completed within the next month, opening its doors to its first patients in the new year.

The MEOC is a dedicated orthopaedic hub with a total investment of £14.9 million, and will operate 48 weeks per year, six days a week, focusing on procedures such as hand and wrist surgeries, foot and ankle treatments, arm and shoulder procedures, carpals, knees, and hips. Its strategic location at Montagu Hospital in Mexborough, ensures that it remains insulated from the typical disruptions experienced by general hospitals, particularly during periods of heightened activity in the winter.

With construction well advanced and the facility watertight, senior leaders across all three participating trusts, as well as South Yorkshire Integrated Care System (ICS), were able to step inside the building and view the work-in-progress earlier this month.

The MEOC is expected to reduce associated waiting times in the region significantly, with the centre to undertake approximately 2,200 orthopaedic procedures in its first year of operation, which accounts for around 40% of the current orthopaedic waiting list.

Patients from the collaborating hospitals in Rotherham, Doncaster, and Barnsley can easily access the MEOC, with it being centrally located in Mexborough and served by regular bus and train links, and the site is no more than 11 miles away from all participating hospital trusts.

As an additional service, those waiting for an orthopaedic procedure locally will have the opportunity to opt to have it undertaken at the MEOC, or instead within their local hospital.

Before opening, simulations will be conducted to ensure the facility is patient ready. In total, the MEOC will be supported by around 70 healthcare professionals. The centre will feature two state-of-the-art theatre units, two anaesthetic rooms and a recovery suite, in addition to 12 inpatient beds.

The team overseeing the project want to understand local people's views to ensure patients have the very best experience within the new facility. You can share your thoughts here: https://www.surveymonkey.co.uk/r/VS3CRSH

Trust celebrates healthcare heroes at the Doncaster Dome

On 2 November, the Trust hosted its annual Star Awards evening to celebrate the hard work and exceptional dedication of its hospital heroes throughout the past 12 months.

This year's highly anticipated awards evening took place at The Dome, hosted by Heart Radio DJ, David 'Dixie' Dixon. Over 500 healthcare professionals from across the Trust attended the evening, hearing the inspiring stories and contributions of all thirteen winners, as well as nominees.

Members of the Trust nominated their colleagues, recognising outstanding achievements and contributions from both individuals and teams that surpassed the call of duty in their roles.

The judging panel faced a challenging task as they reviewed over 800 commendable nominations across 13 categories – a record number of submissions for the event.

During the ceremony, accolades were announced for winners in a variety of different categories, including new honours to this year's awards evening such as Fundraising Champion, Teaching Hospital Award and Agency/Bank Star.

The 13 hospital heroes this year are:

- Patient Champion: Lisa Fluin (Rehab Activities Coordinator)
- Teaching Hospital Award: Abhishek Arora (Specialist Orthopaedic Surgeon)
- Inclusion Champion: Jeena Joseph (Clinical Educator)
- Agency/Bank Star: Switchboard Bank Team
- Medical/Clinical Team: Acute Stroke Team and Ward 16
- Admin Team: Histopathology Admin Team
- Wellbeing champion: Scott Brock (Patient Environment Assistant in Estates & Facilities)
- Change Champion: Jo McQuade and Ward 17
- Rising Star: Liam Boyall (Category Specialist in Procurement)
- Fundraising Champion: Carla Spence (Founder of Ernie's Wish)
- Supporting Team: Capital Planning Team
- Unsung hero: Wayne Chapman (Digital Transformation Admin Manager)
- Star of the Year: Sally Abbott (Colposcopy Nurse)

Hundreds of thousands of NHS patients to be offered the chance to travel for treatment

From 1 November, any patient who has been waiting longer than 40 weeks and does not have an appointment within the next eight weeks will be contacted by their hospital via letter, text, or email, as announced by the NHS and government earlier this year.

As part of the ambitious NHS elective recovery plan, Patient Initiated Digital Mutual Aid System (PIDMAS) offers have been sent to up to 400,000 eligible patients who will then be able to submit their details including how far they are willing to travel – 50 miles, 100 miles or nationally. NHS teams can then identify whether any alternative hospitals have capacity to see them sooner.

Once the patient’s details have been confirmed and the patient would be eligible for the scheme , the patient’s request will be uploaded to the NHS’ innovative hospital matching platform – the Digital Mutual Aid System – to see if NHS or independent sector providers elsewhere in the country can take on their care.

If no alternative hospital is available for patients within eight weeks of starting the process, the patient will remain with their current provider and keep their position on the waiting list. Some patients will not be eligible if their clinical condition is too complex, making it inappropriate to travel.

Eligible patients who want to consider an alternative provider will be contacted directly by their NHS trust or independent sector provider and should not contact their GP practice or hospital.

The Community Diagnostic Centre opens its doors at Montagu Hospital

The Endoscopy Unit at The Montagu Community Diagnostic Centre (CDC) has officially opened its doors, following months of development and construction.

This milestone marks the completion of phase two of a three-phase project, representing a significant investment to enhance health services, particularly within the Dearne Valley area of South Yorkshire.

The CDC introduces a fully functional endoscopy suite to Montagu Hospital with training facilities, and multifunctional clinic rooms, including ultrasound. Additionally, the work initiated during phase one of the project will continue, with mobile units facilitating CT and MRI scanning within the Mexborough site.

The CDC has received funding of just under £25m received in total, of which £9m has been spent in the current phase of development.

Construction on the new endoscopy suite began in March 2023 and is located within the prominent ‘rotunda’ section of Montagu Hospital – the rounded area of the building above the Minor Injuries Unit on level 3.

This area was previously occupied by the Pain Clinic, which has been relocated to the vacant physiotherapy space, following its own refurbishment as part of the CDC investment.

Complimenting the most recent development, the third phase of the project is the Imaging Suite, which will be a new construction located to the rear of the site and will scan around 250 patients a week.

It is hoped that in the future this will enable cardiac imaging and echocardiography.

At present, cardiac Imaging is not a service Doncaster and Bassetlaw Teaching Hospitals provides, with patients having to be referred to Sheffield’s Northern General Hospital. By using MRI and CT technology, it is possible to diagnose a wide range of heart conditions including coronary heart disease, valve disease, and cardiac tumours, this is planned to be live Autumn 2024.

The investment into Montagu also has the addition of The Mexborough Elective Orthopaedic Centre of Excellence, which will also open its doors in January 2024, following funding of over £15 million, bringing overall recent investment to the Montagu Hospital to over £40 million.

An official ribbon-cutting ceremony will take place in December.

2311 - H3 INTEGRATED QUALITY & PERFORMANCE REPORT

Information Item   Executive Directors

REFERENCES

Only PDFs are attached

H3 - Integrated Quality & Performance Report.pdf

Integrated Quality & Performance Report

Reporting Period - September 2023

Report Purpose	Data Source(s)	Report Created	Report Layout Modified	Report Owner	Contact Details	Training
To understand the Trust's current position with respect to the services they deliver.	Mega Cube Data Warehouse MS Forms	04/10/2023	16/11/2023	Executive Director of Restoration, Innovation and Transformation	dbth.informationservicesrequests@nhs.net	Regular training sessions are held, please email for more information.

DBTH Performance - Trust Level View

Aug 23

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

DBTH Health

6.5%

(Last Month 7.5%)

(9+17 / 400 = 6.5 %)

Finance	People	Health Inequalities	Patients	Performance
	Unvalidated			
NOT AVAILABLE	0 %	0 %	31 %	27 %
	0 out of 6 KPI's	0 out of 1 KPI's	9 out of 29 KPI's	17 out of 62 KPI's

Finance

Coming Soon

People

KPI	Value
SET Training	86.06%
Completed Appraisals	%
Employee Turnover	2.35%
Sickness Absence	5.94%
Workforce Vacancies	8.96%
Consultants with Signed Off Job Plans in EJP	55.00%
Time to Fill Vacancies	94 Days

Health Inequalities

KPI	Value
Health Inequalities	0/1

Patients

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

Performance

KPI	Value
Urgent and Emergency Care	0/11
Waiting List	1/6
Cancer	3/8
Activity Against Plan	2/9
Elective Recovery Fund	5/6
Stroke	2/6
Elective Outpatients	1/9
Elective Theatres	3/7

Index

Finance

Coming Soon

People

- People
- People Forms Data
- People Forms Data 2

Health Inequalities

- Ethnicity Recorded

Patients

- IPC
- HSMR
- Patient Safety
- Skin Integrity
- Falls
- Patient Experience
- Claims
- Friends and Family Test
- Audit and Effectiveness
- VTE
- Reducing Length Stay
- Medical Examiner

Performance

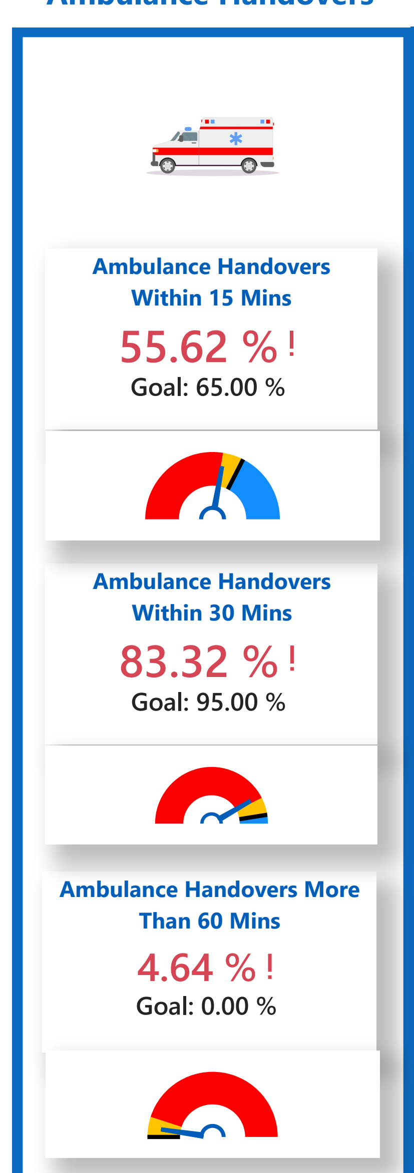
- Urgent & Emergency Care
- Urgent & Emergency Care Trends
- Waiting List
- Waiting List Trends
- Cancer
- Cancer Trends
- Activity Against Plan
- Activity Against Plan Outpatients Trends
- Activity Against Plan Inpatients Trends
- Elective Recovery Fund
- Elective Recovery Fund Trends
- Stroke
- Stroke Trends
- Elective Outpatients
- Elective Outpatients Trends
- Elective Theatres
- Elective Theatres Trends
- All Performance KPIS Trends

Urgent & Emergency Care Sep 23

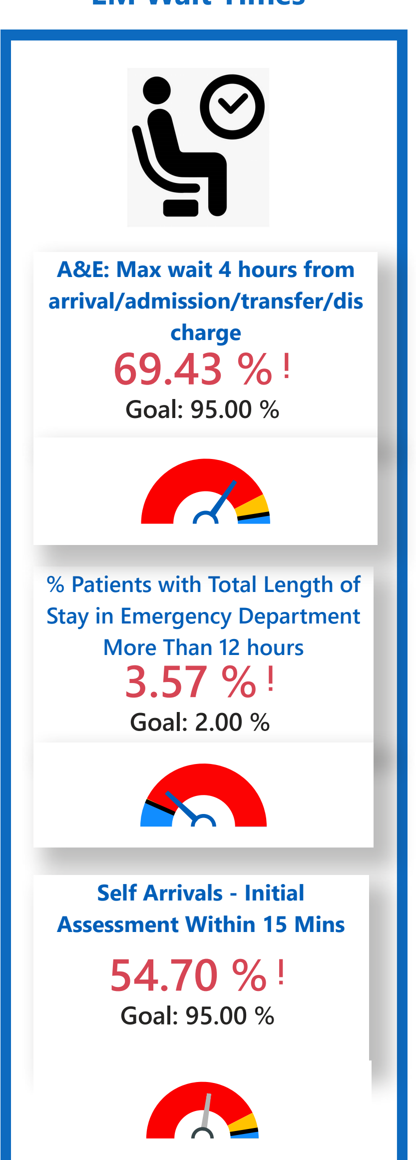
ED Attendances
16373

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

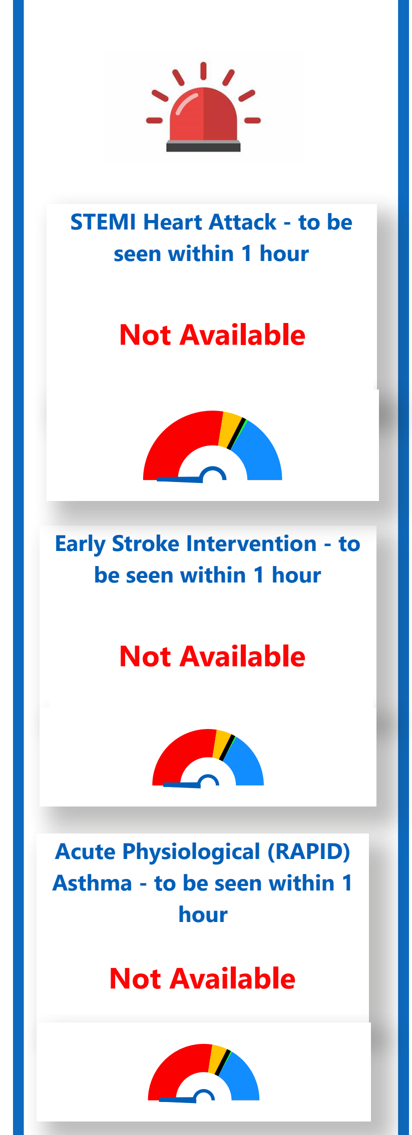
Ambulance Handovers



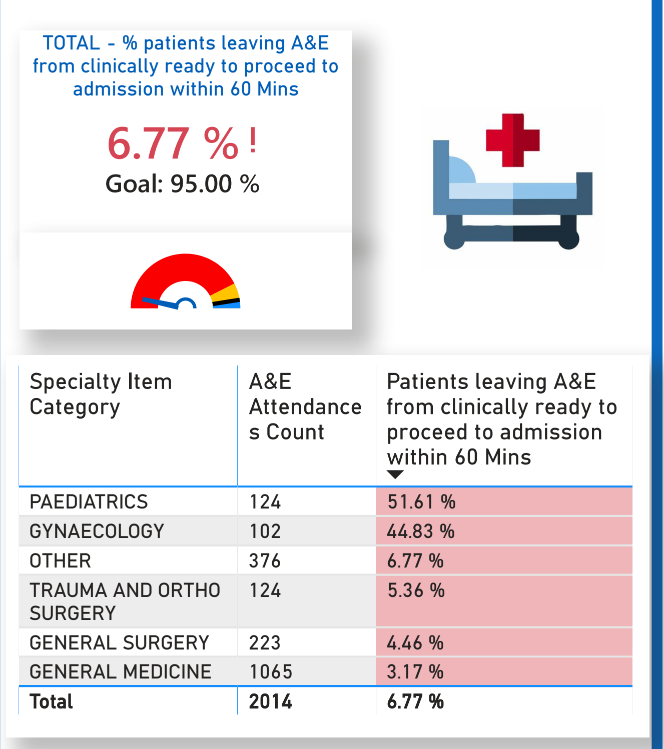
EM Wait Times



Critical Time Standards



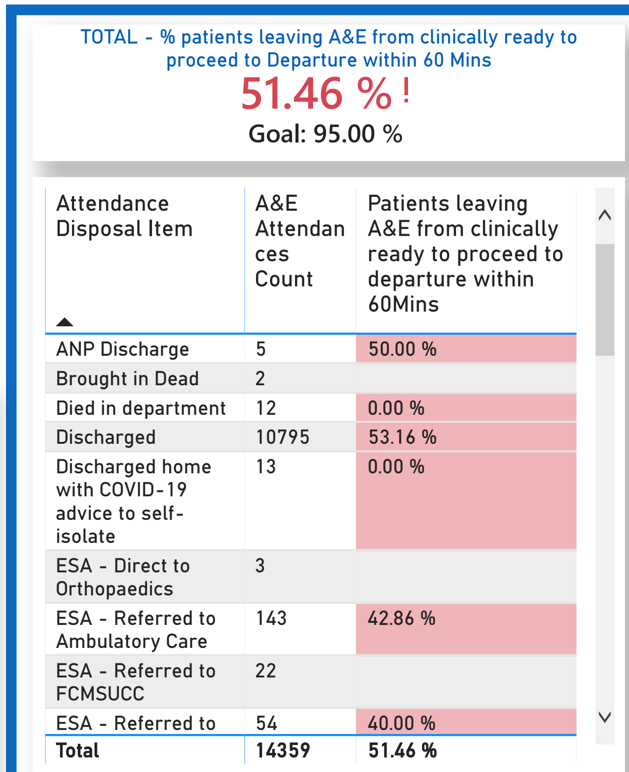
Admission Wait Times



Specialty Item Category	A&E Attendances Count	Patients leaving A&E from clinically ready to proceed to admission within 60 Mins
PAEDIATRICS	124	51.61 %
GYNAECOLOGY	102	44.83 %
OTHER	376	6.77 %
TRAUMA AND ORTHO SURGERY	124	5.36 %
GENERAL SURGERY	223	4.46 %
GENERAL MEDICINE	1065	3.17 %
Total	**2014**	**6.77 %**

Non Admission Wait Times

(For Monitoring Only)



Attendance Disposal Item	A&E Attendances Count	Patients leaving A&E from clinically ready to proceed to departure within 60Mins
ANP Discharge	5	50.00 %
Brought in Dead	2	
Died in department	12	0.00 %
Discharged	10795	53.16 %
Discharged home with COVID-19 advice to self-isolate	13	0.00 %
ESA - Direct to Orthopaedics	3	
ESA - Referred to Ambulatory Care	143	42.86 %
ESA - Referred to FCMSUCC	22	
ESA - Referred to	54	40.00 %
Total	**14359**	**51.46 %**

Hospital

Click here for EM Trends

Urgent & Emergency Care

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

Metric Name	Current Value	Comparison Value	KPI Status	Sparklines
A&E: Max wait four hours from arrival/admission/transfer/discharge	69.43 %	95.00 %		
Ambulance Handovers Within 15 Minutes	55.62 %	65.00 %		
Ambulance Handovers Within 30 Minutes	83.32 %	95.00 %		
Ambulance Handovers More Than 60 Minutes	4.64 %	0%		
% Patients with Total Length of Stay in Emergency Department >12 hours	3.57 %	2.00 %		
TOTAL -% patients leaving ED from clinically ready to proceed to admission within 60 mins	6.77 %	95.00 %		
Self Arrivals - Initial Assessment Within 15 Mins	54.70 %	95.00 %		

Waiting List

Sep 23

Active RTT waiters (Total Incomplete Pathways)

54680

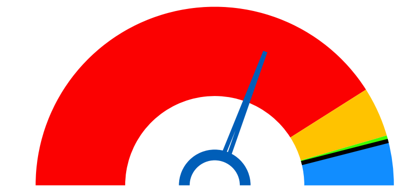
Data refresh | M | All KPIs on this page are refreshed on monthly basis.

RTT Waiters

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

61.47 % !

Goal: 92.00 %



RTT Number of 52 Weeks Waiters

1335

RTT Number of 78 Weeks Waiters

27

Target 0

RTT Number of 65 Weeks Waiters

283

Target 0

RTT Number of 104 Weeks Waiters

0

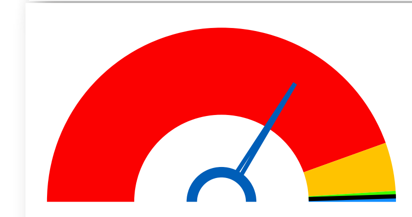
Target 0

Waiters - Diagnostic Activity

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

67.67 % !

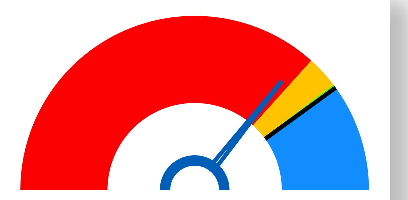
Goal: 99.00 %



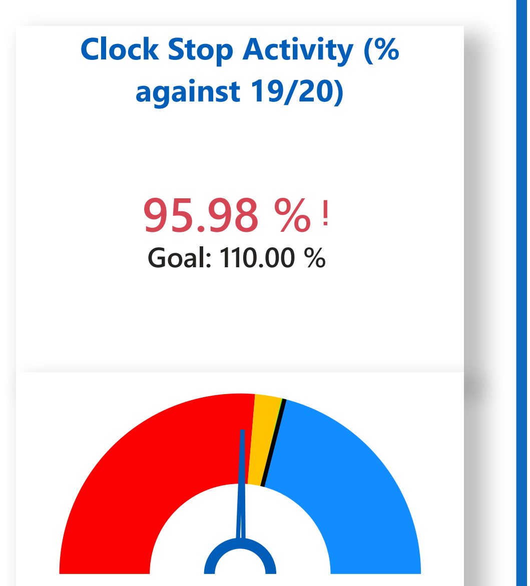
Trust - % DM01 Diagnostic Activity vs 19/20 levels

107.20 % !

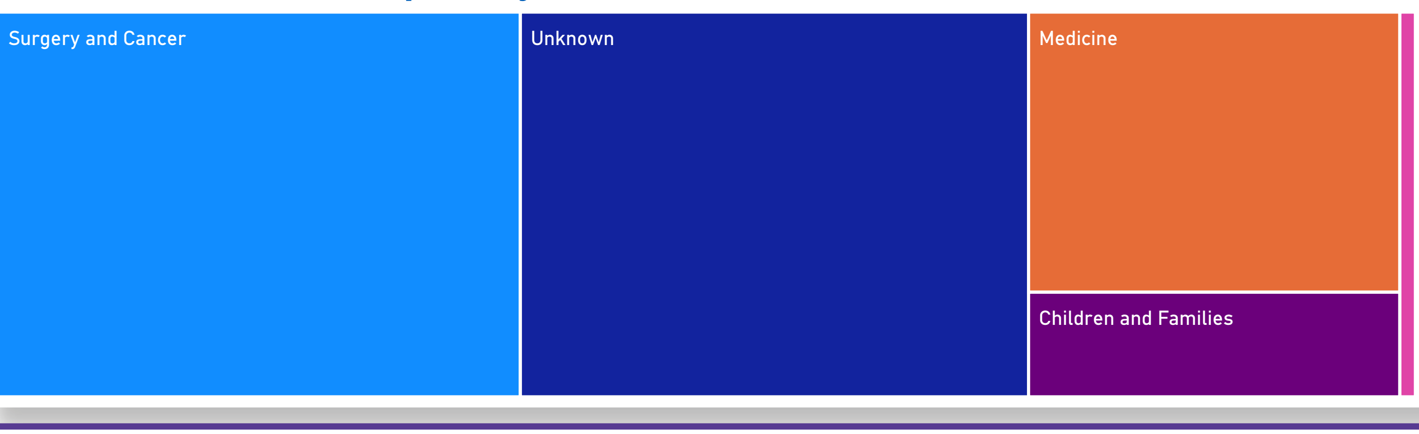
Goal: 120.00 %



RTT Clock Stop Activity



Division (Drill Down For Speciality)



Click here for RTT Waiters Trends →

Waiting List

Data refresh	(M) All KPIs on this page are refreshed on monthly basis.

Metric Name	Current Value	Comparison Value	KPI Status	Sparklines
% of patients waiting less than 18 weeks from referral to treatment	61.47 %	92.00 %	!	
RTT Number of 52 Weeks Waiters	1335			
RTT Number of 78 Weeks Waiters	27	0		
RTT Number of 104 Weeks Waiters	0	0	✓	
% of patients waiting less than 6 weeks from referral for a diagnostics test (DM01)	67.67 %	99.00 %		
Clock Stop Activity (% against 19/20)				

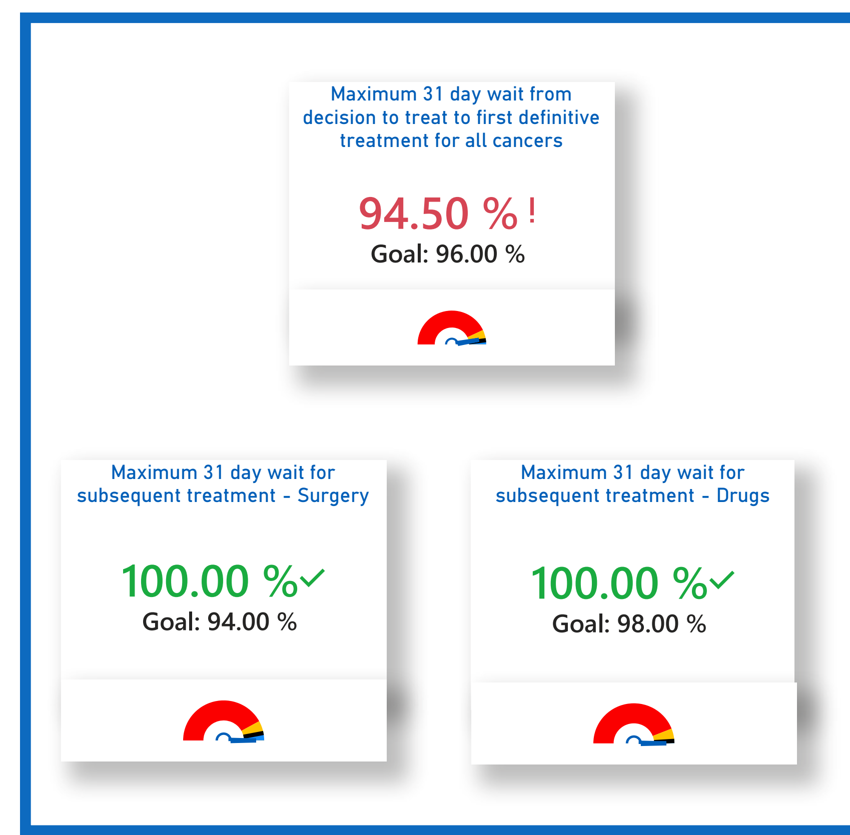
Cancer

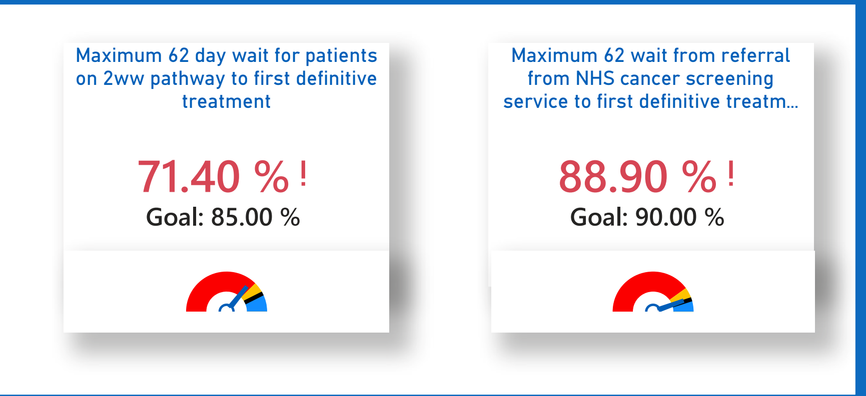
Aug 23

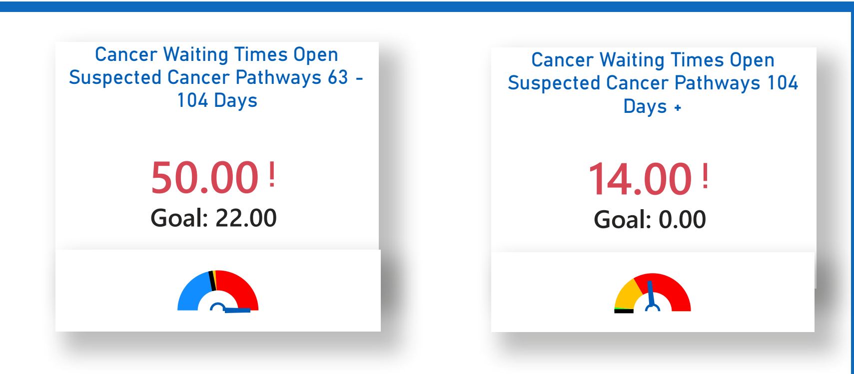
Data refresh	(M) All KPIs on this page are refreshed on monthly basis.

Day 28 Faster Diagnosis Standard (patients received diagnosis or exclusion of cancer within 28 da...

79.20 % ✓
Goal: 75.00 %







Click here for Cancer Trends →

Cancer

Data refresh	(M) All KPIs on this page are refreshed on monthly basis.

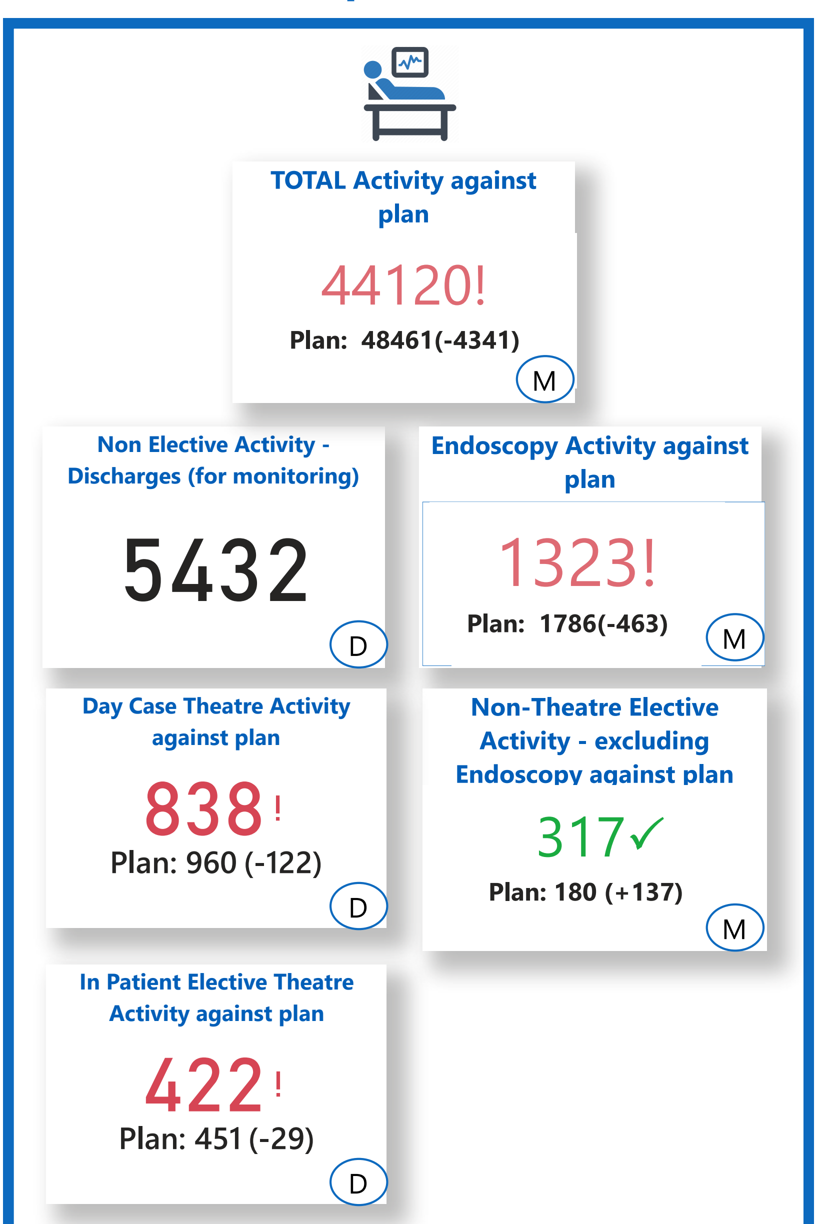
Metric Name	Current Value	Comparison Value	KPI Status	Sparklines
Maximum 31 day wait for subsequent treatment - Drugs	100.00 %	98.00 %		
Day 28 Faster Diagnosis Standard (patients received diagnosis or exclusion of cancer within 28 days)	80.00 %	75.00 %		
Maximum 31 day wait from decision to treat to first definitive treatment for all cancers	93.60 %	96.00 %		
Maximum 31 day wait for subsequent treatment - Surgery	100.00 %	94.00 %		
Maximum 62 wait from referral from NHS cancer screening service to first definitive treatment	77.80 %	90.00 %		
Maximum 62 day wait for patients on 2ww pathway to first definitive treatment	73.20 %	85.00 %		
Cancer Waiting Times Open Suspected Cancer Pathways 63 - 104 Days	40.00	22.00		
Cancer Waiting Times Open Suspected Cancer Pathways 104 Days +	14.00	0.00		

Activity Against Plan

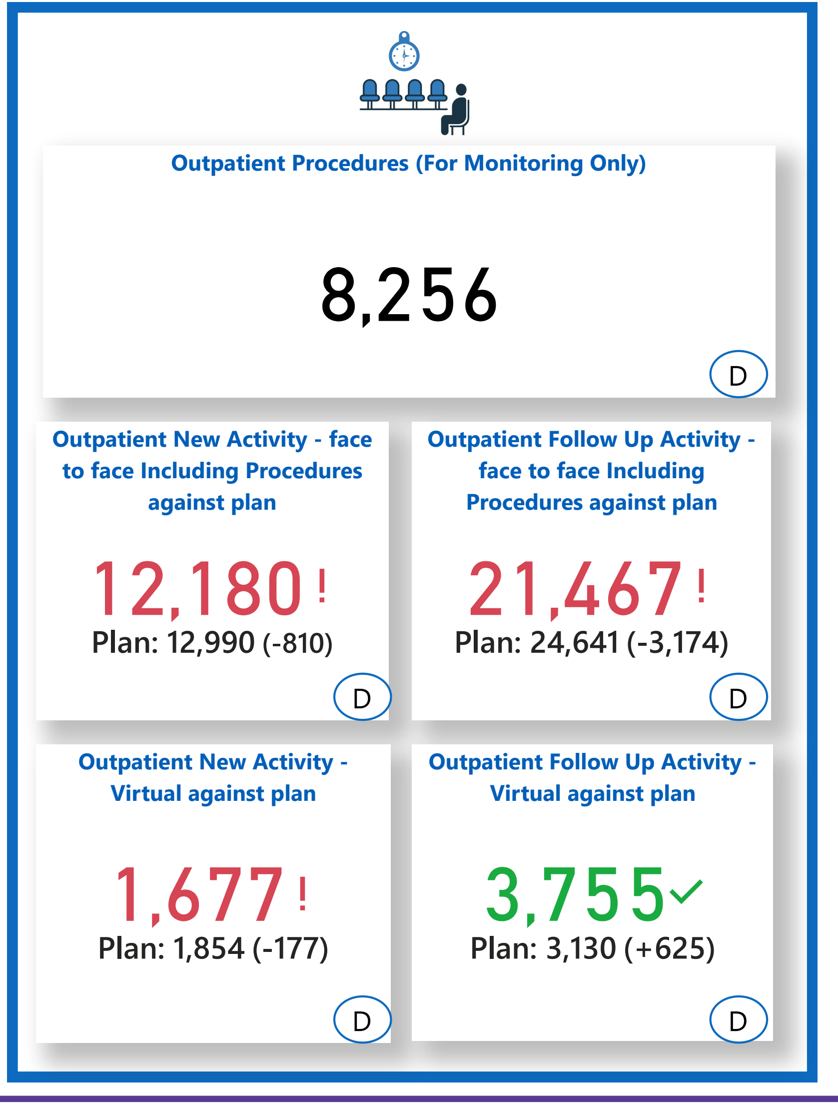
Sep 23

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

Inpatients



Outpatients



Click here for Activity Against Plan Trends →

Division (Drill Down Currently Not Available for Inpatients Section)

Surgery and Cancer

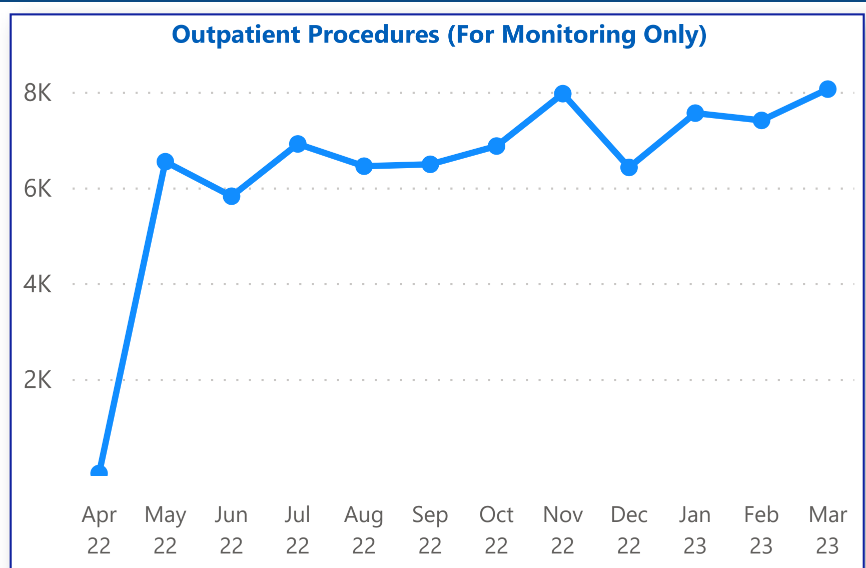
Medicine

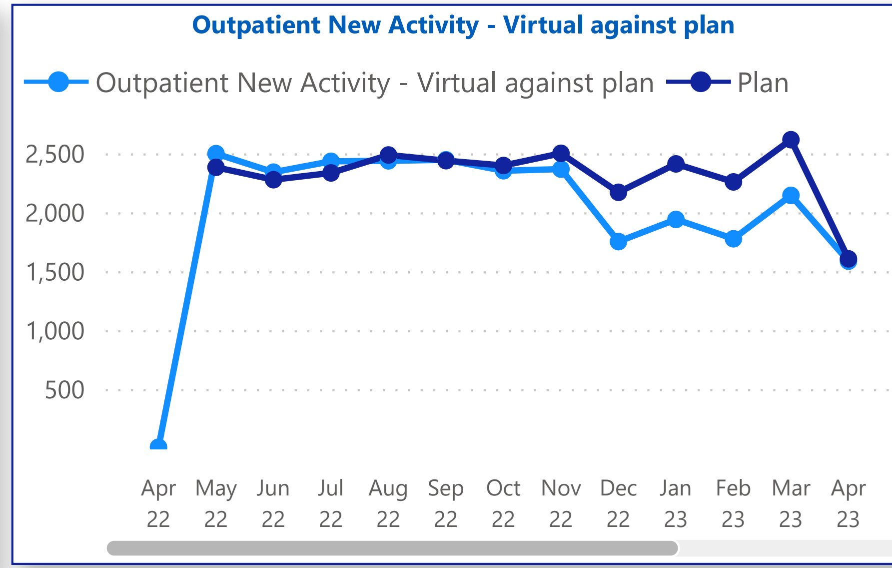
Children and Families

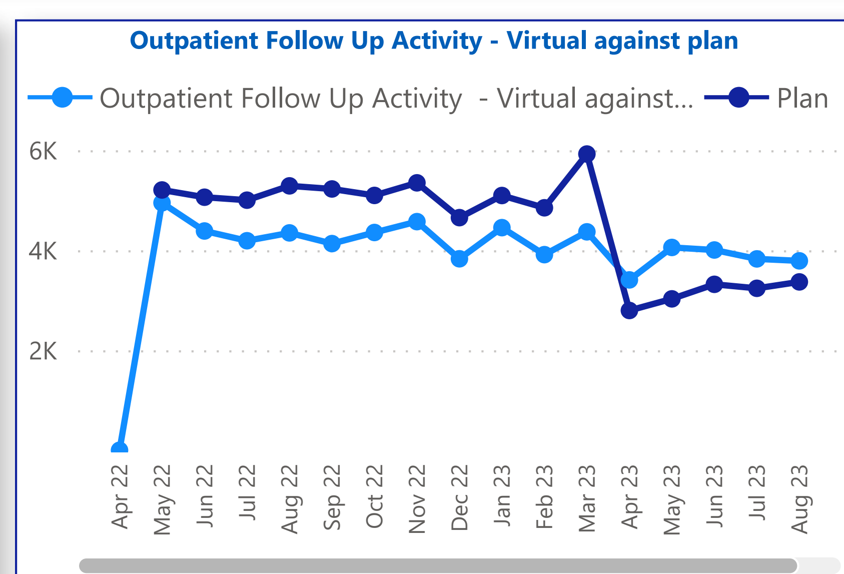
Cli...

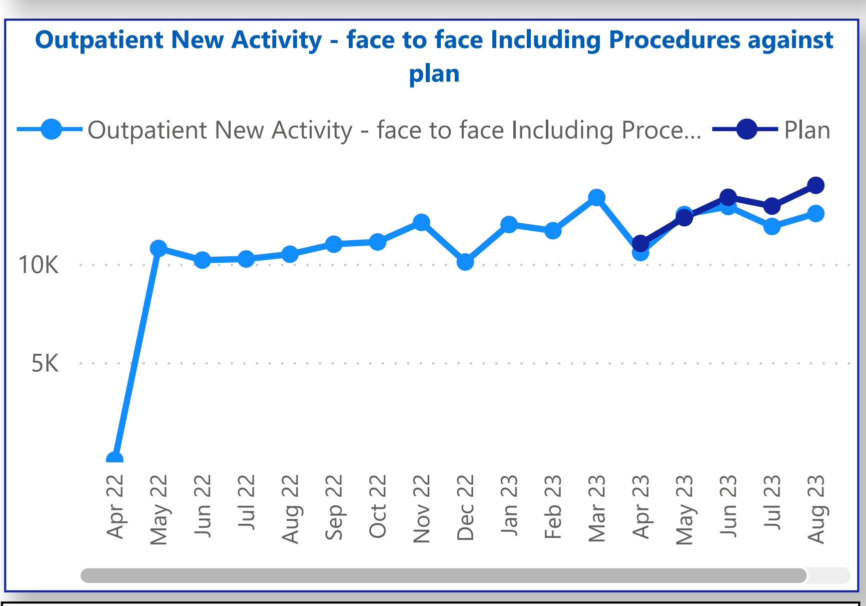
Activity Against Plan Trends - Outpatients

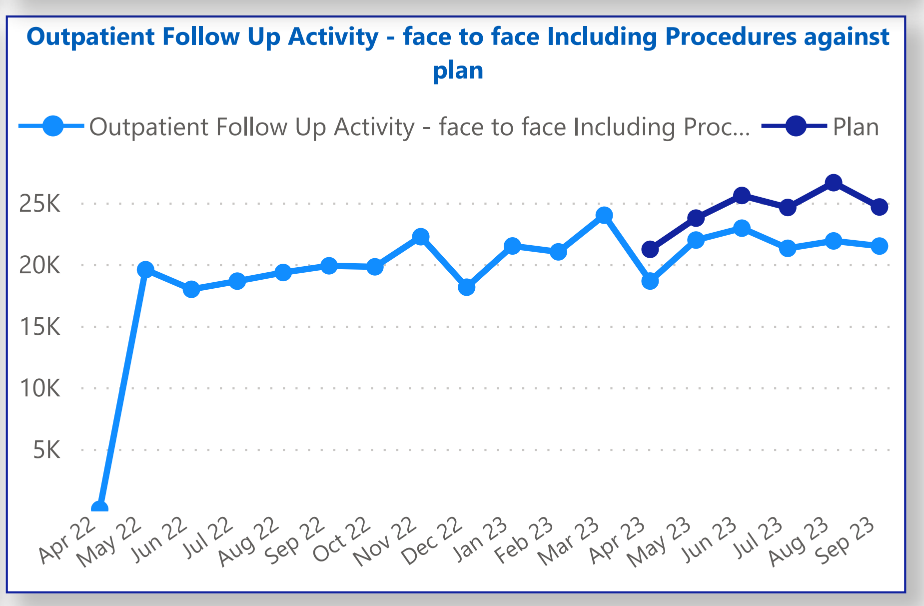
Data refresh | D All KPIs on this page are refreshed on daily basis.





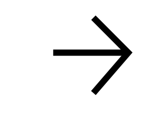






30/04/2022 30/09/2023

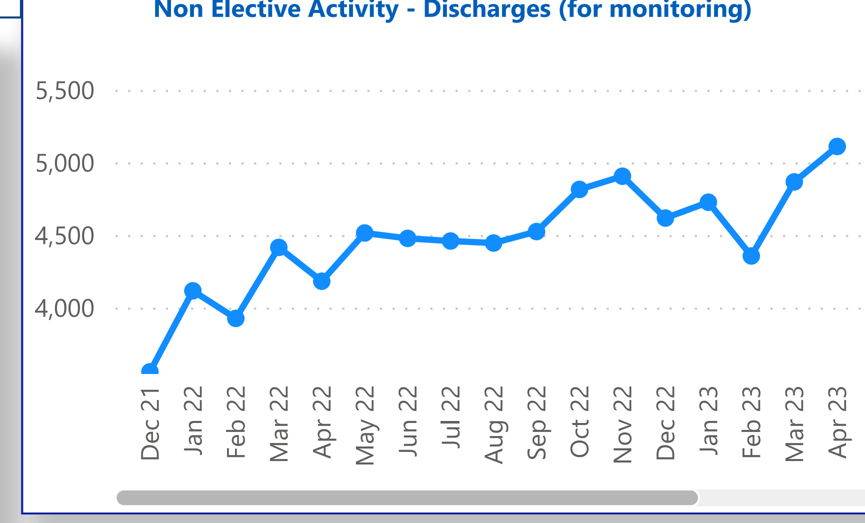
Click here for Intpatients Trends



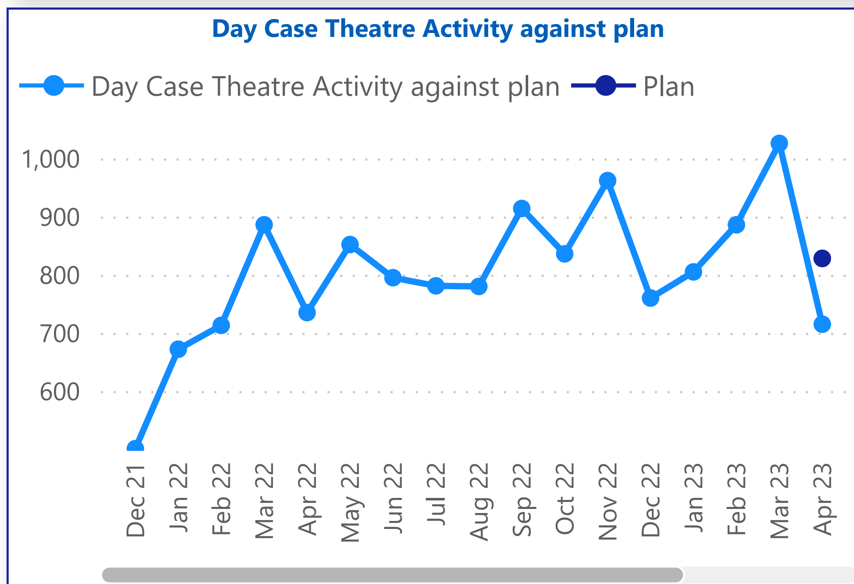
Activity Against Plan Trends - Inpatients

TOTAL Activity against plan

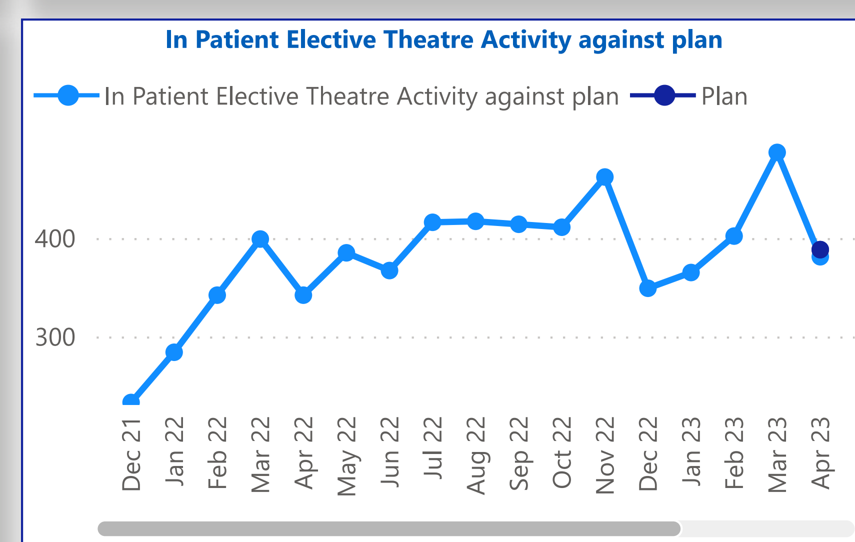
Not Available



Not Available



Not Available



07/12/2021 30/09/2023

Division (Drill Down For Speciality)

Surgery and Cancer | Medicine | Children and Fa...

Elective Recovery Fund

Sep 23

Data refresh All KPIs on this page are refreshed on monthly basis.

Core Activity

TOTAL Activity Value (% against 19/20)

Not Available

TOTAL Independent Sector Activity Value (Sum of Price Actual)

£642,335.69

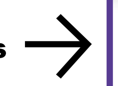
TOTAL Independent Sector Activity Value (Sum of Total Income)

£630,507.51

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

£266,129.57

Division (Drill Down For Speciality)

Click here for Elective Recovery Fund Trends 

Elective Recovery Fund Trends

Data refresh	(M) All KPIs on this page are refreshed on monthly basis.

Metric Name	Current Value	Comparison Value	Sparklines	Year To Date Value
Trust ERF Core Income Value Against 19/20	93.41 %			91.23 %
Outpatient New ERF Core Income Value Against 19/20	95.90 %			91.83 %
Outpatient Procedures ERF Core Income Value Against 19/20	101.37 %			108.96 %
Elective ERF Core Income Value Against 19/20	86.90 %			83.68 %
Daycase ERF Core Income Value Against 19/20	97.22 %			92.57 %

Data refresh	(M) All KPIs on this page are refreshed on monthly basis.

Percentage treated by a stroke skilled Early Supported Discharge team
67.35 % ✓
Goal: 24.00 %

Overall SSNAP Rating
B
Goal: B

Proportion directly admitted to a stroke unit within 4 hours of clock start
40.82 % !
Goal: 75.00 %

Proportion of patients scanned within 1 hour of clock start (Trust)
44.90 % !
Goal: 48.00 %

Percentage discharged given a named person to contact after discharge
40.82 % !
Goal: 80.00 %

Percentage of eligible patients given thrombolysis
100.00 % ✓
Goal: 90.00 %

Click here for Stroke Discharges Trends →

Stroke Trends

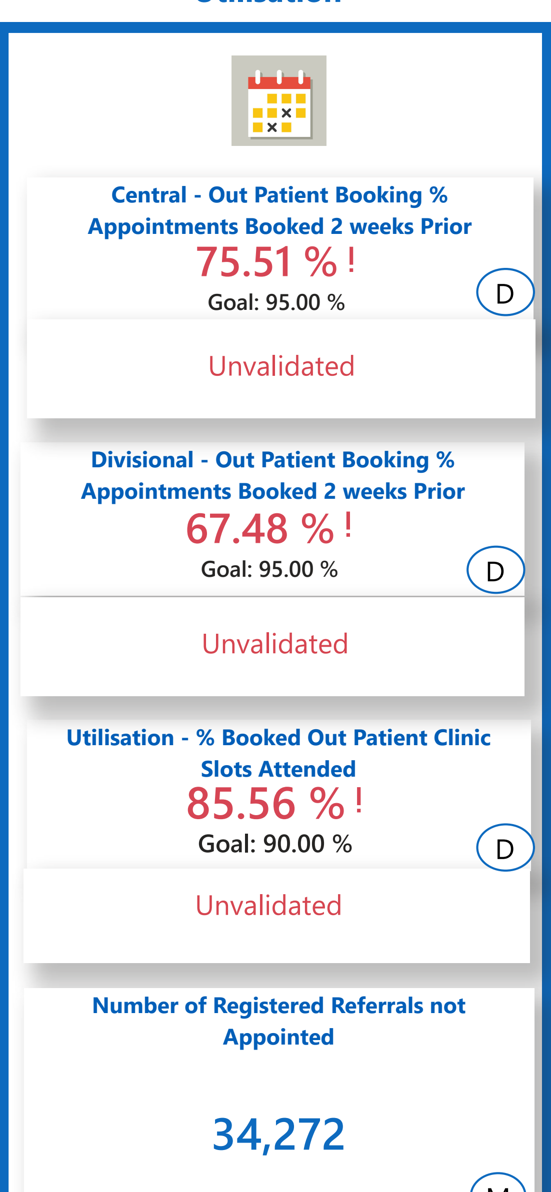
Metric Name	Current Value	Comparison Value	KPI Status	Sparklines
Proportion directly admitted to a stroke unit within 4 hours of clock start	34.85 %	75.00 %		
Percentage treated by a stroke skilled Early Supported Discharge team	66.67 %	24.00 %		
Percentage of eligible patients given thrombolysis	100.00 %	90.00 %		
Proportion of patients scanned within 1 hour of clock start (Trust)	46.97 %	48.00 %		
Percentage discharged given a named person to contact after discharge	59.09 %	80.00 %		

Elective Outpatients

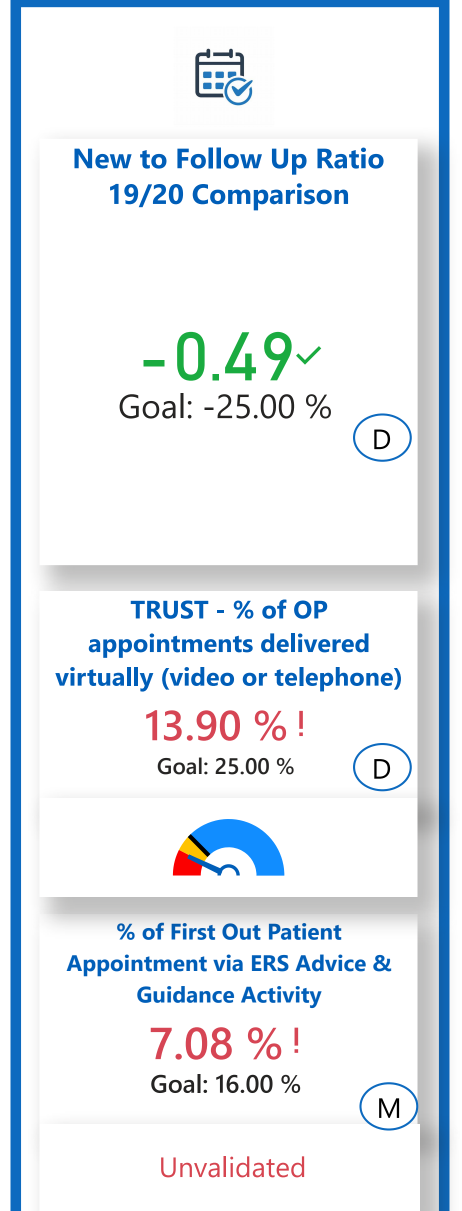
Sep 23

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

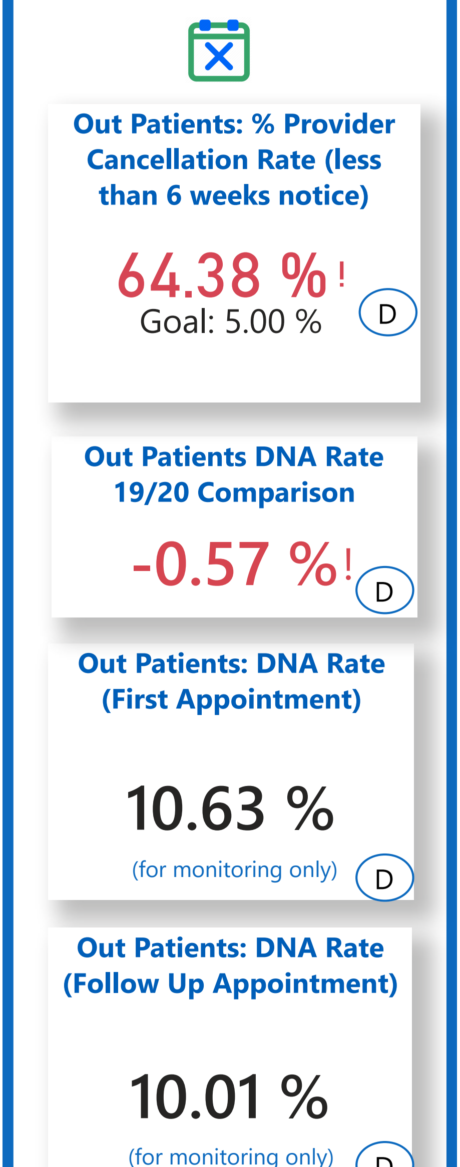
Utilisation



Attended Appointments



Not Attended Appointments



Typing Turnaround

Typing Turnaround Time (dictation to letter sent) (Trust Contract) within 2 WD

In Development

Patient Initiated Follow Up Pathway

TRUST - % patients dicharged onto Patient Initiated Follow Up Pathway in Month

3.32 % !

Goal: 5.00 %

D

Data Quality

Number of Unreconciled Appointments 14 days +

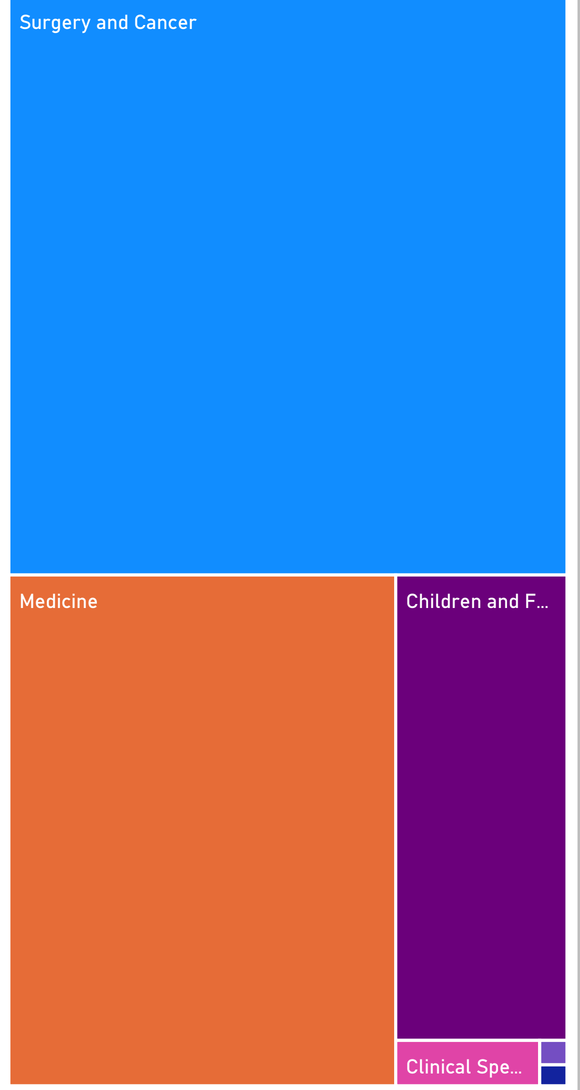
1370 !

Goal: 0

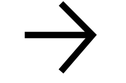
D

Unvalidated

Division (Drill Down For Speciality)

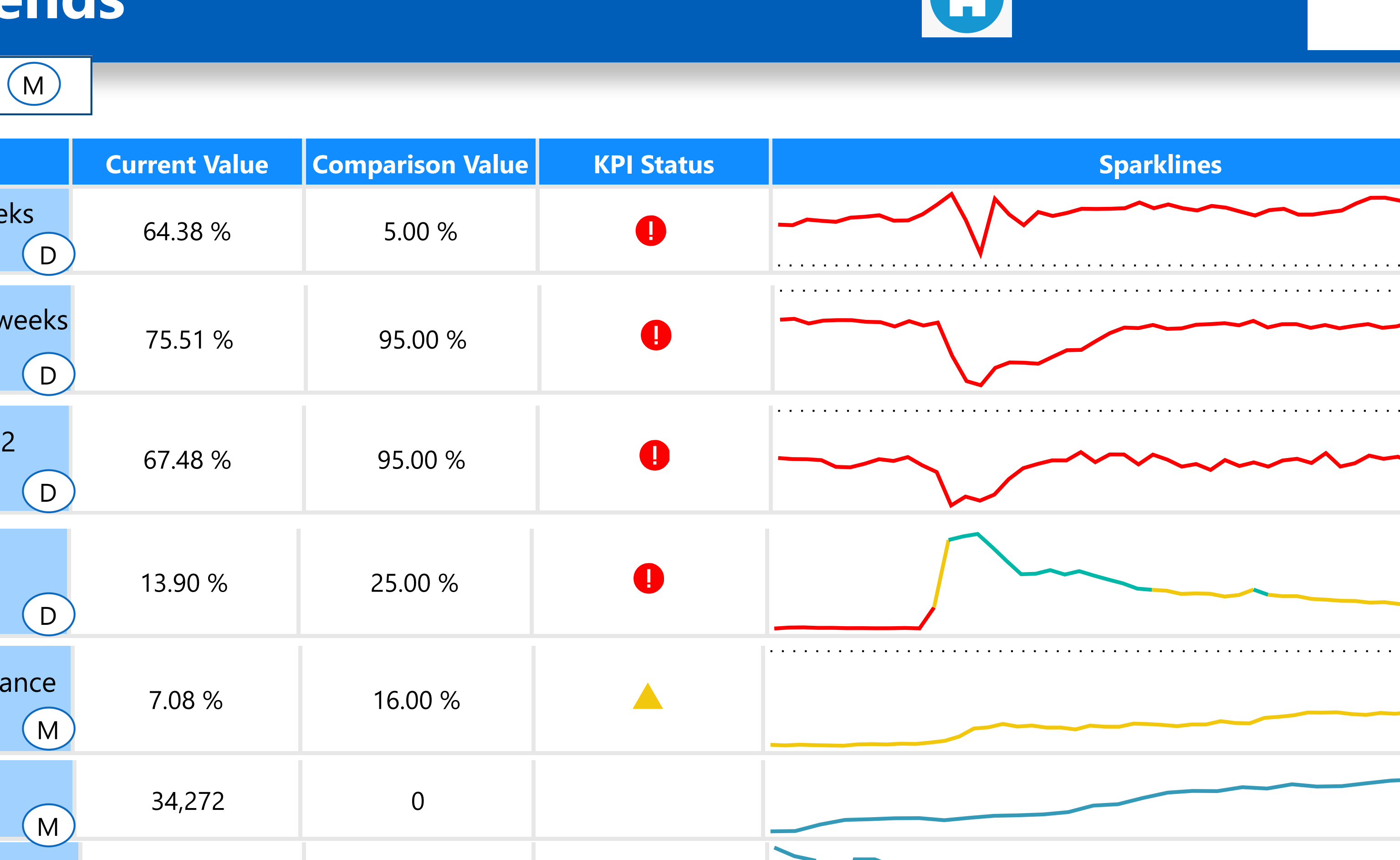


Click here for Elective Outpatients Trends



Elective Outpatients Trends

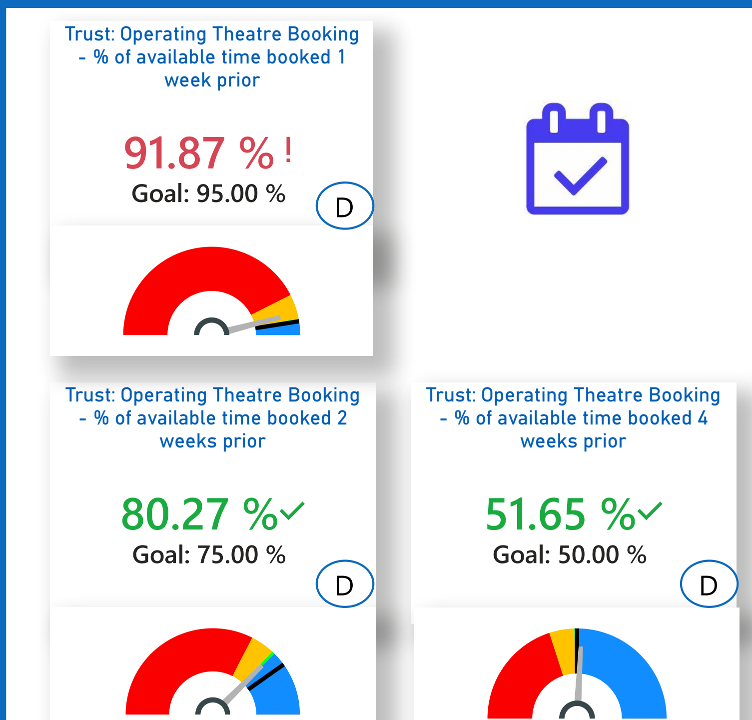
Data refresh	Daily Refresh (D)	Monthly Refresh (M)

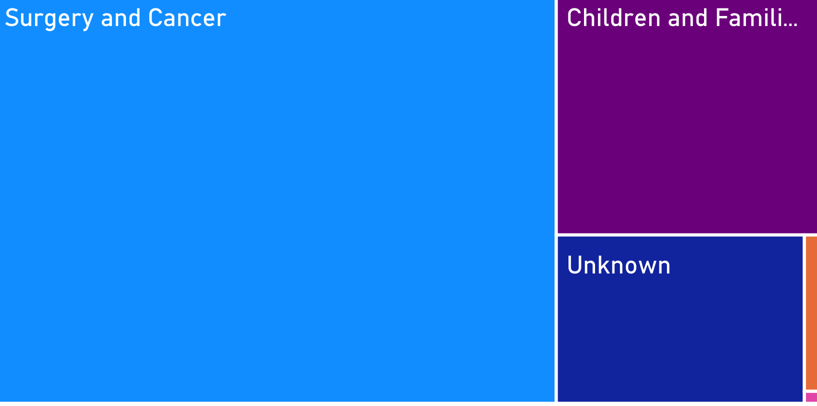


Metric Name	Current Value	Comparison Value	KPI Status	Sparklines
Out Patients: % Provider Cancellation Rate (less than 6 weeks notice) (D)	64.38 %	5.00 %	!	
Central - Out Patient Booking % Appointments Booked 2 weeks Prior (D)	75.51 %	95.00 %	!	
Divisional - Out Patient Booking % Appointments Booked 2 weeks Prior (D)	67.48 %	95.00 %	!	
TRUST - % of OP appointments delivered virtually (video or telephone) (D)	13.90 %	25.00 %	!	
% of First Out Patient Appointment via ERS Advice & Guidance Activity (M)	7.08 %	16.00 %	▲	
Number of Registered Referrals not Appointed (M)	34,272	0		
Typing Turnaround Time (dictation to letter sent) (Trust Contract) within 2 WD (D)	In Development			
Number of Unreconciled Appointments 14 days + (D)	1370	0	!	
TRUST - % patients dicharged onto Patient Initiated Follow Up Pathway in Month (D)	3.32 %	5.00 %	▲	
Utilisation - % Booked Out Patient Clinic Slots Attended (D)	85.56 %	90.00 %	▲	

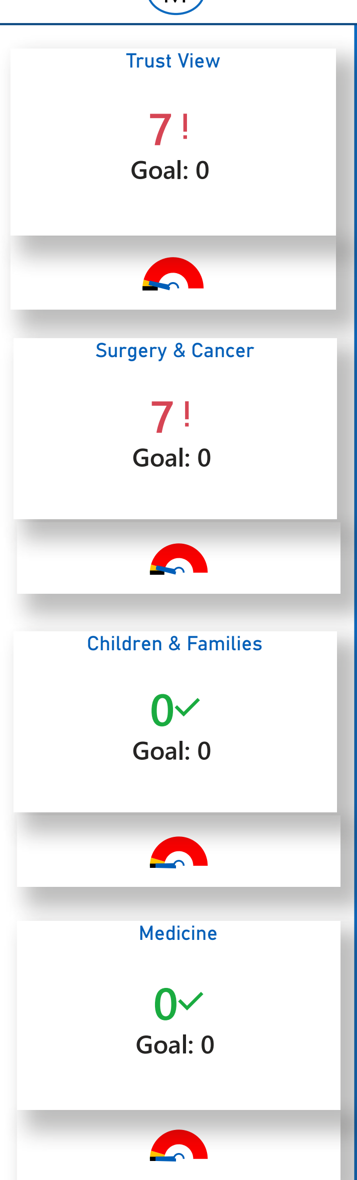
Elective Theatres | Sep 23

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

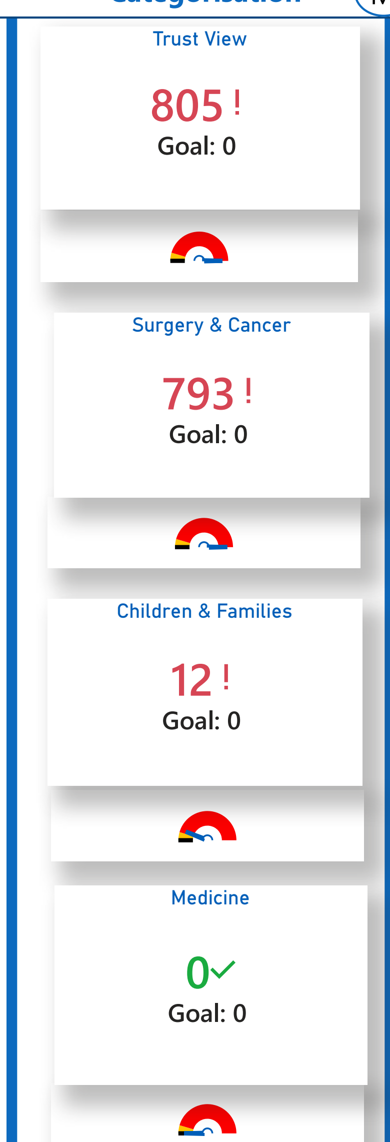




% Cancelled Operations on the day (non-clinical reasons) (M)

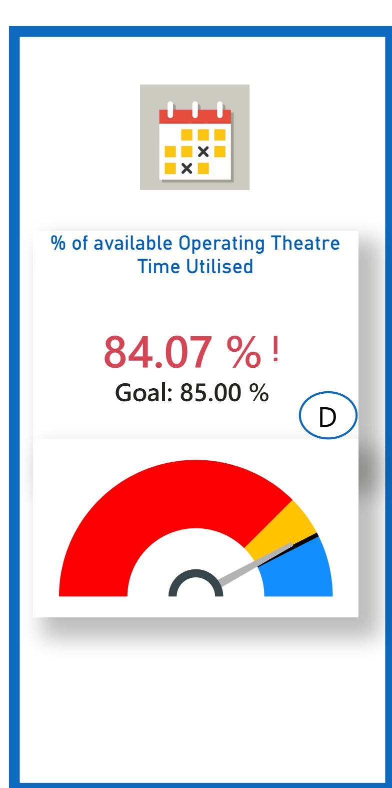


Cancelled Operations Not Rebooked within 28 Days (M)



Number of Priority 2 Patients waiting 28 days + for surgery from date of listing or P2 Categorisation (M)

	Value	Goal
Trust View	805 !	0
Surgery & Cancer	793 !	0
Children & Families	12 !	0
Medicine	0	0



Click here for Elective Theatres Trends

Elective Theatres Trends

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

Metric Name	Current Value	Comparison Value	KPI Status	Sparklines
Operating Theatre Booking - % of available time booked 1 week prior	91.87 %	95.00 %		
Operating Theatre Booking - % of available time booked 2 weeks prior	80.27 %	75.00 %		
Operating Theatre Booking - % of available time booked 4 weeks prior	51.65 %	50.00 %		
% of available Operating Theatre Time Utilised	84.07 %	85.00 %		

Patients: IPC | Sep 23

Data refresh | (M) All KPIs on this page are refreshed on monthly basis.

Hospital Acquired MRSA (Colonisation) Cases Reported in Month

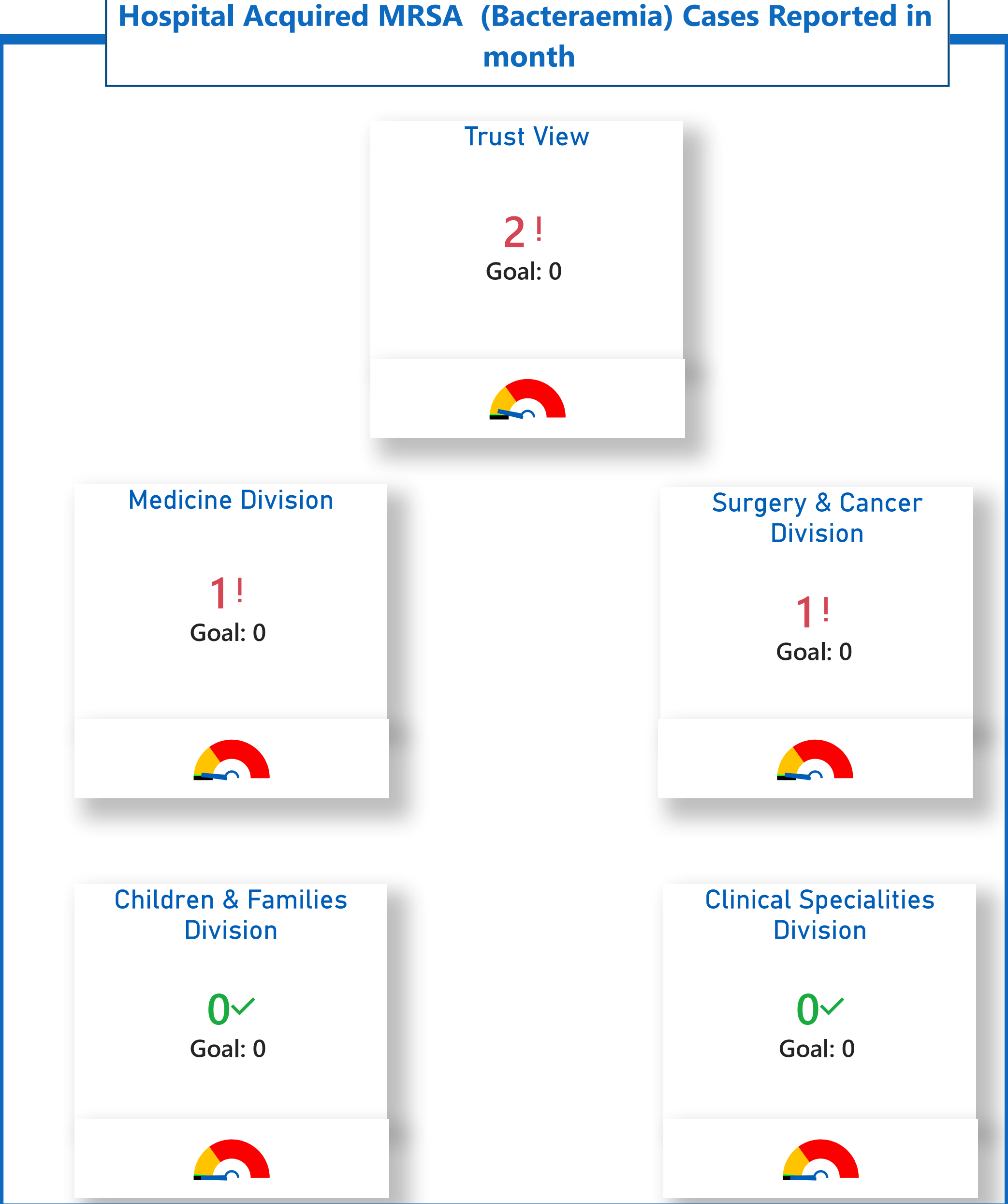
Trust View
2 !
Goal: 0

Medicine Division
1 !
Goal: 0

Surgery & Cancer Division
1 !
Goal: 0

Children & Families Division
0 ✓
Goal: 0

Clinical Specialities Division
0 ✓
Goal: 0



Patients: IPC | Sep 23

Data refresh	(M) All KPIs on this page are refreshed on monthly basis.

Number of Hospital Onset Healthcare associated (HOHA) C.Diff cases in month and YTD

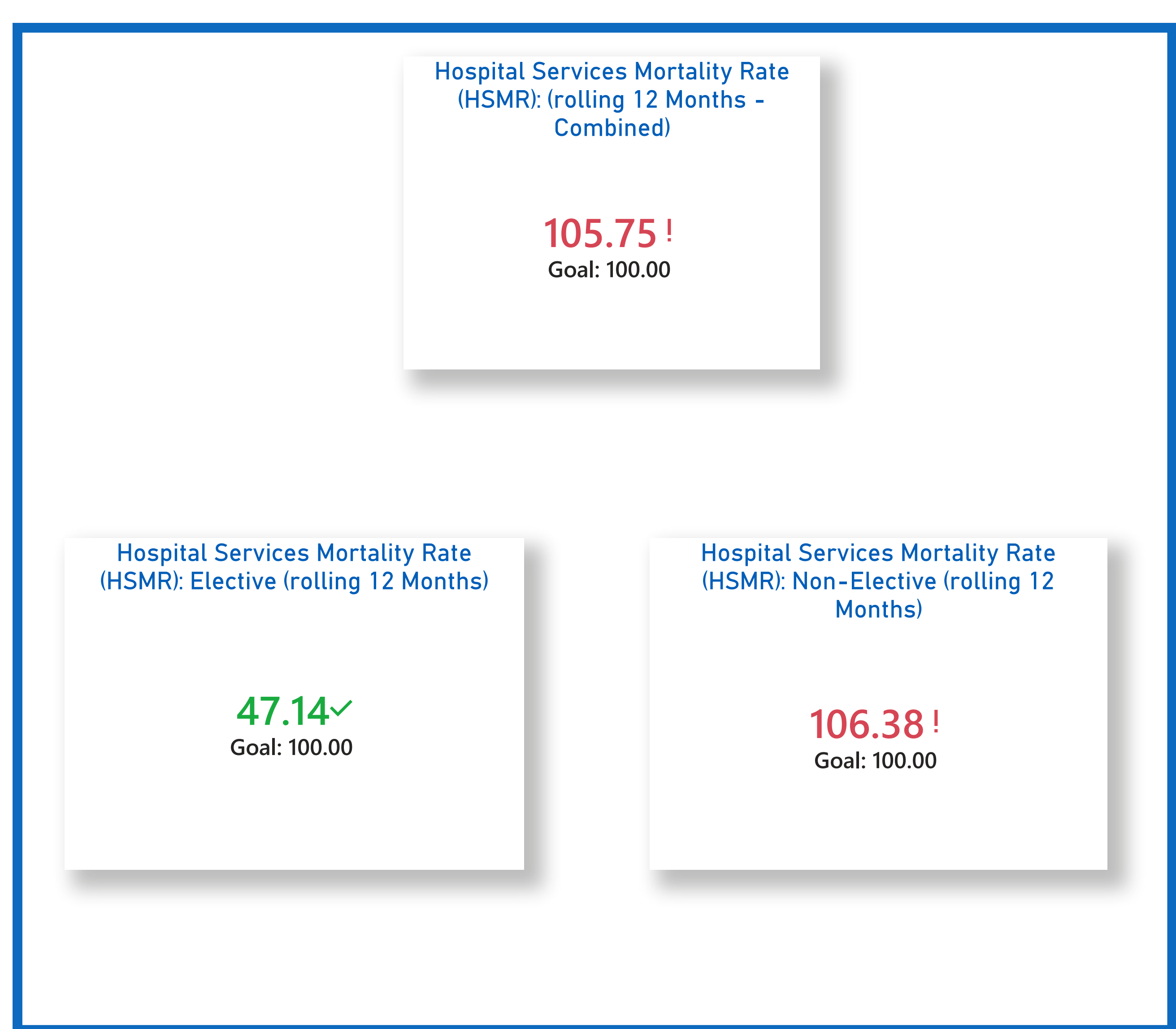
View	In Month	In Month Goal	YTD	YTD Goal
Trust View	4 !	2	30 !	12
Medicine Division	3 !	2	23 !	12
Surgery & Cancer Division	1 ✓	2	5 ✓	12
Children & Families Division	0 ✓	2	0 ✓	12
Clinical Specialities Division	0 ✓	2	2 ✓	12

Number of Community Onset Healthcare associated (COHA) C.Diff cases in month and YTD

View	In Month	In Month Goal	YTD	YTD Goal
Trust View	0 ✓	2	3 ✓	12
Medicine Division	0 ✓	2	0 ✓	12
Surgery & Cancer Division	0 ✓	2	3 ✓	12
Children & Families Division	0 ✓	2	0 ✓	12
Clinical Specialities Division	0 ✓	2	0 ✓	12

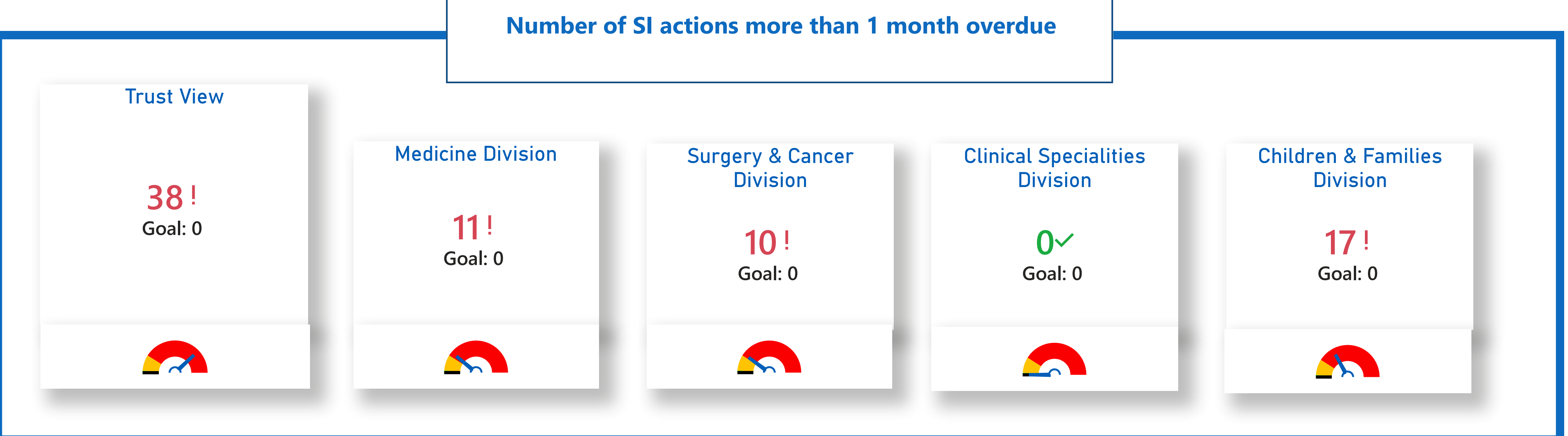
Patients: HSMR | Jul 23

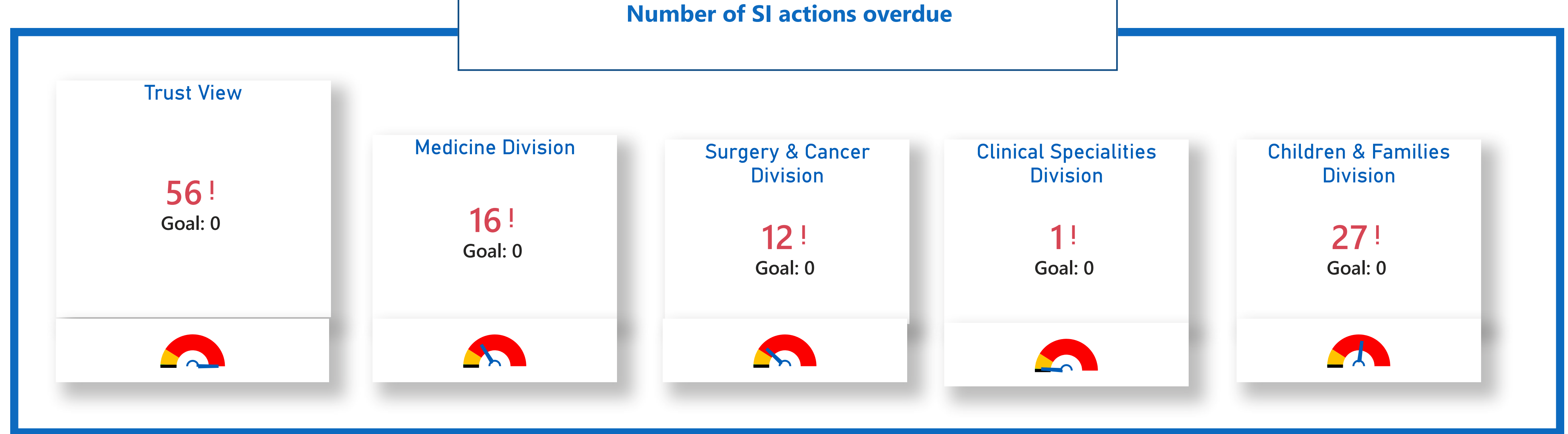
Data refresh All KPIs on this page are refreshed on monthly basis.



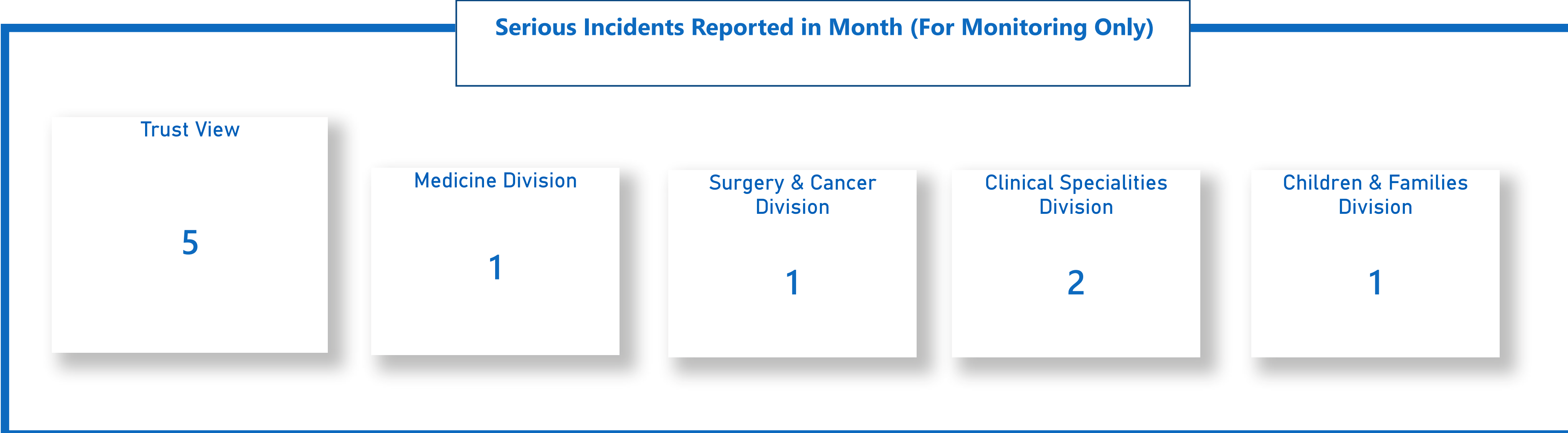
Patients: Patient Safety | Sep 23

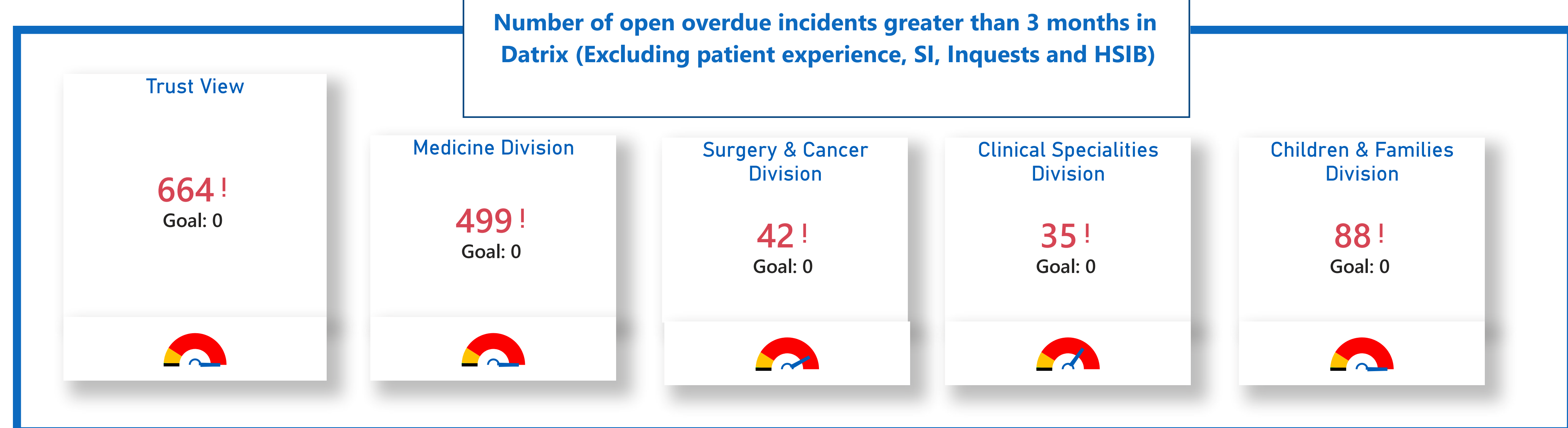
Data refresh (M) All KPIs on this page are refreshed on monthly basis.





Data refresh (M) All KPIs on this page are refreshed on monthly basis.





Data refresh All KPIs on this page are refreshed on monthly basis.

Patients: Skin Integrity | Sep 22

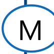
Data refresh M All KPIs on this page are refreshed on monthly basis.

YTD Hospital Acquired Pressure Ulcers (HAPU) Category 2 and above - 20% reduction on 20/21 by March 2023

Area	In Month	In Month Goal	YTD	YTD Goal
Trust View	40 ✓	56	208 ✓	336
Medicine Division	25 ✓	56	120 ✓	336
Clinical Specialities Division	4 ✓	56	17 ✓	336
Surgery & Cancer Division	5 ✓	56	38 ✓	336
Children & Families Division	0 ✓	56	1 ✓	336
Non Inpatient Areas	6 ✓	56	32 ✓	336

Patients: Falls

Sep 23

Data refresh  M All KPIs on this page are refreshed on monthly basis.

Inpatient Falls resulting in low Moderate or Severe Harm reported in month

Trust

11.11 % !

Goal: -10.00 %

Current Year	Last Year
30	27

Medicine

50.00 % !

Current Year	Last Year
24	16

Surgery & Cancer

-70.00 % ✓

Current Year	Last Year
3	10

Children Families

Infinity !

Current Year	Last Year
2	0

Clinical Specialities

0.00 % !

Current Year	Last Year
1	1

Patients: Patient Experience | Sep 23

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

Complaints - New in month

	Trust	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
Value	-25.45 % ✓	-68.97 % ✓	-5.26 % !	-25.00 % ✓	266.67 % !
Goal	-10.00 %				
Current Year	41	9	18	3	11
Last Year	55	29	19	4	3

Complaints Resolution Performance (% achieved closure in agreed timescales with complainant)

	Trust	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
Value	39.00 % !	46.00 % !	50.00 % !	25.00 % !	12.00 % !
Goal	95.00 %	95.00 %	95.00 %	95.00 %	95.00 %

Complaints Upheld / Partially Upheld by Parliamentary Health Service Ombudsman

	Trust View	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
Value	40 !	11 !	19 !	4 ✓	6 !
Goal	4	4	4	4	4

Patients: Claims

Sep 23

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

Claims CNST (patients) - new in month

Trust View	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
9	5	4	0	0

Claims LTPS - (staff) new in month

Trust View	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
2	0	1	0	1

Patients: Friends and Family Test

Sep 23

Data refresh All KPIs on this page are refreshed on monthly basis.

Friends & Family Response Rates (ED) Increase response by year end

6.72 % !
Goal: 10.00 %

Friends & Family Response Rates (Inpatients) Increase response by year end

1.31 % !
Goal: 15.00 %

Patients: Audit and Effectiveness | Sep 23

Data refresh (M) All KPIs on this page are refreshed on monthly basis.

Mixed Sex Accommodation - reported breaches in month

Trust View	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
2 ! Goal: 0	0 ✓ Goal: 0	0 ✓ Goal: 0	2 ! Goal: 0	0 ✓ Goal: 0

NICE Guidance Response Rate Compliance

Trust View	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
93.70 % ! Goal: 100.00 %	94.80 % ! Goal: 100.00 %	92.10 % ! Goal: 100.00 %	89.50 % ! Goal: 100.00 %	89.40 % ! Goal: 100.00 %

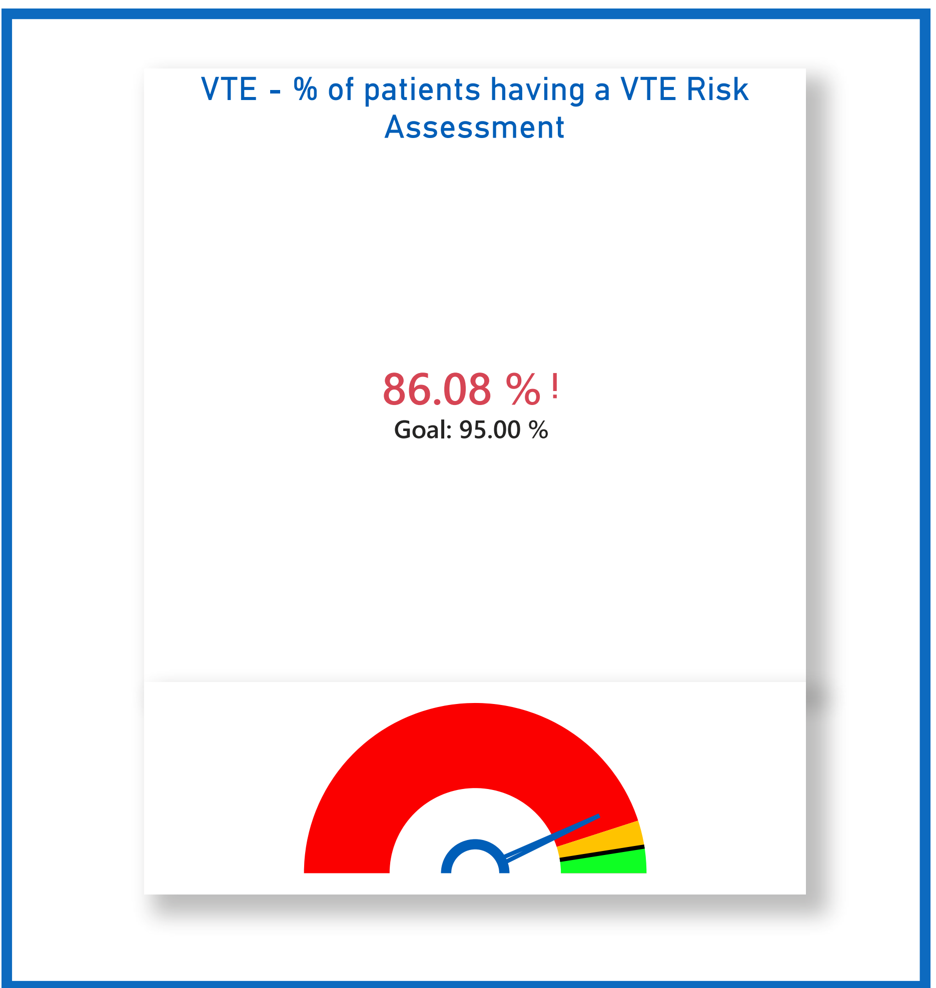
NICE Guidance % Non & Partial Compliance (For Monitoring Only)

Trust View	Medicine Division	Surgery & Cancer Division	Clinical Specialities Division	Children & Families Division
12.20 %	3.47 %	6.66 %	15.60 %	47.60 %

Patients: Medical Examiner | Sep 23

Data refresh All KPIs on this page are refreshed on monthly basis.

Data refresh	M	All KPIs on this page are refreshed on monthly basis.



Patients: Reducing Length Stay | Sep 23

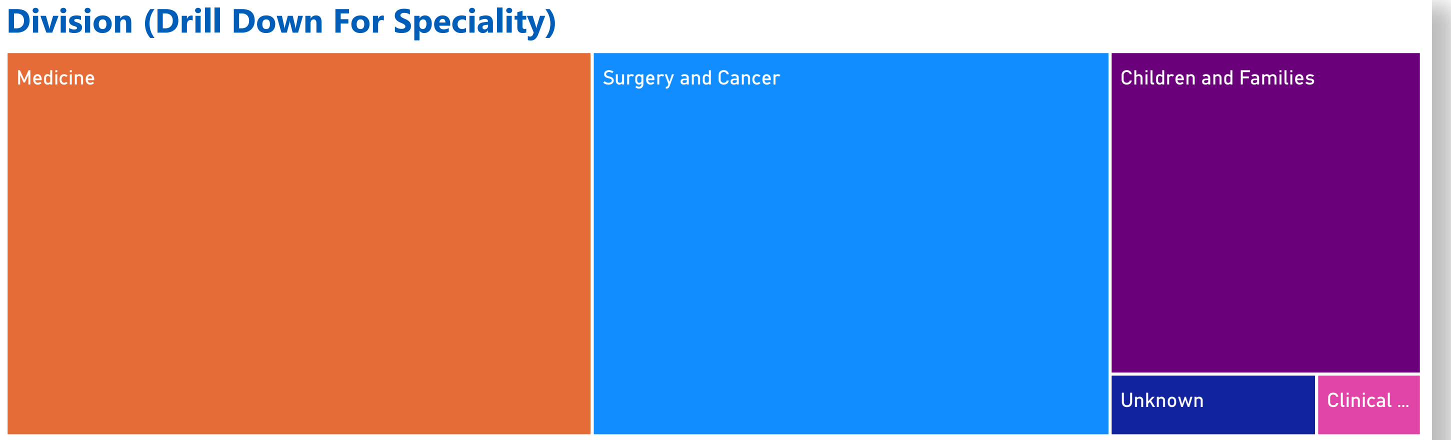
Data refresh (D) All KPIs on this page are refreshed on daily basis.

Days - Reducing length of stay for patients in hospital for 21 days +

16.90 % !

Discharges - Reducing length of stay for patients in hospital for 21 days +

16.26 % !



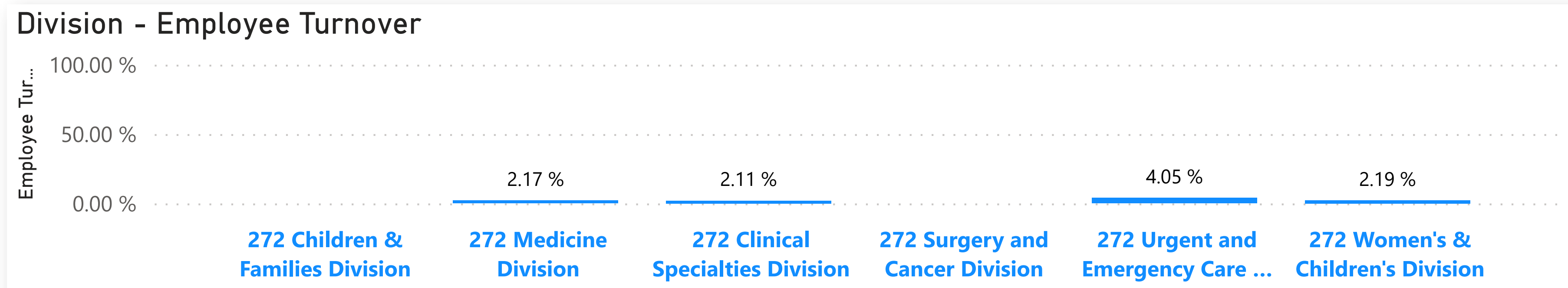
People

Sep 23

Data refresh All KPIs on this page are refreshed on monthly basis.

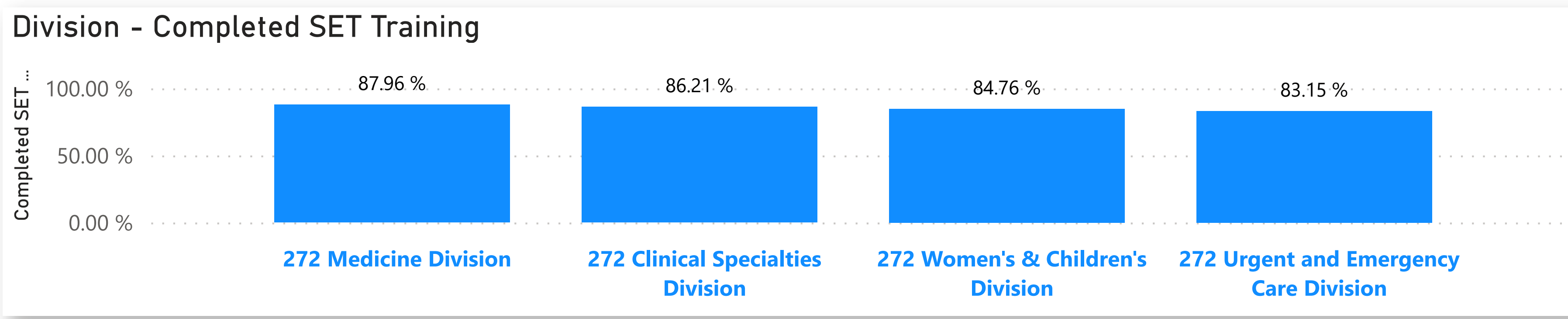
Employee Turnover

2.40 % !
Goal: 0.83 %



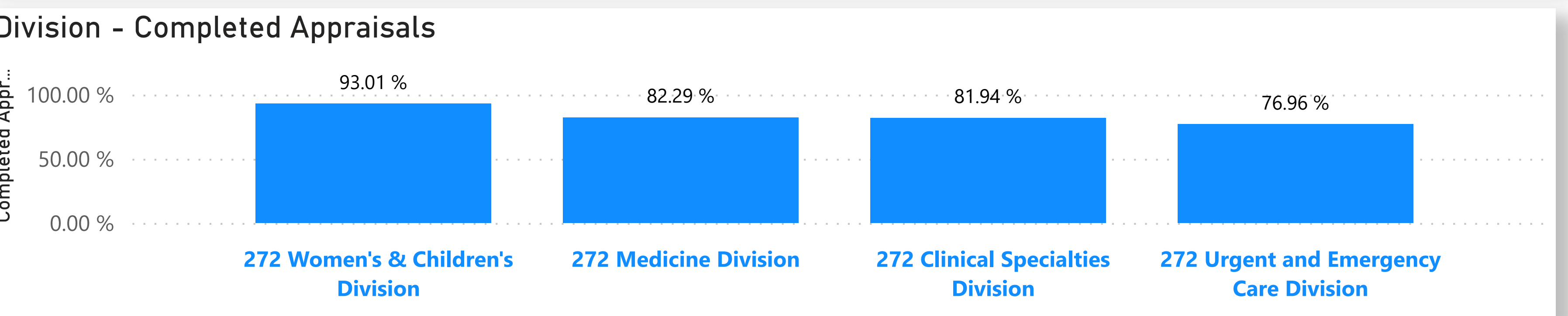
Completed SET Training

86.05 % !
Goal: 90.00 %



Completed Appraisals

83.34 % !
Goal: 90.00 %



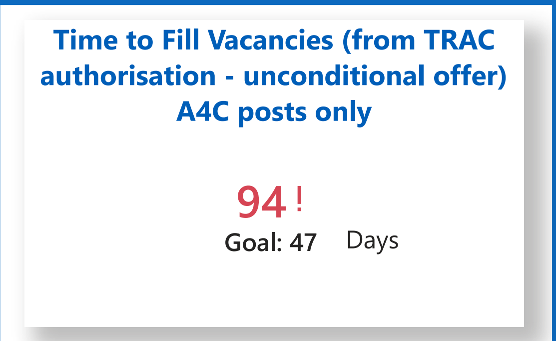
People Forms Data | Sep 23

Data refresh All KPIs on this page are refreshed on monthly basis.

KPI	Value	Goal
Overall Staff Sickness Absence	5.94 % !	5.00 %
Overall Staff Vacancies	8.96 % !	5.00 %
Consultants with Signed Off Job Plans in EJP	55.00 % !	90.00 %
Medicine Division Sickness Absence	6.92 % !	5.00 %
Children & Families Sickness Absence	6.67 % !	5.00 %
Medicine Division Workforce Vacancies	10.57 % !	5.00 %
Children & Families Workforce Vacancies	10.43 % !	5.00 %
Medicine Division Consultants with Signed Off Job Plans in EJP	72.00 % !	90.00 %
Children & Families Consultants with Signed Off Job Plans in EJP	67.00 % !	90.00 %
Surgery & Cancer Sickness Absence	6.40 % !	5.00 %
Clinical Specialties Sickness Absence	5.46 % !	5.00 %
Surgery & Cancer Workforce Vacancies	2.83 % ✓	5.00 %
Clinical Specialties Workforce Vacancies	10.23 % !	5.00 %
Surgery & Cancer Consultants with Signed Off Job Plans in EJP	24.00 % !	90.00 %
Clinical Specialties Consultants with Signed Off Job Plans in EJP	66.00 % !	90.00 %

People Forms Data | Sep 23

Data refresh All KPIs on this page are refreshed on monthly basis.



Medicine Division - Time to Fill Vacancies (Days)

51 !
Goal: 47 Days

Children & Families - Time to Fill Vacancies (Days)

93 !
Goal: 47 Days

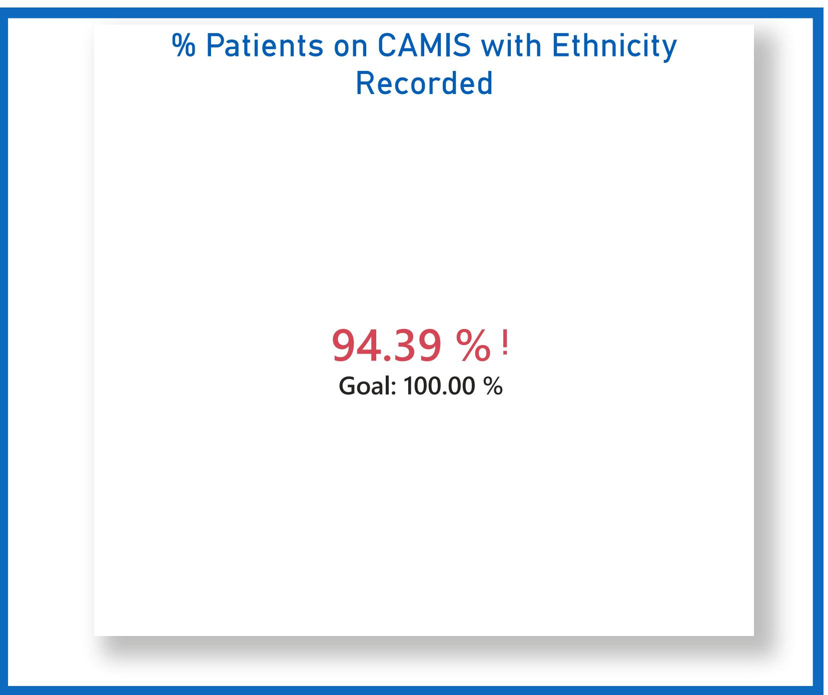
Surgery & Cancer - Time to Fill Vacancies (Days)

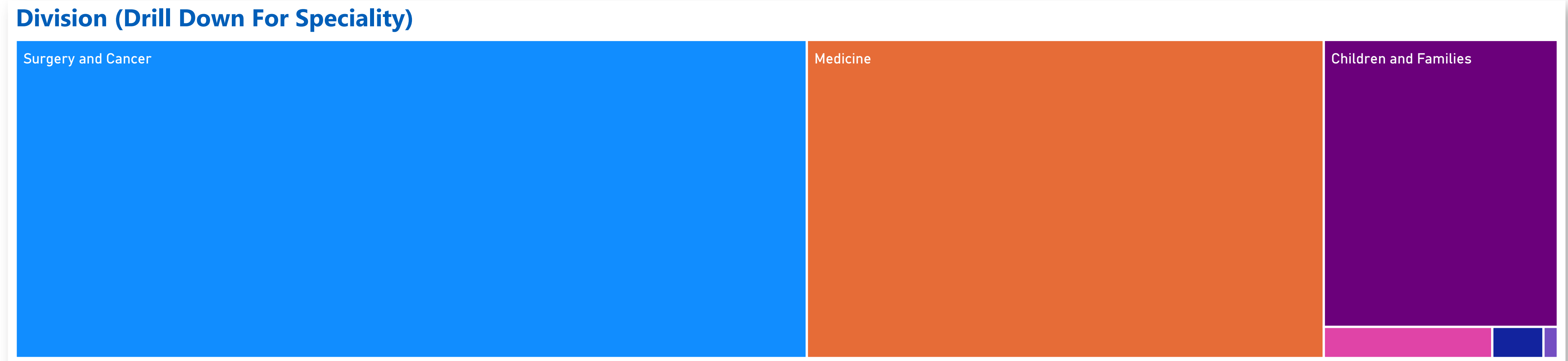
50 !
Goal: 47 Days

Clinical Specialties - Time to Fill Vacancies (Days)

70 !
Goal: 47 Days

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





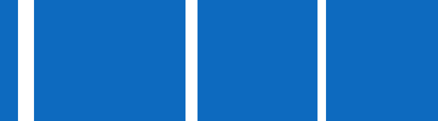
KPI Trends

- Self Arrivals - Initial Assessment Within 15 Mins (Unvalidated)
- Ambulance Handovers within 15 Minutes
- Ambulance Handovers within 30 Minutes
- Ambulance Handovers More Than 60 Minutes
- TOTAL -% patients leaving Emergency Department from clinically ready to proceed to admission within 60 mins
- A&E: Max wait four hours from arrival/admission/transfer/discharge
- % Patients with Total Length of Stay in Emergency Department >12 hours

EM Hospital

- Doncaster Royal Infirmary
- Bassetlaw District Ge...
- Montagu Hospital

Urgent & Emergency Care | Waiting List | Cancer | Elective Outpatients - Not Available | Elective Recovery Fund | Activity Against Plan - Outpatients | Activity Against Plan - Intpatients | Elective Theatres



Ambulance Handovers More Than 60 Minutes

Ambulance Handovers Breaches KPI waited more than 60 Mins | Ambulance Handovers Breaches KPI waited more than 60 Mins Goal

Y axis: 0.00 % | 5.00 % | 10.00 % | 15.00 % | 20.00 % | 25.00 % | 30.00 % | 35.00 %

Data labels: 0.18 %, 2.90 %, 2.72 %, 7.23 %, 5.23 %, 5.69 %, 3.35 %, 0.50 %, 3.69 %, 1.12 %, 6.38 %, 9.27 %, 4.15 %, 4.40 %, 2.63 %, 5.81 %, 6.21 %, 4.44 %, 4.70 %, 9.68 %, 13.78 %, 13.02 %, 16.42 %, 14.90 %, 16.82 %, 11.12 %, 14.59 %, 13.62 %, 18.33 %, 13.52 %, 18.35 %, 22.37 %

X axis: S... 19, Oct 19, N... 19, Dec 19, Jan 20, Feb 20, M... 20, Apr 20, M... 20, Jun 20, Jul 20, A... 20, S... 20, Oct 20, N... 20, Dec 20, Jan 21, Feb 21, M... 21, Apr 21, M... 21, Jun 21, Jul 21, A... 21, S... 21, Oct 21, N... 21, Dec 21, Jan 22, Feb 22, M... 22, Apr 22, M... 22, Jun 22, Jul 22, A... 22, S... 22

Month & Year

2311 - H4 MINUTES OF THE FINANCE AND PERFORMANCE COMMITTEE ? 24 JULY & 21 SEPTEMBER 2023

Information Item Mark Day, Non-executive Director

REFERENCES

Only PDFs are attached

H4 - Finance & Performance Committee Minutes - 24 July 2023.pdf

H4 - Finance & Performance Committee Minutes - 21 September 2023.pdf

FINANCE AND PERFORMANCE COMMITTEE

Minutes of the meeting of the Finance and Performance Committee held on Monday 24 July 2023 at 09:00 via Microsoft Teams

Present:	Mark Bailey - Non-Executive Director Mark Day - Non-Executive Director (Chair) Emyr Jones - Non-Executive Director Jon Sargeant - Chief Financial Officer Kath Smart - Non-Executive Director Denise Smith - Chief Operating Officer
In attendance:	Alex Crickmar - Deputy Director of Finance Kirsty Edmondson-Jones – Director of Innovation & Infrastructure (agenda item C3) Joseph John - Medical Director for Operational Stability and Optimisation Kelly Mackenzie – Consultant in Public Health (agenda item C3) Angela O'Mara - Deputy Company Secretary (minutes) Suzanne Stubbs – Interim Deputy Chief Operating Officer – Urgent & Emergency Care (agenda item B2)
To Observe:	
Apologies	Fiona Dunn - Director Corporate Affairs /Company Secretary Paul Mapley - Efficiency Director Andrew Middleton - Public Governor – Bassetlaw Lynne Schuller - Governor Observer - Bassetlaw

		ACTION
FP23/07/A1	**Welcome, Apologies for Absence and declarations of interest (Verbal)**	
	The Chair welcomed members of the Committee and those in attendance to the meeting. The above apologies for absence were noted and no declarations of interest were received.	
FP23/07/A2	**Requests for any other business (Verbal)**	
	No items of other business were received.	
FP23/07/A3	**Action Notes from Previous Meeting (Enclosure A3)** **Action 2 – Alternative Care Provision for Patients with no right to reside** – agreement was reached at the pre-meet that this action would be closed. Consideration of the matter would be included in the winter planning, to be presented at September's meeting. **Action 3 - FP22/11/B3 – Winter Plan** – action not yet due.	

	<u>Action 4 - FP23/03/D4 - Emergency Preparedness, Resilience & Response Granger Report</u> – the Chief Financial Officer confirmed a date for the next risk summit had been agreed, an update from this meeting and the Lord Markham visit would be provided at the September meeting. **Action to be closed.** **<u>Action 8 - FP23/04/C1 - Clinical Site Strategy</u>** – action not yet due. **<u>Action 10 - FP23/04/C1 - Progress of Bassetlaw Emergency Village Full Business Case</u>** – confirmation was received at the pre-meet that approval had now been granted and funds drawn down. **Action closed**. **<u>Action 11 – FP23/05/C2 - Health Inequalities Draft Strategy</u>** – included on this agenda – **action to be closed.**	
	The Committee: - ***Noted the above updates.***	
FP23/07/B1	**<u>Access Standards Report (enclosure B1)</u>**	
	The Chief Operating Officer confirmed that industrial action continued to impact on activity levels, with further consultant action expected in August 2023. Performance against urgent and emergency care standards had deteriorated in month, despite this the Trust continued to benchmark well, particularly in respect of ambulance handovers and the number of patients waiting in the department for more than 12 hours. The Trust remained an outlier in respect of its diagnostic performance, standards were achieved in five modalities but CT, MRI and audiology remained challenging. A paper proposing a longer-term solution in audiology had been presented to the Trust Executive Group and additional sessions had been requested by the division to manage the CT demand. In respect of elective waits, one patient had breached 104 weeks, due to an incorrect clock stop earlier in the pathway. 78 week waits continued to be difficult in ENT, mutual aid for a specific procedure had been unsuccessful and an alternative inhouse solution was being explored. In Trauma & Orthopaedics, demand remained high, the Trust was on track to achieve 78 and 65 week waits by the end of March 2024. An improved position was reported on 2 week waits, although an increase in demand for gynae two-week referrals required some work to understand whether pathway work was required with primary care. The faster diagnosis standard was maintained and whilst the 62-day standard had not been achieved; the Trust was ahead of its trajectory to reduce the backlog. In response to a question from Non-executive Director, Emyr Jones, the Chief Operating Officer confirmed the diagnostic standards related to completion of the test, rather than the reporting of results, which was subject to review at the Performance, Overview and Support meeting. The Medical Director for Operational Stability and Optimisation confirmed where timescales were challenged, additional sessions were offered, or tests bulk transferred to external agencies for completion. Urgent elective reporting was usually completed by Trust colleagues within 48 hours, with routine elective reporting within five days. The Chief Operating Officer agreed to provide a one-off overview of reporting performance at the next meeting, with future reporting to be determined.	**DS**

	In response to a question from Non-executive Director, Kath Smart with regards to the audiology solution, the Chief Operating Officer confirmed that the report to the Trust Executive Group had highlighted the demand and supply challenges, proposed referral limitations and potential commissioner discussions with regards to an alternative pathway model. A significant amount of work would be required to progress this, so no imminent change in performance was anticipated. The potential for diagnostic mutual aid existed in audiology and dual-energy X-ray absorptiometry (DEXA), the latter was a time limited issue for the Trust. In response to a question from Non-executive Director, Kath Smart, with regards to the delivery of zero 65 week waits, the Chief Operating Officer confirmed the greatest risk to delivery was seen in ENT and trauma and orthopaedics. Mutual aid conversations were ongoing and plans shared across the system, however, the impact on the Trust was expected to be limited. ENT mutual aid had not been possible locally and an approach had been made via a national solution, Digital Mutual Aid System. Going forwards the Chief Operating Officer confirmed plans to ensure that patients were transferred before the first outpatient appointment where mutual aid was agreed. Non-executive Director, Mark Bailey acknowledged the impact of skill mix changes on performance and sought assurance that learning would be incorporated into future planning. The Chief Operating Officer acknowledged further skill mix work would be explored in the Emergency Department, particularly with the primary care provider, FCMS. Doctor waits were recognised to be an issue and there was the potential to explore alternative solutions. In respect of the impact of industrial action, the Chief Operating Officer advised the Chair that the number of cancellations and cases not booked in were quantifiable. Kath Smart confirmed the impact of industrial action had been raised at a recent meeting of the South Yorkshire Chairs and the ICB Chair had indicated all Trusts should be sighted on the activity and financial impact. In response to a question from the Chair with regards to the management of a 104 week breach, the Chief Operating Officer confirmed that as these usually related to an incorrect clock stop, once identified the patient was contacted by telephone, with a view to booking in as soon as possible and with the intention to treat within one month.	
	The Committee: - ***Noted and took assurance from the Access Standards Report***	
FP23/07/B2	**Urgent & Emergency Care (UEC) Improvement Programme (Enclosure B2)**	
	The Chief Operating Officer confirmed receipt of a national communication highlighting the four key areas of focus for urgent and emergency care recovery. The content of the current urgent and emergency care action plan remained relevant and the plan against the national priorities would be agreed at Place. The Interim Deputy Chief Operating Officer confirmed that since the last meeting all project charters had been signed off and key milestones agreed and the monthly highlight reports were appended to the paper. Senior Responsible Officers (SROs) had agreed frailty, same day emergency care, length of stay and transfer of care hubs as the key priorities for delivery.	

	Non-executive Director, Kath Smart shared a concern that it was difficult to see progress against the plan, other than the entry of future dated actions. In respect of the identified improvements to the discharge lounge, the Interim Deputy Chief Operating Officer confirmed that the Bassetlaw lounge was now fully operational and an increase in flow had been seen, beds were now provided in addition to seating. The proposed relocation of the DRI discharge lounge was some weeks off yet, pending receipt of furniture, however real time data was now being captured to support the concept and a change in operational attitude was being seen with a focus on effective use of the discharge lounge, with clarity of understanding around access and exclusion criteria. In respect of the minor injuries' modular unit at DRI, Kath Smart enquired of the plans to increase the current usage, the Interim Deputy Chief Operating Officer confirmed this was the plan, subject to the required upskilling of the workforce, which was currently in train. In response to a question from Non-executive Director, Mark Bailey, the Chief Operating Officer confirmed there was not an agreed urgent and emergency model of care and this would be progressed at Place by the SROs. In respect of system connectivity between the Trust and Rotherham, Doncaster & South Humber NHS Foundation Trust, the Chief Operating Office confirmed there were no current plans, however, there would be a single UEC dashboard, reporting an agreed set of metrics across Place. Non-executive Director, Emyr Jones, sought a view of the level of engagement and momentum across Place, the Chief Operating Officer confirmed there was good engagement, partners understood what was required in terms of delivery and recognised the impact of their organisation's activity on the Trust as an acute provider. With the lack of central support, the Chair enquired what actions would need to be taken by the Trust in respect of the UEC Improvement Programme, the Chief Operating Officer agreed to consider what was required to provide the lost capacity and capability.	 **DS**
	<u>The Committee:</u> - ***Noted and took assurance from the Urgent & Emergency Care Improvement Programme***	
FP23/07/B3	**<u>Elective Activity Report (Enclosure B3)</u>**	
	The report was taken as read and the Committee's attention drawn to the inclusion of diagnostic activity. Non-executive Director, Kath Smart acknowledged the impact of industrial action but encouraged potential improvements and efficiencies not to be overshadowed by this. In respect of theatre efficiency this had been identified as an area of underperformance previously, the Chief Operating Officer confirmed that an improvement plan was in place, utilisation was improving but there was still work to do to deliver the 85% standard on a consistent basis and for this to be embedded as business as usual. The 6-4-2 model of theatre booking was in place but there was scope to improve adoption. The Trust was receiving support from the national Getting It Right First Time Programme, with a focus in orthopaedics where there was excellent colleague engagement. Kath Smart confirmed it would be helpful to include the key risks to delivery in future reporting.	 **DS**

	The Committee welcomed the improved reporting, discussions with regards to inclusion of the Integrated Quality & Performance Report would be considered as part of agenda item E2.	
	The Committee: - ***Noted and took assurance from the Elective Activity Report***	
FP23/07/C1	**Recovery, Innovation & Transformation Directorate Update (Enclosure C1)**	
	The Director of Recovery, Innovation and Transformation provided an update on his portfolio. The Committee's attention was drawn to the ongoing quality improvement work across the Trust, including the review of the strategy, the approval of the Bassetlaw Emergency Village Business Case and progress with the Montagu Elective Orthopaedic Centre. Since the paper had been written a change to the MEOC governance structure had been agreed by the MEOC Board, an internal team would now lead the various workstreams, reporting across the trusts would be via the Acute Federation professional groups. The Trust had been successful in its application for the Green Flag award for the development of accessible on-site green spaces, it was only the second NHS organisation in the country to have received the award. Non-executive Director, Mark Bailey enquired if the apparent lack of engagement in establishing the Trust led workstream meetings caused a concern with regards to the future operation of the Centre, the Director of Recovery, Innovation & Transformation confirmed there had been good clinical engagement and the vision of the Chairs and Chief Executives was aligned across all participating Trusts. In response to a question from Non-executive Director, Kath Smart with regards to the Nottingham and Nottinghamshire sexual health service, the Director of Recovery, Innovation & Transformation confirmed there remained a requirement for the Local Authority to tender, despite the NHS being committed to collaboration. In respect of the Performance, Overview & Support meeting content within the report, the Director of Recovery, Innovation and Transformation confirmed this would be a regular feature going forwards.	
	The Committee: - ***Noted and took assurance from the Recovery, Innovation & Transformation Directorate Update***	

FP23/07/C2	<u>**New Hospital Update (Enclosure C2)**</u>	
	Further to discussions at the confidential Board of Directors meeting in June, the Director of Recovery, Innovation & Transformation's paper identified parallel plans for refurbishment, giving consideration to the Trust's clinical site strategy, and the continued pursuit of a new hospital solution. The paper identified those must do and discretionary actions, including timelines, associated costs and a proposed governance structure, Committee members were invited to share their views. Focusing on the refurbishment route, Non-executive Director, Kath Smart sought clarity on the costs contained within the Premises Assurance Model (PAM) and the Estates Return Information Collection (ERIC) Board reports, as compared to those within this paper. The Director of Recovery, Innovation & Transformation confirmed the costs within ERIC did not include fees and on-costs, so were not directly comparable. Costs had been extracted from the Strategic Outline Case, however, in view of subsequent inflationary pressures there would be a need to review these. In respect of the availability of capital, the Director of Recovery, Innovation & Transformation acknowledged the challenges with the current system and the need for alternative routes. The potential funding expected to be available in the 2023 Autumn Statement was likely to be public dividend capital (PDC) or an uplift to the capital departmental expenditure limit (CDEL). The Chair shared his thoughts on alternative financing and recognised the challenging position which was articulated within the paper.	
	The Committee: - ***Noted and took assurance from the New Hospital Update***	
FP23/07/C3	**Draft Health Inequalities Strategy (Enclosure C3)**	
	The Director of Innovation & Infrastructure and the Consultant in Public Health were welcomed to the meeting. Following a Board Workshop in March 2023, a commitment was given to produce a draft health inequalities strategy, provided as part of today's Committee's papers, and supported by a strategy on a page. The Consultant in Public Health provided an insight into the contributing factors of health inequalities, the local context and the priority areas of prevention, elective care pathways/elective recovery, urgent and emergency care pathways, maternity and best start in life, children and young people and research and innovations opportunities. The key enablers underpinning the strategy were identified and in terms of next steps feedback was invited from the Committee within the next 14 days, after which there would be a period of consultation and the strategy and action plan would be finalised by the end of Q2 2023/24. The Director of Innovation & Infrastructure recognised a number of Trust strategies had been subject to review and confirmed that appropriate connections had been made to ensure the wide reaching impact of health inequalities was taken into consideration.	**All** **JS**

	As much of the data and commentary presented had been known for some time and the initiatives were not dissimilar to previous attempts to address health inequalities, Non-executive Director, Emyr Jones enquired how the approach/actions would differ. It was also suggested that opportunities to work with partners to provide outreach rather than rely on patient presentation may be more effective. The Director of Innovation & Infrastructure acknowledged the positive engagement work of the Place Health Inequalities Lead with community groups and an invigorated focus on health inequalities across all partners, with a desire to work together to drive improvements. The pillars underpinning the strategy were recognised to be critical to success. Non-executive Director, Mark Bailey encouraged a review of what worked well and not so well, to focus future efforts and suggested that quantifying the financial impact of health inequalities would be insightful alongside other reported data. Non-executive Director, Kath Smart encouraged awareness of the long waiting lists for non-consultant led services, including Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD), understanding high intensity users and the wider support required and the importance of linking to the role of the Trust as an anchor institution. The Chair acknowledged the work to date and recognised the increased national focus. In view of the broad approach, he encouraged the identification of key commitments within the strategy.	
	The Committee: - ***Noted and took assurance from the Draft Health Inequalities Strategy***	
FP23/07/D1	**Financial Performance – Month 3 – (Enclosure D1)**	
	The Deputy Director of Finance reported a month three deficit of £4.4m, £12.2 deficit year to date and in line with the plan. This was on the assumption that the elective recovery funding (ERF) paid in month would not be clawed back due to the impact of industrial action. The year-to-date position, excluding ERF, would be a deficit of £13m, £0.8m adverse to plan. Capital spend was £5.2m adverse to plan, the main underspend related to the Montagu Elective Orthopaedic Centre. The cash balance at the end of June was £20.6m, an increase of £7.1m in month. Cash support of £6m had been requested for September, this had been approved, subject to the cash position at the time and the caveats referenced in the paper. In response to a question from Non-executive Director, Emyr Jones with regards to contracts with the commissioner remaining unsigned, the Deputy Director of Finance confirmed the Integrated Care Board was not yet signing contracts, its 2023/24's financial plan had unidentified efficiencies of c£109m, plans for which had not been formalised. The Chief Financial Officer confirmed his understanding that this gap be allocated across providers, a meeting with the ICB's Chief Finance Officer was scheduled for August and once the position was known the detail would be reported to the Committee.	

	The Committee: - ***Noted the Financial Performance Update***	
FP23/07/D2	**CIP Plan 2023/24 Update (Enclosure D2).**	
	In month three the Trust had delivered efficiencies of £1.72m, £1.3 favourable to plan, £4.7m of efficiencies remained unidentified. In response to a question from Non-executive Director, Kath Smart, with regards to opportunities within the agency and sickness management workstream, the Chief Financial Officer confirmed benefits were anticipated in the management of short-term absence, adherence to rota rules and temporary workforce usage. The Chief Financial Officer confirmed opportunities to close the ICB gap were linked to savings arising from a reduction in the rate of inflation and increased levels of ERF from additional activity. A Doncaster Place CIP group had been formed to consider potential benefits and whilst there was the potential for shared working opportunities, it would be unlikely to generate savings in 2023/24 in view of the time to progress and required consultation. In response to a question from Non-executive Director, Mark Bailey, the Chief Operating Officer confirmed that all the elective and urgent and emergency care improvement works were linked to a cost improvement programme. The Chief Financial Officer confirmed he would agree with the Chair future CIP reporting content, including recurrent savings, outside of the meeting. In response to a question from the Chair with regards to the level of engagement, the Chief Financial Officer confirmed a good level of involvement, whilst acknowledging there was always more to be done, including the potential for increased target setting.	**MD/JS**
	The Committee: - ***Noted and took assurance from the CIP Plan 2023/24 Update***	
FP23/07/E1	**Getting it Right First Time (GIRFT) Internal Audit Memo (verbal)**	
	The Medical Director for Operational Stability and Optimisation confirmed that divisional GIRFT leads were now in place, with the exception of the Urgent & Emergency Care division. GIRFT was considered at either the governance or consultant meeting, with bi-annual meetings to review progress against the national standards, which was reported to the Transformation Board. Non-executive director, Emyr Jones, enquired how the reporting structure ensured the principles of GIRFT were embedded within clinical culture, the Medical Director for Operational Stability and Optimisation confirmed this was considered as part of divisional meetings and by raising awareness of individual performance and peer benchmarking in medical appraisals to support a reduction in variation and ensure optimal performance. In order to ensure the Committee were appropriately assured on GIRFT, the Chair suggested he would agree the required reporting outside of the meeting with the Medical Director for Operational Stability and Optimisation.	**MD/JJ**

	The Committee: - ***Noted the Getting it Right First Time Internal Audit Memo***	
FP23/07/E2	**<u>Performance Management Internal Audit Report (verbal)</u>**	
	The Chief Financial Officer confirmed that work continued on the Performance Assurance Framework, all control environments had now been received, which aligned to; the key metrics within the Integrated Quality & Performance Report (IQPR), Trust and directors' objectives. The outputs from the control environments would allow a tailored discussion at the Performance, Overview & Support meetings, which would feed into the Trust Executive Group, with assurance provided to the Finance & Performance Committee. Reporting to the Board Committees would be linked to the IQPR and a decision made as to subsequent reporting to the Board. Non-executive Director, Mark Bailey recognised the work to date, in respect of reporting to Board Committees and following executive discussion he encouraged agreement with the Committee Chairs. Non-executive Director, Kath Smart welcomed the suggested use of the IQPR as a framework to focus discussions at the Board and its Committees. As the completion date to approve and redraft the Performance Assurance Framework was prior to the next Committee meeting, the Chief Financial Officer confirmed he would share a draft for comment.	**JS**
	The Committee: - ***Noted the Performance Management Internal Audit Report***	
FP23/07/F1	**<u>Governor Observations</u>**	
	Both governor observers had sent their apologies.	
FP23/07/G1	**<u>Any Other Business</u>**	
	There were no items of any other business received.	
FP23/07/G2	**<u>Minutes of the Sub – Committee Meetings (Enclosure G3)</u>**	
	<u>The Committee:</u> - ***Noted the Cash Committee Minutes from 23 March 2023***	
FP23/07/G3	**<u>Minutes of the meeting held on 26 June 2023</u>**	
	The Committee approved the minutes of the meeting held on 26 June 2023	
FP23/07/G4	**<u>Assurance Summary (Verbal)</u>**	
	The Committee was assured, on behalf of the Board of Directors on the following matters:	

	• Matters of Concern/Key Risks to Escalate • Major Actions Commissioned/Work Underway • Positive Assurance to Provide • Decisions Made • Progress against committee associated Executive's objectives. The Chair summarised the areas for inclusion in the Chair's Assurance Log.	
	Date: Monday 21 September 2023 Time: 09:00 Venue: Microsoft Teams	
FP23/07/H	Meeting closed at: 12:10	

FINANCE AND PERFORMANCE COMMITTEE

Minutes of the meeting of the Finance and Performance Committee held on Thursday 21 September 2023 at 09:00 via Microsoft Teams

Present:	Mark Bailey - Non-Executive Director Mark Day - Non-Executive Director (Chair) Emyr Jones - Non-Executive Director Jon Sargeant - Chief Financial Officer Kath Smart - Non-Executive Director Denise Smith - Chief Operating Officer
In attendance:	Alex Crickmar - Deputy Director of Finance Fiona Dunn - Director Corporate Affairs /Company Secretary Joseph John - Medical Director for Operational Stability and Optimisation Angela O'Mara - Deputy Company Secretary (minutes)
To Observe:	Andrew Middleton - Public Governor – Bassetlaw
Apologies	Lynne Schuller - Governor Observer - Bassetlaw

		ACTION
FP23/09/A1	**Welcome, Apologies for Absence and declarations of interest (Verbal)**	
	The Chair welcomed members of the Committee and those in attendance to the meeting. The above apologies for absence were noted and no declarations of interest were received. The Chair reinforced the need for papers to be shared in a timely manner to allow Committee members sufficient time to review the papers.	
FP23/09/A2	**Requests for any other business (Verbal)**	
	No items of other business were received.	
FP23/09/A3	**Action Notes from Previous Meeting (Enclosure A3)** **Action 1 - FP22/11/B3 – Winter Plan** – included on the agenda @ B6 – **action to be closed**. **Action 2 - FP23/03/D4 - Emergency Preparedness, Resilience & Response Granger Report** – action closed **Action 3 - FP23/04/C1 - Clinical Site Strategy** – included on the agenda @ C3 - action to be closed.	

	<u>Action 4 - FP23/04/C1 - Progress of Bassetlaw Emergency Village Full Business Case</u> – a**ction closed**.	
	<u>Action 5 – FP23/05/C2 - Health Inequalities Draft Strategy</u> – action closed.	
	<u>Action 6 – FP23/07/B1 – Diagnostic Reporting Time</u> – data/report in development, imaging waiting times to be the initial focus, to be expanded to all diagnostic modalities. The Chief Operating Officer would confirm with the Trust Board Office when the Committee would receive.	**DS**
	The Chair acknowledged the potential impact of increased imaging requests and enquired if this was a matter for the Quality & Effectiveness Committee to take assurance on from a patient safety perspective. The Medical Director for Operational Stability and Optimisation confirmed this was included on the risk register, the Trust was confirmed to be an outlier in respect of CT and Obstetric ultrasound demand and the iRefer software package had been introduced to manage compliance with the Royal College of Radiologists and National Institute for Health and Care Excellence guidelines. The option to include an additional field was being explored to capture approval from the responsible consultant for Junior Doctor requests.	
	Non-executive Director, Emyr Jones enquired why the existing protocols did not have the desired effect, it was agreed that a brief paper to address this be brought to the next Committee meeting. The Medical Director for Operational Stability and Optimisation confirmed a post implementation review of the implementation of iRefer would be completed in due course.	**JJ**
	<u>Action 7 - FP23/07/B2 – UEC Improvement Programme</u> – following the withdrawal of ECIST and considering the challenging financial position at Place, the Chief Operating Officer confirmed the UEC Senior Responsible Officers had reviewed the programme to prioritise key actions to bridge the gap created by the loss of the Improvement Manager and Clinical Lead. Kath Smart recognised the support offered by the Trust's Qi Team on Priority 1 but enquired if this mitigating action was enough and if more could be done across Place. Through consultation with the Chief Financial Officer, the Chief Operating Officer agreed to enquire of potential support from the Better Care Fund at the UEC Board. The Place Finance Directors were also seeking clarity on opportunities, as pressures over winter often sat with the acute provider and risk sharing should be explored.	
	Non-executive Director, Mark Bailey enquired what resource could be redirected to this programme from other areas of improvement to increase the pace of change. Whilst resource had been identified internally from the Project Management Office and the Quality Improvement Team for Priority 1, the challenge was a Place matter, Mark Bailey enquired if it would be appropriate to secure a dedicated UEC resource. The resource issue would be included within the Chair's assurance log to Board.	
	<u>Action 8 - FP23/07/B3 – Elective Activity Report</u> – risks to be included from October. The Chief Operating Officer noted the challenges with data availability and meeting dates and agreed to share a proposal to manage this with the Chair.	
	<u>Action 9 - FP23/07/C3 – Health Inequalities Strategy</u> – action not yet due.	
	<u>Action 10 – FP23/07/D2 – CIP Reporting</u> – the Chair confirmed discussions with the Chief Financial Officer had taken place and opportunities to integrate CIP reporting to evidence the impact on the Trust's finances would be explored. **Action to be closed**.	

	Action 11 - FP23/07/E1 – Getting It Right First Time - to be covered as part of the agenda @ E2. As this paper was not subject to discussion, the action remains open, the Committee to agree frequency of reporting. **Action 12 - FP23/07/E2 – Performance Assurance Framework** – to be covered as part of the agenda @ E1. **Action to be closed**.	
	The Committee: - ***Noted the above updates.***	
FP23/09/B1	**Board Assurance Framework BAF (Enclosure B1)**	
	The Chief Operating Officer brought the Committee's attention to BAF risk three, the content of which remained strategic, rather than operational. Partial assurance was confirmed against the mitigating key controls, as systems were in place but were not necessarily fully effective. The risk appetite was as previously agreed by the Board, this would be subject to review prior to the financial year end. Mark Bailey sought clarity that the open risk appetite was limited to quality and not safety, it was agreed further debate would be required as part of the Board's review of risk appetite. In response to an observation about the lack of detail in the actions, the non-executive director indicated it would be helpful to include high level aspirational headlines. Kath Smart welcomed the inclusion of the strategic risk around capacity, but noted it was difficult to determine if the key assurances listed were working effectively and updated narrative would be welcomed to confirm this. It was also suggested the impact of the continuing industrial action be included. Gaps identified in relation to the elective operational governance framework and the lack of a harm review policy did not have an action to close the gap, the Chief Operating Officer confirmed the harm review policy was in development and was being progressed by the Executive Medical Director. No target risk had been included in this iteration and the Chief Operating Officer agreed to consider this, however, a change was not expected to be seen until March 2024. Links to operational risks were currently under review. The Company Secretary confirmed a Board workshop would take place to review the strategic objectives and risk appetite ahead of the next financial year. The four assurance levels had been updated to provide clarity, recognised to be good practice. Where a gap in current controls existed the need for a supporting action to address this was reinforced. The Chief Financial Officer summarised BAF risk four and recognised the high level of risk associated with the estate, despite extensive ongoing work. The current assurance assigned to key control 1 and 2 was reassessed in view of the four levels of assurance and the lack of capital funding identified as a major issue in reducing the risk. The Trust's estates challenges continued to be raised at a local, regional, and national level and a deep dive discussion would take place at South Yorkshire's Acute Federation Board meeting. Non-executive Director, Kath Smart acknowledged the real challenges demonstrated in this BAF, confirmed she was assured by management actions and recognised the solution was not within the Board's gift and questioned the level of significant assurance assigned. The Chief Financial	**DS**

	Officer reflected on the observations and shared his interpretation which confirmed despite taking all mitigating actions the risk remained. The following feedback would be considered for inclusion: the lack of a capital regime to be reported as a control gap and to review the significant assurance derived from the limited assurance internal audit report on Performance Management. In respect of BAF risk five, the risks associated with the Trust's finances were reported on an ongoing basis and were well known. Consideration would be given to the assurance rating assigned to ICB/Place delivery and savings opportunities, with a focus on what had been delivered. In response to a question from Kath Smart, the assurance level of CIPs would be reassessed following the forecast. It was also agreed to recognise the impact of the finances on the estate as a key issue. There was a need to review the Committee with oversight of BAF risk 6, which was currently documented as the Audit & Risk Committee and the risk associated with tackling health inequalities. In respect of BAF risk seven, the Chief Financial Officer confirmed a Board workshop would take place in October related to NHS Impact. An improved focus on quality improvements had been seen and initial feedback from CQC responded to. Non-executive Director, Kath Smart acknowledged an element of overlap with the People Committee linked to research activity and challenged the consistently assigned significant level of assurance. The following suggestions were made: the inclusion of clinical audit and the use of Monday.com and the support of the Programme Management Office. Non-executive Director, Kath Smart recognised the significant discussion arising from the Committee having oversight of five of the seven strategic risks sat with this Committee.	
	The Committee: - ***Approved the Board Assurance Framework***	
FP23/09/B2	**<u>Access Standards Report (Enclosure B2)</u>**	
	The Committee received the paper, due to the prioritisation of agenda items, the Chair invited observations and questions be shared with him and the report author outside of the meeting. A summary was captured within the Chair's assurance log to Board.	
FP23/09/B3	**<u>Urgent & Emergency Care (UEC) Improvement Plan Update (Enclosure B3)</u>**	
	The Committee received the paper, due to the prioritisation of agenda items, the Chair invited observations and questions be shared with him and the report author outside of the meeting. A summary was captured within the Chair's assurance log to Board.	
FP23/09/B4	**<u>Elective Activity Plan (Enclosure B4)</u>**	
	The Committee received the paper, due to the prioritisation of agenda items, the Chair invited observations and questions be shared with him and the report author outside of the meeting. A summary was captured within the Chair's assurance log to Board.	

FP23/09/B5	**DBTH Self-certification Protecting & Expanding Elective Activity (PRN0073) (Enclosure B5)**	
	NHS England had written to Trusts on 4 August 2023, setting out key priorities to protect and expand elective capacity. Three key actions were identified and Trusts were asked to provide assurance against a set of activities to enable outpatient recovery to be progressed at pace. The self-certification was to be signed off by the Chair and Chief Executives by 30 September 2023. An initial draft was appended to the report, however, further work was required ahead of September's Board meeting. Non-executive Director, Kath Smart thanked the Chief Operating Officer for the helpful summary and recognised the need for additional work and senior management review. Where the assurance statement referenced the Board, Kath confirmed she read this as the Finance & Performance Committee and reflected on the Committee's ability to validate the evidence, specifically she noted the Access Policy and the Independent Sector programme of work which had not been reviewed by the Committee in recent years. The Chief Operating Officer acknowledged the feedback and confirmed that some of the work referenced dovetailed with the elective improvement support programme. Work on the Access Policy would not be completed by the submission of the self-certification and the Company Secretary confirmed it would be helpful to circulate a draft Access Policy to be presented to this Committee before approval at the Trust Executive Group.	**DS**
	The Committee: - ***Noted and took assurance from the DBTH Self-certification Protecting & Expanding Elective Activity (PRN0073)***	
FP23/09/B6	**2023/24 Winter Plans - Delivering Operational Resilience across the NHS - (PRN00645) (Enclosure B6)**	
	In July 2023, NHS England wrote to the Trust setting out the national approach to 2023/24 winter planning, with four areas of focus for systems to help prepare for winter. A normal flu season was expected, with the usual peaks expected in January and February. 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. Roles and responsibilities had been defined and Doncaster Place had identified the following priority areas: same day emergency care, frailty, inpatient flow and length of stay and care transfer hubs. Two winter planning workshops had taken place and should additional funding become available a number of potential schemes had been developed, these had been considered by the Trust Executive Group and an assessed in terms of deliverability and impact in order to prioritise implementation, if funding was made available. Non-executive Director, Kath Smart highlighted that three of the five Urgent and Emergency Care (UEC) programmes were linked to winter plans, in view of the limited progress made confidence levels were low.	

	In response to a question from Mark Bailey, the Chief Operating Officer confirmed that national guidance had been to focus on delivery of the UEC programmes. The Chief Operating Officer confirmed that a business case would be considered by the Corporate Investment Group next week, which if approved would secure the required level of medical hours for same day emergency care. The Chair sought confirmation that the Committee was assured that planning was in line with national guidance but remained concerns about the capacity and speed of works. In response to a question from Non-executive Director, Kath Smart, the Medical Director for Operational Stability and Optimisation confirmed a focus on increasing the utilisation of virtual wards, the Trust was working towards 40-50 patients by the end of November and discussions with RDaSH with regards to the required resource to support this ambition was ongoing. Emyr Jones, Non-executive Director, shared his concern that discussions were ongoing, with resources yet to be identified. The Chair asked if a brief written report on the progress of virtual wards could be brought back to the next meeting.	**JJ**
	The Committee: ***- Approved the 2023/24 Winter Plans***	
FP23/09/C1	**Recovery, Innovation & Transformation Directorate Update (Enclosure C1)**	
	The Committee received the paper, due to the prioritisation of agenda items, the Chair invited observations and questions be shared with him and the report author outside of the meeting. A summary was captured within the Chair's assurance log to Board.	
FP23/09/C2	**Doncaster Royal Infirmary Update (Enclosure C2)**	
	Following the announcement that the Trust's New Hospital Programme (NHP) bid had been unsuccessful a lessons learnt review was undertaken and presented to the confidential Board meeting in June 2023, including potential plans to progress the continuing estate challenges. A number of discussions had taken place with the Advisor to Lord Markham to explore potential next steps. There may be an opportunity announced in the Autumn Statement for unsuccessful NHP applicants to bid for funding and so there was a need to understand what an acceptable proposal would look like. Previously there had been a view to address issues thematically, however, it was suggested a geographical refresh may be more acceptable to ensure all issues within a specific area were addressed. Should an announcement be made in the Autumn Statement, it was expected that the bid would need to be submitted in a very short timeframe. Costings for the bid had been prepared and should that be successful, using the data from previous business cases and Estates returns an estimated cost to refurbish had been established. Remedial work would need to be considered carefully, taking into consideration the current infrastructure, surveys would be arranged to understand the impact of decanting and the required space, an estimated cost was provided, with further discussion to take place at	

	September's confidential Board meeting. Capital receipt opportunities were also being considered, with the support of Integrated Health Projects. The Chair suggested it would be appropriate for the Committee to reflect on the discussions and provide feedback to the Chief Financial Officer ahead of the Board meeting.	
	The Committee: - ***Noted and took assurance from the Doncaster Royal Infirmary Update***	
FP23/09/C3	**Clinical Site Strategy (Enclosure C3)**	
	An extensive piece of work had taken place across all clinical specialities to develop individual strategies. Once complete a clinical site strategy would provide a high-level strategic framework for the role and development of each site. This would inform decisions and priorities for our current service provision and investment. It would also help inform the wider acute strategy and collaboration with the ICSs and other providers across South Yorkshire and Nottinghamshire.	
	The Committee: - ***Noted and took assurance from the Clinical Site Strategy***	
FP23/09/D1	**Financial Performance – Month 5 – (Enclosure D1)**	
	The Committee received the paper, due to the prioritisation of agenda items, the Chair invited observations and questions be shared with him and the report author outside of the meeting. A summary was captured within the Chair's assurance log to Board.	
FP23/09/D2	**ICB and National Financial Update (verbal)**	
	Due to the prioritisation of agenda items no update was provided.	
FP23/09/D3	**Management Accounts Development Programme (Enclosure D3)**	
	The Committee received the paper, due to the prioritisation of agenda items, the Chair invited observations and questions be shared with him and the report author outside of the meeting. A summary was captured within the Chair's assurance log to Board.	
FP23/09/D4	**CIP Plan 2023/24 (Enclosure D4).**	
	The Committee received the paper, due to the prioritisation of agenda items, the Chair invited observations and questions be shared with him and the report author outside of the meeting. A summary was captured within the Chair's assurance log to Board.	
FP23/09/E1	**Performance Assurance Framework (Enclosure E1)**	
	The Committee received the framework and noted its approval by the Trust Executive Group.	

	The Committee: - ***Noted the Performance Assurance Framework***	
FP23/09/E2	**G.I.R.F.T Programme - Trust Update and Forward Plans, including future report arrangements into F&P (Enclosure E2)**	
	The Committee received the paper, due to the prioritisation of agenda items, the Chair invited observations and questions be shared with him and the report author outside of the meeting. A summary was captured within the Chair's assurance log to Board.	
FP23/09/F1	**Governor Observations**	
	The Deputy Lead Governor reflected on the content of the meeting and enquired with the largest deficit in the South Yorkshire system if the Trust's True North objective to be in recurrent surplus remained relevant. The benefits of system working and collaboration were recognised and the progress of the major projects, Bassetlaw Emergency Village and Montagu Elective Orthopaedic Centre was welcomed. The ongoing challenges arising from the continued industrial action were noted.	
FP23/09/G1	**Any Other Business**	
	There were no items of any other business received.	
FP23/09/G2	**Minutes of the Sub – Committee Meetings (Enclosure G3)**	
	The Committee: - ***Noted the Cash Committee Minutes from 23 May & 22 June 2023*** - ***Noted the Capital Monitoring from 22 June 2023***	
FP23/09/G3	**Minutes of the meeting held on 26 June 2023**	
	The Committee approved the minutes of the meeting held on 26 June 2023	
FP23/09/G4	**Assurance Summary (Verbal)**	
	The Committee was assured, on behalf of the Board of Directors on the following matters: • Matters of Concern/Key Risks to Escalate • Major Actions Commissioned/Work Underway • Positive Assurance to Provide • Decisions Made • Progress against committee associated Executive's objectives. The Chair summarised the areas for inclusion in the Chair's Assurance Log.	

	Date: Monday 30 October 2023 Time: 09:00 Venue: Microsoft Teams	
FP23/09/H	Meeting closed at: 12:06	

2311 - H5 MINUTES OF THE PEOPLE COMMITTEE ? 5 SEPTEMBER 2023

Information Item

Mark Bailey, Non-Executive Director

REFERENCES

Only PDFs are attached

H5 - People Committee Minutes - 5 September 2023.pdf

PEOPLE COMMITTEE

Minutes of the meeting of the People Committee held on Tuesday 5 September 2023 at 09:00am via Microsoft Teams

Present:	Mark Bailey, Non-Executive Director (Chair) Hazel Brand, Non-Executive Director Karen Jessop, Chief Nurse Lucy Nickson, Non-Executive Director Mark Day, Non-Executive Director Tim Noble, Executive Medical Director Zoe Lintin, Chief People Officer	
In attendance:	Anthony Jones, Deputy Director of People and Organisational Development Fiona Dunn, Director Corporate Affairs/Company Secretary Gavin Portier, Head of Organisational Development, EDI, and Wellbeing Kelly Turkhud, Vocational Education Manager Sam Debbage, Director of Education and Research Shaina O'Hara, PA for Director of Finance (Minutes)	
To Observe:	Laura Brookshaw, 360 Assurance Mark Bright, Public Governor - Doncaster	
Apologies:	Alexis Johnson, Public Governor – Doncaster Nick Mallaband, Medical Director for Workforce and Speciality Development	
		ACTION
PC05/09/A1	**Welcome, apologies for absence and declarations of interest (Verbal)**	
	The Chair welcomed members and those in attendance. No apologies for absence were noted and no conflicts of interest were declared.	
PC05/09/A2	**Requests for Any Other Business (Verbal)**	
	No items of other business had been received.	
PC05/09/A3	**Actions from previous meeting (Enclosure A3)**	
	Action 1 PC02/05/D2 Overview of Improvement Projects - Covered within the agenda. **Action Closed** **Action 2 PC04/07/C5 Freedom to Speak Up – Bi-Annual Report -** Circulated. **Action Closed**	
PC05/09/B1	**Board Assurance Framework (Verbal)** The Chief People Officer shared the new format of the Board Assurance Framework (BAF) template. This was an updated version since being presented and support at the Board in July, this was the first time presented in this format at the People Committee. It was noted that the 'worked example' in the Board paper was the People one. It was agreed that progress updates would go to the relevant sub committees quarterly which tie in with going to Board on a quarterly basis as well as the Executive Director's objectives on a quarterly basis. Any key questions on specific items will be covered later in the agenda.	

	In response to a question from Lucy Nickson, Non-Executive regarding risk appetite and being prepared to accept the possibility of some workforce risk as a direct result of innovation. The Chief People Officer explained the risk appetite for all areas was defined as a Board over a year ago and was due to be revisited again this year. The Director of Corporate Affairs provided an example when recruiting a large number of colleagues such as international nurses or midwives, and being aware that workforce experience may not be that high, however, a support network available within the practice development team. The Chief Nurse advised of a similar debate regarding risk appetite at the Quality Effectiveness Committee meeting, the Executive Directors had agreed the intention to review the overarching risk appetite as they are not very specific. Lucy Nickson, Non-Executive Director asked if DBTH workforce shortages correspond nationally and there are no specifics within this region that need to be noted in the BAF. The Chief People Officer advised as the system was maturing, there was a better line of sight of the system view as well as the organisational view. Improvements have been seen year on year with thoughts on how to articulate for the future. In response to a suggestion by Mark Day Non-Executive Director to provide a better explanation behind the actions. The Non-Executive Directors all agreed with accessibility to all readers to understand the BAF even though supporting papers would provide the level of assurance that the overarching risks are being managed. The Director of Corporate Affairs would assist with the articulation of the document to ensure consistency. The Chair asked to highlight the assurance on the reports which would be useful.	**FD**
	The Committee: - ***Noted and took assurance from the Board Assurance Framework***	
PC05/09/B2	**People Strategy Assurance Report & IQPR** The Chief People Officer confirmed that going forward the IQPR report would sit alongside the People Strategy Assurance Report on the agenda. The report outlines key actions since the last meeting against the People Strategy, key actions planned for the next two months, the current position on success measures and any risks or interdependencies to share with the People Committee. The report also includes an update on the NHS Long Term Workforce Plan, additional work on alignment and connecting with Place, system partners and national bodies. Specific actions within the strategy are highlighted within the report when actions have been closed within the last two months. In response to a question by Lucy Nickson, Non-Executive Director regarding gap analysis around the implications for the whole of the system for the workforce plan. The Chief People Officer highlighted the scale of the expansion and the work which surrounds this piece of work. Fortunately, partnerships were already in place which was a positive. The Chair asked to consider showing success measures on the IQPR dashboard and link to improvements and to compare key data. The Chair noted that the IQPR has key indicators and that the annual Staff Survey is an important source of data for measuring improvements linked to the People Strategy. The Chief People Officer to discuss with the Chief Financial Officer outside of the meeting how to build key Staff Survey measures into the dashboard and present the work of the committee in this Trust wide dashboard at Executive Director level. A further question by the Chair relating to turnover and any data indicating problematic areas. The Chief People Officer highlighted if any hot spots that come to the surface could	**ZL**

	be linked to exit interviews, however this was an evolving process and could be more systematic. Lucy Nickson, Non-Executive Director asked what success measures there were around the "softer" just culture such as Freedom to Speak Up as it was not clear what changes or improvements there were. The Chief People Officer referred back to linkage to the staff survey to measure improvements year on year, Freedom to Speak Up had a more targeted approach and these were specific questions in the survey. The Chair confirmed significant assurance of the plan as it develops. However, further assurance was requested on how the measures relate to the survey, once this information is available each year.	
	The Committee: - ***Noted and supported the People Strategy Assurance Report & IQPR People Data***	
PC05/09/C1	<u>**Engagement and Leadership**</u> The Chief People Officer highlighted key aspects of the paper including the preparation for the 2023 staff survey as well as impact and actions from the previous year's survey. More detail had also been provided within the paper on the Flexible Working workstream. Reward and Recognition noted the highest nominations ever received for the Stars Award, 801 nominations were judged by a team of people and shortlist announcements would commence within the next couple of weeks. Hazel Brand, Non-Executive Director asked to check that the first ICS awards for Notts and Nottinghamshire Awards had been featured, the Chief People Officer would check with the Acting Communications and Engagement for the comprehensive list. Hazel Brand would be representing DBTH at the awards. The Chief People Officer later updated the committee that the deadline for the Notts ICS Awards had not yet been reached, however DBTH would be submitting in 7 award categories.	
	The Committee: - ***Noted, assurance was taken from the Engagement and Leadership Report***	
PC05/09/C2	<u>**Education Report**</u> On behalf of the committee, the Chair congratulated the Director of Education & Research who had been made an Honorary Professor at Sheffield Hallam University in recognition of her clinical and academic contribution to education and research. In relation to SET, the Director of Education & Research provided an overview and some rationale why actions had been purposely delayed due to individual and Trust level compliance differing. The work undertaken to migrate into the new HR dashboard Derick, had found some migration challenges. An ESR Steering Group had been set up to ensure the accuracy of the data, so managers are more confident when looking at that data. The Derick dashboard would allow leaders to interrogate data around SET compliance, see where the hot spots are and mitigate around the risk. Business cases are due to be presented at the September Corporate Investment Group outlining resource challenges with the delivery of Resuscitation and manual handling training. To provide oversight and Governance, the introduction of a ReST approval panel (RAP) was presented at the last Workforce Education Committee (WEC) and was fully supported. Approval for this new process would be taken to the Trust Executive Group (TEG) in September 2023.	

	The study leave policy had been updated and launched with the medical study policy to be reviewed with the support of the Medical Director's office and medical leads. The Education Quality deep dive aligning with Q1 and the General Medical Council (GMC) survey outlined a triangulated review of all the learner data reviewing overall performance. There are a series of engagement events for all learners, discussions include confidence of escalation and a reminder of the educational escalation pathway. The GMC survey had been discussed at the Executive Directors' meeting, where assurance was provided on the progress. The main outlier indicator for DBTH was inductions and the team were evaluating corporate and local inductions. It was found that DBTH had stood still, whilst others improved so with the help of other organisations a review would be undertaken to understand how improvements to induction could be made. DBTH was ranked 190 out of 220 Trusts nationally, DBTH meet standards required for induction for safety. A gold status had been awarded to DBTH for the Preceptorship Programme and the Trust had been shortlisted for the Nursing Times Workforce awards. In response to a question by Lucy Nickson, Non-Executive Director around any concerns the Director of Education & Research had, concerns were shared on capacity to offer resuscitation training. The additional resource request would alleviate clinical pressures. The Chair asked about the progress and balance of educational requirements and statutory requirements with additional items in the curriculum. The Director of Education & Research confirmed the progress this year, however it was not a full business model. As the role specific topics are agreed, it would form next year's business planning. With the introduction of RAP, topics, frequency etc would be built into workforce planning. In response to a further question regarding DBTH's position within the GMC ranking, the Director of Education & Research confirmed that it was an improvement journey and the intention was to learn from other organisations to improve scores as Trusts are benchmarked against one another. The introduction of engagement events would generate more conversations to understand the narrative. The Chair challenged thoughts of the Trust and expectations of where DBTH would sit within the ranking. The Chief People Officer explained the intention to aspire to be the best, work to realistic and stretching targets along the journey as well as getting the right balance. In response to a further question around benchmarking and where would it feature against the strategy. The Chief People Officer and the Director of Education & Research to share at a future committee meeting data reflecting the ambitions on improvement, not just General Medical Council(GMC) data but all relevant data.	**ZL/SD**
	The Committee: - ***Noted and took assurance from the Education Report***	
PC05/09/C3	<u>**Just Culture**</u> The Chief People Officer provided an update over the last 6 months, the steering group had been meeting regularly. The Chief People Officer highlighted the several workshops involving divisional and department teams, Associate Chief Nurse for Patient Safety and Quality, Senior People Business Partner and the Freedom to Speak Up Guardian covering Just Culture and associated cultural themes. Two Just Culture development sessions are planned for October with the Leadership Assembly and the Speaking up Champions and other partners. There had been an increase in volume of cases and improvement in time scales. The Chief People Officer expressed a desire as DBTH	

	further embed the Just Culture ethos, opportunities for colleagues to resolve concerns informally will increase, in turn would reduce the number of formal case work. Key policy are included within the report. In response to a question by the Chair, the Chief People Officer shared how data was analysed and the use of different measures such as employee relation cases, number of suspensions etc which the Deputy Director of People and Organisational Development was currently working on. Nationally there are check-list tools that could be referred to. The Chief Nurse confirmed there was a lot about Just Culture on the NHSE PSIRF website, as well as available discussion groups and platforms.	
	The Committee: - ***Noted and took assurance from the Just Culture Report***	
PC05/09/C4	<u>**Appraisal Season**</u> The Deputy Director of People and Organisational Development provided an overview of the key points from the report. DBTH achieved its highest appraisal completion rate at 87.40%, although this fell short of the 90% completion target. Improvement ideas for 2024 had already been captured. Focused targeting to establish details of all colleagues who had not received an appraisal. The Chief People Officer was encouraged by the improving position, however suggested as an organisation the outcome could be better and was not satisfied with the completion rate. Lucy Nickson, Non-Executive Director agreed with the comment made by the Chief People Officer and challenged if teams know how to achieve the target. The Chief People Officer advised that TEG members had been asked to explore issues in their areas and gave the example whereby sickness absence occurred within the department; however outstanding reviews were not delegated on behalf of the absentee for completion. The Deputy Director of People and Organisational Development provided assurance of what measures could be undertaken to improve this process. Year on year data to be used to provided more targeted support. Opportunities to learn from other Trusts, plus ideas to combine with exit interviews conversations.	
	The Committee: - ***Noted and took assurance from the Appraisal Season Report***	
PC05/09/D1	<u>**Widening Participation Report**</u> The Vocational Education Manager provided an overview of DBTH widening participation activities for Q1 23/24 and the change of governance processes for apprenticeship activity at the Trust. The report was also shared at the last WEC meeting. School activity had seen a busy Q1 where DBTH were able to engage with primary schools across the region, this had been positively received. Since introducing the DBTH Health Career Ambassador there had been increased activity involving key stage 1 and key stage 2 students. During 22/23 engagement was recorded with 4787 key stage 1 – 5, the Ambassadors will help widened the outreach work. Q1 saw the "We care into the future events, evaluations and feedback are being collated. 500 Y8 students attended these events.	

	The 'Panjango' project was recently concluded, whereby a virtual tour of a clinical theatre setting showcasing careers had been offered across all local authorities in South Yorkshire. This would be sighted on Panjango's website for the next 5 years. The delay in recruiting a Project Manager halted the Centre of Excellence work with Doncaster Place partners to develop career pathways. The role of Project Manager would be funded by NHSE, an update would be shared with the committee once recruited. The Apprenticeship Operational Group (AOG) was formed when the levy was introduced to ensure fair access to the apprenticeship levy, workforce growth and efficient use of the levy. Following a review of AOG it had been agreed that the governance of apprentices would be incorporated within WEC as part of its annual workplan. DBTH had been invited to join the National Medical Apprenticeship Group which was aligned with seeking new roles via apprenticeships. The apprenticeship pay scale had been reviewed and presented to the Executive team. A Pharmacy Associate Apprentice had been awarded the Health, Science, Care & Education Apprentice of the year at the Sheffield College apprenticeship awards. The award was not only testament to the dedication of the apprentice but also to those who provide support to all the apprentices on the programme. Work experience, by October there would be around 50 on programme. There are challenges around aligning to jobs, there was a profiling tool launched, however work has to be undertaken to map across to job descriptions. The Did Not Attend (DNA) rate for Clinical Attachments remains high and the team continue to explore the reasons as there was a cost which surrounded this attendance. A new framework and guidelines for Clinical Attachments had been revised ready to be shared. Rotherham and Barnsley partners are now planning to replicate the "We Care into the Future" event, with support from DBTH. The team continue to increase engagement with the local authority, particularly around young people. In response to a question by Lucy Nickson, Non-Executive around a new University Technical College (UTC), the Vocational Education Manager confirmed change of attendance on the committee whereby the Vocational Education Manager would attend. There would be opportunities to include engagement activities with the existing UTC. The Director of Education and Research added that as an organisation, DBTH had supported the application for the Health and Care UTC, contact had been made with the Principal of the overarching Brighter Futures to understand next steps. Hazel Brand, Non-Executive Director to share feedback following the 'Aspirations Week' discussion held at the local primary school with the Vocational Education Manager which would be captured in the talent for care data. The Chair noted that it was good to see the collaboration between Rotherham and Barnsley. In response to a further comment by the Chair regarding the virtual theatre and the use of the camera, the Vocational Education Manager confirmed there was a plan to further utilise the camera. The Chair asked that the Vocational Education Manager provide assurance around DNA for Clinical Attachments in a future report.	**KT**

	In response to a question by the Chair regarding hard to reach communities. The Vocational Education Manager highlighted ongoing work with Department for Work and Pensions (DWP) who have employed a company to reach out to the Roman Gypsy community. One school had already reached out to explore opportunities, in turn the team are looking to target schools who don't reach out to DBTH. Continued support from Advance Housing & Support and DWP Bassetlaw to work closely with DBTH. The Director of Education and Research highlighted that DBTH are undertaking an innovative approach by driving apprenticeships in midwifery for the Gypsy communities.	
	The Committee: - ***Noted and took significant assurance from the Widening Participation Report***	
PC05/09/D2	**Overview of Improvement Projects (Occupational Health)** The Deputy Director of People and Organisational Development updated the committee on key points from the report. Some of the improvement work commenced back in 2022, part of the work identified an external review to be undertaken, which commenced early 2023. Key points to note within that work were a significant increase in pre-employment checks. The Occupational Health (OH) team structure proposal of additional investment had been had been developed in readiness for submission of a business case at the Corporate Investment Group meeting. Improvements had been made to manage the referral process; an electronic process had been put in place with positive feedback received. Key achievements to date are securing the 5 year accreditation of the SEQOHS. The development of OH services for the future are being lead at an ICB level, the lead OH Manager, who DBTH share the role with Barnsley was heavily involved with growing OH. Future updates would be reported to the committee. An action plan was developed to reflect the improvement work completed to date plus the recommendations from the external review. A key recommendation was to undertake a thorough review of external contracts. In addition, to review meeting structures and Corporate Governance structures within the team, to also ensure they are fit for purpose and to include development and progression within the structures. The Deputy Director of People and Organisational Development highlighted an item not included within the paper, the change of the line management structure within People and OD, alignment of the OH team with the Wellbeing team. The line management structure would transfer over to Head of Organisational Development, EDI, and Wellbeing. The Chair noted that it was good to see a comprehensive set of actions and work being undertaken. The Chair summarised how this piece of work was measured by means of being linked into the improvement plans through Monday.com, being part of the service review as well as the 5 year accreditation. In response to a question by Lucy Nickson, Non-Executive Director on how much OH capacity was required. The Deputy Director of People and Organisational Development advised the new information system had provided further opportunities to undertake quality work e.g. OH referrals had been scrutinised and identified as not appropriate for OH. The external review also helped to inform this work. The Chair requested a summary of improvements to be presented to the committee at a later date.	**AJ**

	The Committee: - ***Noted and took assurance from the Overview of Improvement Projects (Occupational Health) report***	
PC05/09/D3	**Workforce Supply and Demand** The Deputy Director of People and Organisational Development highlighted that although dates for the deep dive workshops had been communicated, not as many sessions had taken place, the introduction of smaller focused support sessions would complement this approach. The Trust wide sickness absence target had been increased from 3.5% to 5% to more accurately compare with national and local benchmarking. Divisional and corporate area targets had also been set which would in turn contribute to achieving the overall Trust target. Ongoing monitoring of sickness in this new way would be sighted through the Performance Overview and Support meeting. In response to a question by Lucy Nickson, Non-Executive Director regarding the use of the KPMG Strategy Workforce Planning tool and its intention. The Deputy Director of People and Organisational Development confirmed the idea of the tool was to use pre-populated data to give an overview for managers which would then instigate a deep dive workshop. The tool would also provide scenario planning. The Chief People Officer provided further assurance of the connectivity with the People and Organisational Development team and other directorates such as Finance and Recovery, Innovation and Transformation that are aware of future scenarios. Once it was fully embedded it would become a useful tool. The Deputy Director of People and Organisational Development confirmed the team are at stage 3 of a 3 stage roll out programme, the action plan was sighted on Monday.com.	
	The Committee: - ***Noted and took assurance from the Workforce Supply and Demand Update***	
PC05/09/D4	**Safe Staffing** The Chief Nurse highlighted key points from the report and asked to note that care hours patient per day are gradually increasing, which was expected given the ongoing recruitment activity. A summary of key points and actions following the gap analysis review undertaken by NHS England regional nurse and workforce team was included within the report. To note the team highlighted inconsistencies with DBTH workforce data, the decision to use either ESR or the finance ledger data was still to be decided. The Chief Nurse highlighted the integration of the National Institute for Clinical Excellence (NICE) into Datix. The report includes incident reporting which demonstrates where there are staffing shortfalls also demonstrating the use of the escalation policy. The Chief People Officer updated the committee on a project on establishment control. A QI session was undertaken on process mapping to make improvements as part of this ongoing project. In response to a question by Head of Organisational Development, EDI, and Wellbeing, the Chief Nurse confirmed the availability of electronic prescribing, the Nervecentre also provides data on pain management.	
	The Committee: - ***Noted and took assurance from the Safe Staffing Report***	
PC05/09/D5	**Job Planning**	

	The Executive Medical Director updated the committee on key highlights. The number of people with job plans had increased to 373 in total. The figure for job plans being signed off fluctuates daily as there are various stages of agreement. The current status is:- 208 job plans agreed and signed off. 70 job plans agreed and waiting Clinician/Manager sign off. 35 job plans agreed/re-published, these drop off prior to the 12 month expiry date. The divisional trajectories are discussed at the Clinical Director workshops. Draft findings following the QI workare to be discussed later in the month. The policy was being shared for comment within the leadership teams, it was based on the BMA policy. As the process moves to business as usual with a framework of support by the Executive Medical Director's office, the policy, escalation and mediation processes. The responsibility for ensuring job planning takes place in the divisions sits with the Divisional Directors who report into the Chief Operating Officer. Progress reports are fed into TEG each month. The Chair advised that frequency of this report would be agreed outside of the meeting.	**TN/ZL /FD**
	The Committee: - ***Noted and took assurance from the Job Planning Report***	
PC05/09/E1	**<u>360 Assurance Report (Bank & Agency Controls)</u>** The Chief People Officer updated the committee on the need to undertake this audit. The audit opinion was a limited assurance. The team are on track to complete the next set of actions by the end of September, having achieved July's deadline. This report would be sighted at both the Audit and Risk committee and the Finance and Performance meeting.	
	The Committee: - ***Noted the 360 Assurance Report (Bank & Agency Controls)***	
PC05/09/E2	**<u>Workforce Education Terms of Reference</u>** The Chief People Officer shared the new Workforce Education Committee terms of reference which had been supported by the committee themselves. In response to a question by Hazel Brand, Non-Executive the members of the committee would liaise with counterparts, members would cover as part of their updates. The Chief People Officer explained the structure of reporting groups, TEG would be the top of the structure. The requirement for a piece of work to agree/clarity structure and governance to be concluded. The Director of Corporate Affairs confirmed the structure that TEG go through the subcommittees before going to Board.	
	The Committee: - ***Approved the Workforce Education Terms of Reference***	
PC05/09/F1	**<u>Governor Observations (Verbal)</u>** Mark Bright, Governor noted the launch of the Long Service award programme and asked if the number of colleagues at each grading of experience would identify shortfalls. The Chief People Officer confirmed age profiling would link in with workforce planning.	

	Mark Bright highlighted discussions from the GMC survey feeding through to having a result now. Improvements were noted in ED, Trauma, Orthopaedic and Obstetrics on the matrix. Referring back to May 2022 papers, the introduction of a college tutor and deputy within the Obstetrics and Gynaecology department who initiated changes to rotas, improving handovers, altering team structures etc. Was it possible that some of the changes made back then are filtering through to have a result now. In response the Director of Education & Research confirmed that this reenforces the importance of engagement discussions with trainees and college tutors and actions the tutors put in place would be shared across specialities. The Chair thanked Mark Bright for his contribution to the committee as his term of office come to an end, however Mark would be standing again.	
	The Committee: - ***Thanked the Governor observer for his observations.***	
PC05/09/G1	**<u>Minutes of the Sub-Committee Meeting</u>**	
	The Committee noted: i) Teaching Hospital Board Minutes – 16/03/23 (N/A) ii) Equality, Diversity, and Inclusion Minutes – 22/05/23 iii) Health & Wellbeing Committee Minutes – 12/06/23 iv) Speaking Up Forum Minutes – 25/05/23 v) Research & Innovation Committee Minutes – 25/05/23 & 25/07/23 vi) Workforce Education Committee Minutes – 10/02/23 (N/A)	
PC05/09/H1	**<u>Chief People Officer Objectives</u>** The Chair highlighted that the objectives would sequence through Board.	
	The Committee: - ***Noted the Chief People Officer Objectives***	
PC05/09/H2	**<u>Any Other Business (Verbal)</u>** Nothing to discuss.	
PC05/09/H3	**<u>Minutes of the Meeting held on 4 July 2023</u>** The minutes were approved by the committee.	
	The Committee: - ***Approved the minutes of the meeting held on 4 July 2023***	
PC05/09/H4	**<u>Items of escalation to the Board of Directors (Verbal)</u>**	
	There were no items of escalation to/from: i. People Sub-Committees ii. Board Sub-committees iii. Board of Directors	

PC05/09/H5	<u>**Assurance Summary (Verbal)**</u>	
	The Committee was asked by the Chair if it was assured, on behalf of the Board of Directors on the following matters. Any matters where assurance was not received, would be escalated to the Board of Directors: - Matters discussed at this meeting, - Progress against committee associated Executive's objectives, - Are there any emerging new risks identified?	
	The Committee were assured on behalf of the Board of Directors on: ***- Matters discussed at this meeting*** ***- Progress against committee associated Executive's objectives,*** **- Are there any emerging new risks identified?**	
PC05/09/H6	<u>**Date and time of next meeting (Verbal)**</u>	
	Date: Tuesday 7 November 2023 **Time: 9.00am** **Venue: Microsoft Teams**	
PC05/09/I1	Meeting closed at: 11:54	

2311 - H6 - MINUTES OF THE QUALITY & EFFECTIVENESS COMMITTEE ? 1 AUGUST 2023

Information Item Jo Gander, Non-executive Director

REFERENCES

Only PDFs are attached

H6 - Quality & Effectiveness Committee Minutes - 1 August 2023.pdf

QUALITY AND EFFECTIVENESS COMMITTEE

Minutes of the meeting of the Quality and Effectiveness Committee
Held on Tuesday 1 August 2023 at 13.00
via Microsoft Teams

Members:	Hazel Brand - Non-executive Director Jo Gander - Non-executive Director (Chair) Karen Jessop - Chief Nurse Emyr Jones - Non-executive Director Lucy Nickson - Non-executive Director Tim Noble - Executive Medical Director	
In attendance:	Lesley Barnett, Deputy Director of Nursing for Cancer, Chemotherapy & End of Life Services (agenda item B1) Fiona Dunn - Director Corporate Affairs / Company Secretary Heather Jackson - Director of Allied Health Professionals Lois Mellor - Director of Midwifery Angela O'Mara - Deputy Company Secretary (minutes) Karen Shay-Nutt – End of Life Lead Nurse (agenda item B1) Addette Spenceley – Learning from Deaths Nurse (agenda item E1)	
To Observe:		
Apologies:	Peter Abell - Public Governor – Bassetlaw Lynne Logan - Public Governor – Doncaster	
		ACTION
QEC23/08/A1	**Welcome, apologies for absence and declarations of interest**	
	The Chair welcomed members and those in attendance. The above apologies for absence were received and no declarations of interest were made.	
QEC23/08/A2	**Request for Any Other Business**	
	No items of other business were raised.	
QEC23/08/A3	**Actions from Previous Meeting**	
	Action 1. QEC22/12/E4 - Audit and Effectiveness Business Case – the business case remained on the cost pressure list but was unlikely to be supported and alternative options were being explored. The Executive Medical Director suggested the action be closed. **Action 2. QEC23/04/CI Learning from Tendable Audits** – the action was not yet due.	

	<u>Action 3. QEC23/04/E1 Risk ID 3209 – Patient Tracking Inaccuracies</u> – the solution was being piloted prior to implementation and an update would be provided to the next meeting. **<u>Action 4. QEC23/04/E1 Hospital Standardised Mortality Ratio (HSMR</u>**) – the action was not yet due; the Chair would agree with the Executive Medical Director how this would be reported to October's Quality & Effectiveness Committee. **<u>Action 5. QEC23/06/E1 - Allocation of PAs for Maternity Clinical Director</u>** – assurance was provided that the allocation was split across the Clinical Director and wider team members.	
QEC23/08/B1	**<u>National End of Life Care Audit Results Presentation</u>**	
	The Deputy Director of Nursing for Cancer, Chemotherapy & End of Life Services and the End of Life Lead Nurse were welcomed to the meeting to present the 2022 National End of Life Care Audit (NACEL) results. The audit was commissioned on an annual basis by the Healthcare Quality Improvement Partnership, on behalf of NHSE. The audit considered the quality and outcomes of care of patients during their admission to an acute, community and mental health patient facility at the end of life. Progress was monitored against the five priorities of care identified in "One Chance to Get it Right" and NICE quality standards. The components of NACEL were summarised and achievements against each audit standard reported for Doncaster Royal Infirmary (DRI) and Bassetlaw Hospital. At DRI, the Trust scored higher, or the same as the national average in 8 of the 12 domains. At Bassetlaw, the Trust scored higher, or the same as, the national average in 7 of the 10 domains. The care and culture of end of life care was considered and the following key recommendations were noted: • to review the education and training of bank and agency staff • to improve the education and training offer by the end of life and specialist palliative care teams • review end of life care documentation to ensure recording was appropriate when patient and family members were not communicated with The audit results had been presented to the relevant committees, a series of workshops had taken place and a local action plan developed to address the recommendations. The Deputy Director of Cancer recognised the positive results and welcomed the introduction of Nerve Centre to capture discussions, the opportunity to regroup and consider educational priorities and was encouraged by a good level of engagement in the workshops and a clear passion for patient care. In response to a question from Non-executive Director, Lucy Nickson, the End of Life Nurse acknowledged the impact of Covid on end of life services and colleagues' confidence levels. Support for nursing and medical colleagues caring for patients on an end of life pathway was critical to aid decision making and raise awareness. In respect of a correlation between the audit results and complaints, the End of Life Lead Nurse confirmed that the majority of concerns related to a lack of recognition that the patient	

	was at the end of life. The Deputy Director of Cancer had oversight of all cancer related complaints and the Chief Nurse reviewed all complaints and confirmed no themes were apparent, learning was captured and shared to ensure lessons were learnt. With regards to patient's discharge wishes, the End of Life Lead Nurse confirmed an early conversation took place when the patient was recognised to require an end of life care plan. The Deputy Director of Cancer acknowledged the collaboration across South Yorkshire and Nottingham & Nottinghamshire systems to support effective end of life care. In response to a question from Non-executive Director, Hazel Brand, the End of Life Lead Nurse recognised the need to provide appropriate training and education to bank and agency staff, regular temporary staff would undertake the Trust's statutory training package. Non-executive Director, Emyr Jones recognised the importance of end of life training and education for the wider workforce, including medical and non-nursing colleagues, and encouraged this be considered as part of core training requirements. The Chair thanked the Deputy Director of Cancer and the End of Life Lead Nurse for their presentation.	
	The Committee: - ***Noted the National End of Life Care Audit Presentation***	
QEC23/08/C1	**Board Assurance Framework**	
	The Chief Nurse had worked closely with the Executive Medical Director to populate the framework relating to the delivery of the strategic objective "To provide outstanding care and improve patient experience" which identified the strategic risk, current risk score, key controls, identified gaps in controls and actions to close those gaps. The Executive Medical Director acknowledged the work to date and shared his appreciation with the Company Secretary. The new format was welcomed by non-executive colleagues. The Chair suggested it would be helpful for the current assurance level descriptors to be consistent with those used by the internal auditors and enquired if there should be a reference to the risks associated with virtual wards and the Getting It Right First Time Programme. Alignment of the assurance descriptors was felt to be sensible, however, inclusion of operational matters was discouraged as part of this strategic document, with assurance on those matters to be received as part of the agenda. In response to a question from Non-executive Director, Lucy Nickson, it was confirmed that the key issues box related to the risk of the identified issues occurring, rather than a current organisational issue; it was suggested this be reworded to potential issues/risks. Committee members were reminded that these items had the potential to impact delivery of the strategic objective. In respect of the current risk appetite, the Chief Nurse sought clarity on the plans to review this, which the Company Secretary confirmed would be undertaken prior to the financial year end.	**FD**

	The Committee: - ***Noted and took assurance from the Board Assurance Framework***	
QEC23/08/C2	**Chief Nurse Report**	
	The Chief Nurse brought the Committee's attention to the key highlights of the Patient Safety report, noting a continued improvement in the number of overdue incidents in excess of three months. In respect of duty of candour, there would be a revision to the language used in correspondence, in line with the requirements of the Patient Safety Incident Response Framework (PSIRF). There was the potential for this to impact upon wider Trust correspondence and policies. Non-executive Director, Hazel Brand highlighted a recent press article relating to the inspection of maternity services in Manchester by the Care Quality Commissions and a concern regarding the effectiveness of hand washing and sought assurances that Trust guidelines were adhered to. The Chief Nurse confirmed the fundamentals of handwashing remained unchanged and were a key focus of infection prevention and control and assessed via Tendable audits. In respect of the duty of candour and serious incident data, the Chief Nurse advised Non-executive Director, Lucy Nickson that the reduction in duty of candour compliance was being addressed by an improvement action plan. In respect of serious incidents, the historic nature of the data was noted and as the Trust transitioned to PSIRF there would be a need to revisit serious incident actions plans to establish that actions remained valid and deliverable. With regards to the quality report, the Trust was within the C. difficile threshold, however, the threshold was recognised to be more challenging as the number of cases increased. This issue was not unique to the Trust and a system summit to refocus attention was being planned by the Integrated Care Board's Chief Nurse. A detailed Trust action plan was also in place, with minimal themes and lapses in care identified. An outbreak of Glycopeptide Resistant Enterococci (GRE) was reported in orthopaedics, the outbreak was not isolated to the Trust and inter hospital transfers were being considered. A robust action plan was in place.	
	The Committee: - ***Noted and took assurance from the Chief Nurse Report – Quality & Safety***	
QEC23/08/D1	**Maternity & Neonatal Report**	
	The Director of Midwifery reported progress against the Year 5 Clinical Negligence Scheme for Trusts (CNST) standards, the latest version had seen a change to seven of the ten standards and this was currently being worked through. A shortened timeframe for completion was noted, with submission due by 1 February 2024, the return was expected to be presented to the Board of Directors in December 2023. The main area of concern related to training requirements, which had changed significantly from Year 4 standards. The requirement for neonatal life support training had been amended in version two of the Year 5 standards and the completion date extended to 31 March	

	2024. All remaining safety actions were on target and were monitored on a monthly basis by the CNST Oversight Committee, areas of concern would be escalated to the Childrens & Families Board and the Trust Executive Group. An overview of the seven immediate and essential actions from part one of the Ockenden Report was presented in the paper. The Local Maternity & Neonatal System had developed documentation to report delivery against the single delivery plan, this would be received by the Collaborative Board in August for ratification. The Chair recognised the short time frame for submission of CNST and enquired of any support required, the Director of Midwifery recognised the impact of industrial action on the medical workforce and confirmed that delivery of a safe service remained the priority. All efforts to deliver training across professional groups would be taken. In response to a question from Non-executive Director, Hazel Brand, the Director of Midwifery and Chief Nurse confirmed collaborative working across the LMNS to address training requirements. Non-executive Director, Emyr Jones recognised the volume of evidence for the different maternity returns and enquired of plans, at a regional or national level, to amalgamate. He also acknowledged the importance of all professionals across maternity and neonatal services working together as a team. The Director of Midwifery confirmed the most senior colleagues from maternity, neonatal, obstetrics and operations were enrolled on NHSE's mandatory Perinatal Leadership Programme. The Trust had also invested in a people and organisational development programme of work. The Chief Nurse confirmed a requirement of Year 5 CNST standards was for the executive and non-executive maternity safety Board champions to join, access and provide evidence of usage of the FutureNHS Collaboration Platform, examples of which were provided in the paper. In respect of the non-executive maternity safety board champion, Emyr Jones had agreed to offer his support to ensure non-executive cover, alongside Jo Gander.	
	The Committee: - ***Noted and took assurance from the Maternity & Neonatal Report***	
QEC23/08/E1	**<u>Executive Medical Directors Report</u>**	
	The Executive Medical Director's report summarised the business considered by the Clinical Governance Committee during May and June 2023, which included the Infection, Prevention & Control Committee's annual report, sub-committee reports and the Q4 2022/23 Learning from Deaths Report. The Executive Medical confirmed there had been a total of 591 deaths during the quarter, five of which were subject to a Learning Disability Mortality Review and subsequent Structured Judgment Reviews (SJR). The report highlighted the main causes of death, scrutiny by the medical examiners and completion standards in respect of death certificates. A summary of identified learning and recommendations were identified. Non-executive Director, Emyr Jones recognised the work to improve delays in issuing death certificates and welcomed the focus on simple yet innovative solutions. The various	

	sources of learning from deaths were acknowledged and a view taken as to how this could be considered in a joined up way. The Trust's approach to learning from deaths and SJRs was being evaluated, including an assessment of processes and procedures adopted by neighbouring Trusts. The Learning from Deaths Nurse confirmed she would liaise with the End of Life Lead Nurse to consider co-ordinated reporting, plans to review the report content for this Committee was confirmed by the Executive Medical Director. The Chair requested an update on progress be provided at the next meeting.	**TN**
	The Committee: - ***Noted and took assurance from the Executive Medical Directors Report***	
QEC23/08/E2	**<u>Internal Audit Report – Governance of Clinical Audit</u>**	
	The Executive Medical Director confirmed an action plan to address the outcomes of the internal audit was under development. The audit had highlighted misalignment of the governance structure, reduced levels of representation at the Audit & Effectiveness Committee, delays in completion of audits and action plans, with a significant percentage of completed audits not meeting the required standard. The monitoring of clinical audit had transitioned to Monday.com. in the latter part of 2022. The Associate Medical Director for Patient Safety would lead on this work on behalf of the Executive Medical Director. Non-executive Director, Emyr Jones shared his concerns in respect of the effectiveness of clinical audit in the Trust and its contribution to patient safety and sought assurance that ongoing work to address this was moving at pace to embed an audit culture. The Executive Medical Director recognised audit was not fully embedded across the Trust, in view of the significant volume of audits he suggested it may be appropriate to establish a selection criteria for non-mandated audits, with a focus on those which added knowledge, value and impacted positively on patient care. Non-executive Director, Lucy Nickson, encouraged the consideration of potential research opportunities arising from audits. In view of the lack of detail relating to clinical audit in the minutes of the Clinical Governance Committee and the frequency of presentation, the Chair felt it was difficult to take assurance from the current report and suggested it would be helpful to arrange a deep dive discussion prior to the next meeting of this Committee to understand the challenges and proposed next steps. It was also suggested that the Clinical Governance Committee receive a monthly update in order to ensure improved reporting and visibility. Non-executive Director, Emyr Jones welcomed the opportunity to secure improved clinical audit awareness and suggested it would be helpful to understand what the Trust's expectations were of clinical audit. It would also be worthwhile to consider the assurance route to establish if this was working effectively. The Chief Nurse confirmed plans to meet with the Executive Medical Director after summer leave to review the allocation of resources across their portfolios. In respect of the lines of assurance this had recently been discussed at an Executive Team time out and the newly recruited Deputy Chief Executive, due to commence in post in October, would lead on this work.	**JG**

	The Committee: - ***Noted the Internal Audit Report – Governance of Clinical Audit***	
QEC23/08/E3	**<u>Audit & Effectiveness Annual Report</u>**	
	The Committee received the Audit & Effectiveness Committee's annual report which summarised the work of the Committee during 2022/23. A total of 118 NICE guidelines had been considered, 85 audits completed, with 233 audits in progress. The time commitment to support clinical audit as part of the clinical governance role was recognised to be challenging and as discussed previously was under review.	
	The Committee: - ***Noted the Audit & Effectiveness Annual Report***	
QEC23/08/F1	**<u>Overview of Upcoming Visits & Visit Outcomes (verbal)</u>**	
	The Company Secretary confirmed no reports had been received to date, although details of anticipated visits had started to filter through following a request from the Chief Nurse. Requests would be collated in order that any potential gaps could be identified. Anticipated visits and reports should continue to be provided to the Trust Executive Group, in line with the Management of Reviews, Visits, Inspections and Accreditations Policy (CORP/COMM 11). In terms of this agenda item, the Company Secretary confirmed this should include all regulatory, externally reported reviews, accreditations and peer review to ensure that the Committee was assured that standards were being met.	
	The Committee: - ***Noted the Overview of Upcoming Visits & Visit Outcomes***	
QEC23/08/G1	**<u>Governor Observations</u>**	
	Apologies had been received from both governor observers.	
QEC23/08/H1	**<u>Sub-Committee Meetings</u>** - Clinical Governance Committee Minutes – 19 May & 16 June 2023 - Patient Experience & Involvement Committee – 3 May & 7 June 2023	
	The Committee: - ***Noted the Sub-Committee minutes***	

QEC23/08/I1	**<u>Any Other Business</u>**	
	In response to a question from Non-executive Director, Lucy Nickson the Chief Nurse confirmed that winter resilience would be considered by the Finance & Performance Committee. The Chair confirmed she would meet with the Company Secretary and Committee non-executives to review the workplan, after which an updated copy would be shared with the Chief Nurse and Executive Medical Director for review prior to approval at October's Committee meeting.	**JG/FD**
QEC23/08/I2	**<u>Minutes of the meeting held on 6 June 2023</u>**	
	The Committee: - ***Noted and approved the minutes from the meeting held on 6 June 2023***	
QEC23/08/I3	***Issues escalated from/to:*** i) QEC Sub-Committees ii) Board Sub-Committees iii) Audit & Risk Committee	
QEC23/08/I4	**<u>Assurance Summary</u>** The Committee was asked if it was assured, on behalf of the Board of Directors on the following matters. Any matters where assurance was not received, would be escalated to the Board of Directors: - Matters of Concern/Key Risks to Escalate, - Major Actions Commissioned/Work Underway - Positive Assurance to Provide - Decisions Made - Progress against committee associated Executive's objectives	
	<u>The Committee:</u> - *Was assured on the above matters.*	
QEC23/08/I5	**<u>Date and time of next meeting (Verbal)</u>**	
	Date: **Tuesday 3 October 2023** **Time:** **13:00** **Venue:** **Microsoft Teams**	
	Meeting End time 16.01	

2311 - H7 MINUTES OF CHARITABLE FUNDS COMMITTEE - 15 JUNE 2023

Information Item

Richard Parker OBE, Chief Executive

REFERENCES

Only PDFs are attached

H7 - Charitable Funds Committee Minutes - 15 June 2023.pdf

CHARITABLE FUNDS COMMITTEE

Minutes of the meeting of the Charitable Funds Committee
Held on Thursday 15 June 2023 at 13.30
via Microsoft Teams

Trustees:	Emyr Jones - Non-executive Director Hazel Brand - Non-executive Director (Chair) Jo Gander - Non-executive Director Jon Sargeant - Chief Financial Officer Kath Smart - Non-executive Director Lucy Nickson - Non-executive Director Mark Bailey - Non-executive Director Mark Day - Non-executive Director Richard Parker - Chief Executive Suzy Brain England OBE - Chair of the Board Tim Noble - Executive Medical Director	
In attendance:	Adam Tingle - Acting Director of Communications and Engagement Angela O'Mara - Deputy Company Secretary Fiona Dunn - Director Corporate Affairs / Company Secretary Shaina O'Hara - PA to the Deputy Director of Finance (minutes)	
To Observe:	Sheila Walsh - Public Governor (Bassetlaw)	
Apologies:	Denise Smith, Chief Operating Officer Karen Jessop - Chief Nurse Matthew Bancroft - Head of Financial Control Norma Brindley - Executor and Representatives of the Fred & Ann Green Legacy Zoe Lintin - Chief People Officer	
		ACTION
CFC23/06/A1	**Welcome and Apologies for Absence (Verbal)** The Chair welcomed the trustees and those in attendance to the meeting. The above apologies for absence were noted.	
CFC23/06/A2	**Conflicts of Interest (Verbal)**	
	No conflicts of interest were declared.	
CFC23/06/A3	**Actions from previous meeting** **Action 1 - CFC22/06/D1 – Committee Workplan** – income performance to be included in the workplan, content to be agreed post meeting. **Action closed.**	

	Action 3 - CFC22/12/B3 – Portfolio Ethical Considerations – Draft letter to Trustees to seek review was outstanding. Deadline extended to September 2023. **Action 5 – CFC23/03/B1 – Investment Portfolio Review** – action not yet due. **Action 6 – CFC23/03/C1 – Fundraising Strategy** – revised deadline of September 2023. **Action 7 – CFC23/03/D3 – Drawdown of Funds** – **Action closed**. **Action 8 – CFC23/03/D3 – Fred & Ann Green Fund** – **Action closed**. **Action 9 – CFC23/03/E1 – North Notts Nectar Trail** – Update included in the overview of current and planned activities. **Action closed**.	
	The Committee: - ***Noted the updates and agreed actions to be closed***	
CFC23/06/B1	**Review of Fund Balances**	
	The Chief Financial Officer provided the key highlights from the report, which provided an overview of income and expenditure, which was lower than planned due to the phasing of the fundraising activity and limited fundraising requests. A liquidity plan was included at appendix A and the investment advisors were aware of the Trust's expected future requirements. In response to a question from Lucy Nickson, Non-Executive Director, regarding the appointment of the investment advisors, the Chief Financial Officer confirmed the current investment managers had been appointed approximately two years ago, contracts were usually arranged on a 3 years +2 basis and would be reviewed in due course. In response to an enquiry from the Chief Executive, with regards to trustees' views on the required level of operating capital, the Chief Financial Officer suggested there may be a need to revisit this in view of the potential expenditure from the Fred & Ann Green funds. Going forwards, the Chair of the Board suggested it would be helpful for the report to identify the split between the general fund and the Fred & Ann Green fund. Lucy Nickson recognised the need for the fund raising strategy to align with the Trust's strategy, the latter would be progressed when the Deputy Chief Executive was in post. Outside of the meeting agreement would be reached on reporting by the Chair of the Board, Chief Financial Officer and Committee Chair.	**JS/HB/ SBE**
	The Committee: - ***Noted the Review of Fund Balances.***	

CFC23/06/B2	**Approval of Expenditure** a) Christmas Gift b) Top-up Degree Nurse Programme	
	Christmas Gift The Acting Director of Communications & Engagement presented a proposal to recognise and reward colleagues at Christmas by gifting a £25 voucher. It was suggested that payment would be made via Vivup to provide greater flexibility, allowing colleagues the option to donate their voucher and for unredeemed offers to be retained within the Trust's Charitable Funds balance. The reward would be offered to all substantive employees as at 1 December 2023, contractors such as Sodexo would not be included. Should the offer be continued into future years Lucy Nickson enquired of the income/fundraising plan to support this. The Chief Executive recognised the potential for this gesture to be viewed as a regular commitment, which could be subject to review and acknowledged the need for a supporting plan. In response to a question from the Chief Executive, the Acting Director of Communications & Engagement indicated he did not expect donations of the voucher back to the Charity to be eligible for gift aid but agreed to look into the matter. The value of £25 had been agreed to avoid any complications with cumulative colleague benefits. The Committee recognised this offer may be time limited, as funding was currently dependent upon charitable donations/funding going forwards. The case was **approved**. Top-up Degree Nurse Programme The Chief Financial Officer highlighted key points from the paper requesting funding for the Degree Nursing Programme to support the second year costs of £155K. In response to a question from the Chair, the Chief Financial Officer suggested this funding should be considered as a one-off case. The Chief Executive Officer recognised the benefits of developing the Trust's own colleagues but that there should not be an assumption this would be funded by charitable donations going forwards, particularly as the anticipated NHS workforce plan was likely to see a marked increase in training capacity which would need to part of the Trust's long term workforce plan. The Chief Financial Officer clarified why this request was deemed to be an "above and beyond" request as without support from charitable funds this could not be part of the Trust's revenue programme, due to the current financial position. The Committee considered at length opportunities to fund through charitable funds and agreed to support this one-off top up, noting the need to consider ongoing requirements as part of the Trust's workforce strategy. The case was **approved**.	

	The Committee: - ***Approved the expenditure, as detailed above.***	
CFC23/06/B3	**<u>Charitable Funds Development Committee Report</u>**	
	The Chief Executive brought the Committee's attention to an error in the paper, where the reported total value of cases differed and this would be clarified post meeting. Mark Bailey, Non-Executive Director sought assurance that the items of work correlated to feedback in the staff survey and in order to manage works in an efficient and effective way suggested similar requests should be considered as a scheme of work. The Chief Executive Officer recognised that the Charitable Funds Development Committee was introduced to cover limited value environmental and quality improvements and suggested it would be helpful for the Chief Nurse to review the Terms of Reference to ensure funds were spent in line with the Trust's strategic priorities, with a focus on efficiency and effectiveness. Future reports should include a full explanation of approved bids.	**KJ**
	The Committee: - ***Noted the Above and Beyond Committee Report.***	
CFC23/06/C1	**<u>Draft Fundraising Strategy</u>**	
	The draft strategy remained in development, the Acting Director of Communications & Engagement expected this to be shared within the week, with a view to approving a final version at September's meeting. The Chair suggested once the draft was received it would be helpful to arrange a workshop to consider and provide feedback.	
	The Committee: - ***Noted the update on the draft fundraising strategy.***	
CFC23/06/C2	**<u>Overview of Current and Planned Activities</u>**	
	The Acting Director of Communications & Engagement provided an overview of fundraising, donations, and planned activities for the year to date. The Chief Financial Officer provided an update in respect of plans to utilise Fred & Ann Green charitable funds, a number of schemes were being considered, including a proposal for the rehabilitation unit at Montagu and at Doncaster Royal Infirmary, the conversion of a modular theatre to support a surgical robot. It was anticipated that the business cases would be presented to the Corporate Investment Group to allow presentation to September's Committee meeting. Should approval be required outside of this timeframe it may be necessary to take a Chair's action, the Committee's support to approve requests in a timely manner was sought to allow	

	orders to be placed. The Chief Executive reported that regional wait times for robotic prostrate surgery were in excess of 26+ weeks, with only one robotic centre in South Yorkshire. In addition and following the Trust's unsuccessful New Hospital Programme bid there was a need to consider the use of robotics for service delivery and retention of colleagues. In response to a question from Lucy Nickson, Non-Executive Director, regarding the review of fundraising income performance, the Acting Director of Communications & Engagement confirmed this would be considered as part of the strategy. With regards to building relationships with donors, the Acting Director of Communications & Engagement confirmed that this was part of the work of the fundraiser and the value of good stewardship was recognised.	
	The Committee: - ***Noted the Overview of Current and Planned Activities***	
CFC23/06/D1	**<u>Committee Effectiveness Review</u>**	
	The Company Secretary circulated the report to capture a baseline for the workings of the committee. The review questions covered: • Committee Focus • Committee Engagement • Committee Team Working • Committee Effectiveness • Committee Leadership Work to address some elements was already in train, for example the use of Team Engine and the reintroduction of the Chair's assurance log. The Chair noted the areas of improvement and acknowledged the ongoing work of the Committee.	
	The Committee: - ***Noted the review of the Committee Effectiveness Review***	
CFC23/06/D2	**<u>Committee Workplan</u>**	
	Lucy Nickson, Non-Executive Director, suggested the monitoring of income performance be included within the workplan. The Company Secretary sought further guidance to take this forward and agreed to discuss the specifics outside of the meeting.	**FD/LN**
	The Committee: - ***Approved the Committee Workplan***	

CFC23/06/D3	**Charitable Funds Committee Annual Report 2022/23**	
	The Annual Report was approved, post meeting an amendment was made to section six (meetings and membership) to include the Chief People Officer's attendance.	
	The Committee: - ***Approved the Charitable Funds Committee Annual Report 2022/23***	
CFC23/06/E1	**Governor Observations (Verbal)**	
	The Governor observer welcomed the discussion in respect of the Fred and Ann Green funds and looked forward to hearing the outcome at a future meeting. In respect of the Nectar Trail initiative, it was confirmed that the Trust was a supporter of the scheme initiated by North Notts Business Improvement District.	
CFC23/06/F1	**Minutes of the Sub-Committee Meeting**	
	The Committee: - ***Noted the minutes of the Charitable Funds Development Committee of 6 February & 7 March 2023***	
CFC23/06/F2	**Minutes of the Charitable Funds Committee Meeting held on 9 March 2023**	
	The Committee - ***Approved the minutes from the Charitable Funds Committee of 9 March 2023***	
CFC23/06/F3	**Any Other Business**	
	No items of other business were received.	
CFC23/06/F4	**Assurance Summary** The Committee is asked if it is assured, on behalf of the Board of Directors on the following matters. Any matters where assurance is not received, will be escalated to the Board of Directors: - Matters discussed at this meeting, - Progress against committee associated Executive's objectives, - Divisional compliance with the Trust's risk management process **The committee was assured.**	

CFC23/06/F5	**<u>Date and time of next meeting</u>** Thursday 14 September 2023 Via MS Teams Time 13:30		
	Meeting closed:	15:11	

2311 - H8 MINUTES OF AUDIT & RISK COMMITTEE - 20 JULY 2023

REFERENCES

Only PDFs are attached

H8 - Audit & Risk Committee Minutes - 20 July 2023.pdf

AUDIT AND RISK COMMITTEE

Minutes of the meeting of the Audit and Risk Committee
Held on Tuesday 20 July 2023 at 09:30 via Microsoft Teams

Present:	Kath Smart, Non-Executive Director (Chair) Emyr Jones, Non-Executive Director Jo Gander, Non-Executive Director Mark Bailey, Non-Executive Director Mark Day, Non-Executive Director	
In attendance:	Alex Crickmar, Deputy Director of Finance Angela O'Mara, Deputy Company Secretary Dan Spiller, Ernst & Young Denise Smith, Chief Operating Officer (Presenting H1) Howard Timms, Acting Operational Director of Estates & Facilities Jon Sargeant, Chief Financial Officer Laura Brookshaw, 360 Assurance Mark Bishop, Local Counter Fraud Specialist (Presenting H2) Rebecca Tomkins, Ernst & Young Ruth Vernon, 360 Assurance Sean Tyler, Head of Compliance Shaina O'Hara, PA to the Deputy Director of Finance (Minutes) Tim Noble, Executive Medical Director (Presenting F2)	
Observer:	Dennis Aktin, Public Governor Doncaster Rum Thomas, PCCU Consultant (Board Delegate) Sarah Bowers, 360 Assurance Shirley Spoors, Lead Healthcare Scientist for DBTH (Board Delegate)	
Apologies:	Fiona Dunn, Director Corporate Affairs / Company Secretary	
AR23/07/A1	**Welcome, apologies for absence and declarations of interest (Verbal)**	**ACTION**
	The Chair welcomed members, attendees and observers to the meeting, the above apologies for absence were noted and no declarations of interest were made. The meeting was noted as quorate.	
AR23/07/A2	**Actions from previous meeting (Enclosure A1)**	
	Action 1 - AR22/10/F2 Emergency Planning Core Standards Return (EPRR) enclosed within the agenda. Action closed. **Action 2 - AR23/04/C1 Audit Follow-up Closure Rate** Action closed. **Action 3 - AR23/04/C1 Clinical Audit Report** Action closed.	

	<u>Action 4</u> - AR23/04/C1 Closure of Audit Recommendation Action closed. **<u>Action 5</u> - AR23/04/C1 Audit Follow-up Recommendations** Action closed. **<u>Action 6</u> - AR23/04/C2 Risk Management Board Assurance Log** enclosed within the agenda. Action closed. **<u>Action 7</u> - AR23/04/C2 Risk Management Training** the implementation date to remain as October 2023. **<u>Action 8</u> - AR23/04/C5 System Review** agreed to review **discharge and length of stay**. Action closed. **<u>Action 9</u> - AR23/04/D1 2022/23 HFMA Year-end Reminders for NHS Audit Committees** Action closed. **<u>Action 10</u> - AR23/04/E1 Use of Single Tender Waiver** Action closed. **<u>Action 11</u> - AR23/04/F2 Inclusion of Audit Recommendation on Corporate Risk Register** Action closed. **<u>Action 12</u> - AR23/04/F3 Declarations of Interest** enclosed within the agenda. Action closed. **<u>Action 13</u> - AR23/06/B1 360 Assurance GIRFT Memo & Performance Management Audit** enclosed within the agenda. Action closed. **<u>Action 14</u> - AR23/06/B1 360 Assurance - Clinical Audit Report** enclosed within the agenda. Action closed. **<u>Action 15</u> - AR23/06/C2 Draft Annual Governance Statement** enclosed within the agenda. Action closed. **<u>Action 16</u> - AR23/06/C2 Annual Governance Statement 2022/2023** amendments to the wording made to the AGS, this would be presented at the Board meeting on 25 July.	
AR23/07/A3	**<u>Request for any other business (Verbal)</u>**	
	No requests for any other business were received.	
AR23/07/B1	**<u>LCFS Progress Report</u>**	
	The Local Counter Fraud Specialist (LCFS) shared the key points from the progress report. In response to a question from Mark Bailey, Non-Executive Director, the LCFS confirmed there wasn't an increase fraud reporting, the team were getting better at identifying this would include preventative measures. In answer to another question raised on ensuring all colleagues were aware that working for another Trust or working whilst off sick would be identified and included in awareness raising around the policy and new Civica system. The Chair asked about the new strategy, particularly around developing skills which were required to meet future needs for counter fraud. The LCFS confirmed that the aim within the next few years was for every member to obtain the qualification of a certified government counter fraud professional. In response to a further question regarding colleagues understanding the need to make a declaration of interest. The LCFS team were working closely with the recruitment team, testing the recruitment process plus access to Trac to capture information at source. A centralised recruitment team would be a huge benefit for	

	the LCFS team. The Chief Financial Officer confirmed that a business case for the centralisation was currently on hold.	
	The Committee: - ***Noted and took assurance from the LCFS Progress Report***	
AR23/07/B2	**<u>Counter Fraud Annual Report</u>**	
	The Local Counter Fraud Specialist shared the key points from the annual report. The report demonstrated evidence supporting the counter fraud functional standard return. In response to a question from the Chair, the LCFS advised that the Trust had sufficient evidence to satisfy the quality assessment inspection. Site visits would normally be undertaken due to insufficient evidence or to demonstrate good practice. Mark Bailey, Non-Executive Director highlighted the Counterfraud KPI's demonstrating a positive assurance picture.	
	The Committee: - ***Noted and took assurance from the Counter Fraud Annual Report***	
AR23/07/C1	**<u>360 Assurance Progress Report</u>**	
	Bank & Agency Spend – Limited Assurance Outcome 360 Assurance advised following a request at the end of the last financial year to include bank and agency spend as the request of the CFO and Audit Committee. A standard procedure with clear expectations was developed. Further work on compliance with rota rules and sickness management is underway. In response to a question from Mark Bailey, Non-Executive Director regarding measuring to see if this was embedded, 360 Assurance highlighted some of the issues were already being addressed with grip and control meetings and would report on the closure of the recommendations. In response to a question from the Chair, the Chief Financial Officer and 360 Assurance confirmed that Zoe Lintin was the executive lead and was responsible for signing off the report. A further question regarding questioning if an amendment of delegation of powers was required. The Chief Financial Officer confirmed once the standard operating procedures (SOP) were concluded they would review the SoP for consistency. <u>Data Security & Protection Toolkit – Substantial Assurance Outcome</u> 360 Assurance only raised one low risk relating to IG training and induction monitoring. 360 Assurance expressed thanks to Ken Anderson, Chief Information Officer and his team for enabling an efficient and organised audit. In response to a question from Emyr Jones, Non-Executive Director, 360 Assurance advised the Caldicott Function was used and further evidence would be shared to provide assurance. 360 Assurance apologised for excluding the Caldicott guardian from the distribution list. The Chair would pass on thanks and recognition to Ken Anderson, Chief Information Officer and his team for their hard work and diligence.	

	The Committee: - ***Noted and took assurance from the 360 Assurance Progress Report***	
AR23/07/C2	**<u>Audit Reports including:</u>** - Bank & Agency Spend - Data Security & Protection Toolkit	
	<u>Bank & Agency Spend – Limited Assurance Outcome</u> 360 Assurance advised following a request at the end of the last financial year to include bank and agency spend as the request of the CFO and Audit Committee. A standard procedure with clear expectations was developed. Further work on compliance with rota rules and sickness management is underway. In response to a question from Mark Bailey, Non-Executive Director regarding measuring to see if this was embedded, 360 Assurance highlighted some of the issues were already being addressed with grip and control meetings and would report on the closure of the recommendations. In response to a question from the Chair, the Chief Financial Officer and 360 Assurance confirmed that Zoe Lintin was the executive lead and was responsible for signing off the report. A further question regarding questioning if an amendment of delegation of powers was required. The Chief Financial Officer confirmed once the standard operating procedures (SOP) were concluded they would review the SoP for consistency. <u>Data Security & Protection Toolkit – Substantial Assurance Outcome</u> 360 Assurance only raised one low risk relating to IG training and induction monitoring. 360 Assurance expressed thanks to Ken Anderson, Chief Information Officer and his team for enabling an efficient and organised audit. In response to a question from Emyr Jones, Non-Executive Director, 360 Assurance advised the Caldicott Function was used and further evidence would be shared to provide assurance. 360 Assurance apologised for excluding the Caldicott guardian from the distribution list. The Chair would pass on thanks and recognition to Ken Anderson, Chief Information Officer and his team for their hard work and diligence.	
	The Committee: - ***Noted the Audit Reports & their respective assurance opinions***	

AR23/07/D1	**External Audit Report**	
	Rebecca Tomkins, Ernst & Young highlighted that updates from the June ARC meeting were reflected in blue within the report. A "clean" opinion was provided and set out in section 4. Ernst & Young highlighted the work undertaken to reach the opinion. Errors were identified in the application and implementation of the new lease standard and a small number of adjustments were identified. Given the low value of the errors and nature of them being projected, these would remain uncorrected and would be included in the letter of representation, both referenced under audit differences on page 26. One other main change outlining an additional low level control recommendation referring to the formalisation of controls around fixed asset disposals and the approval process. The conclusion on prior year recommendations has been updated and the Committee now has a full picture of all the recommendations, including those closed from the previous year. The Chair raised a concern that the accounts were filed a week late, as the timetable provided for the timely submission of accounts. The Committee noted there had been a joint session on 18 July and Dan Spiller, Ernst & Young updated the Committee on the discussions held at the post audit review, confirming lessons were learnt and there was plans in place for future audits to go smoother with a more detailed timetable being produced for future years. The Chief Financial Officer clarified, although accounts were submitted late no censure or final warning was received and NHS England had been informed throughout. The actions for future were more robust planning, more assurance at Executive level on progress. The team continued to work well to reach the end goal together. The Chair highlighted the errors previously raised to ensure the Committee were sighted. The Chair advised a mid-year ARC review of progress against the recommendations around PPE, reconciliation, renumeration report, payroll and PPE disposal to see sight of improvements and any updates.	
	The Committee: - ***Noted and took assurance from the External Audit Report***	
AR23/07/E1	**Single Tender Waiver Report**	
	The paper was taken as read. The Chair was assured from the report that appropriate controls were in place when signing off a single tender waiver.	
	The Committee: - ***Noted and took assurance from the Single Tender Waiver Report***	
AR23/07/E2	**Losses and Compensation**	
	The paper was taken as read.	
	The Committee: - ***Noted and took assurance the Losses and Compensation Report***	

AR23/07/E3	**Standing Financial Instructions, Standing Orders and Delegation of Powers Policies**	
	The Deputy Director confirmed the main changes had been set out in the front sheets and cover paper. The delegation limits had been reset for the Director of Finance and Deputy Chief Executive now they had returned to their substantive roles. Procurement tendering limits had been updated to align with the Integrated Care Board (ICB), this had been previously agreed by the ICB Directors of Finance. The use of the Trust seal practice had been updated. Given the financial position and as financial controls were tightened, other documents such as agency controls would be reviewed. In response to a question by Emyr Jones, Non-Executive Director regarding the tendering process changes to ensure the Trust had the ability to make decisions as an organisation. The Deputy Director of Finance explained that the Trust was still in charge of tendering, levels had been changed to ensure alignment when seeking joint procurement with the ICB to ensure better value for money. The Chief Financial Officer highlighted future works looking at an ICS wide procurement team. In response to a question by the Chair, the Deputy Director of Finance confirmed there were constraints written within the policies to encourage local suppliers to bid for NHS work and supporting local suppliers. The Chair confirmed the Committee was happy to recommend the policies to the Board of Directors for approval.	
	The Committee: - ***The Committee approved the Standing Financial Instructions, Standing Orders and Delegation of Powers Policies***	
AR23/07/F1	**Board Assurance Framework Progress Update**	
	The Chief Financial Officer explained why the Board Assurance Framework (BAF) would not be presented to the Public Board meeting on 25 July. An additional meeting was agreed to take place on 24 July, to discuss the new layout, once this version had been discussed it would be circulated virtually outside of the meeting. The proposal would be to take virtual questions and agree a separate meeting to close it off. The Chair and Non-Executive Directors raised their concerns and disappointment with the pace of progress. Mark Bailey, Non-Executive Director confirmed the Trust was fully committed to continue with the BAF. The Chair would discuss with the Chief Executive Officer outside of the meeting their concerns, clarification of the future plan and the possibility of presenting the BAF at the Confidential Board meeting and communicate the plan. In response to a question by the Chair about any substantive changes to the seven risks that went into the various breakthrough objectives, the Chief Financial Officer advised it would be part of the discussions on 24 July. The Chief Financial Officer advised of one concern raised, risk seven, which scored a six, the Board thought this was low and would form part of the discussion on 24 July. The Chair highlighted that decisions on risk need to be in compliance with the Risk Management Strategy and this was being refreshed, due for approval in the Autumn.	**KS**

	The Committee: - ***Noted the Board Assurance Framework Progress Update***	
AR23/07/F2	**Risk Management Board - Progress & Metrics**	
	The Executive Medical Director highlighted this was the first time this style of report had been presented at the Audit and Risk Committee meeting. The Trust Executive Group (TEG) had already had sight of the report for approval. In summary, the Risk Management Board looked at all risks of 15+, with the option to bring any 12+ new risks for discussion in case following moderation the score increased. The 15+ risks had been reviewed to ensure mitigations were in place and actively followed up and it was noted that 50% of the risks had action plans. Due to some sickness absence, additional cover arrangements had been put in place to assist with a more detailed analysis which would utilise the Datix function, identify which risks were new/old and have been well mitigated or resolved. The analysis highlighted the spread of risk across corporate and divisional areas. In response to a question by Jo Gander, Non-Executive Director regarding the reason why 50% of risks were without an action plan, the Executive Medical Director explained this was a new process, the expectation would be to achieve 100%. A question around the extreme risks under surgery and cancer services which were not appropriately graded and consistency should be picked up at the Risk Management Board. Mark Day, Non-Executive Director raised concerns that risks were being raised without a mitigating action. The Executive Medical Director confirmed that all risks had mitigations in place and the actions display these in greater detail. The Chair highlighted the report was produced at the request of the Audit and Risk Committee to obtain assurance that the process was working to get the 15+ risks and any backlog addressed. This report would be used to demonstrate continuous improvement and the Chair confirmed the commitment to review all of the high risks by October 2023. The Executive Medical Director would bring this report back to the Audit and Risk Committee meeting in October 2023. In response to a question by Laura Brookshaw, 360 Assurance how it was going to link in with the Corporate Risk Register. The Executive Medical Director confirmed the steps from the risk register to Risk Management Board and the 15+ risks would be considered by TEG for inclusion on the Corporate Risk Register. The summary of activity report would be presented to this committee. The Chair asked how to make the distinction between those that were corporate risks and those that were not. The Executive Medical Director explained the overarching risk would sit on the corporate register. The Chair suggested an open action for the Non-Executive Directors and Internal Audit to link in with the Executive Medical Director for any additions to the progress report. In response to the outstanding action point 7, regarding bringing forward Risk Management Training, the Executive Medical Director advised this training would be much broader for a larger audience and wouldn't have the capacity to bring this training forward. The Chair agreed to leave this action open with an end date of October 2023.	**TN** **TN**
	The Committee:	

	- ***Noted and took assurance from the Risk Management Board - Progress & Metrics Report***	
AR23/07/F3	**<u>Declarations of Interest, Standards of Business Conduct Update</u>**	
	The Deputy Company Secretary provided an overview and highlighted an improved level of reporting which would continue to be monitored. The year end and position confirmed 73% of colleagues declared as decision makers. Colleagues were aware of the roll out of CIVICA declare onto the web-based system. Since writing the report the figures had increased to 76% a. In response to a question by the Local Counter Fraud Specialist regarding further communication to all colleagues reminding them to declare secondary incomes. An agreed communication between the Director of Corporate Affairs and the Acting Director of Communication and Engagement to be circulated.	**FD/AT**
	The Committee: - ***Noted and took assurance from the Declarations of Interest, Standards of Business Conduct Update***	
AR23/07/G1	**<u>Board Committees Annual Report</u>**	
	Quality and Effectiveness Committee – Jo Gander, Non-Executive Director Finance & Performance Committee – Mark Day, Non-Executive Director People Committee – Mark Bailey, Non-Executive Director The Committee Annual Reports had been approved by the various committees and were received for assurance. The Chair requested an amendment to the workplan to allow sight of the annual reports alongside the annual accounts, yearend opinions and annual governance statement. A question by the Chief Financial Officer regarding circulation of the annual reports to the Board members who do not attend this committee would be confirmed outside of the meeting. The Chair confirmed the normal process was to receive all three Annual Reports at the Audit Risk Committee from a point of view of effectiveness and accountability. The Audit & Risk Committee Annual Report would make reference to the three reports seen, before being presented at the Board meeting.	**FD**
	The Committee: - ***Noted and took assurance from the Board Committees Annual Reports***	

AR23/07/G2	**<u>Audit & Risk Committee Annual Report</u>**	
	The Chair presented the Audit and Risk Committee Annual Report. The Chair highlighted the missing commentary for inclusion of the ISA 260 opinion indicating the 'clean' opinion on the accounts and referencing the five recommendations would be amended prior to submission to the Board meeting.	
	The Committee: - ***The Committee approved the Audit & Risk Committee Annual Report***	
AR23/07/H1	**<u>Emergency Preparedness, Resilience & Response Annual Review</u>**	
	The Chief Operating Officer highlighted key points from the paper to note. A review of the work plan indicated several areas were off track in 22/23, a huge amount of focus in the latter part of the year was on industrial action planning. The focus for 23/24 was to deliver the core standards starting with the review of all policies and plans, as well as regular testing of the emergency plans to ensure all colleagues were fully trained and able to fulfil their obligations. The Deputy Chief Operating Officer would chair a monthly meeting with the Emergency Planning Group and share a Chair's Assurance report each month at the Trust Executive Group (TEG). The work plan activity had been carefully set in line with the deadlines for the self-assessment submissions by the end of September. The intention was to undertake as much as possible by the end of Q2. In response to a question by Emyr Jones, Non-Executive Director regarding debrief procedures following each industrial action, the Chief Operating Officer confirmed live exercising was beneficial and debrief exercises would continue. The Chair welcomed fresh eyes, a fresh perspective and increased grip and control on Emergency Preparedness, Resilience and Response (EPRR). In response to a question on resourcing, the Chief Operating Officer confirmed the team was fully established and the capacity to deliver was adequate, resourcing had been benchmarked against other Trusts. In response to a question by Mark Day, Non-Executive Director regarding the uptake of training. The Chief Operating Officer highlighted the percentage rates related to regional training which covered legislation and responsibilities which were mandatory. Local training focused on the operational response, however the training complemented one another.	
	The Committee: - ***Noted and took assurance from the Emergency Preparedness, Resilience & Response Annual Review***	
AR23/07/H2	**<u>Health and Safety Bi-Annual Report</u>**	
	The Acting Director of Estates and Facilities covered key points from the report from October 22 to March 23. Following a recent site visit to Bradford District Care (BDC) to discuss the organisations journey on successfully obtaining accreditation for the ISO 45001 standard and the Royal Society for the	

	Prevention of Accidents (RoSPA) Gold Award. A collaborative relationship had been established with agreed future support from BDC to help the Trust achieve accreditation. A new Health and Safety strategy had been developed to improve health and safety across DBTH. Following final approval at the August Health and Safety Committee meeting, a summary of key points would be shared throughout the Trust. Data for accidents and incidents including an increase of sharps injuries reported were enclosed in the report. In response to a question by Jo Gander, Non-Executive Director in relation to the increase of sharps injuries reported. The Head of Compliance suggested the increase may be due to more awareness of reporting procedures. The Chair in discussion with Mark Bailed suggested the outcome of the deep dive results would appropriately sit with the People Committee. In response to a question by Mark Day, Non-Executive Director on the reporting of incidents and the confidence that all incidents were appropriately reported. Training around the health and safety culture had increased awareness to ensure incidents were appropriately reported. The Head of Compliance highlighted Qi work being undertaken, and one of the main objectives was around reporting and improving the process. In response to a question by Mark Bailey, Non-Executive Director regarding a walk round of areas with a 'new set of eyes', bi-weekly walk rounds would be resurrected as these would form part of their objectives. The Head of Compliance adopted a health and safety, security and fire inspection report which BDC use, all areas of DBTH would be visited commencing 26 July. A further question asked by Mark Baily relating to routinely capturing risk assessments with the use of the electronic system. The Head of Compliance advised that due to the infancy of this system, a small number of questions relating to fire were initially added. A larger set of questions had been requested. The system would provide quarterly information in between the annual audit. In response to a question by the Chair, the Acting Director of Estates and Facilities provided an overview of fire safety; works scheduled, completed and on hold so the Committee had a sense of compliance across the Trust. The overarching capital programme focuses on the areas that were issued with the enforcement notices. The Fire Task and Finish Group monitored these works along with other areas across the Trust. A full review undertaken of risk assessments, compartmentation survey, updated fire safety plans which include fire alarms. Both elements continued to progress and achieve targets agreed with South Yorkshire and Notts Fire & Rescue, these results would be presented on a monthly basis to provide assurance that actions were being progressed. The Chair commended the team on progressing the accreditations which would provide assurance of quality training to protect the health and safety of colleagues and patients. The Chair also asked about a date for the implementation of the internal health and safety alert system. The Head of Compliance advised the expectation would be to introduce in Q3. The Head of Compliance updated further that the Health and Safety Committee would be reviewing their agenda, terms of reference along with the effectiveness of committee members.	**ST** **HT/ST**
	The Committee: - ***Noted and took assurance from the Health and Safety Bi-Annual Report***	

AR23/07/I1	**Governor Observations**	
	The Governor observed the NED challenge regarding the delay of the BAF and echoed the point made by the Non-Executive Director that the Trust was fully committed to the BAF. The Governor thanked the committee and advised he would not stand for a further term of office. The Chair thanked the Governor on behalf of the Committee.	
AR23/07/J1	**Any Other Business**	
	No items of other business were received.	
AR23/07/K1	**Sub Committee Minutes**	
	The Committee noted: i) Information Governance Committee Minutes – **no items to raise**.	
AR23/07/L1	**Information Item**	
	Standards of Business Conduct & Employees Declarations Policy had been approved at the Trust Executive Group held on 12 June 2023**.**	
AR23/07/M1	**Minutes of the Meeting Held on 20 June 2023**	
	The minutes of the above meeting were approved.	
AR23/07/M2	**Audit and Risk Committee Work Plan**	
	The Chair requested within the meeting to realign the work plan to improve the reporting at year end.	**KS/FD**
AR23/07/M3	**Issues escalated from/to:** **i)** QEC, F&P, and People Committees – **Bank and Agency spend to be presented at People Committee and Sharps Deep Dive to be presented to the People Committee.** ii) ARC Sub-Committees iii) Board of Directors *Kath Smart, Chair*	 **KS**
AR23/07/M4	**Assurance Summary** The Committee was asked if it was assured, on behalf of the Board of Directors on the following matters. Any matters where assurance was not received, would be escalated to the Board of Directors: - Matters discussed at this meeting - Progress against committee associated Executive's objectives - Any new Emerging risks that have been identified from the meeting? The Chair reported the key risks to escalate were the BAF and Bank and Agency report. The ISA 260 report would be presented at the Board meeting which formed part of the accounts	

	update, also would sit within the annual report. Positive assurances noted were the Data Security Toolkit, Health and Safety and Emergency Preparedness, Resilience and Response.		
AR20/06/M5	**<u>Date and time of next meeting (Verbal)</u>**		
	Date: Time: Venue:	19 October 2023 09:30 Microsoft Teams	
	Meeting Close:	11:47	

2311 - H9 MINUTES OF TRUST EXECUTIVE GROUP - 11 SEPTEMBER & 9 OCTOBER 2023

REFERENCES

Only PDFs are attached

H9 - Trust Executive Group Minutes - 11 September 2023.pdf

H9 - Trust Executive Group Minutes - 9 October 2023.pdf

TRUST EXECUTIVE GROUP

Minutes of the Meeting of the Trust Executive Group (TEG)
Held on Monday 11 September 2023 @ 2pm via Microsoft Teams

Present:	Richard Parker – Chief Executive (Chair) Professor Sam Debbage - Director of Education & Research Fiona Dunn - Director of Corporate Affairs / Company Secretary Kirsty Edmondson-Jones - Director of Innovation & Infrastructure Jochen Seidel – Divisional Director for Clinical Specialties Suzanne Stubbs – Deputy Chief Operating Officer Andrea Squires - Divisional Director of Operations (Emergency medicine) Ken Anderson - Chief Information Officer Anthony Jones – Deputy Director of P&OD Kirsty Clarke – Divisional Director of Nursing Surgery Donna Smith - ED Business and Operational Manager Alex Crickmar - Deputy Director of Finance Denise Smith – Chief Operating Officer Karen Jessop – Chief Nurse Anurag Agrawal - Divisional Director for Medicine Nick Mallaband - Medical Director for Workforce and Specialty Development (interim Executive Medical Director)	
In attendance:	Laura Brookshaw - 360 Assurance Anneleisse Siddall – Corporate Secretary (Minutes) Helen Burroughs - Divisional Director of Operations (Children and Families) Kate Carville - Divisional Director of Nursing for Medicine Robert Mason - Head of Quality Improvement Lucy Hammond - Divisional Director of Operations (Surgery and Cancer) Lauren Bowden - Divisional Director of Operations (Specialty Medicine) Andrew Potts - Divisional General Manager for Clinical Specialities Anna Hegarty – Interim Head of Nursing Samantha Fawkes – Acting Head of Nursing for Children's and Neonate Howard Timms – Acting Director of Operational Estates and Facilities Justin Fowler – Head of Business Services Nicki Sherburn – Deputy Divisional Nurse of surgery	
Apologies:	Zoe Lintin - Chief People Officer Jon Sargeant – Chief Finance Officer and Director of Recovery, Innovation & Transformation (RIT) Nicki Sherburn – Deputy Divisional Director of Surgery and cancer Laura Churm - Divisional Nurse for Children and Neonates Eki Emovon - Divisional Director for Children and Families Emma Galloway –Divisional Nurse Clinical Specialties Heather Jackson – Director of Allied Health Professionals Howard Timms – Acting Director of Operational Estates and Facilities Dr Tim Noble - Executive Medical Director	
		ACTION
TEG11/09/A0	**Internal Audit Acton Log Update**	

	Laura of 360 Assurance informed 82% actions had been implemented on time with 91% overall implementation. Laura highlighted Appendix C which confirmed the actions due and asked if colleagues needed further detail, this could be requested. Laura gave a brief description in relation to the preparation of October 2023's Audit Risk Committee to complete the following. <u>2022-2023</u> - staff retention/returned to work - Waiting List Management Order <u>2023-2024</u> - Policy Management framework - Business Planning - Stage One of internal audit opinion work The Chief Executive stressed the importance of closing actions on time to improve services and thanked the team for facilitating of closing actions.	
	The Committee: - ***Noted the Internal Audit Acton Log Update.***	**<u>All</u>**
TEG11/09/A1	**<u>Welcome and Apologies for Absence (Verbal)</u>**	
	The Chief Executive welcomed attendees to the meeting and explained that Laura Sherburn, Chief Executive of Primary Care Doncaster and Nabeel Alsindi, Place Medical Director of Doncaster ICB, had joined for part one of the Trust Executive Meeting. The Chief Executive also welcomed Mr Pande as the Divisional Director for surgery, and welcomed Emma back following a period of maternity leave. The above apologies for absence were noted.	
TEG11/09/A2	**<u>Matters Arising / Action Log</u>**	
	There were no matters arising and no actions from August 2023.	
TEG11/09/A3	**<u>Conflict of Interest (Verbal)</u>**	
	There was no conflict of interest declared.	
TEG11/09/A4	**<u>Requests for any other business (Verbal)</u>**	
	There had been no requests made for other business.	
TEG11/09/A5	**<u>CEO Update</u>**	
	The Chief Executive noted issues in achieving elective and diagnostic recovery and the challenge of reducing waiting time at seventy-eight and sixty-five weeks wait which were being seen locally and nationally.	

	The Chief Executive highlighted the conclusion of the trail of Lucy Letby trial and the understandable concerns in relation to patient safety, and freedom to speak up and that a paper would be presented to the Board of Directors in September which would describe wider issues and some of the early lessons and actions which can be identified from the publicity to date. The Chief Executive expanded on the issues which result from the decision that DRI would not now be part of the New Hospital programme. He confirmed that work would need to continue and that the Trust would continue to press for additional funding as described in the recent articles in HSJ. The Chief Executive confirmed that the draft final business case for the South Yorkshire & Bassetlaw pathology network would be available by 22 September 2023. If approved by the Acute Trust Boards the South Yorkshire Bassetlaw Pathology Network would formally commence on the 1st of April and 2024. As this is a period of change for a number of colleagues it would be important to ensure that clear and accurate communication is available.	
	The Committee: - ***Discussed and noted the CEO Update.***	
TEG11/09/B1	**<u>Medical Director Clinical Update</u>**	
	The Interim Medical Director shared key points from the medical director's update. <u>Job planning</u> The Interim Medical Director confirmed that to have 100% completion 373 job plans must be completed, at present 303, 81% had been completed or were in process. The Acting Medical Director explained that as the Division of Surgery had been without a Divisional Director for a substantial period, the completion rate had been much lower than other Divisions. It is expected that with the appointment of a new Divisional Director the position would now improve. It was confirmed that a Job Plan Consistency Committee had been established which had divisional and HR representation and that meetings had taken place between consultants and medical managers in relation job planning processes with the option to invite non-medical/business managers. The Divisional Director for Medicine asked what the sign off process involved. The Acting Medical Director confirmed that unless the JP created a precedence or exceeded agreed standards there was a one sign off from the clinical director. The Chief Operating Officer asked if it would be appropriate to include operational managers within job planning discussions to better reflect service needs and the connection to annual plans. The Acting Medical Director agreed integration would be positive with further discussions to be had. The Divisional Director for Medicine highlighted how Medicine and Urgent Emergency Care have taken positive steps on the completion of job plans.	

	The Acting Medical Director highlighted other key points within the paper. - Getting It Right First Time (GIRFT) Engagement sessions had taken place. - The use of Virtual Ward for appropriate patients and pathways needed to be actively supported as utilisation remains low. - The Trust had reached 91% completion of Medical Appraisal standards against the 85% national target. - The Associate Medical Director for clinical governance had carried out positive work with Hospital Standardised Mortality Ratio (HSMR). The Chief Executive raised a discussion in relation to a point raised at the Trust Medical Committee (TMC) where it had been strongly suggested that Clinical and Divisional Directors should not be involved in medical appraisals due to being involved in job planning. The Chief Executive asked if others in the team had concerns, they could bring it to the attention of the group with a possible reword of policy.	
	The Committee: - *Noted the Medical Director Clinical Update* - *DDs and CDs to consider and offer thoughts to the Associate Medical Director on the impact of DD's and CD's not being involved in appraisals.*	**DD's/ CD's**
TEG11/09/B2	**<u>Chief Nurse Report</u>**	
	The Chief Nurse updated on the Patient safety Incident Response Framework (PSIRF) and confirmed that the Trust remained on track to comply with the national timeline. Next steps included finalising a PSIRF implementation plan which had been reviewed by stakeholders, and was ready to send to the Quality and Effectiveness Committee for final sign off. The Chief Nurse highlighted concerns with C Difficile and that discussions would take place with Divisions to ensure that action plans, particularly for antimicrobial prescribing are aligned to divisional performance. The Chief Nurse noted Glycopeptide Resistant Enterococcus (GRE) had remained static and remained under review by the Director of Infection and Control. National Patient Experience surveys had been received and would be released nationally on 12 September 2023. The Chief Nurse provided an overview of nursing and midwifery staffing in which care hours per patient day had increased to 8.3 with vacancy positions gradually improving. Newly qualified nurses and midwives would join the team in September and October.	

	The Committee: - *Noted the Chief Nurse Report.*	
TEG11/09/B3	**Perfect Week**	
	Laura Sherburn of Primary Care Doncaster highlighted that PCD had been working with NHSE to undertake a pilot the Perfect Week methodology within General Practice's - General Practise Improvement Week. It was confirmed this would take place at the Burns practice week commencing 09 Oct 2023 and that this would see an open door for system partners to engage with the programme. Laura invited TEG to actively support the work and participate in the opportunity to improve services ahead of autumn and winter pressures. The Chief Executive thanked Laura for update and encouraged colleagues to get involved.	
	The Committee: - *Noted the Perfect Week and the opportunity to get involved.*	**All**
TEG11/09/C1	**Governance Update (Verbal)**	
	The Director of Corporate Affairs / Company Secretary gave a brief update on the Standards of Business conduct and declarations of interest, and provided information on the Fraud Prevention Notice in relation to working additional substantive roles and the need to inform employers. Divisional Teams were asked to make colleagues aware of updates. The Director of Corporate Affairs / Company Secretary confirmed the Civica database had achieved 85% compliance which included fifty declarations of outside employment. if there were any questions or advice needed colleagues could contact The Director of Corporate Affairs / Company Secretary. The Chief Executive reiterated the importance of declaring secondary roles as per regulations associated with the Counter Fraud Government Agency. The Director of Corporate Affairs / Company Secretary highlighted the policies around reviews and inspections, which had been circulated via email April 2023, Divisions were asked to note the policies and ensure reviews and reports are brought to TEG. The Director of Corporate Affairs / Company Secretary informed of Board Assurance Framework updates that had been approved by Executives and the Board. Of the updates, these included seven strategic risks and reporting processes, each risk would be under review monthly within Quality Effective Committee, Finance and Performance and quarterly to Board of Directors linking with current objectives.	**All** **All** **All**

	The Committee: - *Noted the Governance Update and required actions.*	**All**
TEG11/09/D1	**Finance Update**	
	The Deputy Director of Finance informed the group of key updates within the month five position. • There had been an overall reported £3.5m deficit for month five and £20m year to date deficit, this is within plan. However, the position has deteriorated with in month expenditure increased by £1m of which £500K related to pay costs in nursing and medics, and £500K in non-pay. • £6.3m cash support would be received from the national team and a request for the full year cash support, £25m would be made as part of the Trusts financial plan up to January 2024. The cash support attracts an interest rate of 3.15%. • The ICB had posted a £29.6m deficit at month five with a significant unidentified CIP. • A national meeting was due to be held with Directors of Finance on Wednesday 13 September 2023. Due to the nature of concerns, the Deputy Director of Finance had requested departments worked with finance and asked for further engagement over the next couple of weeks to complete a full year forecast. The Chief Executive asked the group to ensure teams remained focused and used resources wisely. The Chief Operating Officer asked if the Deputy Director of Finance could meet to discuss the differences between DERIK figures and the update given. The Deputy Finance officer agreed to meet outside of TEG. The Acting Medical Director asked about the impact of Industrial action. The Deputy Finance officer confirmed that the national team had adjusted the ask in respect of the delivery of ERF rather than adjusting financial positions. The Acting Medical Director asked if the Doctors pay award had been included and adjusted within the plan. The Deputy of Finance confirmed the Trust would be funded for uplifts. The Chief Nurse noted that there was an expectation that temporary staffing would increase due to school holidays, however a new cohort of newly qualified nurses would reduce the impact of temporary staffing costs. The Divisional Director for Medicine asked for clarification on spend and income within the Emergency Department. The Deputy Director of Finance confirmed monitoring had been undertaken against activity baseline, this information had been provided to	**All** **AC/ DS**

	colleagues but the Deputy Director of Finance would be happy to discuss outside of TEG.	
	The Committee: - *Noted the Finance Update.*	
TEG11/09/D2	**Operational Update (Verbal)**	
	The Chief Operating Officer noted deterioration within Urgent and Emergency Care with the 4-hours emergency care access reduced to 67% with an increase in 12-hour wait from arrival at 3.17%. The Chief Operating Officer informed mutual aid had been requested to support elective recovery but had been unsuccessful so another plan would need to be made. The Chief Operating Officer thanked all who participated in the series of Winter Plan workshops. The Trust had been asked to focus on four key areas within NHS guidance and 4 programmes had been selected: 1. High impact Interventions. 2. Scenario Planning. 3. Roles and Responsibilities. 4. Staff support, health and wellbeing. It was asked of the group to provide feedback to the Chief Operating Officer by Friday 15 September 2023 on impacts and prioritisation of schemes. The Deputy Finance Officer confirmed that the financial plan did not include additional investment for winter as funding had already been allocated to the scheme identified from the 22/23 winter plan. The Chief Operating Officer confirmed that operations and finance had worked successfully with a confirm and challenge approach and that work to ensure delivery of the agreed improvement programmes would continue as delivery of these was an essential component of reducing winter pressures.	
	The Committee: - *Noted the Operational Update.*	
TEG11/09/D3	**People Update**	
	The Deputy Director of P&OD provided four updates. Appraisal Season At the end of appraisal season the Trust had undertaken 87.76% appraisals. It was noted that this was the best performance in recent years but had fallen short of the 90% target. Colleagues were asked to look to improve the position to achieve the 90% standard.	**All**

	Health and Wellbeing The Deputy Director of P&OD gave a summary of the Health and Wellbeing survey in relation to retention rates and keeping fit and healthy. The survey had a response rate of 30% and had shown positive feedback around complimentary services. The Deputy Director of P&OD informed of further work on sickness absence data in efforts to reduce long periods of sickness. The Deputy Director of P&OD was pleased to announce the Trust had received Menopause Friendly Accreditation individually and recognition as a member of the ICP. Long Service Awards The Deputy Director of P&OD shared how the Long Service award had been finalised, refreshed and relaunched to recognise employees for their contributions to the NHS. Staff Survey 2023 Improvement work had been carried out on the staff survey for 2023 in efforts to exceed 2022 response rate of 65%, and to enhance anonymity by grouping small departments together. The Chief Nurse stressed the importance of completing appraisals as CQC would measure the Trust based on the target set. The Divisional Director for clinical services informed that staff retention has not always been able to be maintained due to lack of progression within the Trust. The Chief Nurse agreed it had been difficult, but that it was important to ensure consistency within the Trust and the ICS. The Deputy Director of P&OD confirmed there had been some automatic progressions specific to DBTH, however for future progressions there would be a need to align with workforce around succession planning and talent management. The Chief Executive stated a discussion with the Acute Federation would need to take place.	
	The Committee: - *Discussed the People Update.*	
TEG11/09/D4	**CQC Update**	
	The Chief Nurse updated TEG on the unannounced CQC inspection which had taken place over a period of three days commencing 22 August 2023, initial feedback had been given and the Trust had responded with immediate actions. The trust had now received confirmation of the initial feedback and the Chief Nurse would circulate this to members of TEG for oversight. The Chief Nurse explained that members of CQC team would visit again on the 12 and 13 September 2023 to undertake a document review and asked that Divisions support where necessary. There would also be a visit from CQC Well Led inspection from the 2 to 4 October 2023. It was expected that the Trust would received confirmation of the Outcome of the inspection by the end of the financial year. As this was in effect a whole	**KJ**

	hospital inspection it could result in a ratings review prior to the implementation of the CQC's new assessment framework.	
	The Committee: - *Noted the CQC Update.*	
TEG11/09/E1	**Recovery Innovation and Transformation (RIT) Update**	
	The Director of Innovation and Infrastructure informed how the Trust had been asked by the ICB to submit a baseline assessment in relation to QII, therefore workshops with relevant topics had been underway which would set out methodology for self-assessment. The Director of Innovation and Infrastructure shared with the group how the Theatre and Recovery modules had been built to plan and were due to be delivered 22 September 2023. As part of the build the rota development was near to completion but was four weeks behind. The Director of Innovation and Infrastructure confirmed that the Trust had been as asked by NHSE to trial a climate change assessment and adaptation tool as part of the Green Plan.	
	The Committee: - *Discussed the RIT Update.*	
TEG11/09/F1	**Education and Research Update**	
	The Director of Education and research informed terms and reference had been provided for a role specific approval group. It was asked of the group for nominations to the group to ensure governance oversight by the end of September 2023.	
	The Committee: - *Supported the approval group and agreed to provided nominations.*	**All**
TEG11/09/G1	**ICS Update**	
	The Chief Executive informed that following all ICS's being required to make a running cost reduction SYB and Notts ICS were moving to implement their plans which would lead to revised management structures.	
	The Committee: - *Noted the ICS Update.*	
TEG11/09/H1	**Acute Federation Update**	
	The Chief Executive informed that Dr Joe Butterworth had been appointed as the Acute Federation's Medical Director and that Dr Mike Richmond had been appointed as the Chair of TRFT.	
	The Committee: - *Noted the Acute Federation Update.*	

TEG11/09/I1	**Any other Business (Verbal)**	
	The Chief Executive updated on the closure of the phlebotomy service at Eco Power Stadium with services returning to pre pandemic arrangements. The Acting Medical Director asked If it would be appropriate to talk with the primary care team in relation to next steps. The Chief Executive agreed it would be appropriate. The Director of Innovation and Infrastructure confirmed that RAAC had been removed at BDGH ad that work had been carried out by nominated structural engineers, AJP. The Deputy Divisional Nurse of surgery informed of plaster tiles falling down in Ward 26, with no signs of aging, the Chief Executive confirmed the Acting Director of Operational Estates and Facilities had been investigating this issue. The Chief Executive confirmed it would be the Deputy Divisional Nurse for Surgery, Nikki Sherburn's, last TEG meeting and thanked her for her hard work and effort over many years wishing her well in her new role.	
	The Committee: - *Noted Any other Business.*	
TEG11/09/I2	**Children & Families Board Update**	
	There was no update given for this item.	
TEG11/09/I3	**Minutes of the Trust Executive Group meeting dated Wednesday 14 August 2023**	
	The Committee: - *Approved minutes dated 14 August 2023.*	
TEG11/09/I4	**Date and time of next meeting (Verbal)**	
	Date: Monday 09 October 2023 Time: 14:00 – 17:00 Venue: Via Microsoft Teams	
	The meeting closed at: 16:30	

TRUST EXECUTIVE GROUP

Minutes of the Meeting of the Trust Executive Group (TEG)
Held on Monday 09 October @ 2pm via Microsoft Teams

Present:	Richard Parker – Chief Executive (Chair) Zara Jones – Deputy Chief Executive Sam Debbage - Director of Education & Research Fiona Dunn - Director of Corporate Affairs / Company Secretary Kirsty Edmondson-Jones - Director of Innovation & Infrastructure Jochen Seidel – Divisional Director for Clinical Specialties Suzanne Stubbs – Deputy Chief Operating Officer Andrea Squires - Divisional Director of Operations (Emergency medicine) Ken Anderson - Chief Information Officer Anthony Jones – Deputy Director of P&OD Kirsty Clarke – Divisional Director of Nursing Surgery Donna Smith - ED Business and Operational Manager Alex Crickmar - Deputy Director of Finance Denise Smith – Chief Operating Officer Karen Jessop – Chief Nurse Anurag Agrawal - Divisional Director for Medicine Nick Mallaband - Medical Director for Workforce and Specialty Development (interim Executive Medical Director) Zoe Lintin – Chief People Officer	
In attendance:	Laura Brookshaw - 360 Assurance Anneleisse Siddall – Corporate Secretary (Minutes) Helen Burroughs - Divisional Director of Operations (Children and Families) Kate Carville - Divisional Director of Nursing for Medicine Robert Mason - Head of Quality Improvement Lauren Bowden - Divisional Director of Operations (Specialty Medicine) Andrew Potts - Divisional General Manager for Clinical Specialities Anna Hegarty – Interim Head of Nursing Samantha Fawkes – Acting Head of Nursing for Children's and Neonate Howard Timms – Acting Director of Operational Estates and Facilities Justin Fowler – Head of Business Services Nicki Sherburn – Deputy Divisional Director of Surgery and cancer Laura Churm - Divisional Nurse for Children and Neonates Eki Emovon - Divisional Director for Children and Families Emma Galloway –Divisional Nurse Clinical Specialties Heather Jackson – Director of Allied Health Professionals Howard Timms – Acting Director of Operational Estates and Facilities Andrew Pope – Interim Chief Information Officer	
Apologies:	Dr Tim Noble - Executive Medical Director Jon Sargeant – Chief Finance Officer and Director of Recovery, Innovation & Transformation (RIT) Lucy Hammond - Divisional Director of Operations (Surgery and Cancer)	
		ACTION

TEG09/10/C1	**Risk Management Board Update**	
	The Medical Director explained there were two risks brought to TEG, 3056 STH move from Lorenzo and Risk 3209 Inadequacies in Current manual paper-based tracking. The Medical Director informed further improvements had been made with the support of the Risk manager and Divisions.	
	The Committee: - ***Noted the Governance Update.***	
TEG09/10/D1	**Finance Update**	
	The Deputy Director of Finance updated on the month five position which reported a deficit of £3.5m, and a deficit of £20m year to date, it was noted month six position had deteriorated but final reports had not yet concluded. The Deputy Director of Finance also pulled out key points from the paper provided to TEG. • Temporary staffing spends had not shown further reduction, specifically in nursing. Medical staff agency cost hadn't reduced but were consistent. • The Deputy Director of Finance asked divisions to review their budgets with Finance Business Partners with specific attention to increased purchase of drugs and clinical supply costs. • Elective Recovery Funding (ERF) performance was up £400K at month five, this had been due to the ERF target being reduced from 103% to 101% in relation to Industrial Action, however further guidance indicated that in month six activity would be spread over the financial year which contributed to £1m off plan, year to date. • Capital position was behind plan due to phased MEOC and BEV spending. • The cash balance at the end of August was £15m which had been reduced from £30m due to capital spend and Trust deficit. • £6m National cash support money had been received and the Trust had requested the full £25m cash support. The Deputy Director of Finance thanked all for their support in the bottom up forecast work.	
	The Committee: - ***Noted the Finance Update.***	
TEG09/10/D2	**Operational Update (Verbal)**	
	The Chief Operating Officer informed that the emergency planning initial self-assessment contained sixty-two core standards in which the Trust would have to assess if partial or fully compliant. The Chief Operating Officer stated the Trust was compliant	

	in 41 standards and partially compliant in 21 which equalled 66% compliant against a minimum of 77%. The Chief Operating Officer informed feedback would be received on the Trust's initial self-assessment submission by 27 October 2023 with a five-day turnaround for requests for additional information. The Final assessment would be carried out by local and regional colleagues with a final assessment provided to Trust Boards by 31 December 2023. The Chief Operating Officer informed on the Trusts bed position ahead of winter and assured this had been reviewed with partners and Divisional teams. The Director of Corporate Affairs / Company Secretary asked how the Trust measured within the system in relation to EPRR Standards. The Chief Operating Officer confirmed there hadn't been final submissions to measure against.	
	The Committee: - ***Noted the Operational Update.***	
TEG09/10/D3	**<u>People Update</u>**	
	The Chief People Officer highlighted three key points from the People Update and asked for TEG support / feedback. • The Staff Survey at the time of the meeting had a completed response rate of 33%. TEG members were asked to encourage all departments to complete. • There had been a strategic workforce planning tool implemented in business planning in preparation for 2024. • A Speaking up strategy draft had been circulated and feedback was welcomed outside of TEG.	
	The Committee: - ***Discussed the People Update.***	
TEG09/10/D4	**<u>The DBTH Way Presentation</u>**	
	The Head of OD, EDI and Wellbeing supported the Chief People Officer's presentation of the DBTH Way this included developing the Framework, Launch and embedding and What did it mean for us as a Trust. Members of TEG highlighted topics of discussion within breakout rooms. • Treating everyone how you wish to be treated, and executives role modelling exemplary standards. • Ward visits could be used to accept and give feedback. • Themes leading by example and find opportunities to check and challenge in a realistic way. • How to put things into practice.	

	• How teams are supported. • What this meant as a team. • What is not acceptable. The Chief People Officer thanked all for discussions and reiterated the importance of using the values of DBTH way.	
	The Committee: - ***Noted and participated in the DBTH way.***	
TEG09/10/E1	**Recovery Innovation and Transformation (RIT) Update**	
	The Director of Innovation and Transformation discussed how a meeting had been held with the Deputy Director of Infrastructure and Investment for the Department of Health and Social Care to discuss critical infrastructure and potential funding. it was noted a bid would need to be submitted with a paper submitted through F&P and then to the Board. The Director of Innovation and Infrastructure highlighted how the Trust had self-assessed against the NHS impact standards which provided detailed guidance for Quality Improvement and Innovation in organisations. The Director of Innovation and Infrastructure was pleased to share positive feedback which had been received from the CQC during their inspection in relation to Quality Improvement.	
	The Committee: - ***Discussed the RIT Update.***	
TEG09/10/F1	**Education and Research Update**	
	The Director of Education and Research informed that an Educational Quality Framework had been developed and final feedback would be welcomed by close of play 16 October 2023 in preparation for a formal launch. The Director of Education and Research drew attention to educational frameworks with widening participation in apprenticeship, work experience and clinical attachments. The Director of Innovation and Infrastructure would seek support from TEG members in relation to annual NHSE self-assessment.	**ALL**
	The Committee: - ***Noted the Education and Research Update.***	
TEG09/10/G1	**ICS Update**	
	The Chief Executive informed the ICS was implementing a running cost reduction programme which had been identified nationally. The detailed changes were currently out for staff consultation with a view for implementation to commence in January 2024.	
	The Committee:	

	- ***Noted the ICS Update.***	
TEG09/10/H1	**Acute Federation Update**	
	The Chief Executive informed key points within the Acute Federation had been EPR, Winter Challenges, and recovery and finance. The Chief Executive Informed Acute Federation had appointed Dr Joe Butterworth as Medical Director.	
	The Committee: - ***Noted the Acute Federation Update.***	
TEG09/10/I1	**Any other Business (Verbal)**	
	The Chief Nurse reminded the group of the QPIA Policy signed off at TEG and noted if a QPIA had been undertaken that did not fall under the QI Team this would be reviewed by the Chief Nurse or the Medical Director, an email would be circulated after the meeting. The Director of Corporate Affairs / Company Secretary asked for confirmation from Divisions that the action log had been actioned. The Divisions acknowledged the action log and were content to close actions. The Chief Executive thanked Ken Anderson for the commitment he had shown to the Trust and wished him well in his new role.	**KJ**
	The Committee: - ***Noted Any Other Business.***	
TEG09/10/I2	**Children & Families Board Update**	
	No update was given from the Children and Families Board as the meeting had not been quorate.	
TEG09/10/I3	**Minutes of the Trust Executive Group meeting dated Wednesday 11 September 2023**	
	The Committee: - ***Approved Minutes dated 11 September 2023.***	
TEG09/10/I4	**Date and time of next meeting (Verbal)**	
	Date: Monday 13 November 2023. Time: 14:00 – 17:00 Venue: Via Microsoft Teams	
	The meeting closed at: 16:40	

2309 - I OTHER ITEMS

2311 - I1 MINUTES OF THE MEETING HELD ON 31 OCTOBER 2023

Decision Item | Suzy Brain England OBE, Chair of the Board | 12:25

5 minutes

REFERENCES

Only PDFs are attached

I1 - Draft Public Board of Directors Minutes - 31 October 2023.pdf

BOARD OF DIRECTORS – PUBLIC MEETING

Minutes of the meeting of the Trust's Board of Directors held in Public on Tuesday 31 October 2023 at 09:30 via MS Teams

Present:	Suzy Brain England OBE - Chair of the Board (Chair) Hazel Brand - Non-executive Director Mark Day - Non-executive Director Jo Gander - Non-executive Director Dr Emyr Jones - Non-executive Director Zara Jones - Deputy Chief Executive Zoe Lintin - Chief People Officer Dr Nick Mallaband - Acting Executive Medical Director Lucy Nickson - Non-executive Director Richard Parker OBE - Chief Executive Jon Sargeant - Chief Financial Officer Kath Smart - Non-executive Director Denise Smith - Chief Operating Officer
In attendance:	Simon Brown – Deputy Chief Nurse Lois Mellor - Director of Midwifery Angela O'Mara - Deputy Company Secretary (Minutes) Emma Shaheen - Director of Communications & Engagement
Public in attendance:	Laura Brookshaw – 360 Assurance Denise Carr - Public Governor Bassetlaw Gina Holmes - Staff Side Annette Johnson – Public Governor Doncaster Andrew Middleton - Public Governor Bassetlaw Joseph Money – Staff Governor Lynne Schuller - Public Governor Bassetlaw Sheila Walsh - Public Governor Bassetlaw
Apologies:	Mark Bailey - Non-executive Director Fiona Dunn - Director of Corporate Affairs / Company Secretary Karen Jessop - Chief Nurse

P23/10/A1 **Welcome, apologies for absence and declaration of interest (Verbal)**

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

P23/10/A2 **Actions from Previous Meetings**

There were no active actions.

P23/10/B1 **Chair's Assurance Log – Quality & Effectiveness Committee (enclosure B1)**

Jo Gander, Chair of the Quality & Effectiveness Committee provided an overview of the four quadrants of the Chair's assurance log, positive assurance, areas of major works, areas of focus and decisions made.

Work was ongoing in respect of the clinical governance structure and clinical audit, with a clinical audit deep dive scheduled for 20 November 2023. Compliance with safety action eight of the Clinical Negligence Scheme for Trusts (CNST) continued to be closely monitored by the Director of Midwifery, and Chief Nurse, to support the required training compliance of 90%. The Committee had approved the Patient Safety Incident Response Plan (PSIRP).

The Board:

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

P23/10/B2 **Maternity & Neonatal Update (Enclosure B2)**

The Director of Midwifery brought the key highlights of the report to the attention of Board members. Safety action eight continued to be the greatest risk in achieving Year 5 CNST standards, monitored via the CNST and Ockenden Oversight Committee. The challenges of meeting the compliance rate were recognised, impacted by August's junior doctor rotation. On a positive note, the Board welcomed the intake of 26 whole time equivalent (WTE) newly qualified midwives in mid-October.

The Chief Executive reflected on the challenges related to CNST safety action eight and highlighted the impact of industrial action throughout the year. In response to a question from the Acting Executive Medical Director, completion of in-year training had been considered by the Local Maternity & Neonatal System (LMNS), however, compliance with the standard required completion within the organisation. This matter had been raised at a regional level and was to be escalated nationally in support of partnership working. The wider impact on passporting arrangements was recognised.

In response to a question from Non-executive Director, Hazel Brand, the Director of Midwifery confirmed the need for pre-conception health education, raising awareness and addressing those health risks which had the potential to impact on pregnancy related outcomes. The Chair of the Board noted the need for effective partnership work to support this educational approach.

In response to a question from Non-executive Director, Lucy Nickson, the Director of Midwifery confirmed that the newly qualified midwives received extensive support, with pastoral care from a dedicated resource, including a Professional Midwifery Advocate. The skill mix of the workforce was considered, with mitigating actions to address identified risks. This support was recognised to be a critical part of recruitment and retention.

Non-executive Director, Jo Gander sought clarification on the SCORE survey and enquired how this work dovetailed with the Patient Safety Incident Response Framework and Just Culture. The Director of Midwifery confirmed this was a focused piece of cultural work in maternity services and how best to join this up with the Trust wide work would be discussed with the Chief People Officer.

The Chief Executive acknowledged the importance of system working, critical at times of high demand to ensure service provision, there was good evidence of collaborative working across the LMNS and the Chair of the Board confirmed the Trust's commitment to partnership with a purpose.

In response to a question from Kath Smart in respect of learning from complaints and incidents, the Deputy Chief Nurse confirmed that learning opportunities were taken across the organisation. The introduction of Patient Safety Incident Reporting Framework (PSIRF) was welcomed and would provide a rich source of learning across the NHS. Learning from immediate safety actions was addressed in a timely manner.

The Board:

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

P23/10/B3 <u>**Midwifery Workforce (Enclosure C2)**</u>

The Director of Midwifery's report provided a six-monthly update on the midwifery staffing position, utilising the national Birthrate Plus® tool, in conjunction with clinical judgement.

The latest assessment report, received in August 2022, reflected an increase in acuity since the previous assessment of 2019. Despite a very positive intake of newly qualified midwives the Trust's position remained below that recommended by Birthrate Plus® and the Board offered its support to continue to recruit up to the recommended levels.

In response to a question from the Chair of the Board, with regards to whether commissioner funding was in line with Birthrate Plus® recommendations, the Chief Executive confirmed funding was received from differing sources, via the LMNS on a pro-rata basis and as part of the baseline contract. The funding did not necessarily reflect the level of deprivation in the communities served, which was a factor for the Trust, however, funding to support delivery of a modern maternity service was recognised to be a national challenge.

The Board:

- ***Noted and took assurance from the Midwifery Workforce Report***

P23/10/C1 **Chair's Assurance Log – Finance & Performance Committee (verbal)**

Non-executive Director and Committee Chair, Mark Day, provided a verbal summary following yesterday's Finance & Performance Committee meeting.

The pace of delivery of the Urgent and Emergency Care Improvement Programme was a concern, a number of workstream highlight reports were difficult to take assurance from and in order to seek a Place view, the Executive Place Director had been invited to join the next meeting.

Whilst the Committee was assured by the framework supporting the Cost Improvement Programme, there was a need to review and recover savings against the plan.

A long-term financial forecast had been presented to the Committee which clearly articulated the ongoing financial challenges the Trust would face; the importance of partnership working was recognised, and it was recommended that the Board should consider how best to focus next steps. The Committee was assured by the understanding of the financial position and the in-year plan.

The Directorate of Recovery, Innovation & Transformation continued to progress significant schemes of work, an alternative workforce solution was being considered to support the planned opening of the Mexborough Elective Orthopaedic Centre in January 2024, pending substantive appointments.

In terms of decisions, the Committee had reviewed the Full Business Case for the South Yorkshire & Bassetlaw Pathology Target Operating Model and the Health Inequalities strategy. Both would be recommended to the Board for approval, it was suggested that measures to demonstrate progress of delivery against the strategy be determined.

The written Chair's assurance log would be submitted to the Trust Board Office for uploading to Team Engine.

The Board:

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

P23/10/C2 **Finance Update (Enclosure C2)**

The Chief Financial Officer reported a month six deficit of £4.1m, £23.9m deficit year to date and £1.4m adverse to plan. The variance to plan was driven by Elective Recovery Fund underperformance and the cost of industrial action.

The cash balance as at 30 September 2023 was £21.6m, an increase in month of £6.7m. The Trust received £13.4m in month through revenue and capital cash support, offset by the Trust's deficit position and the Public Dividend Capital revenue payment. An approved cash drawdown request of £14.9m was in place for Q3, £6.3m of which would be received in October.

The Trust had delivered £1.4m of savings in month, £0.4m adverse to plan.

A series of remedial actions to address the financial plan had been agreed, details of which would be communicated across the organisation later this week.

Whilst acknowledging the financial pressures, the Chief Executive recognised operational demand for urgent and emergency care, diagnostics and cancer service and workforce challenges and stressed the importance of a balanced approach to delivery of the financial plan, ensuring that public money was spent wisely.

At a system level there remained unidentified savings of £109m.

The Board:

- ***Noted the Finance Update***

P23/10/D1 **True North, Breakthrough & Corporate Objectives Q2 2023/24 (Enclosure D1)**

The Chief Executive provided the Q2 update on progress towards delivery of 2023/24 corporate objectives, aligned to the delivery of the Trust's strategic aims. The Board Assurance Framework (BAF) identified the risks to delivery of the strategic aims, appropriate gaps in controls and mitigating actions which could be triangulated with the True North and corporate objectives. The paper included an update on the Chief Executive's objectives, which would be reported via Monday.com going forwards.

The Chief People Officer confirmed the requirement for all Board members to have a SMART (specific, measurable, achievable, relevant, and timebound) equality, diversity, and inclusion (EDI) objective by March 2024. Due to the timing of appraisals this had already been incorporated into non-executive director objectives and would be included in the appraisal conversation for executive colleagues this year. The Trust's EDI plan supported this, demonstrating the organisation's commitment to EDI.

In response to a question from Non-executive Director, Lucy Nickson, the Chief Operating Officer confirmed that the final winter plans would be presented to the Trust Executive Group and Finance & Performance Committee in November 2023. Learning from previous winter plans had been identified and acted upon and the need for a partnership approach acknowledged.

Non-executive Director, Kath Smart identified the majority of the objectives remained in progress, which was not unexpected at Q2. The oversight at Board Committees was welcomed, recognising not all elements were entirely within the Trust's control. As the year progressed the Chief Executive recognised that there may well be some elements which stall, particularly as we enter the winter months, and progress would require internal focus, alongside partner collaboration, ensuring that virtual ward opportunities were maximised to support flow through the hospital and timely and safe discharge of those patients who were medically fit.

The Chief People Officer reflected on her objectives related to the delivery of multi-year strategies which she would not expect to be delivered mid-year.

The Chair of the Board confirmed a change of meeting structures would see Chairs join the bi-monthly Doncaster Place Partnership Forum with effect from December 2023.

The Board:

- ***Discussed the Q2 Update of the Corporate Objectives***

P23/10/D2 **Board Assurance Framework (Risks 1-7) & Trust Risk Register (Enclosure B2)**

Following a review by the Board Committees, the updated Board Assurance Framework was introduced by the Deputy Chief Executive. The framework had been iteratively developed to meet the recommendations of the Head of Internal Audit Opinion in articulating the risks to delivery of the strategic aims. There would be further refinement over time to ensure actions and controls were SMART and ultimately the Board Assurance Framework would be used to drive the agendas and work plans of the Board Committees. The Deputy Chief Executive highlighted the connection to the corporate objectives and whilst each risk stood alone, recognised the interconnectivity between them.

The supporting Trust Risk Register was provided, the work of the Risk Management Board was recognised in progressing this and further development and analysis would continue.

In response to a question from Non-executive Director, Jo Gander, the Chief Executive encouraged active discussion and challenge at Board Committees to influence the content, scoring and delivery. The Board Assurance Frameworks were live documents, updated on an ongoing basis. In respect of the clinical governance processes referenced in BAF1, the Acting Executive Medical Director was aware of the need to progress this work and was doing so with the support of the Chief Nurse. A fresh eyes review of organisational governance would be completed by the Deputy Chief Executive.

Reflecting on the topics of discussion at today's Board, the Chief Executive noted that all seven strategic risks had been referenced which validated their appropriateness.

In respect of strategic risk three, Non-executive Director, Kath Smart suggested a review of the current risk rating of 12 in view of current capacity, inclusion of the waiting list clinical prioritisation internal audit report was recommended as a control to close the gap and the lack of any linked operational risks highlighted. The Chief Operating Officer confirmed she was currently reviewing the operational risks and would reflect on the suggestions made.

Following recent press coverage, Non-executive Director, Hazel Brand enquired if the Trust's risk register included a risk linked to the use of artificial intelligence (AI). Failure to protect against a cyber-attack was included and whilst there was the potential for technology to be exploited, this was likely to be the subject of a national directive. The Chief Executive recognised the potential for AI to assist healthcare provision, e.g. the use of robotics and a business case would be received at a future Charitable Funds Committee, further opportunities to explore AI may be the subject of a board workshop.

The Board:

- ***Noted and took assurance from the Board Assurance Framework & Trust Risk Register***

P23/10/D3 **Chair's Assurance Log – Audit & Risk Committee (Enclosure D3)**

Kath Smart shared the key highlights from the Audit & Risk Committee's assurance log, which had been adapted to include levels of assurance for areas of concern and positive assurance. This approach would be adopted by the remaining Board Committees in future reports.

The limited and moderate assurance internal audit reports had been referred to the relevant Board Committee and further clarification had been sought on the use of lone worker devices.

The Emergency Preparedness, Resilience and Response annual assurance process had returned an initial self-assessment of 66% compliance, which resulted in an overall rating of non-compliant. Feedback on the initial submission was awaited.

The Committee recommended the refreshed Risk Management Policy for Board approval.

The Board:

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

P23/10/D4 **Chair's Assurance Log – Charitable Funds Committee (Enclosure D4)**

Non-executive Director, Hazel Brand provided an overview of the positive assurance, areas of major works, areas of focus and decisions from September's meeting.

The Committee recommended approval of the refreshed Charitable Funds Policy and the Charitable Funds Committee terms of reference to the Board.

The Board:

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

P23/10/D5 **Charitable Funds Policy & Charitable Funds Committee Terms of Reference (Enclosure D5)**

The Deputy Company Secretary presented the refreshed Charitable Funds Policy and Charitable Funds Committee terms of reference, recommended for approval by the Charitable Funds Committee.

The content of the policy and terms of reference had been aligned to reflect all voting board members as trustees and the removal of the terms of reference as an appendix to the policy.

The Board:

- ***Approved the Charitable Funds Policy & Charitable Funds Committee Terms of Reference***

P23/10/D6 **Review of Risk Identification, Assessment and Management Policy (Enclosure D6)**

The Deputy Company Secretary presented the draft Risk Management Policy, updated following extensive consultation and in accordance with best practice recommendations from the Trust's internal auditors.

The policy had been recommended for approval by the Audit & Risk Committee.

The Board:

- ***Approved the Review of Risk Identification, Assessment and Management Policy***

P23/10/D7 **Use of Trust Seal (Enclosure D7)**

The report confirmed the use of the Trust Seal on the Bassetlaw Emergency Village contract, which had been subject to scrutiny by the Head of Procurement and the Chief Financial Officer.

The Board:

- ***Noted the use of the Trust Seal***

P23/10/E1 **Any other business (to be agreed with the Chair prior to the meeting)**

No items of other business were received.

P23/10/E2 **Governor Questions regarding the business of the meeting (10 minutes) ***

On behalf of the Council of Governors, the Lead Governor asked the following questions:

"Do NEDs feel they have sufficient assurance that the method of compartmentalisation employed at times of fire and emergency will effectively maintain patient and staff safety and ease evacuation if required?"

As Chair of the Audit & Risk Committee, Kath Smart confirmed the Committee received assurance on fire and health and safety matters. In addition, on an annual basis the Board received the Premises Assurance Model assessment which provided assurance on regulatory and statutory requirements relating to its estate.

Non-executive Director, Hazel Brand, confirmed the requirement for all board members to undertake mandatory fire safety training and this awareness and internal controls provided internal assurance, with external assurance provided by South Yorkshire and Nottinghamshire Fire & Rescue Service.

Following the internal incident in the Women & Children's Hospital in April 2021, the Chief Financial Officer confirmed the Trust had commissioned an external report, the recommendations from which had informed an action plan. The Health & Safety Committee had oversight of this improvement plan and a quarterly progress update was reported to the Finance & Performance Committee. Horizontal evacuation was possible at Bassetlaw and Montagu, whilst Doncaster Royal Infirmary required a decant area.

"Are NEDs assured that the quality of rest rooms for non-resident consultants and Senior Doctors are maintained to a good condition and standard in order to provide good quality rest to enable safe working practices?"

The Chief Executive confirmed that rest room provision had been discussed at the Trust Medical Committee, where photographs of the refreshed facilities had been shared, as with any refurbishment the need for ongoing maintenance was acknowledged. In

addition, sleep pods had been procured to provide a private, quiet space to rest and alternative private sector accommodation sourced.

The Chief Financial Officer confirmed the potential for alternative, longer term solutions to be explored across the estate, including the recently cleared Lister Court.

"Governors note the need to adhere to CNST standards within a designated timeframe. Are NEDs assured that a robust action plan is available to meet the standards enabling the Trust to meet its True North Value and Vision of being the safest trust in England."

Dr Emyr Jones, Deputy Chair of the Quality & Effectiveness Committee and Board level Maternity Safety Champion commended the Director of Midwifery and her team for their considerable efforts towards delivery of this standard, the challenges faced had been discussed at agenda item B2. Whilst there was a financial impact of non-compliance, the focus remained on delivery of a safe and quality service, where identified risks were mitigated. Prior to the submission date a meeting of the Maternity Safety Champions would take place and an up-to-date position would be validated. As part of its responsibilities, the LMNS had recently completed a confirm and challenge review.

The Lead Governor welcomed the need for the passporting of training, which signalled the commitment to collaborate, a statutory duty of the 2022 Health & Care Act.

The Board:

- ***Noted the governor question***

P23/10/E3 **Minutes of the meeting held on 26 September 2023 (Enclosure E3)**

- ***The Board approved the minutes of the meeting held on 26 September 2023***

P23/10/E4 **DBTH Self-certification Protecting & Expanding Elective Activity (Enclosure E4)**

- ***The Board noted the DBTH Self-certification Protecting & Expanding Elective***

P23/10/E5 **Date and time of next meeting (Verbal)**

Date: Tuesday 23 November 2023
Time: 09:30am
Venue: MS Teams

P23/10/F **Close of meeting (Verbal)**

The meeting closed at 11:25

2311 - I2 ANY OTHER BUSINESS (TO BE AGREED WITH THE CHAIR PRIOR TO THE MEETING)

Discussion Item | Suzy Brain England OBE, Chair of the Board | 12:30

2311 - I3 GOVERNOR QUESTIONS REGARDING THE BUSINESS OF THE MEETING

Discussion Item | Suzy Brain England OBE, Chair of the Board | 12:30

10 minutes

2311 - I4 DATE AND TIME OF NEXT MEETING

Information Item | Suzy Brain England OBE, Chair of the Board | 12:40

Date: 19 December 2023
Time: 9:30
MS Teams

2311 - I5 WITHDRAWAL OF PRESS AND PUBLIC

Board to resolve:
That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public

2311 - J MEETING CLOSE

12:40