ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Committee Supporting Papers	**Agenda Item**	Paper W
Sponsoring Executive	Kathryn Lavery, Chair		
Report Author	Various		
Meeting	Board of Directors	**Date**	26 September 2024

Suggested discussion points (two or three issues for the meeting to focus on)

With reference to the earlier agenda item (15b) EPRR provisional standards submission (Annex 6 to Paper K) attached to this paper is the **Business Continuity Management Policy**. This has been revised and updated to reflect the current processes in place at the Trust and in line with the Standards it is presented for approval by the Board of Directors, having previously been supported via the Operational Management Group (OMG).

The following reports, received and discussed by the Quality Committee (QC) and People & Organisational Development (POD) Committee are presented today to be noted by the Board of Directors. A commitment has been made to achieve future annual reporting to Board in July 2025.

Health, Safety and Security including Fire Safety Annual Report 2023/24 – The QC received the report in relation to health, safety, fire and security. The version received did not contain specific detail of fire safety although the topic was discussed by the QC. The version included within this Board pack now contains that information relating to fire safety.
Safe Staffing – Six Monthly Review – The QC received a six-month review of Safe Staffing and noted that it contained evidence of the operational management of day to day safe staffing and forward look to manage nurse staffing resources effectively.
Medical Revalidation Annual Report 2023/24 – the POD Committee was Assured that robust systems and processes are in place for Medical Revalidation, including adherence to the national requirements.
Guardian of Safe Working Hours – the POD Committee was Assured that there are appropriate systems and processes in place to ensure safe working hours and compliance to regulatory requirements for our trainee doctors.

Alignment to strategic objectives (indicate with an 'x' which objectives this paper supports)	
Business as usual	x

Previous consideration

The documents have been presented to the Quality Committee (17 September 2024) and People & Organisational Development Committee (21 August 2024).
Business Continuity Policy was received by CLE OMG meeting in September and the content supported for recommendation to the Board for approval.

Recommendation

The Board of Directors is asked to:

x	**CONSIDER** and note the appended reports for information
x	**APPROVE** the Business Continuity Management Policy

Impact

Trust Risk Register		O 4 /23, N 8/24, NQ 16/23, RCG 5/24					
Strategic Delivery Risks							
System / Place impact							
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

Appendix (please list)

Refer to Agenda Pack B

Rotherham Doncaster and South Humber NHS Foundation Trust

Business Continuity Management Policy

DOCUMENT CONTROL:	
Version:	1.2 draft (to be V2 when issued)
Ratified by:	Board of Directors
Date ratified:	
Author:	EPRR Officer
Responsible committee/individual:	Trust Accountable Emergency Officer
Date issued:	
Review Date:	
Target Audience:	All Staff
EPRR Core Standards Reference:	44 – BC Policy Statement

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Distribution List

Issued To	Hard Copy/Electronic
Accountable Emergency Officer (Chief Operating Officer)	Electronic
EPRR Team	Electronic
Copy available via EPRR page on the Trust Intranet	Electronic
MOS, SMOC and DOC colleagues via: L:\Corporate\Trust OnCall Rotas\.....	Electronic
Emergency Cupboard – Boardroom 2, Woodfield House, Tickhill Rd, Doncaster	Hard Copy
All colleagues with a role in the policy	Electronic

Record of Amendments

Version	Date	Author	Description of Change
V1.1	14/08/2024	David Harvey	Complete rewrite of the policy in order to bring the policy fully in line with the requirement of NHSE and of IOS 22301.
V1.2	16/09/2024	David Harvey	Updated based on the Trust wide consultation and the recommendations raised via this consultation.

Contents

1.0 Introduction

Business continuity is the key discipline that sits at the heart of building and improving the resilience of organisations. It is a tried and tested methodology that an organisation should adopt as part of its overall approach to managing risks and threats. Business Continuity Management (BCM) is a management led process which identifies and mitigates risks and disruptions that could affect the ability of the organisation to continue to deliver its prioritised activities during a disruptive incident. BCM identifies organisational continuity requirements and implements recovery strategies. It also supports the design and implementation of plans and procedures used by professionals to protect and continue the value creating operations of an organisation during a disruption.

The Civil Contingencies Act 2004 and its associated statutory guidance places a duty on Rotherham Doncaster and South Humber (RDaSH) NHS Foundation Trust as a Category 1 responder to have Business Continuity Plans in place so that they can perform their critical activities in the event of an emergency or business interruption. All NHS funded organisations are expected by the Department of Health and Social Care to ensure that their Business Continuity Management System (BCMS) conforms to the requirements laid out in International Organisation for Standardisation ISO22301: 2019 – Societal Security – Business Continuity Management and its associated guidance as well as the service specifications and the business continuity requirements withing the NHS England EPRR Core Standards.

1.1 Scope

This policy applies to all parts of RDaSH, embracing all directorates, teams and individuals with no exclusions although emphasis is placed on those departments who are responsible for or directly support the Trust key functions. The policy is to be read in conjunction with the Trust's emergency plans and falls within the remit of the RDaSH EPRR arrangements.

For the purpose of this policy a business continuity incident is an event or occurrence that disrupts (or might disrupt) RDaSH's normal service delivery below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level.

1.2 Aim of the BCMS Policy

To have an effective BCMS in place to meet our legal and statutory obligations, to ensure that in the event of a business disruption or emergency we can meet the needs of our patients by continuing to deliver the Trust's seven prioritised activities.

1.3 BCMS Policy Objectives

To meet the needs of our patients

- Continue to develop, maintain and continuously improve a BCMS taking into account: our patients, our partners, our risks, lessons identified, feedback from users and stakeholders which maintains and enhances compliance with ISO22301, International Standard for Business Continuity
- Use the BCMS to identify, protect and maintain prioritised activities, in order to deliver and recover service to an acceptable level as defined by the Trust
- To develop appropriate plans, arrangements and processes which address the risks; tolerate, treat, transfer or terminate the impact of any disruption to the BCMS identified prioritised activities
- To maintain, exercise and test the plans, arrangements and processes and 6 where changes are identified, revise plans, arrangements and processes so that the elements of the BCMS remain current and effective in operation
- To embed business continuity into the culture of the organisation through training and education and raising awareness through staff engagement
- All RDaSH departments' Business Continuity Leads will come together at least annually to ensure that business continuity plans are developed collaboratively to ensure appropriate interdependences between departments are written into plans
- Business Continuity Leads will meet at least annually with the EPRR Team to revise plans and arrangements and provide assurance of ongoing continuous improvement
- The Trust will set annual business continuity specific objectives for the BCMS at the EPRR Group

1.4 Associated Plans

This plan should be read in conjunction with the following plans and policies:

Critical/Major Incident Plan
Incident Control Centre (ICC) Plan
EPRR Incident Communication Plan
Emergency Preparedness, Resilience and Response (EPRR) Policy
Risk Management Framework
Business Continuity Management Guidance Document

2.0 Process

RDaSH will take the approach required by the ISO 22301:19 standard and the Business Continuity Institute Good Practice Guide (GPG) (updated 2023) which will ensure that the Trust develops a Business Continuity System which is in line with the Civil Contingencies Act (2004) statutory requirements relating to business continuity. This approach, based on best-practice, will ensure that the organisation can achieve its objectives for business continuity.

It adopts the well-established Business Continuity Management lifecycle.

The Trust is committed to maintaining its alignment to ISO 22301 as part of its continual improvement and assessment which is conducted by independent auditors.

The BCMS guidance document supports the Trust BCMS Policy by provided specific information, templates and guidance on RDaSH's intention in relation to the BCMS and should always be adhered to in the development of any new BC plans and arrangements.

The absence of business continuity may have critical consequences; therefore, the Trust adopts the process as part of good management practice, contributing towards the reduction of risk, thus ensuring that the key strategic intentions and core values of the service are achieved.

This obligation requires more than simply writing business continuity plans. The Trust is committed to an on-going management and governance process, fully supported by the Board which is appropriately resourced.

- Each department will have a current and up to date Business Impact Analysis
- Each department will have a current and up to date Business Continuity Plan
- Each department will have a current and up to date Staff Mapping document
- Each department will have completed risk assessments in relation to its Business Continuity risks
- Each department will test annually its business continuity arrangements via an exercise and produce a report of the exercise, the Trust will accept an 80% compliance rate on testing and exercising
- Each department will identify lessons and establish an action plan to embed learning into established practice, monitoring and reporting will be by the EPRR team
- The EPRR Team will conduct audits of the Business Continuity Management arrangements of all it's suppliers or commissioned providers who are deemed to be vital to the provision of any of the Trust's critical activities.

3.0 Risk

The Trust, in line with current guidance and policy, will continually risks assess all risks faced by the Trust including climate change, with these risks then feeding into the Trust's Business Impact Analysis and Business Continuity Plans. Identified Business Continuity risks will be handled and dealt with as part of the Trust's wider EPRR risk register. For further details please see the Trust's Emergency Preparedness, Resilience and Response (EPRR) Policy and Risk Management Framework.

4.0 Business Continuity Management Guidance Document

The Trust will maintain a Business Continuity Management Guidance Document, which will supplement this policy, providing additional information, detail and templates to all departments and staff within the Trust. This guidance document will include the following things as a minimum:

- The process and requirements for conducting a Business Impact Analysis/ Assessment, including corporate templates for this document.
- The process and requirements for conducting creating a Business Continuity Plan, including corporate templates for this document.
- Further detail regarding the requirement to conduct exercises of Business Continuity Plans, including exercises in a box templates.
- Sets out a clear process for auditing business continuity management within the trust itself and within its commissioned suppliers and providers who are connected to providing the Trust's critical services.

5.0 Training expectations for staff

5.1 EPRR Team

The EPRR Manager and EPRR Officer will maintain the appropriate training and awareness, competencies and currency in relation to the BCMS.

5.2 BC Leads

Each department must have an identified, competent BC Lead. Nominated individuals must meet the requirements of the BC Lead role profile; full training and on-going support will be provided to the BC Lead by the EPRR Team. Assessment of competence will be conducted by the EPRR Team; any learning gaps will be escalated to the plan owner. Any additional none BC specific competency requirements will be identified in the Trusts Training Needs Analysis (TNA).

5.3 RDaSH Staff

All staff have access to information on the Trust's intranet to improve understanding of the topic. In addition, a business continuity awareness e-learning package is available to all staff on ESR. Department/Service heads are responsible for promoting uptake within their departments.

6.0 Business Continuity Incidents and Plan Activation

6.1 Authorisation Level for the Activation of a Business Continuity Plan

The authorisation level for the activation of a business continuity plan within the Trust is significantly different to that of a critical/major incident, with this being due to the nature of business continuity incidents. As such the authorisation level for the activation of a business continuity plan and incident is that of a Band 7 Team Leader and above, or equivalent, within the Trust.

6.2 Management of a Business Continuity Incident

The management of a Business Continuity Incident will be conducted as standard in line with and using the normal management and supervision structure of the Trust. With Business Continuity issues being escalated via these normal channels from service level to directorate level and finally to a whole organisation response.

There will be no special or additional Command and Control structures or functions put in place as standard when responding to a Business Continuity Incident within the Trust.

In a situation occurs where the Business Continuity Incident escalates to such an extent (such as a requiring a whole organisation response) that there becomes the need to stand up a command and control structure, then the Chief Operating Officer or their Deputy may choose to do this, or the Director on call out of hours, as specified within the out of Hour Management Provision Policy. In the event of this occurring the command and control structure detailed within the Trust Critical/Major Incident Plan should be followed, and this Plan should be referred to.

Additionally, if the Chief Operating Officer, their Deputy, or the Director on call decide that an Incident Coordination Centre (ICC) needs to be established to be able to effective respond to a Business Continuity Incident the Trust Incident Coordination Centre (ICC) Plan should be followed.

6.3 Moving from Business Continuity to a Critical/Major Incident

A business continuity incident is an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level. Once an incident moves away from this definition and starts to meet the definition of a Critical or Major Incident, then the Trusts Critical and Major Incident Plan should be activated and followed.

6.3.1 Definition of a Critical Incident

A Critical Incident is any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions.

6.3.2 Definition of a Major Incident

A Major Incident is defined as an event or situation with a range of serious consequences which requires special arrangements to be implemented by one or more emergency responder agency. Or any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented.

6.4 Communication During a Business Continuity Incident.

If there becomes a need for large scale or specific communication with staff, patients or the wider public during the response to a Business Continuity Incident, then the Trust's EPRR Incident Communication Plan should be referred to and active as required.

7.0 Implementation of this Policy

The latest approved version of this document will be posted on the Trust Intranet site and on the RDaSH Resilience Direct webpage for all members of staff to view. New members of staff will be signposted to how to find and access this guidance during Trust Induction.

8.0 Monitoring compliance with this Policy

The effectiveness of this policy and the BCMS objectives will be monitored through:

- The Trust's EPRR Group and Operational Management Group, with these groups providing assurance to the Trust Executive Group (TEG)
- The BCMS will be subject to an annual top management review as defined in the ISO22301 international standard
- The outcome of the annual top management review, along with an update on business continuity actions and issues, will be reported to the Trust Board in the EPRR update
- Audit of the BCMS as per the RDaSH BCMS internal audit programme covering the whole of the BCMS on a rolling 3-year programme
- Training records, progress reports, BCMS tracking documents
- Debriefs and lessons identified via debrief reports and reporting via the EPRR Team.

9.0 References

BRITISH STANDARDS INSTITUTE. ISO22301:2019 Societal Security Business Continuity Management Systems – Requirements. London: BSi BUSINESS CONTINUITY INSTITUTE Good Practice Guidelines 2023 available at; www.thebci.org
CABINET OFFICE. 2004. The Civil Contingencies Act 2004, London: Cabinet Office
NARU. 2015. NHS England Emergency Preparedness Resilience and Response Framework.

Rotherham Doncaster and South Humber NHS Foundation Trust

Annual Report 2024

Health, Safety and Security including Fire Safety

Jill Cross
Health and Safety Lead

September 2024

RDaSH nurturing the power in our communities

Contents

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Executive Summary

This report is intended to provide assurance that the Trust is meeting its legal requirements in relation to health, safety, security including Fire Safety.

In addition the Health and Safety Team continue to contribute to patient focused activities, including carrying out ligature risk assessments.

Performance overview

94% **Compliance with health & safety training** Training and information	**6112** **Incidents reviewed** Monitoring
10 **RIDDOR incidents reported** 1 less than 2022/23	**7** **Health and safety policies reviewed**
96.2% **Compliance with Fire Safety training**	

Key legal requirements for health and safety and actions taken by the Trust to comply with these are summarised below. It is important to note that although the Trust has many suitable and legally compliant health and safety arrangements in place, there is still evidence from workplace monitoring and incident reporting which demonstrates that sometimes risk assessments have not been completed.

Legislation	Description of actions/ compliance	Recommendations
Health and Safety at Work Act 1974	• Written health and safety policy. • Consultation with trade union and health and safety representatives at the Health, Safety and Security. Forum that meets every two months • Health and safety training is mandatory for all employees.	Prompt repair of building damage and regular maintenance by Estates.
Management of Health & Safety at Work Regulations 1999	• Risk assessments required within policies. • Annual health and safety inspection programme in place. • Health and safety annual report • Health, Safety and Security training in place that includes risk assessment.	Continue to identify where risk assessments are not in place through health and safety inspections.

	• Individual risk assessments carried out for pregnant workers (Family Leave Policy). • Individual risk assessments carried out for young people on placements. • Competent persons appointed. • System in place to report areas of further action, following inspection to Care Group Director.	
Display Screen Equipment Regulations 1992 (amended 2002)	• DSE policy in place. • DSE self-assessment checklist in place. • Information periodically circulated on agile/home working and DSE assessments. • Training is available for staff on ESR, however it is not mandatory. Manual Handling training contains some DSE elements.	On-going audit of local arrangements with Manual Handling Team and supply of suitable equipment
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)	• RCA Investigations in place for all RIDDOR incidents and the findings are shared with the H&S Forum and where appropriate Environmental Risk in Clinical Areas Group • Incident Management Policy in place detailing RIDDOR reporting process. • All RIDDOR incidents are reported to HSE	✓
Health & Safety Information for Employees Regulations (Amendment) 2009 Health & Safety Consultation with Employees Regulations 1996 Safety Representatives and Safety Committees Regulations 1977	• Health and safety law poster is displayed in Trust premises, providing information about how to contact HSE and EMAS. • Health, Safety and Security Forum in place to allow consultation with trade union and staff representatives about health and safety arrangements. • Policy review consultation process.	✓
Control of Substances Hazardous to Health 2002 Electricity at Work Regulations 1989	• COSHH policy in place, compliance is reviewed annually as part of health and safety inspections. • Incident reporting process in place to identify any areas of risk. • Authorising Engineers for Estates-related topics (asbestos and electricity).	✓

Workplace (Health Safety & Welfare) Regulations 1992 Provision and Use of Work Equipment Regulations 1998 The Control of Noise at Work Regulations 2005 Control of Asbestos Regulations 2012 Personal Protective Equipment at Work Regulations 2022	• Person lifting equipment tested at timescales required by relevant regulations. • Estates and Facilities leads in place to advise. • Health and Safety Team in place to advise. • PPE and Work Equipment policies in place. • Advice and guidance from Infection Prevention and Control (IPC) Team in place. • Fit Testing process in place. • First Aid policy in place. • Guidance in place for managers on completing first aid risk assessments. • System in place to escalate for action if first aid risk assessment is not up to date as found during health and safety inspections.	
Regulatory Reform (Fire Safety) Order 2005 (RRFSO)	Key actions required to ensure arrangements are legally compliant include: • Further development of safety information resources to clarify roles and responsibilities at all levels, with particular focus on managers. • Further development of a health and safety audit programme to compliment the health and safety inspections for clinical areas. • Continuation of the review of DSE and home working arrangements and the provision of suitable IT equipment in collaboration with IT. • Review of RIDDOR reporting processes and paperwork to tie in with the recently updated HSE reporting form.	✓

1. Introduction

This report reviews health and safety performance throughout the Trust during the financial year 1st April 2023 to 31st March 2024. Its intention is to provide assurance around legal compliance and to highlight any areas for improvement.

Effective management of health and safety risks helps the Trust to:

- Maximise the well-being and performance of its employees
- Prevent people getting injured, ill or killed by their work
- Minimise the likelihood of prosecution and consequent penalties
- Reduce reputation damage
- Encourage better relationships with partners and contractors

2. Background

The Health and Safety at Work Act (HSWA) 1974 is the UK's primary health and safety legislation and sets out the framework for managing workplace health and safety in the UK. It defines the general duties of employers (section 2) and employees (sections 7 and 8) as well as owners. The other main legislation is the Management of Health and Safety at Work Regulations 1999. These can be found in appendix one and two.

- A safe place of work
- Adequate welfare provisions for employees at work
- Suitable information and training at induction, introduction of new or increased risks and to refresh knowledge
- Equipment and personal protective equipment needed for health and safety purposes and ensure it is maintained
- A written health and safety policy where there are more than 5 employees
- A means of consulting employees about their risks at work and current preventive and protective measures
- A 'competent person' to oversee health and safety.

They must also:

- Manage risk and carry out risk assessments
- Take action to reduce or eliminate risks

A number of other secondary health and safety regulations sit beneath the primary legislation of the HSWA. These are specific to individual workplace hazards, some of which are relevant to the activities of the Trust and some which are not.

Applicable regulations include:

- COSHH (Control of Substances Hazardous to Health)
- Health and Safety (Display Screen Equipment)
- Health and Safety (Sharp Instruments in Healthcare)
- Lifting Operations and Lifting Equipment
- Manual Handling Operations
- Personal Protective Equipment at Work
- Provision and Use of Work Equipment
- Regulatory Reform (Fire Safety) Order
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
- Work at Height
- Workplace (Health, Safety and Welfare)
- Provision and Use of Work Equipment
- Regulatory Reform (Fire Safety) Order 2005 (RRFSO)

Failure to do so could result in prosecution or fines. Directors remain liable for health and safety failings even if responsibility is delegated to a third party.

This report will review the current arrangements in place to ensure compliance, monitoring arrangements to check their suitability and recommendations for further action.

3. Assessment

The Trust has a variety of processes and arrangements in place to manage health and safety in the workplace, in line with the legal requirements. These include:

3.1. Competent health and safety advice

The Health and Safety Team hold suitable skills, qualifications and experience to provide competent advice to the Trust. The Health and Safety Lead meets the requirements of the Health and Safety at Work Act to be the Trust's nominated 'competent' person for health and safety and is a chartered health and safety professional.

3.2. Policies

The Trust is compliant with the requirement to have a written health and safety policy. The policy provides details about the arrangements for health and safety in the Trust, including roles and responsibilities, risk assessment and training. This incorporates the health and safety statement signed by the Chief Executive, demonstrating the Trust's commitment to effective safety management.

The policy is supported by a comprehensive suite of health and safety policies that address statutory requirements. The policies are kept under on-going review and are generally reviewed every 3 years unless there are legislation or other changes that suggest they need amendments. The Health and Safety Team also provide an input into other Trust policies that may have a safety aspect.

It is considered that there are sufficient policies to cover the main risks in the Trust.

3.3. Consultation and communication

The Trust consults employees and trade unions regarding health and safety through relevant meetings, as required under legislation. The key meeting for the discussion of employee safety is the Health, Safety and Security Forum. This meets every two months and acts is a means of consulting, informing, and discussing health, safety, fire and security issues, including policies.

In addition, relevant health and safety information and employee incident data is also provided to various Trust meetings.

3.4. Training and information

Overall compliance with health and safety training was 94% in 2023/24. This is a 1% reduction compared to 2022/23 (Appendix 1).

The Health and Safety Team now incorporates sharps training which is a requirement of a Health and Safety Executive (HSE).

The Team recently requested South Yorkshire Police to deliver a dangerous dog training course to employees. This is particularly beneficial for community colleagues who visit patients' premises where dogs may be present.

The Health and Safety Team also have an intranet site containing comprehensive information that is accessible to all Trust employees. There is on-going work to continue to provide useful and relevant information to employees via this route.

3.5. Risk assessment and mitigation

All topic specific health and safety regulations, such as manual handling require risk assessments to be carried out.

Risk assessments are carried out at a Care Group level and may apply to individuals rather than tasks or groups. However, all areas have developed a health and safety folder with the support of the Health and Safety Team, providing guidance about the content so that all of the information is contained in one location and is accessible to employees. Monitoring of the folder content and risk assessments during annual health and safety inspections provides reasonable assurance that suitable risk assessments are in place. This has been deemed as positive practice in other Trusts and ensures a structure is in place to highlight risks in areas and how these are managed.

Details about specific topics are given in the following sections.

3.5.1. Display Screen Equipment (DSE)

There is recognition from incident reports and requests for specialised DSE assessments and equipment that employees are suffering from musculoskeletal injuries from the use of computer equipment. A link to increased agile and home working is likely, based on feedback from colleagues and the details contained in incident reports.

The Health and Safety Lead and Manual Handling Team have been working with Information Technology colleagues to provide additional equipment for employees who are hybrid or home workers. This has been supported by internal information communications to raise awareness of the requirements.

Online DSE training is available via the ESR portal and all employees who regularly use computer equipment are required to undertake a DSE self-assessment.

3.5.2. Lone working

Employees who work alone are required to complete a lone working risk assessment and submit a copy to the Trust's Security Advisor. The assessments are created and maintained locally and are viewed as part of the annual health and safety inspection.

The Health and Safety Team have recently undertaken an audit to identify work groups who are likely to be lone workers and provided information and advice about lone working risk assessments and lone working devices. The Team regularly monitor use of the lone working devices supplied by an external company. The company is currently updating the devices in the Trust which requires the return of existing devices. This has highlighted that many devices are not being used and a number have been lost, resulting in a financial cost to the Trust.

3.5.3. Pregnant workers

When an employee informs the Trust that they are pregnant the Trust has a legal duty to undertake a separate individual risk assessment, as there may be additional risks. A risk assessment should be carried out and retained locally. The trigger for a risk assessment to be completed is when an employee declares their pregnancy and contacts the People and Organisational Development Team. A copy of the assessment is forwarded to the Health and Safety Team for review. This process seems to work well and a high number of assessments are received on a regular basis.

Whether an employee remains working in a high-risk area, such as a mental health ward lies with the individual, as pregnancy and maternity is a protected characteristic under the Equality Act.

3.5.4. Personal Protective Equipment (PPE)

The recent increase in measles cases required the use of respiratory protective equipment, specifically FFP3 face masks. However, for the masks to work effectively and protect the user there must be a tight fit to prevent the ingress of the virus. Face fit testing must be carried out to ensure the correct fit for each user due to the variation in facial characteristic between individuals.

The Health and Safety Team provided support to the Infection Prevention and Control (IPC) Team to ensure that sufficient numbers of face fit testers were identified and trained to carry out mask fitting and testing for employees who could potentially come into contact with infected individuals.

There is now a high level of assurance that relevant employees have a suitable mask to provide protection against infection.

3.5.5. Fire Safety Regulations

There are 127 buildings in the estate that require a fire risk assessment (FRA). Currently there are 10 buildings not in use, 1 recently vacated and 9 for which, CHP/Landlord complete the FRA.

As of 5 July 2024, 53 FRAs have been completed and a further 13 booked in. Patient and higher risk areas have been prioritised.

There are no fire safety risks to escalate from the Fire Safety Officer.

Assessment of completed Fire Risk Evacuation Procedures

- **Fire Evacuation Procedures** – These are reviewed and discussed during the FRA to ensure they meet the requirements of the building and work processes. Any concerns will be discussed during the FRA or at a date that suits the occupants.

- **Fire Drills –** To meet HTM recommendations these are required to be completed annually. RDaSH policy advises to follow the frequency advised by the Fire Safety Advisor. These are reviewed during the FRA and/or following a completed drill.

- **Fire Extinguishers –** Form part of the daily fire safety checks and are being completed to a high standard in the buildings assessed so far. Extinguishers are subject to an annual service by the appointed competent contractor.

- **Fire Signage –** Only minor issues have been identified and have been addressed by the Fire Safety Advisor. Fire signage is under constant review and is part of the FRA's, any signage required is being dealt with in a timely manner.

- **External Fire Escape Stairs –** A gap in structural and condition checks was identified. The trust has 4 sets of external fire escape stairs, structural

surveys were completed on these during the 22nd and 23rd February by Peter Vincent Design Ltd. and no significant issues were found.

The recommendations for remedials are in the process of being addressed. An agreement has been reached to schedule condition checks using the new maintenance reporting system.

- **Emergency Lights Annual Testing –** Records confirm the annual discharge testing is being completed by a contractor.

- **Annual Fire Alarm Servicing –** This is being carried out by a fire alarm contractor and is compliant. Every device on the system is checked once a year and the whole system functionality is checked.

- **Fire Door Inspections –** Functionality and damage checks are completed as part of the fire safety daily checks. The FRA process has found that the daily checks are completed diligently.

- **Fire Compartment Inspections –** Integrity of compartmentation is reviewed under the FRA process

- **Fire Hydrants -** Currently reviewing the position regarding maintenance and signage. Awaiting further advice from SYFRS Water Officer.

Details of the Fire Safety training results can be found in the table in Appendix 2.

4. Monitoring

In order to ensure legal compliance and to provide assurance to the Trust Board it is not sufficient to simply implement risk controls. They must be monitored to ensure that they are fit for purpose and adequately control the recognised risks. Failure to do so can result in injuries, damage to property or equipment, prosecution, fines, reputational damage to the Trust and compensation claims.

The Trust's Health and Safety Team monitor two main metrics to provide assurance of legal compliance:

- **Lagging indicators**
- **Leading indicators**

4.1. Incident reporting

The Trust records all accidents and incidents using an electronic incident reporting system (Ulysses Safeguard) in line with the requirements of the Social Security Regulations. Encouraging incident reporting continues to be a priority area for action.

4.1.1. Incident overview

There was a total of 11308 incidents of all types across the Trust in 2023/24. This is a 4% increase since 2022/23.

The top 5 most frequent incidents by cause were:

- Pressure ulcers (present on arrival at the Trust or Trust acquired)
- Patient self-harm
- Physical abuse
- Medication errors
- Verbal abuse

These mirror the trends in 2022/23.

Adverse healthcare events and information governance (IG) / data security incidents show the largest increases compared to 2022/23. IG incidents increased by 14% (670), with 44% of these due to incorrect entry on medical records, whilst data disclosed in error and confidential information / missing data also had large numbers of incidents. The following departments reported the largest number of IG incidents:

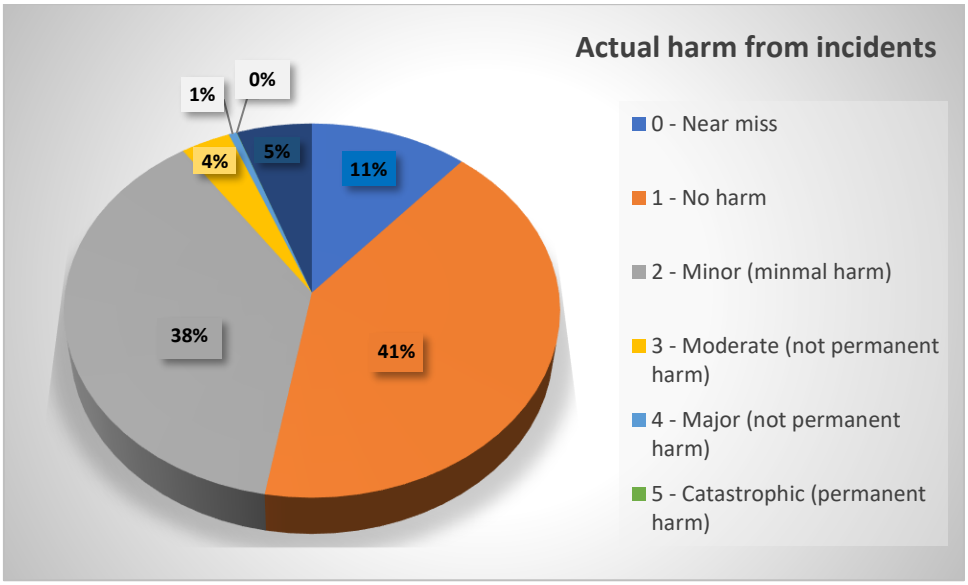
- CAMHS (Children's Care Group)
- Children's Community Physical Health (Children's Care Group)
- Doncaster Neurological Rehab Outreach (Physical Health)
- Health Visitors (Children's Care Group)
- Talking Therapies (North Lincolnshire AMH and Talking Therapies)
- Vaccination and Immunisation Team (Children's Care Group)

A 15% increase in adverse healthcare incidents was due to pressure ulcers (present on admission or Trust acquired), medication errors and patient self-harm incidents.

Whilst violence and abuse incidents are some of the most frequently reported incident types, there has been a reduction (16%) in the number of reports compared to 2022/23. Safeguarding and mortality incident categories also show reductions in the number of incidents of 21% (101) and 15% (106) respectively. All patient deaths are reviewed by the Trust's Mortality Operational Group to determine if there has been a lapse in care.

The majority of incidents (94%) resulted in no harm or minimal harm to employees, patients or others, as can be seen in Figure 1. All patient safety events (incidents reported) are reviewed by the Patient Safety Team and Care Group leads. This feeds into the twice weekly safety huddles, Harm Free Care (Group) and the Quality and Safety Group.

Figure 1

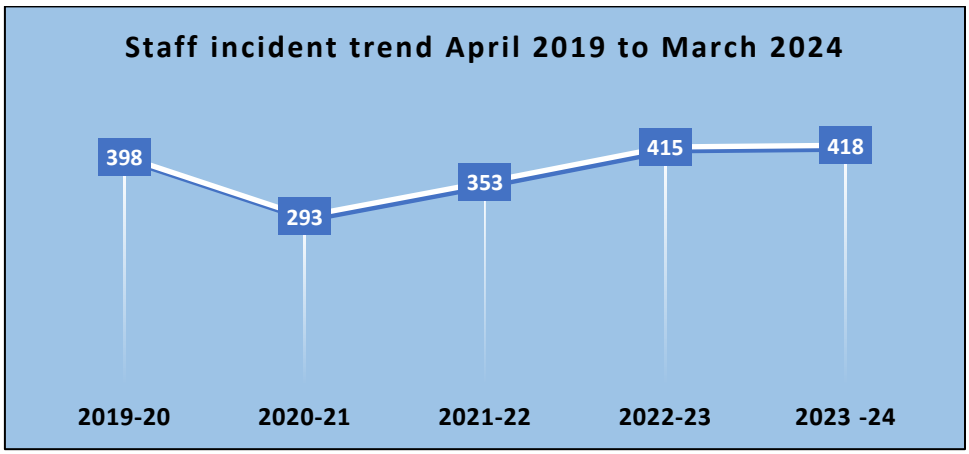


4.1.2. Staff incidents

There were 418 staff incidents reported in 2023-24.

Incidents categorised as staff incidents have increased by 0.7% since 2022/23. However, the number of incidents is in line with previous years, showing low variation over the last 5 years (figure 2). During 2020-21 there was a slight reduction in incident numbers related to reduced numbers of employees in the workplace during the covid pandemic.

Figure 2



The Health and Safety Team review all staff incidents and carry out an investigation that is proportional to the severity of the incident. Any learning is shared via the Health, Safety and Security Forum, communicated through Trust Communications, and forwarded to Care Group Nurse Directors for dissemination, where relevant.

There are 2 patient safety huddles every week, which have reduced the number of incidents incorrectly categorised and the number classified as ‘unknown’ cause.

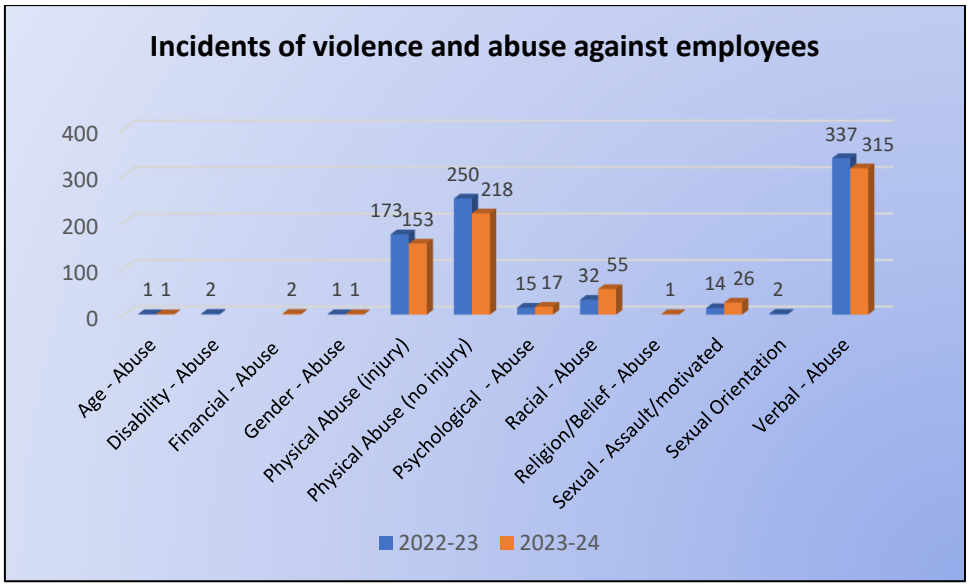
Following identification of an increasing trend in animal injuries the Health and Safety Team arranged for South Yorkshire Police to deliver dangerous dog training to employees. This included how to recognise dog behaviours and how to react to these in order to minimise harm to individuals. This is combined with procedural processes to highlight when a dog is present in a patient's home and request its temporary removal to another room whilst community colleagues are there.

4.1.3. Violence and aggression against staff

Incidents involving threats and violence are more likely to occur due to the nature of health conditions experienced by patients within the Trust's care. Colleagues are provided with training on how to respond to threats and violence and in de-escalation techniques. Incidents where restraint has been used are reviewed by Care Groups and by ERICA.

In 2023/24 there was a small reduction of 38 incidents (4.3%) of violence against staff when compared to 2022/23. The main causes are detailed on Figure 4. These include incidents perpetrated by patients, others (often patient's family members) and other staff. Most incidents occurred in adult and older persons mental health services. However, Doncaster Community Services and Drug and Alcohol Services also have moderately high levels of incidents.

Figure 4



The number of incidents resulting in physical injury to staff has reduced by 12% (20) and no incidents are recorded as causing serious harm to employees. However, it is of note that a number of these have resulted in staff injuries that have required at least 7 days of absence from work. These were reported under RIDDOR as detailed in section 4.1.4. Doncaster AMH and Rotherham AMH had the highest number of this type of incident, accounting for 77% (118) of the total, with older persons wards reporting the most incidents. This included The Glade in Rotherham (21) and Laurel

Ward in Scunthorpe (19). One patient on The Glade was responsible for 43% (9) of the incidents and these were related to staff interactions during patient personal care.

Racial abuse

There was a 72% (23) increase in incidents of racial abuse of staff. Most incidents again occurred on adult mental health wards. Kingfisher Ward in Rotherham accounted for 13 (24%) of the incidents, although these involved a number of patients.

Work is being undertaken within the Anti Racism Alliance together with the Equality and Diversity Team on the reporting of racist incidents. Staff are supported when incidents are reported and actively encouraged to involve the police as this is a hate crime.

An Acceptable Behaviour or 'red card' Policy is currently under development to make clear that racist behaviours are unacceptable and detailing what action will be taken against perpetrators. This is due to be launched on 1st October 2024.

The Trust's RRI Team are available to visit wards to provide practical advice on minimizing harm to employees from patient violence.

Sexual abuse

There has been an increase in sexual abuse or sexually motivated behaviours against employees from 14 in 2022/23 to 26 in 2023/24. Behaviours included trying to kiss staff, touching them inappropriately, such as on the buttocks or breasts or using sexually explicit language. There are no trends in relation to individuals or location.

In 2023 the Trust signed up to the National Sexual Safety Charter. As signatories to this charter, the Trust commits to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce.

4.1.4. RIDDOR incidents

Accidents that result in the most serious type of injuries to staff, contractors, and visitors whilst at work or on Trust premises must be reported to the Health and Safety Executive (HSE) under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). The Trust's Health and Safety Lead reports and investigates all RIDDOR incidents.

During 2023/24 there were 10 RIDDOR incidents, a reduction of 1 incident from the same period in 2022/23.

Table 1 summarises the main causes of the incidents. Full details are provided in Appendix 4.

Table 1

Incident cause	Number of incidents	Injury
Slip, trip or fall	4	2 x wrist fractures 1 x rib fracture 1 x ankle fracture
Contact with an item	2	Fingertip removed Cut and bruising
Physical abuse	1	Wrist fracture
Manual handling	1	Pulled muscle
Dog bite	1	Arm wound
Needlestick	1	Potential to contract a blood-borne virus.

Half of the incidents resulted in bone fractures due to falls (1 as the result of a physical assault). Falls are usually the main cause of the more serious staff injuries. The majority (75%) occurred off Trust premises where it is difficult to control the environment. Two of the incidents occurred due to poor lighting. Community employees have been issued with torches to improve environmental awareness at night.

The other incidents resulted in injuries requiring more than 7 days off work.

There are fewer incidents due to violence, falling from 3 to 1, inline with the reduction in violence and abuse incidents against employees.

Seven of the incidents occurred in Doncaster Physical Health, 1 in Doncaster AMH, 1 in Rotherham AMH and 1 in Corporate Services, on a North Lincolnshire AMH ward.

The needlestick injury was reported as a dangerous occurrence as the needle was contaminated with patient blood and the patient had a known hepatitis C infection. The needlestick process was followed, bloods were taken from both the injured person and the patient and the employee was not infected. The reporting process is now displayed in sluice areas so that domestic staff are aware of what to do and the patient uses his diabetic test needles in the treatment room. Domestic staff have also attended face to face health and safety training that incorporates sharps training.

4.2. Audit and inspection

Whilst learning from incidents is a useful way of future prevention. It is better to prevent accidents happening in the first place by carrying out more proactive preventative activities. The Health and Safety Team carry out a rolling programme of premises inspections that review the existing health, safety and security arrangements to ensure that the Trust is legally compliant. The inspections allow identification of any potential risks, unsafe activities, or unsafe buildings so that these may be addressed by the building manager to prevent accidents.

Health and safety inspections are carried out annually, whilst security inspections are undertaken every two years, although any security issues are also noted during health and safety inspections. All findings are reported to the responsible manager and followed up by the Health and Safety Team to determine progress. Outstanding issues are escalated to the Care Group Director.

Outstanding inspections may relate to delays in ward areas related to patient illness or unoccupied buildings due to temporary suspension of services. It should be noted that some buildings were unoccupied, so did not need inspections during this period, although they are still included in the premise numbers.

Common themes, trends or issues of note identified during the inspections are provided below:

- Risk assessments for first aid, lone working, DSE and working at height (where relevant) were not always in place.
- Employees in some areas were not aware of local lockdown procedures.
- The security of some areas was not adequate and could potentially allow access to unauthorised persons and the theft of property or equipment.
- Issues with the state of repair in some buildings, including damp.
- Building repairs not carried out in a timely manner.
- Some task specific training has not been completed. E.g. Oxygen training and safe use of ladders.
- Converations with the learning and development team around the provision of mandatory training

Care group leadership teams have received feedback on trends or issues following health and safety inspections

All areas are required to have a health and safety folder containing key health and safety documents so that relevant information is kept together in a location that is accessible to all employees.

5. Recommendations

1. The Trust's compliance with the NHS England Violence Prevention and Reduction (VPR) Standards are currently being reviewed to ensure alignment with requirements of the NHS Standard Contract. See Violence Prevention and Reduction paper tabled separately.

2. It is recommended that violence and abuse workstreams are linked to ensure cross-team awareness and the safety of our colleagues and estate is drawn together.

3. A new security standard will be implemented in the NHS in 2025, requiring completion of a self assessment, similar to that required for emergency planning. Executive sponsorship from the nominated Security Management Director is underway.

Appendices

Appendix 1 – Health and Safety Training 2023/24

	Health and Safety % Compliance	
Care Group	**% Compliance**	**Number outstanding**
Children's	95.7	29
Corporate Services	91.2	76
Doncaster AMH & LD	93.7	50
North Lincolnshire AMH & Talking Therapies	97.3	25
Physical Health & Neurodiversity	96.0	33
Rotherham AMH	95.1	24

Appendix 2 – Fire Safety Training 2023/24

	Fire Safety % Compliance	
Care Group	**% Compliance**	**Number outstanding**
Children's	97.61	16
Corporate Services	90.63	65
Doncaster AMH & LD	96.62	27
North Lincolnshire AMH & Talking Therapies	98.25	8
Physical Health & Neurodiversity	97.91	17
Rotherham AMH	96.83	16

Appendix 3 – Fire Training Results

Org L3	Required	Achieved	Compliance %	Number of non-compliant staff
Children's Care Group (CCG)	669	653	**97.61%**	**16**
Corporate Assurance	39	34	**87.18%**	**5**
Doncaster Mental Health & Learning Disabilities Group	798	771	**96.62%**	**27**
Estates	70	63	**90.00%**	**7**
Finance & Procurement	36	33	**91.67%**	**3**
Informatics Service	75	75	**100.00%**	**0**
Medical, Pharmacy & Research	59	56	**94.92%**	**3**
North Lincs Mental Health & Talking Therapies Group (NLCG)	456	448	**98.25%**	**8**
Nursing & Facilities	247	205	**83.00%**	**42**
Operations	42	42	**100.00%**	**0**
People & Organisational Development	103	100	**97.09%**	**3**
Physical Health & Neurodiversity Care Group	814	797	**97.91%**	**17**
Rotherham Care Group	505	489	**96.83%**	**16**
Strategic Development	18	16	**88.89%**	**2**
Therapies & Psychological Therapies	5	5	**100.00%**	**0**

Appendix 4 – RIDDOR Incident Causes

Incident cause	Number of incidents	Details
RIDDOR reason – Injury (over 7 day absence or specified injury)		
Physical abuse (injury) – patient on staff	1	• An employee went to lock a patient's bedroom to prevent another patient entering the room. Whilst doing so a patient pushed the employee out of the way, causing them to fall, landing on their wrist. They were diagnosed with a wrist fracture.
Fall – slip, trip or fall on same level	4	• A community employee visited a patient's home when it was dark and tripped up a step, causing a chipped ankle bone and bruising.
		• A community employee fell outside a patient's home. Whilst walking up the driveway, which was not well lit, they did not see a metal foot on the gate. They were diagnosed at hospital with a hairline wrist fracture.
		• An employee was out on community visits and needed to use the bathroom. They used the facilities at a supermarket. When leaving the store they stepped in a pothole and fell, landing

		on their side. They were taken to hospital and diagnosed with broken ribs.
		• An employee fell off the kerb whilst at work and was diagnosed at hospital with a broken ankle.
Dog bite	1	• A community colleague was bitten by a dog at a patient's home. Absent from work for more than 7 days.
Manual handling – patient	1	• When moving a patient to a wheelchair the employee took the brakes off and moved the wheelchair backwards. They heard their back crack and felt pain. Their GP diagnosed a pulled muscle. Absent from work for 2 weeks.
Contact with an object	2	• Staff member caught their finger in the laundry room door, which slammed on it due to the draught from the open window.
		• An employee trapped their finger in a closing door and required surgery.
RIDDOR reason – Dangerous occurrence		
Needlestick - Dirty	1	• A domestic suffered a needlestick injury whilst cleaning a patient's room. The needle had been used and the patient was a know carrier of hepatitis C. Employee not infected.

Report Title:	**Bi-annual safe staffing review**
Author(s):	Rachel Kumar, Assistant Director of Nursing (Workforce Lead)
Accountable Director:	Steve Forsyth, Chief Nursing Officer

Executive Summary

The annual safer staffing declaration report was received at board in March 2024 and received partial assurance. There were identified gaps in governance, oversight, controls, and mechanisms flagging concerns over the trust's compliance with the national quality board workforce safeguards. In line with the National Quality Board workforce safeguards all inpatient wards should undertake a bi-annual safe staffing review.

This is to ensure the right people, with the right skills, are in the right place at the right time, this report outlines the first bi-annual review of 2024-2025 for all 18 inpatient wards, broken by care group including next steps, recommendations as well as plans for the next review in October-November 2024 aligned to budget setting.

The report outlines a comprehensive and systemic review of quality and workforce metrics, acuity tools where available (MHOST and SNCT) all underpinned by a clinical judgement discussion with key stakeholders including e-roster team, finance, ward leaders and care group directors of nursing, overseen by our executive chief nursing officer.

The recommendations are to improve efficiencies and **align former safe staffing** changes to a governance process in line with the NQB workforce safeguards. The data collections in August 2024 are **not recommending** any further changes to approved establishments.

A further data collection will take place in October 2024 with a review in November 2024 to re-assess this position ensuring any potential request for changes are aligned to the cycle of budget setting.

Key headlines

- North Lincs care group- The MHOST acuity tool indicated for Mulberry Ward the possible requirement for an additional registered nurse. However, clinical judgement discussion highlighted this was potentially due to staff supporting the 136 suite which had an impact on registered nurse and non-registered nurse requirements. The care group are reviewing the 136-suite model to mitigate against Mulberry staffing being utilised. This will be re-visited at the October 2024 data collection.

- Rotherham care group – The e-roster system has been amended to reflect care group budget (establishment) of 3 healthcare support workers (Non-registered nurse) on all shifts for all wards except Kingfisher ward (PICU) which has been amended to 4 healthcare support workers on all shifts. This is what the wards have been working to.

- Doncaster MH and LD – Brodsworth, Cusworth and Skelbrooke are working over budgeted establishment. This has been working above with an additional healthcare support worker per shift. Local actions are in place to review this impact. Windermere is working under budgeted establishment. Care group to review over-establishment and manage the approved budget accordingly. Care group to share changes through monthly safe staffing reviews and complete a QSIA. The care group has been requested to implement a 136 suite staffing model which has been budgeted for. Best practice would also recommend a QSIA is completed for Emerald service re-design which has been shared with the care group.

- Doncaster PH- In 2022-2023 a change was made by the operational and corporate nursing team to Hazel staffing for registered nurse on nights to 2 from 1 and an additional non-registered nurse (Healthcare support worker) on the late shift to align with Hawthorne ward. This is currently not

budgeted for. A requested has been made to review impacts and evaluate the temporary change, review budgets for both wards re any slippage and complete a QSIA.

- Nursing associates and inpatient roles and responsibilities requires further clarity, a workforce plan across the organisation is in progress to review this position in September 2024.
- Undertaking this workforce data collection and review highlighted possible productivity efficiencies with the implementation of consistent shift times across the organisation. This could potentially support further capacity to fund out of hours leadership cover. A meeting is in place in September 2024 to progress this opportunity.
- Actual staffing use was higher than the recommended requirements for all wards during the reporting period. The rationale was articulated in workforce reviews/data collections through a clinical judgement discussion. The main themes were acuity, covering short term sickness and vacancy backfill for hard to recruit to roles (learning disabilities nursing). Our agency reduction plan and transition to NHS-P may support further efficiencies. This will be monitored closely for any direct correlation.
- A potential driver for the additional use of temporary staffing is the utilisation of supportive enhanced/supportive therapeutic observations. A data report is underdevelopment to review the number of hours utilised in enhanced/supportive therapeutic observations. A quality improvement project is underway with workforce quality improvement visits planned on 20 09 2024 aligning to peer reviews. A shared face to face learning event for all colleagues (circa 100 delegates) is planned for November 2024 with national and regional speakers to support this essential agenda. All with the intent to improve the quality of our enhanced observations which will in turn improve the trusts enhanced observation productivity and efficiencies. An expression of interest has also been made to join a national NHS-E QI enhanced observation collaborative to be part of this learning network. The Chief Nursing Officer for the trust is also a member of the productivity advisory board which will drive forward the national changes.

September 2024 Quality Committee is asked

- to receive this report and accept that no establishment (budget) requests are being made and the current processes, controls and mechanisms are robust to draw this conclusion.
- to agree a systematic approach is in place to ensure effective inpatient staffing governance that supports the oversight of safe delivery of care to those in receipt of inpatient services.

All this ensures the trust continues to deliver and commit to **strategic objective 4** to deliver high quality and therapeutic based care for our own sites and in other settings. A further bi-annual review/data collection will take place in November 2024 and all inpatient wards where an acuity tool is available will take place in October 2024. An update will be provided to November 2024 Quality Committee and board following these data collections.

The Rotherham Doncaster and South Humber NHSFT Bi-Annual Inpatient Safe Staffing Review 2024-2025

The National Quality Board (2016) states that providers:

“Must deploy sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively. They should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times. They must use an approach that reflects current legislation and guidance where it is available.”

The trust must formally ensure the National Quality Board 2016’s guidance is embedded in the safe staffing governance.

The trust must ensure the following four components in their safe staffing processes:

- Evidence-based tools (where they exist)
- Professional judgement
- Outcomes
- Compare staffing with peers

NHS England assess compliance against this in the yearly assessment in which the trust will be required to confirm the staffing governance processes are safe and sustainable. The annual governance statement is also triangulated, and sense checked against regulatory and performance management processes.

A significant component to this compliance is that the trust must ensure there is an assessment of the nurse staffing numbers and skill mix set in the annual budget (establishments). This is based on acuity and dependency data and using an evidence-based acuity tool where available. This must be reported to the board by a ward twice a year, in accordance with the NQB guidance and other NHS-E resources. The review must be linked to professional judgement and outcomes.

As outlined by CQC’s well-led framework guidance (2018), NQB guidance and the trust policy, any changes to staffing or service, and introduction or redesign of new roles, must have a full quality impact assessment review.

The fundamental purpose of a safe staffing review is to ensure that sufficient nursing capacity and capability is available to provide individualised, person-centred care in a safe and effective way. This is achieved through consideration of a range of decision-making factors which have been clearly articulated in a framework of expectations set out by the National Quality Board enabling a triangulated approach to staffing decisions (Diagram 1).

Diagram 1

Aim

To ensure the right people, with the right skills, are in the right place at the right time, this report outlines the first bi-annual review of 2024-2025 for all 18 inpatient wards, broken by care group including next steps, recommendations as well as plans for the next review in October-November 2024 aligned to budget setting.

Members

The members of the workforce reviews and data collections were:

- Chief nursing officer providing oversight and attendance where required
- Care group directors of nursing and/or care group director
- Assistant director of nursing (safe staffing lead)
- Members of the multidisciplinary team including chief allied health professional and psychology leads
- Ward leaders
- E-rostering systems manager
- HR
- Performance
- Finance

Workforce data collections

Our mental health inpatient wards inclusive of rehabilitation, psychiatric intensive care unit, acute, and older people's wards utilised the Mental Health Optimisation Staffing Tool (MHOST). The training took place in April 2024 and the data collection took place in May 2024 over the full month.

Our physical health inpatient wards inclusive of neurorehabilitation and rehabilitation wards utilised the Safer Nursing Care Tool (SNCT). The training took place in June 2024 and the data collection took place in July 2024 over the full month.

Our learning disabilities forensic ward, drug and alcohol inpatient service, and the hospice, have no available acuity tool. Therefore, a workforce review took place utilising workforce and quality indicators outlined and summarised below.

Data-set for workforce review

As well as an acuity tool where available, the following metrics were also reviewed, assessed and triangulated against the various sources of data during a clinical judgement discussion as part of the review.

The metrics for each ward were:

- Benchmarking against peer trusts where available (noting 2023-2024 data only available. The 2024-2025 data will be reviewed in the second workforce data collections in November 2024).
- Leaver rates
- Fill rates for the previous 6 months
- Sickness
- Occupied bed days
- Vacancies
- Complaints
- PSIIs
- Staffing incident reports
- Staff fulfilment – unfilled, temporary staffing, substantive
- Total staffing inclusive of temporary staffing for month of acuity tool collection where required
- Medication errors
- Incident data (top 10 causes, level of harm, incident type and injuries)
- Mandatory and statutory training including compliance on fundamentals of care– Mental Health Act, Mental Capacity Act, resuscitation, reducing restrictive interventions, safeguarding and infection prevention and control
- Seclusion (where appropriate)
- Staffing numbers, budget along with a comparator
- Care Hours Per Patient Day used in month compared to acuity tool recommendation where required.
- Acuity tool recommendation of staffing, actual and budget
- Clinical judgement discussion including acuity discussions

Appendix 1 provides an example workforce data pack which provides the detail of the workforce assessment which took place in the context of a clinical judgement discussion.

A care group breakdown detailing all actions and plans is detailed in appendix 2 for reference, key headlines from the reviews and next steps are outlined below.

Findings

The board is being requested to approve the actions taken to support the care groups in managing the current approved establishment (budget) activity to ensure wards staffing is safe for those in receipt of services. A care group breakdown detailing all actions and plans is detailed in appendix 2 for reference, key headlines from the reviews and next steps are outlined below.

These actions have been developed and populated through the triangulation of various data sources and intelligence including workforce and quality indicators and a clinical judgement discussion with a wide multi-disciplinary team (Appendix 1 provides an example template). The actions are to support improving governance around pre-existing changes.

The recommendations are to improve efficiencies and **align former safe staffing** changes to a governance process in line with the NQB workforce safeguards. The data collections in August 2024 are **not recommending** any further changes to approved establishments.

A further data collection will take place in October 2024 with a review in November 2024 to re-assess this position ensuring any potential request for changes are aligned to the cycle of budget setting.

Key headlines

- North Lincs care group- The MHOST acuity tool indicated for Mulberry Ward the possible requirement for an additional registered nurse. However, clinical judgement discussion highlighted this was potentially due to staff supporting the 136 suite which had an impact on registered nurse and non-registered nurse requirements. The care group are reviewing the 136-suite model to mitigate against Mulberry staffing being utilised. This will be re-visited at the October 2024 data collection.

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- Nursing associates and inpatient roles and responsibilities requires further clarity, a workforce plan across the organisation is in progress to review this position in September 2024.

- Undertaking this workforce data collection and review highlighted possible productivity efficiencies with the implementation of consistent shift times across the organisation. This could potentially support further capacity to fund out of hours leadership cover. A meeting is in place in September 2024 to progress this opportunity.

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Next Steps

The trust will continue to ensure there is a daily, weekly and monthly staffing oversight and governance process outlined in the Inpatient Safe Staffing Report to supplement the bi-annual safe staffing workforce data collection and review. This bi-monthly report continues to highlight the daily management of staffing and challenges with actions to mitigate the risks.

This report offers assurance to the Quality Committee that there are robust governance process and monitoring and evidence-based decision making around safe staffing across the inpatient areas in the Trust.

September 2024 Quality Committee is asked

- to receive this report and accept that no establishment requests are being made and the current processes, controls and mechanisms are robust to draw this conclusion.
- to agree a systematic approach is in place to ensure effective inpatient staffing governance that supports the oversight of safe delivery of care to those in receipt of inpatient services.

All this ensures the trust continues to deliver and commit to **strategic objective 4** to deliver high quality and therapeutic based care for our own sites and in other settings. A further bi-annual review/data collection will take place in November 2024 and all inpatient wards where an acuity tool is available will take place in October 2024. An update will be provided to November 2024 Quality Committee and board following these data collections.

Classification: Official

Publication reference: PR1844

NHS England

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.2 Feb 2023

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020 but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

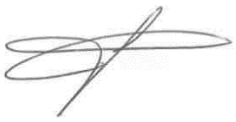
Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

The Responsible Officer (RO) for RDaSH at the time of writing this report is Dr Sunil Mehta, Deputy Medical Director. Dr Mehta is a Consultant Psychiatrist with over 12 years' experience and is registered with the GMC he completed the appropriate training to become RO in advance of being appointed by the board in July 2024.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Statement from the RO: *I am satisfied that the designated body continues to provide sufficient funding and resource for me to carry out my duties and responsibilities in relation to my RO role.* *Dr Graeme Tosh*  Date: 30/06/2024

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

The list of prescribed connections is held on the GMC Connect website is regularly checked against staff lists held on the Electronic Staff Record (ESR) by a member of the Trust Revalidation Support Team who also receives notifications of staff changes from the Medical Staffing Team in the Workforce Directorate.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

The Medical Appraisal Policy is active on the trust's public website and has been agreed with the BMA via the joint Local Negotiating Committee. The policy has been reviewed and is in the process of being reviewed by the LNC before being ratified. Review July 2024 completed by the Trust Revalidation Support Team and process for implementing changes underway.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

The Regional Appraisal Network in Mental Health is attended by the RO and the appraisal lead; it forms a useful benchmarking and peer review system. Internally we hold annual reviews of our appraisal process and provide feedback to our appraisers.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

We are guided by the GMC in terms of establishing RO responsibility. All our doctors (locum and substantive) are invited to attend the monthly consultants' meetings and the educational programmes for CPD activity, and such data will be provided to locums and where appropriate their Agency RO's if / when required. We supply relevant clinical governance information to their own RO e.g. complaints, serious incidents etc.

Section 2a – Effective Appraisal

All doctors in this organisation are offered an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

Effective appraisals within the trust are guided by our comprehensive Medical Appraisal Policy, they are monitored by 20% random sampling by the RO (Completed in August 2024).

Appraisals are predominantly undertaken in the period December-March remotely via Microsoft Teams or face-to-face. Centrally compiled data is used for individual doctors as a contribution to their supporting information. Information on Complaints, Serious Incidents and IR1's are provided to individuals directly into their L2P account (our current appraisal management software).

The total number of employed doctors was 69 in the year 2023-2024. Out of 69, 59 had a completed RDaSH appraisal, all of which have been submitted to the appraisal team and signed off.

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

There were 10 instances of doctors not completing an appraisal:

- 7 remain on long term sick leave
- 1 has recently returned from long term sick leave and will complete and appraisal in due course.
- 1 is on maternity leave
- 1 did not engage with appraisal and has been referred to the GMC for non-engagement, they have appealed a GMC decision to remove their licence to practice.

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

I can confirm that this is the case, some minor amendments have been agreed by the local Trust Revalidation Support Team (02/07/2024), these are going to the Joint Local Negotiating Committee (19/08/2024) for their approval and then final policy revision should be agreed before September 2024 Board of Directors meeting where it can be given final approval.

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Appraiser refresher training takes place annually and is delivered by the Medical Appraiser Lead (Dr Sunil Mehta). In the year 2023-2024 period the Trust had 16 trained appraisers to cater to approximately 69 doctors. There has been no issue with our ability to carry out timely appraisals.

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

The trust offers and monitors compliance with annual refresher training to ensure all appraisers are up to date and compliant, this is delivered by the Medical Appraisal Lead. Any appraisals undertaken by new appraisers are reviewed by the Medical Appraisal Lead and they are provided with feedback. Reminders are sent to all Appraisers that they demonstrate in their own appraisal how they keep up to date as an appraiser. In 2023-24 five doctors have been trained to become an Appraiser. The training was delivered by the Medical Appraiser Lead.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

The Trust Revalidation Support Team (TRST) meets quarterly and is part of the appraisal quality assurance process. The agenda includes the management of the system for appraisals, data flow including (complaints, SI's, appraisers matching, policy review, new starter assurance checks), changes to guidance and a formal discussion on IR1's which have been screened and categorised by the Revalidation Team. It reviews the appraisal feedback and spots any trends or cause for concern to be actioned. This also includes targeted feedback to the new appraisers. On an annual basis the RO reviews a sample of 20% of all appraisers for quality and consistency and feeds this back to TRST and the doctors involved.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as of 31 March 2024	69
Total number of appraisals undertaken between 1 April 2023 and 31 March 2024	59
Total number of appraisals not undertaken between 1 April 2023 and 31 March 2024	10
Total number of agreed exceptions	9

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

36 recommendations to the GMC were made during this appraisal cycle.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

In this appraisal cycle 2023-24 of our 69 doctors 37 required revalidation. Of these 37, 34 were recommended for revalidation on time and revalidation was approved by the GMC.
In one instance due to annual leave, the RO did not recommend revalidation in good time and this corrected within 24 hours.
One was deferred due to non-engagement and subsequently referred to the GMC and one was deferred due to ill health and has subsequently relinquished his licence to practice.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

The trust has a system of governance and assurance that is approved by the Board of Directors. It includes a Board Assurance Framework, and formal sub committees of the Board which receives assurance regarding relevant areas such as serious incidents, complaints, audit activity and staff training. Relevant supporting information is supplied to doctors such as incident reports, complaints and SI's.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

The Trust system relating to the conduct and performance of medical staff is in accordance with the MHPS framework and is explicitly mentioned in the relevant policies. Serious concerns about medical performance are and should be managed outside of the appraisal system. Relevant information is supplied to doctors for their appraisals, but doctors are expected to bring information of relevance that may not be known to the Trust e.g., complaints in relation to other parts of their whole scope of work.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

We have agreed policy and processes and follow the detail of Maintaining High Professional Standards.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

If the RO determines that there are serious concerns in relation to a medical practitioner, they are brought to a panel including the CEO, Executive Director of People and OD. It is the panel that determines whether a formal response via the MHPS process is appropriate and therefore this acts as a quality assurance steps. Any formal MHPS processes against a doctor are noted in the Private section of the Board of Directors. No formal MHPS processes were instigated against a Trust doctor in the 2023-2024 appraisal year. In light of the 'fair to refer' guidance, we will convene an internal panel to review any referrals to the GMC or MHPS, the panel consists of the Medical Appraisal Lead, the trust Equality & Diversity Lead and a Director who is not involved in the direct line management of the doctor in question. This panel will review the potential referral to ensure that it is fair and non-discriminatory.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

We supply relevant data when this is asked for in relation to revalidation and appraisal to other RO's. This includes when a doctor has a new prescribed connection (usually when they leave the Trust) or when a doctor has a different RO (e.g. agency doctor) but also works in our Trust. Where we have concerns that have arisen since the end of an appraisal cycle and that doctor leaves, we will identify their new RO (via the GMC) and if necessary and pass that information on to the RO; we will also inform the doctor that we have taken this action.

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

All staff must undergo relevant Mandatory/Statutory training e.g. Equality & Diversity, in addition the Trust must publish equality data in relation to certain protected characteristics (Race and Disability) every year. The organisation has developed an understanding with the Regional Appraisal Network, where concerns about a doctor is being assessed to consult an independent representative from with the Network.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

A checklist system for new starters is in place and monitored by the Medical Staffing Team, and further checks are carried out by the Revalidation Support Team. For Locums, the Agency will have their own framework but the doctor must be compliant with the Trusts own requirements and this information be provided by the agency and reviewed by the EMD. The Trust only uses national framework agencies accredited for supplying agency doctors.

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of actions since last Board report**
- There has been one referral for non-engagement with appraisal, the GMC moved to remove this doctor's licence to practice as of 02/08/2024 but the doctor has appealed and is expected to provide evidence to the GMC for the appeal by the 23rd of September 2024.
- The responsible officer role has changed from Dr Graeme Tosh to Dr Sunil Mehta.
- Network and Development event held annually with the Appraisers to share experiences and problem solve.
- The RO is satisfied that all other necessary appraisals have been conducted in the appraisal cycle.

- **Actions still outstanding**
- The current RO Dr Sunil Mehta is leaving the Trust on the 2nd of September 2024, a plan is in place for this role to be taken by Dr Diarmid Sinclair, Deputy Medical Director as of the 1st of September 2024, this has been approved by the Board of Directors.

- Regarding the Medical Appraisal Policy some minor amendments have been agreed by the local Trust Revalidation Support Team (02/07/2024), these are going to the Joint Local Negotiating Committee 19/08/2024 for their approval and then final policy revision should be agreed before September 2024 Board of Directors meeting where it can be approved.

- **Current Issues**

None to report

Overall conclusion:

There are no current concerns about the management of governance of systems and processes in the Trust to deal with medical appraisal and revalidation with assurance provided to demonstrate that they operate effectively.

The feedback from the medical staff in relation to their appraisals 2023-2024 was very positive.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

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Rotherham Doncaster and South Humber NHS Foundation Trust

Guardian of Safe Working Hours (GoSWH)'s Report on Doctors in Training

01 June 2024
to
31 July 2024

Dr Babur Yusufi
Guardian of Safe Working Hours

August 2024

RDaSH leading the way with care

Executive Summary

This report only covers a period of two months; from 1 June 2024 to 31 July 2024.

In this report, Guardian of Safe Working Hours (GoSWH) provides details of trainees currently subject to TCS 2016/2019, information on exception reporting, on-call related provisions in work schedule and the levying of fines, concerns raised by the trainees around safety and work environment and action taken and further recommendations resulting from the above. He shows tables of exception reports and comments on any relevant trends. In addition, the GoSWH provides a summary of key issues discussed at recent Junior Doctors' Forum and related meetings.

In April 2024, there were fifty-four trainees working in the Trust, with five vacant posts.

A total of 33 exceptions were reported, over the two-month period: 17 in Rotherham and 8 each in Doncaster and North Lincs. Ther is a decrease of 10 ERs from the preceding two months. Most Exception Reports were for Breech of Rest Periods (25) and Excess Hours worked during On-call (5). There was one Immediate Safety Concern report, which were managed efficiently and effectively.

Time-off in Lieu (TOIL) and Payments were taken for all breaches of rest periods during On-call, except one where the outcome was not clear. TOIL was also agreed for working beyond contracted hours during daytime.

There were no ERs of missed educational opportunities or major gaps in the Rota.

The trend of improvement in clinical supervisors'/ trainees' engagement with the ER process continues as only 3 out of 33 ERs (9%) were not properly actioned.

ER trends, show higher contractual rest breaches in Rotherham, followed by Doncaster and North Lincs. Doncaster has now crossed the threshold for a review of Work Schedule which will be undertaken in November, in form of First On-Call monitoring over a period of 4 weeks. The number of ERs in North Lincs remains stable.

New Rota has now been fully implemented Rotherham and North Lincs.

A total of £21,229 have accumulated in GoSWH's account, by the end of 1st quarter in 2024, out of which £7,961 have been paid to the doctors and a balance of £13,269 remains. Monies in GoSWH's account are spent on well-being and safety and professional development of the junior doctors, following the decisions made in the JDF.

Topics discussed in July's JDF were (1) Electronic Handover SOP (2) Change of Name; from "Junior Doctors" to "Resident Doctors" (3) Safety of Junior Doctors during On-Call (4) Higher Trainees' S12(2) Work during On-Call and Rest Breaches (5) First On-Call Workload Monitoring (6) Venue of future JDFs

Provision of permanent Admin Support for the JDF and GoSWH requires attention.

Introduction

The 2016 Terms and Conditions of Service for NHS Doctors and Dentists in Training England (TCS 2016) were introduced nationally on 05 October 2016. Since August 2017 the Trust has had higher trainees, core trainees, foundation trainees and GPVT trainees taking up TCS 2016. Most trainees are now subject to TCS 2016.

In this report, Guardian of Safe Working Hours (GoSWH) provides details of trainees currently subject to TCS 2016/2019, information on exception reporting, on-call related provisions in work schedule and the levying of fines, concerns raised by the trainees around safety and work environment and action taken and further recommendations resulting from the above. He shows tables of exception reports and comments on any relevant trends. In addition, the GoSWH provides a summary of key issues discussed at recent Junior Doctors' Forum and other related meetings.

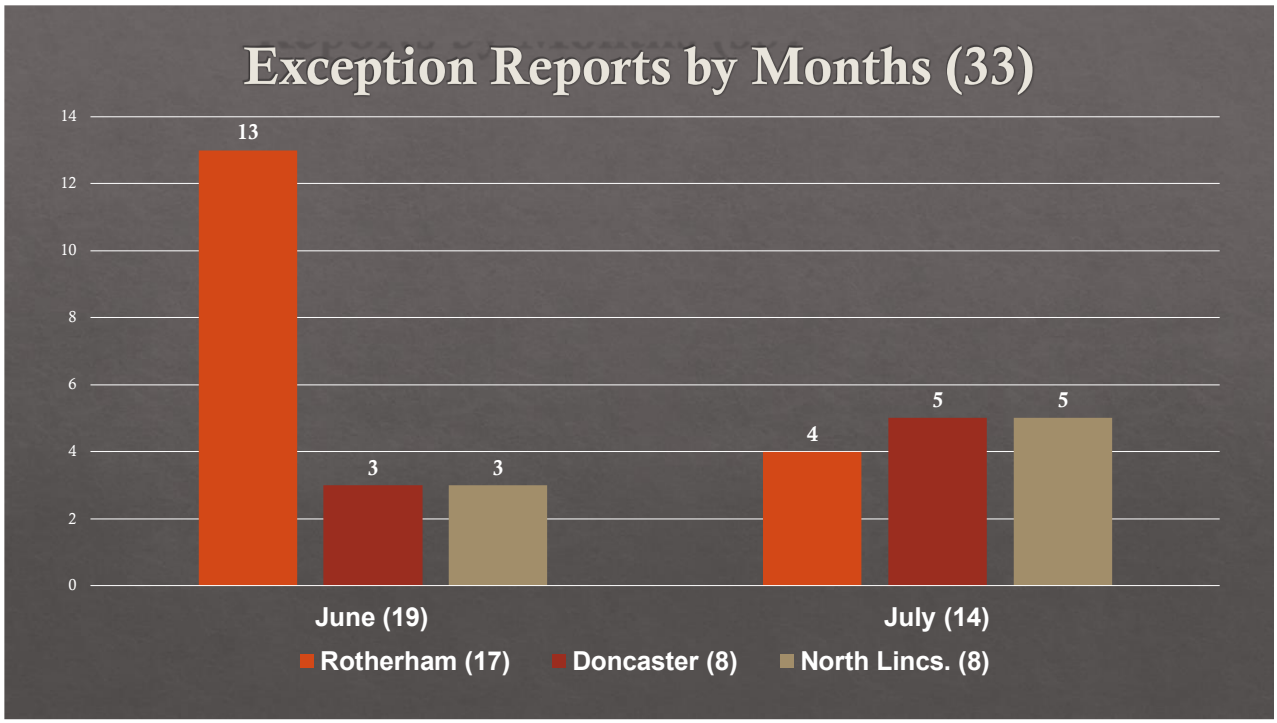
Current RDASH Doctors in Training

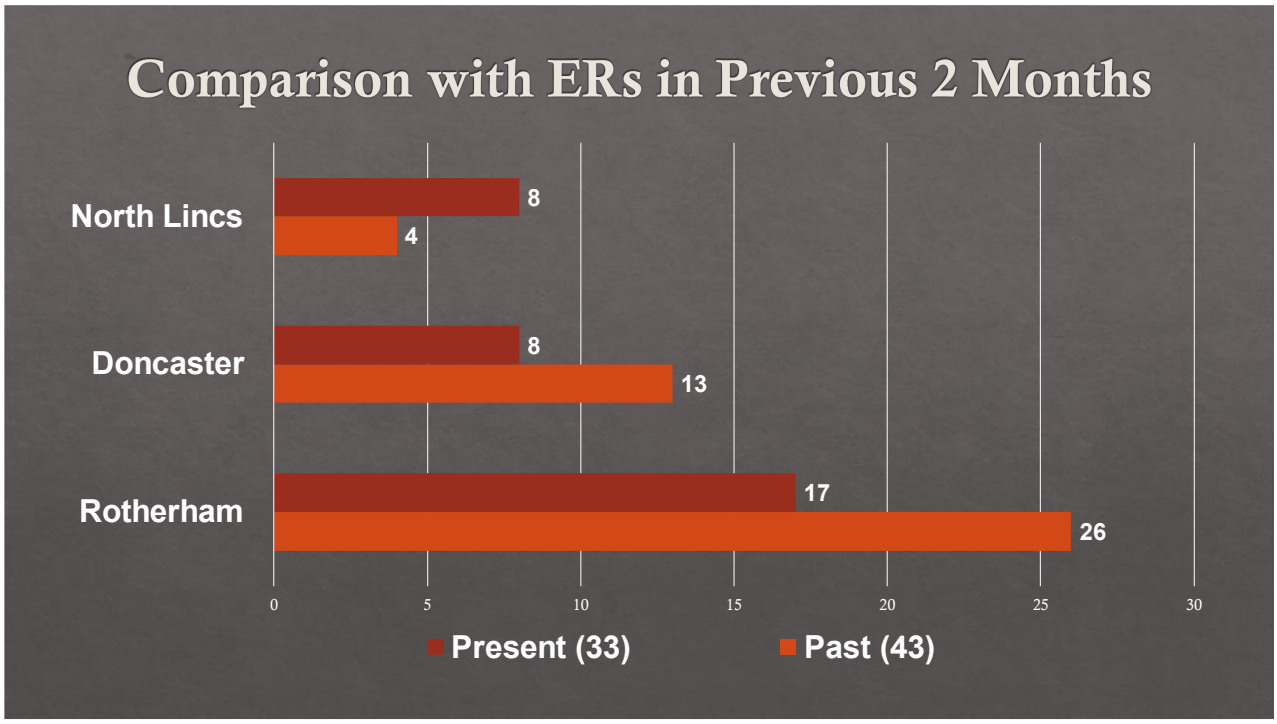
There are 54 trainees working in the trust with 5 vacant posts, from the start of the new rotation in April 2024. A breakdown of their grades is as follows:

	GP	CT	F2	F1	HT ST	**Total**	Vacant
Doncaster	4	3	3	3	6	**19**	0
Rotherham	2	13	2	4	6	**27**	1
North Lincolnshire	1	1	1	4	1	**8**	4
TOTAL	**7**	**17**	**6**	**11**	**13**	**54**	**5**

Exception Reports (ERs)

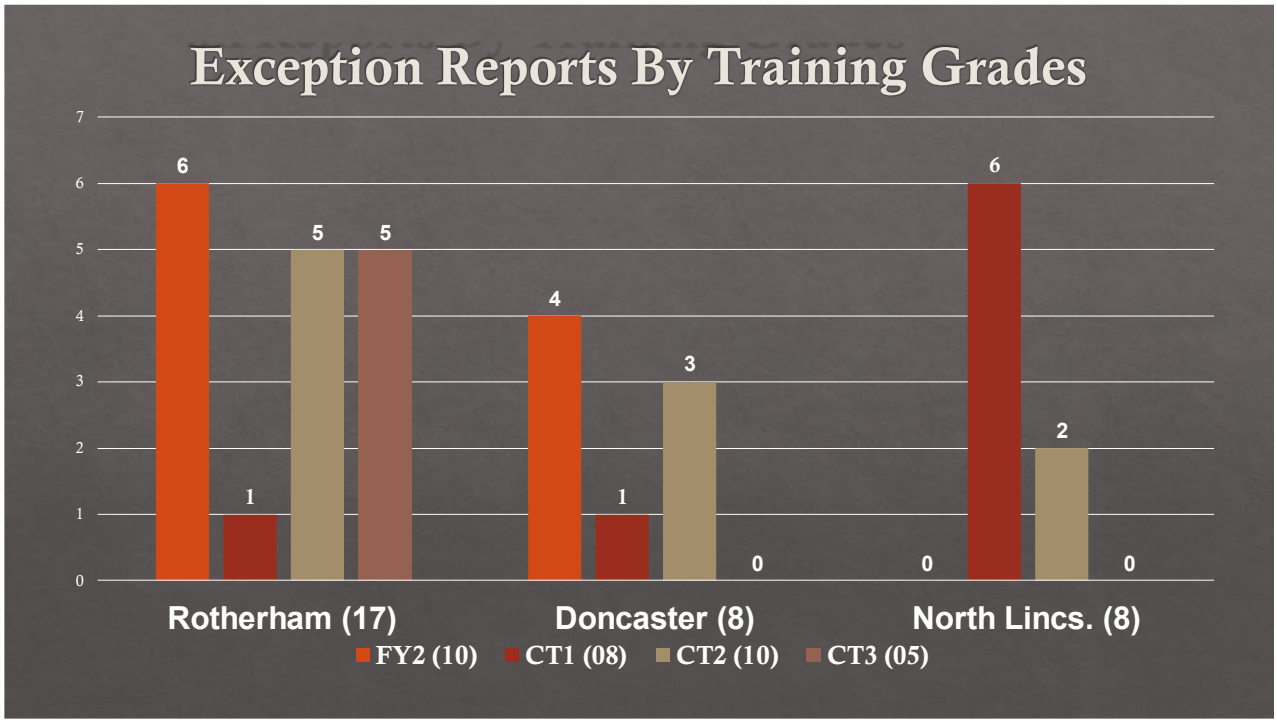
There was a total of 33 Exceptions reported from 1 June 2024 to 31 July 2024. This is 10 less than that reported in previous 2 months.





52% of ERs originated from Rotherham (as against 60% in the two months before), with 24% from Doncaster (as against 30% from previous period) and 24% from North Lincs (10% previously). This is a decrease in ERs from the previous months, except in North Lincs.

Rotherham continues to produce most ERs.

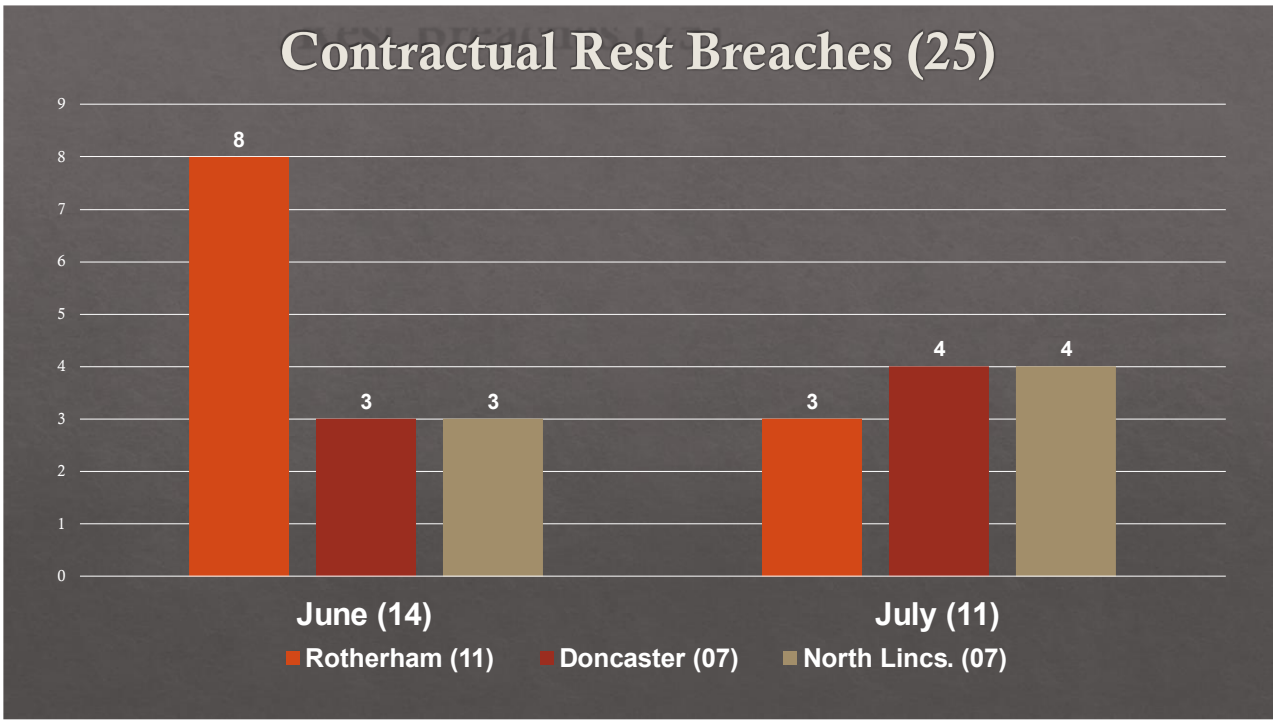


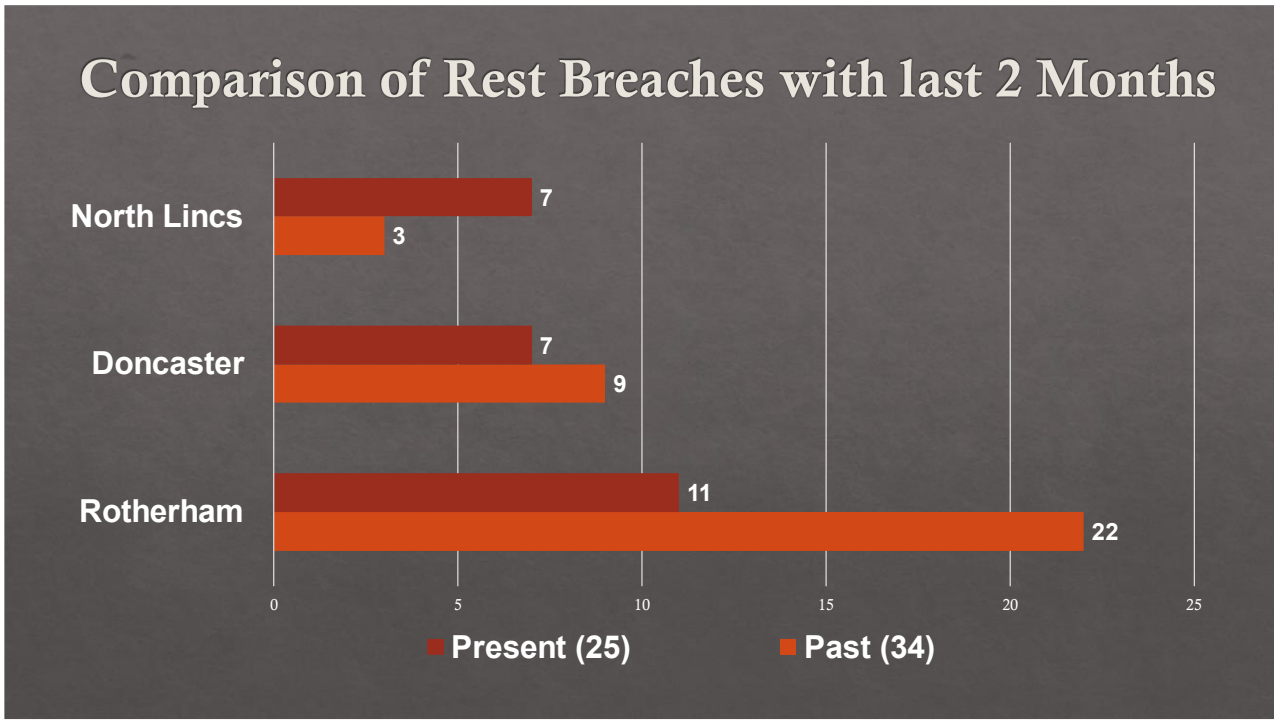
Most ERs were initiated by FY2 and CT2 (30% each), followed by CT1 (24%), and CT3 (16%). There were no reports submitted by Foundation Year 1 (FY1) and higher trainees i.e. ST.

Immediate Safety Concern (01)

	Rotherham	Doncaster	North Lincs.
June	1 (ST2) Doctor Fell Ill	0	0
July	0	0	0

There was one Immediate Safety Concern report, from Rotherham. The doctor on-call worked fell ill at the start of on-call and another doctor took over.





It is a contractual requirement for doctors on non-resident On-Call to avail 8 hours of rest in 24 hours, 5 hours of which should be continuous between 2200hrs and 0700hrs. Breach in these conditions results in Time Off in Lieu (within 24 hours of On-Call) or Payment in exceptional circumstances. This breach also attracts GoSWH's fine.

The overall number of rest breaches (n = 25) across all three sites, over the period, is less than that for the preceding 2 months. Following pattern has been observed.

1. 1 in 6 On-calls breached Contractual Rest Requirements in Rotherham
2. 1 in 9 On-calls breached Contractual Rest Requirements in Doncaster
3. 1 in 9 On-Calls breached Contractual Requirements in North Lincs.

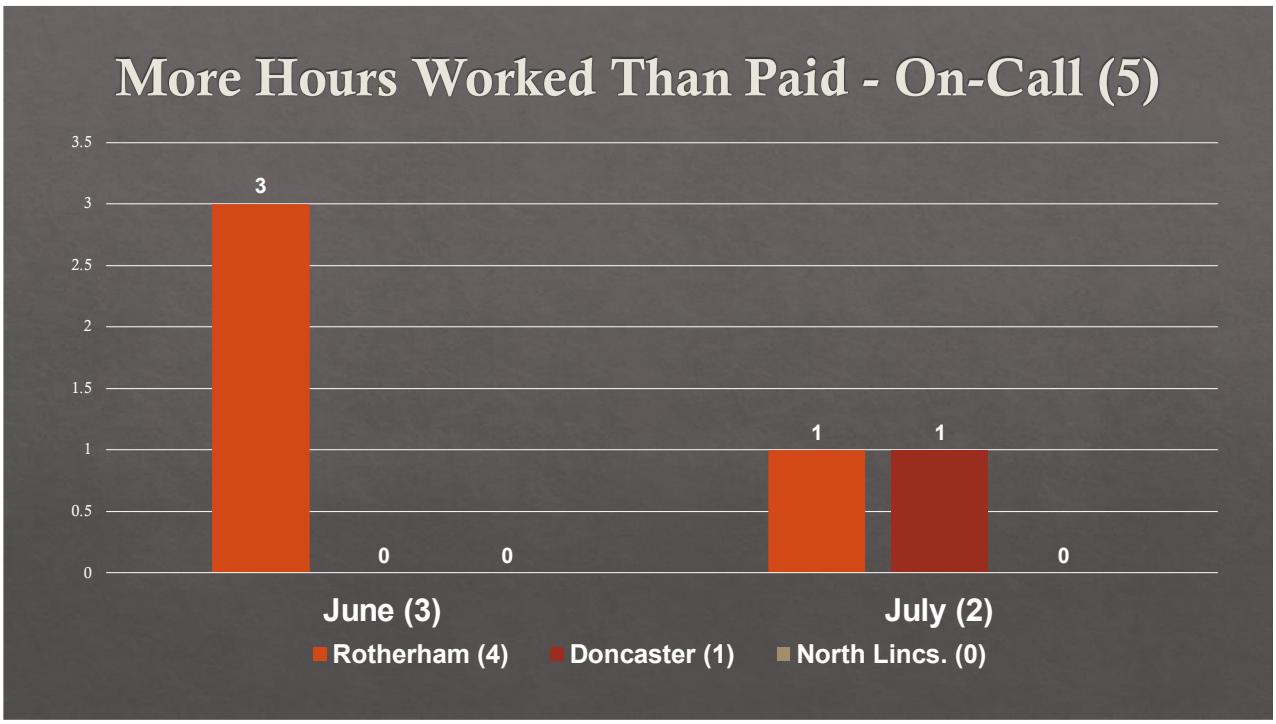
Rotherham continues to remain the hot spot for the Rest Breaches, followed by Doncaster and North Lincs

Inappropriate Calls (02)

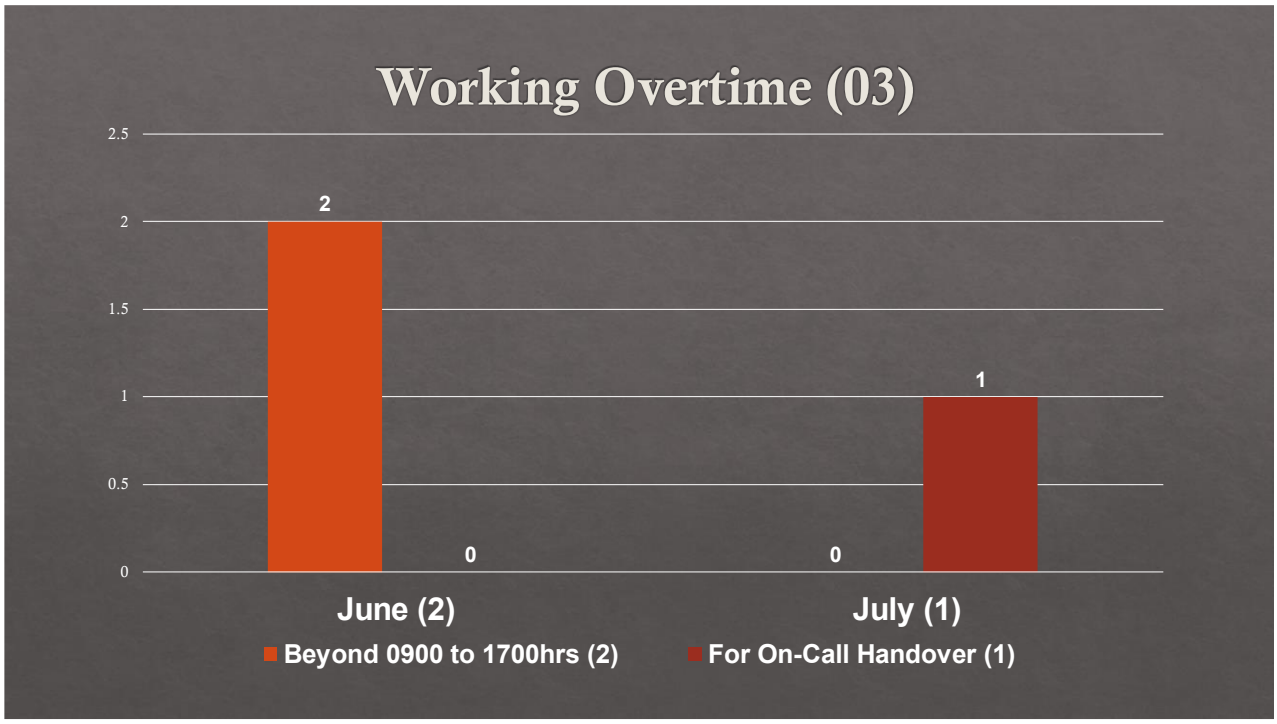
	June	July
Rotherham (0)	0	0
Doncaster (2)	0	2
North Lincs. (0)	0	0

Exceptions Reports from Doncaster suggest 1 out of 7 (14%) Rest Breaches was a result of Inappropriate calls from some wards.

Doncaster has now crossed the acceptable limit of not having more than 1 Rest Breach in 10 On-Calls. A Work Schedule review will be conducted, details of which will follow.



There number of these Exception Reports remain the same as in the previous three months. It is however to be noted, the figures given in work schedules are based on an average of number of hours worked across all on-call duties over the period of rotation and while individual variations can occur, the expectation is the average would remain the same. Most reports have originated from Rotherham.



There were 3 episodes of doctors working beyond their contracted hours i.e. working beyond 1700hrs and after on-call for handover. Time-off In Lieu was agreed on these occasions.

Exception Reports Outcomes

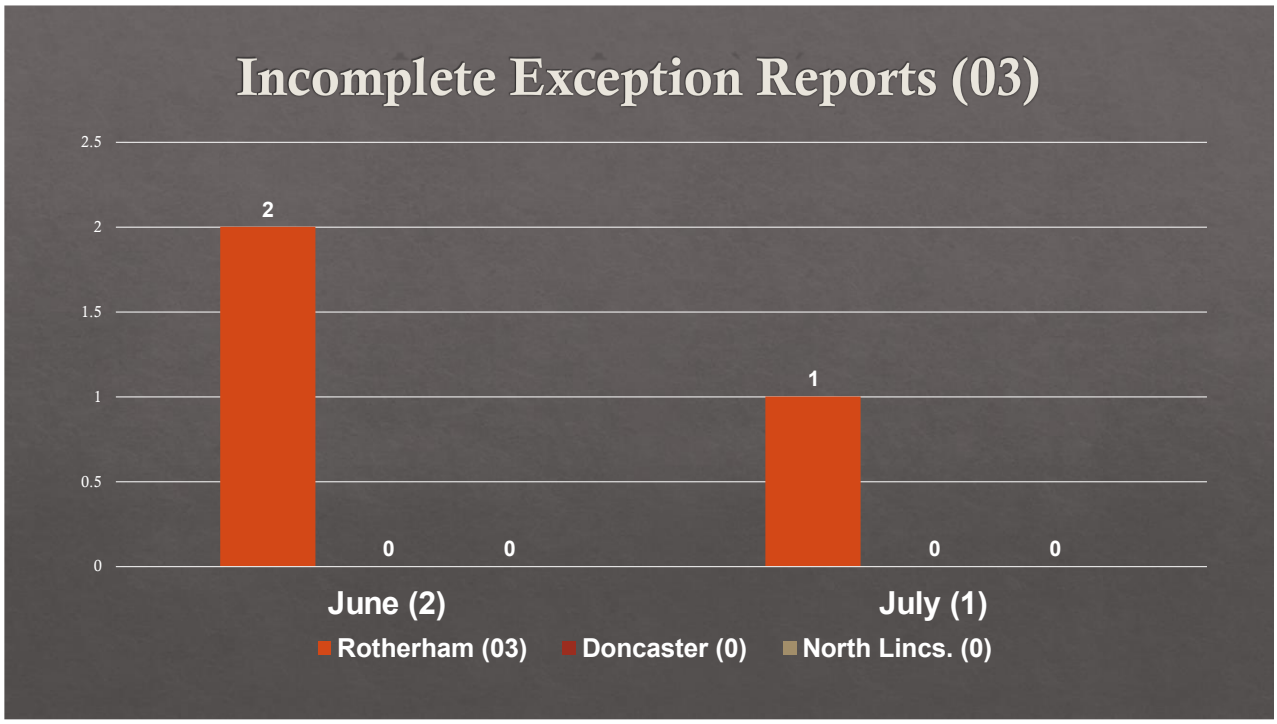
	ROTHERHAM				DONCASTER				NORTH LINCS.			
	TOIL	Pay.	NA	NR	TOIL	Pay.	NA	NR	TOIL	Pay.	NA	NR
Breach of Rest (24)	10	01	X	01	07	0	X	0	07	X	X	0
Overtime (Regular Working Hours) (2)	2	0	X	X	0	0	X	0	0	X	X	0
Overtime (On-call Handover) (1)	0	0	X	X	X	X	X	X	1	X	X	0
More Hours Worked (During On-Call) (4)	0	X	3	X	0	X	X	X	0	X	01	0

LEGEND:
TOIL = (Time Off in Lieu)
Pay. = Payment
NA = Not Applicable– No Outcome required but for Information Only
NR = Outcome Not Recorded

For Contractual Rest Breaches, Time off Lieu (TOIL) was the documented outcome on 24 (96%) occasions (out of which payment was also agreed on one occasion, as well), while no outcome was recorded in 1 (4%) report.

Working beyond daytime work hours attracted TOIL on all occasions i.e. 2 out of 2 (100%)

For working more hours during on-call than those given in Work Schedule, no immediate action was required, except for identifying GoSWH's fines for contractual rest breaches and gauging workload for further actions.



Thanks to the concerted efforts of GoSWH, DPGME and Medical Staffing, there has been a significant overall reduction in incomplete Exceptions Reports. Over the last two months period there were only 3 ERs which were not duly processed by the Clinical Supervisors and Trainees (9%).

ERs not Completed (Clinical Supervisors = CS)

	CS "A"	CS "B"	CS "C"
Rotherham	1	1	1
Doncaster	XXX	XXX	XXX
North Lincs.	XXX	XXX	XXX

Total Number of Un-processed ERs = 3 (Out of 33) (9%)

There are only 3 Clinical Supervisors, who did not complete Exception Reports, all from Rotherham. Medical Staffing/ GoSWH/ DPGME will continue to send reminders to the doctors to complete the reports.

Trends in Exception Reporting

Following trends have been observed:

1. There was only one Immediate Safety Concerns reported and it was effectively managed.

2. Rotherham remains on top once it comes to On-call Rest Breaches, followed by Doncaster and North Lincs

3. New Rota Design has been implemented in Rotherham and North Lincs and this will mitigate the issue of excessive workload and rest breaches. Details given below.

4. The increase in Exceptions related to Rest Breaches in Doncaster. Work Schedule Review for all three sites has been planned for November this year.

5. All the Exceptions were resolved satisfactorily through Time Off in Lieu (TOIL) or payment, barring one, where the outcome is not clear.

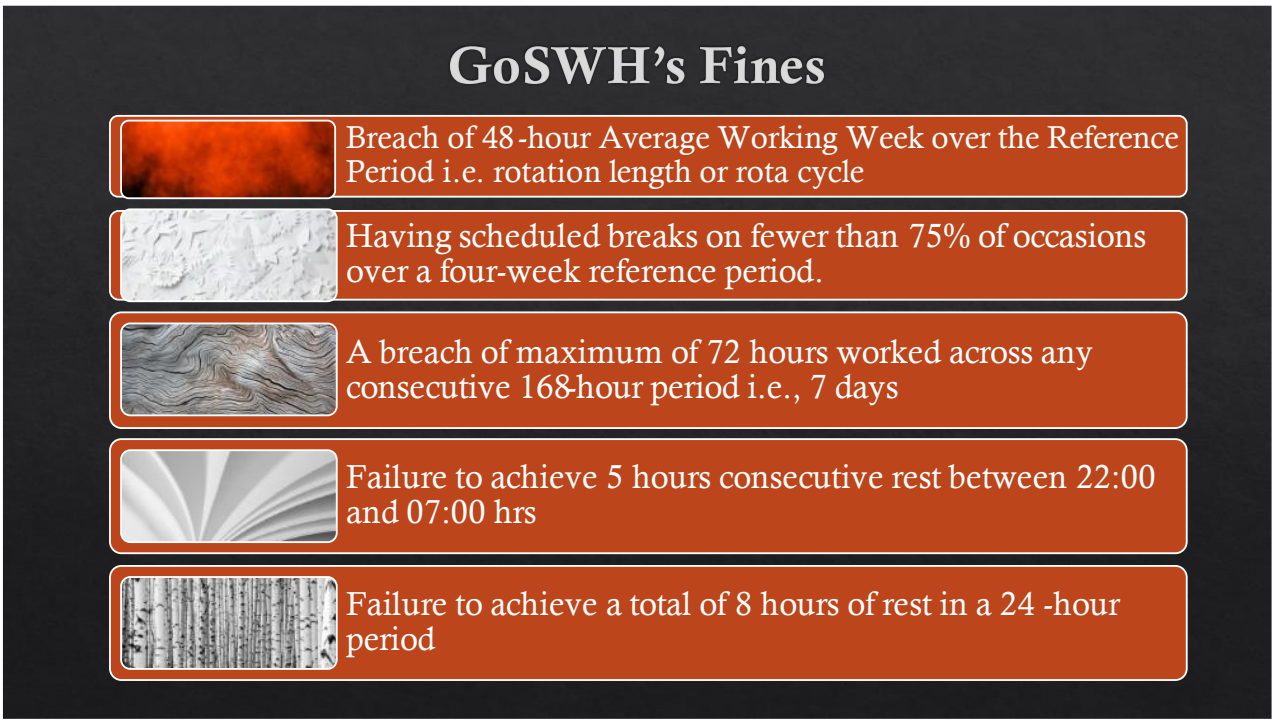
6. There were no reports for Missed Educational Opportunity.

7. There has been a significant improvement of Junior Doctors and Clinical Supervisor's engagement with the Exception Reporting process.

There were no rota gaps identified.

GoSWH's Fines:

The following breaches results in GoSWH's Fines.



Total fines £21k since Feb 2023
GoSWH - £13k allowable expenditure (from previous financial years)
Fines to be utilised within the financial year (exception given this year)

Year	Quarter	Sum of Total Fine	Sum of GoSWH	Sum of Payment to Dr
22/23	Q4 22/23	£3,922	£2,451	£1,471
22/23 Total		£3,922	£2,451	£1,471
23/24	Q1 23/24	£2,169	£1,355	£813
	Q2 23/24	£2,445	£1,528	£917
	Q3 23/24	£2,719	£1,699	£1,019
	Q4 23/24	£3,212	£2,007	£1,204
23/24 Total		£10,544	£6,590	£3,954
24/25	Q1 24/25	£6,762	£4,226	£2,536
24/25 Total		£6,762	£4,226	£2,536
Grand Total		£21,229	£13,268	£7,961

Till the end of 1st quarter in 2024, the **total amount** collected in GoSWH's fines was **£21,229**, out of which **£7,961** have been **paid to the doctors** and a balance of **£13,269 sits in GoSWH's account**. Monies in GoSWH's account are spent on well-being and safety and professional development of the junior doctors, following decisions in the JDF.

Rota Re-design and Implementation in Rotherham and North Lincs:

Hybrid Rota Design i.e. a mix of Contractual Terms and Conditions related to Resident and Non-resident On-Call has been implemented, following a Local Agreement between Junior Doctors' Reps/ BMA and Medical Staffing/ Trust Management.

Details of the shifts are as follows.

HYBRID ROTA – LOCAL AGREEMENT

- **Minimum Shift Duration (Twilight Shift):** 4:30 Hours
- **Maximum Shift Duration:** 12:30 Hours
- **Contractual Rest Breach Conditions don't apply:** No GoSWH's fines
- **Renumeration:**
  - Twilight Shift: Resident On-Call Rate
  - Long Day/ Night Shifts: Average Number of Hours worked per shift over entire Rota Cycle

ROTHERHAM (DOCTORS = 16)

Shift	Time	Type	Days	Post-Shift Rest
Twilight Mon - Thu	1700 – 2130 hrs	Different Doctors (Non-Resident)	1 Each	Nil
Night Mon – Thu	2100 – 0930hrs	Same Doctor (Non-Resident)	4 consecutive	48 Hours off
Twilight Fri Long Day Sat - Sun	1700 – 2130 hrs 0900 – 2130 hrs	Same Doctor (Non-Resident)	3 consecutive	48 Hours off
Night Fri - Sun	2100 – 0930hrs	Same Doctor (Non-Resident)	3 consecutive	48 Hours off

NORTH LINCS. (DOCTORS = 9)

Shift	Time	Type	Days	Post-Shift Rest
Twilight Mon - Thu	1700 – 2130 hrs	Different Doctors (Resident)	1 Each	Nil
Night Mon – Thu	2100 – 0930hrs	Same Doctor (Non-Resident)	4 consecutive	48 Hours off
Twilight Fri Long Day Sat - Sun	1700 – 2130 hrs 0900 – 2130 hrs	Same Doctor (Resident) (Non-Resident)	3 consecutive	48 Hours off
Night Fri - Sun	2100 – 0930hrs	Same Doctor (Non-Resident)	3 consecutive	48 Hours off

Other changes are as follows.

OTHER ASPECTS

- **Bank Holidays:** Long Day and Night Shifts
- **Locum Rates:** Still under Negotiation
- **Next On-Call Monitoring:** Nov 2024
- **On-Call Handover:** Only Electronic Now

Junior Doctors' Forum (JDF)

JDF was convened on Thursday 18 July and the following were agreed.

1. **Electronic Handover SOP** – Questions have been raised about the regular audit of e-Handover and further consultations have opened about who will be responsible for regular undertaking of this audit.

2. **Change of Name; from "Junior Doctors" to "Resident Doctors"** – Given this recent development, it was asked if the name of Junior Doctors' Forum (JDF) could

be changed to Resident Doctors' Forum (RDF). GoSWH advised since the constitution of Junior Doctors' Forum (JDF) was a part of Junior Doctor's Contract, advice would be sought from NHS Employers and Workforce, Training and Education NHS England.

3. **Safety of Junior Doctors during On-Call** - Concerns had been raised in different forums, including the JDF about the safety of junior doctors working and travelling alone across different sites, especially late at night, during on-call. It was agreed for the Consultants and Junior Doctors on-call to check-in at the start of on-call duty and think about alternatives, if mobile phone network is not available. This was later added to daily On-Call information sheet and information sent to all consultants and trainees. However, it was later felt appropriate by the DPGME and Executive that current arrangements were appropriate to mange risks and this step will be required.

   GoSWH is now communicating with the author of Lone Working Policy to include Junior Doctors' On-Call Work in the Policy and with Executive Medical Director and Director of Health Informatics about the issues with Mobile Network Coverage in across different sites in the Trust.

4. **Higher Trainees' S12(2) Work during On-Call and Rest Breaches** – This is being addressed through Trust's Policy Document on S12(2) work for the doctors, which is in consultation stage. This will be discussed further in the forthcoming JDF.

5. **First On-Call Workload Monitoring –** It was agreed for this to take place for 4 Weeks in November 24.

6. **Venue of future JDFs -** It was agreed that if this meeting cannot be held in a room with conferencing facilities, the meeting should take place on-line.

7. **Outstanding area for discussion in the next JDF –** This includes rates for On-Call Locums.

Administrative Support for JDF and GoSWH:

While a temporary arrangement has been made through Corporate Admin Support Team (CAST), a permanent solution must be implemented.

Dr Babur Yusufi
Guardian of Safe Working Hours (GoSWH) for RDaSH

13 August 2024