Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD MEETING - PUBLIC (REDUCED AGENDA)

BOARD MEETING - PUBLIC (REDUCED AGENDA)

27 June 2023

09:30 GMT+1 Europe/London

Virtual -TEAMS

Join on your computer, mobile app or room device
Click here to join the meeting

AGENDA

2306 - A MEETING BUSINESS

Suzy Brain England OBE, Chair

REFERENCES

Only PDFs are attached

00 Public Board Agenda - 27 June 2023 -V2.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting Held in Public
To be held on Tuesday 27 June 2023 at 09:30
Via MS Teams

Enc		Purpose	Time
A	**MEETING BUSINESS**		**09:30**
A1	Welcome, apologies for absence and declarations of interest *Suzy Brain England OBE, Chair* *Members of the Board and others present are reminded that they are required to declare any pecuniary or other interests which they have in relation to any business under consideration at the meeting and to withdraw at the appropriate time. Such a declaration may be made under this item or at such time when the interest becomes known* *Members of the public and governor observers will have both their camera and microphone disabled for the duration of the meeting*		
A2	Actions from previous meeting *Suzy Brain England OBE, Chair*	*Review*	5
B	**True North SA1 - QUALITY AND EFFECTIVENESS**		**09:35**
B1	Chair's Assurance Log – Quality & Effectiveness Committee *Jo Gander, Non-executive Director*	*Assurance*	5
B2	Maternity & Neonatal Update *Lois Mellor, Director of Midwifery*	*Assurance*	10
B3	Midwifery Workforce Report *Lois Mellor, Director of Midwifery*	*Assurance*	10
C	**True North SA4 – FINANCE & PERFORMANCE**		**10:00**
C1	Chair's Assurance Log – Finance & Performance Committee *Mark Day, Non-executive Director*	*Assurance*	5
C2	Operational Performance Update *Denise Smith, Chief Operating Officer*	*Assurance*	10
C3	Finance Update *Jon Sargeant, Deputy Chief Executive*	*Assurance*	10
C4	New Hospital Programme Update **(verbal)** *Jon Sargeant, Deputy Chief Executive*	*Note*	5

D	**GOVERNANCE & ASSURANCE**		10:30
D1	Chair's Assurance Log – Audit & Risk Committee *Kath Smart, Non-executive Director*	*Assurance*	5
D2	Chair's Assurance Log – Charitable Funds Committee *Hazel Brand, Non-executive Director*	*Assurance*	5
D3	NHS Provider Licence - Self-certification 2022/23 *Fiona Dunn, Director Corporate Affairs / Company Secretary*	*Approve*	*5*
D4	Use of Trust Seal *Fiona Dunn, Director Corporate Affairs / Company Secretary*	*Approve*	*5*
E	**INFORMATION ITEMS (To be taken as read)**		**10:50**
E1	South Yorkshire & Bassetlaw Acute Federation Annual Report 2022/23 *Richard Parker OBE, Chief Executive*	*Information*	
F	**OTHER ITEMS**		**10:50**
F1	Any other business (to be agreed with the Chair prior to the meeting) *Suzy Brain England OBE, Chair*	*Discussion*	5
F2	Governor questions regarding the business of the meeting (10 minutes)* *Suzy Brain England OBE, Chair*	*Discussion*	10
F3	Minutes of the meeting held on 23 May 2023 Suzy Brain England OBE, Chair	*Approval*	5
F4	**Date and time of next meeting:** **Date:** Tuesday 25 July 2023 **Time:** 09:30 **Venue:** MS Teams	*Information*	
F5	**Withdrawal of Press and Public** Board to resolve: That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. *Suzy Brain England OBE, Chair*		
	MEETING CLOSE		**11:10**

*Governor Questions

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

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

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

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

Suzy Brain England OBE
Chair of the Board

2306 - A1 WELCOME, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST

Suzy Brain England OBE, Chair 09:30

Members of the Board and others present are reminded that they are required to declare any pecuniary or other interests which they have in relation to any business under consideration at the meeting and to withdraw at the appropriate time. Such a declaration may be made under this item or at such time when the interest becomes known

Members of the public and governor observers will have both their camera and microphone disabled for the duration of the meeting

2306 - A2 ACTIONS FROM PREVIOUS MEETING

Decision Item Suzy Brain England OBE, Chair

5 minutes

NOTE: There were no active actions for review

REFERENCES

Only PDFs are attached

A2 - Board of Directors Action Log - 23.5.2023.pdf

Action notes prepared by: Angela O'Mara
Updated: 23 May 203

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Action Log

Meeting	Board of Directors (Public)				**KEY**
Date of latest meeting:	23 May 2023				**Completed**
					On Track
					In progress, some issues
					Issues causing progress to stall/stop
No.	**Minute No.**	**Action**	**Responsibility**	**Target Date**	**Update**
1.	**P23/05/D4**	**Operational Performance Report** To be circulated to the Board of Directors post meeting once the narrative has been finalised.	**DS**	**31 May 2023**	

2306 - B TRUE NORTH SA1 - QUALITY AND EFFECTIVENESS

2306 - B1 CHAIR'S ASSURANCE LOG - QUALITY & EFFECTIVENESS COMMITTEE

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

5 minutes

REFERENCES

Only PDFs are attached

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

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

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

Subject:	**Quality & Effectiveness Committee Meeting**	**Board Date:** June 2023
Prepared By:	Jo Gander	
Approved By:	Quality & Effective Committee Members	
Presented By:	Jo Gander, Chair of the Quality & Effectiveness Committee	
Purpose	The paper summaries the key highlights from the Quality & Effectiveness Committee meeting held on 6 June 2023	

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Whilst no formal items were identified for escalation, QEC was asked to note risks identified and be assured that appropriate mitigations are in place, all of which will be discussed and monitored through specialty and divisional clinical governance meetings, with high and extreme risks being discussed and managed at the Risk Management Board.	• Business case developed to fund separation of Clinical Governance and Audit roles. Follow up required to confirm impact on Clinical Audit delivery. • PSIRF and Quality Strategy development continues. • Three-year delivery plan for Maternity and Neonatal services - QEC noted the new requirements of the national 'Single Delivery Plan' and the assessment of the current Trust position against those requirements. QEC will continue to actively monitor progress towards achievement of those requirements.
Positive Assurances to Provide	**Decisions Made**
• Assurance received from the Medical Director re outstanding actions from February meeting although business case approval from separation of Clinical Audit and Governance roles represents a cost pressure and will require further follow up. • Great progress provided by Chief Nurse and team on PSIRF delivery, Quality Strategy draft and Quality Framework development. • Progress made in March and April with compliance on Duty of Candour across divisions. • Alignment of DBTH with ICB Quality and improvement priorities • Triangulation of incidents, patients' safety events, patient safety and other quality data via the Care Accreditation Recognition for Excellence (CARE) Framework. • People Strategy cross-cutting Quality & Effectiveness work	• Confirmation of agreement at board that future updates on Virtual Wards will be presented at Finance & Performance Committee moving forward, with any Quality/Safety issues being referred to QEC for consideration as necessary. • Draft QEC Annual Report 22/23 approved by committee.

2306 - B2 MATERNITY & NEONATAL UPDATE

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

10 mins

REFERENCES

Only PDFs are attached

- B2 - Maternity & Neonatal Update.pdf
- B2 - Board Surveillance April 2023.pdf
- B2 - Glossary of Terms.pdf

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	27 June 2023	**Agenda Reference:**	**B2**		
Report Title:	Maternity & Neonatal Update				
Sponsor:	Karen Jessop, Chief Nurse				
Author:	Lois Mellor, Director of Midwifery Laura Churm, Divisional Nurse (paediatrics)				
Appendices:	Perinatal Surveillance Dashboard				
Report Summary					
Purpose of report:	To update the Board of Directors on performance, key issues, and developments in Maternity and Neonatal Services.				
Summary of key issues/positive highlights:	• No neonatal deaths this month • No current HSIB cases • Training under review • CNST year 5 published • Midwifery vacancies continue • One to one care in labour levels good • Details in relation to neonatal services are included • High level medical workforce information has been provided				
Recommendation:	For the Trust Board of Directors to take assurance from the detail provided within this Maternity report.				
Action Require:	~~Approval~~	**Information**	**Discussion**	**Assurance**	~~Review~~

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

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

Assurance Route			
Previously considered by:		Governance Meetings Children's & Families Board (verbal updates)	
Date :	15 June 2023	**Decision:**	To continue to monitor
Next Steps:		Support to continue improvements in maternity & neonatal service, and achieve year 5 CNST standards	
Previously circulated reports to supplement this paper:			

Monthly Board Report

May 2023

Additional information in support of this report is provided in conjunction with the Board Surveillance PowerPoint Presentation.

1. Findings of review of all perinatal deaths

1.1 Stillbirths and late fetal loss > 22 weeks

There were no stillbirths in May 2023.

1.2 Neonatal Deaths

No neonatal deaths have been reported.

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

Work is ongoing with local maternity and neonatal system complete the reduced fetal movement guideline.

The Serenity Suite is due to be opened on 15th June 2023 which will provide a calm environment where a bereaved family can spend time together.

2. Neonatal Services

Neonatal staffing is 89% recruited with 77% of establishment at work, with 12% maternity leave. The Qualified in Speciality ratio remains at 70% of total registered nurse within neonatal services. During April we had 92% of shifts resourced within British Association of Perinatal Medicine (BAPM) standards, of the 8% that didn't meet the standard, half was due to a gap in the supervisory coordinator role, the remaining 5 shifts were short of registered nurses due to high acuity. There was no clinical compromise and the nurse in charge did not escalate the shift as a concern.

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

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

2.1 Avoiding Term Admissions into Neonatal Units (ATAIN)

We are consistently meeting the national target (6%) for term admission and generally within the target for the local ambition (5%), in April we were 2.8%. When reviewing our data it was noted that there had been an error in the submitted data, this has now been rectified. Our current avoidable admission percentage is 10% for May; however, the local

Maternity and Neonatal System (LMNS) are reviewing the formula for calculating this percentage as there has been a change this financial year. Work is still ongoing looking at Respiratory Distress Syndrome and if this is linked to an increase in C-section rates and the need to increase the temperature of theatres to reduced neonatal admissions due to low temperature.

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

There has been no change from last month, the reduction in active cases appears to be a national trend.

Cases to date	
Total referrals	22
Referrals / cases rejected	4
Total investigations to date	18
Total investigations completed	18
Current active cases	0
Exception reporting	0

3.1 Reports Received since last report

No investigations currently.

3.2 Current investigations

None.

4. Serious Incident Investigations (Internal)

There have been no serious incidents in May 2023.

5. Training Compliance

The service has continued to deliver training in all areas, however the publication of the new CNST standards on 31st May 2023 has changed the requirements for Safety Action 8. The final training compliance to 31st May 2023 is detailed below, and a more detailed assessment of the current position, required provision and delivery is planned to take place on 12th June 2023.

The new standards require the service to review the training needs analysis for the service, review the qualifications of those delivering the training and maintain training at 90% or above consistently over a period of a year.
An urgent meeting has been arranged with the education department, on 15th June 2023 to discuss the implication of the changes.

K2 E learning package and Cardiotocograph (CTG) Study Day

The training position on 31st May 2023 was:

Staff Group	Number	Number Compliant	K2 CTG Compliance	Number of staff undertaken Fetal Monitoring Study Day	Study Day Compliance
90% of Obstetric Consultants	**14**	**11**	**100 % ↑**	**11**	**78.6% ↓**
90% of All other Obstetric Doctors including trainees	**23**	**21**	**91.3 % ↓**	**8**	**34.8%↓**
90% of Midwives	**193**	**173**	**89.6% ↓**	**58**	**30.1% ↓**
90% of NHSP Midwives	**17**	**15**	**88.2% ↑**		**0% ↓**

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

Staff Group	Number	Number Compliant	Prompt Compliance
90% of Obstetric Consultants	14	11	**78.6% ↑**
90% of All other Obstetric Doctors including trainees	34	21	**61.8% ↓**
90% of Midwives	200	158	**79% ↓**
90% of NHSP Midwives	28	15	**53.6% →**
90% of Maternity Support Workers	76	45	**59.2% ↓**
90% of Obstetric Anaesthetic Consultants	19	15	**87.9% →**

Newborn Life Support Training

Staff Group	Number	Number Compliant	NLS Compliance
90% of Midwives	200	175	**87.6 % ↑**
90% of NHSP Midwives	27	27	**100% →**

6. Service User Feedback

International day of the Midwife has been an opportunity to celebrate the excellent care given by midwives, and maternity voices partnership chair shared a large number of positive experiences from women that currently use the service.

The chair of the group is about to go onto Maternity leave therefore maternity leave cover and deputy will be appointed in the next few weeks.

The service continues to work closely with the maternity voices partnership engaging with local groups and families.

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

None.

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

None.

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

Year 5 CNST was published on 31st May 2023, and the requirements dare being thoroughly reviewed. The initial assessment of the safety actions suggests that meeting the requirements for training (safety action 8) is going to be a challenge.

10. Board Level Safety Champion

Karen Jessop (Chief Nurse) visited Triage on 25th May 2023 at Doncaster and spoke to the staff working in the area. They explained how the service works and raised the following concerns:

- Funding is needed for a call waiting system to support the triage service
- The centralised fetal monitoring system would assist with managing the workload in triage
- Triage are seeing an increased number of scan reviews from ante natal assessment unit and clinic which is impacting on the workload

Plans to address these areas:

- Charitable funds to be used for the call waiting system
- The centralised monitoring is being progressed
- Scan review process to be reviewed by the Matron

Closed concerns from previous visits:

- Rotation of band 7 coordinators had ceased
- Induction of labour guideline not always followed
- WIFI drop out in the modular build

The maternity safety champions met after the site visit and discussed the three year deliver plan for maternity and neonatal services. It was acknowledged that there was ongoing review and discussion of the plan happening at all levels, and that there would be an update at the next meeting.

11. Perinatal Surveillance dashboard

For this month we have seen improvement in:

- No off pathway deliveries across both sites “right baby right place”
- No reported stillbirths for May
- The number of women who are smoking at the time of delivery
- Drop in post-partum haemorrhages at Bassetlaw from last month
- There has been an increase in reported incidents across both sites.

There has been an increase in term admissions to the neonatal unit/special care baby unit these are reviewed within the incident review meeting and the ATAIN meeting – working toward amalgamating these two reviews.

12. Midwifery staffing

There are currently 20.77 WTE midwifery vacancies at DBTH, this is against the existing funded establishment. This has remained stable for some time, and the recruitment of newly qualified midwives in October 2023 and the six international midwives we have recruited will significantly improve this position. The service is currently utilising agency and NHS P midwives to support the service and maintain safe staffing levels.

Despite the midwifery challenges we continue to provide high levels of one to one care in labour (one midwife to one woman). This metric is from admission, and if it is not possible to provide one to one care straight away this is considered non-compliant. Current compliance is:

Doncaster - 100%
Bassetlaw - 100 %

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

Doncaster

Red Flag	**Number of times**
Delayed or cancelled critical time activity	2
Delay between presentation and triage	1
Management Actions taken	
Redeploy staff internally	22
Staff unable to take allocated breaks	2
Unit on divert	8
Escalate to Manager on call	2

Bassetlaw

Red Flag	**Number of times**
Delay between admission for induction and beginning of process	**2**
Management Actions taken	
Redeploy staff internally	4
Staff unable to take allocated breaks	2
Unit of divert	3
Escalate to Manager on call	2

This shows proactive management of the situation using the information in the birthrate+ ® App that is used on central delivery suite and labour ward.

13. Medical Workforce

A new consultant obstetrician has commenced in post and is currently undergoing an induction process.

14. Conclusion

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

NE&Y Regional Perinatal Quality Oversight Group
Highlight Report

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

LMNS: South Yorkshire and Bassetlaw

Reporting period: April 2023 – June 2023

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

Maternity unit: DBTH – Doncaster

KPI (see slide 4)	Measurement / Target		Doncaster Rate		
			April	May	June
Caesarean Section rate	Elective	<13.2 %	16.9%		
	Emergency	<15.2 %	29.1%		
Preterm birth rate	≤26+6 weeks	0	0.9%		
	≤36+6 weeks	<6%	8.6%		
Massive Obstetric Haemorrhage	≥1.5l	<2.9%	3.8%		
Term admissions to NICU		<6%	2.61%		
3rd & 4th degree tear	SVD (unassist'd)	<2.8%	0%		
	Instrumental (assisted)	<6.05 %	0%		
			0%		
Right place of birth		95%	99%		
Smoking at time of delivery		<11%	10.5%		
Percentage of women placed on CoC pathway		35%	0%		
Percentage of women on CoC pathway: BAME / areas of deprivation	BAME	75%	0%		
	Area of deprivation		0%		
			0 %		

Month/Quarter		Red flag alert	Open > 30 days	Unactioned Datix	Maternity Serious Incidents	Maternity Never Events	HSIB cases	Still Births (All / Term / Intrapartum)			HIE cases (2 or3)	Neonatal Deaths Early	Neonatal Deaths Late	Notification to ENS	Maternal Mortality (direct / indirect)	
2022/2023	April	37	145	0	0	0	0	1	0	0	0	3	0	0	0	0
	May															
	June															
	Q1															

Maternity Red Flags (NICE 2015)

		April	May	June
1	Delay in commencing/continuing IOL process	26		
2	Delay in elective work	1		
3	Unable to give 1-1 care in labour	0		
4	Missed/delayed care for > 60 minutes	10		
5	Delay of 30 minutes or more between presentation and triage (LWAU)	0		

NE&Y Regional Perinatal Quality Oversight Group
Highlight Report

LMNS: South Yorkshire and Bassetlaw

Reporting period: April 2023 – June 2023

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

Maternity unit — DBTH – Bassetlaw

KPI (see slide 4)3.9%	Measurement / Target		Bassetlaw Rate		
			Jan	Feb	March
Caesarean Section rate	Elective		13.6%		
	Emergency		31.4%		
Preterm birth rate	≤26+6 weeks	0	0		
	≤36+6 weeks	**<6%**	7.62%		
Massive Obstetric Haemorrhage	**≥1.5l**	<2.9%	7.6%		
Term admissions to NICU		<6%	0.9%		
3rd & 4th degree tear	SVD (unassist'd)	<2.8%	0%	0%	
	Instrumental (assisted)	<6.06 %	0%		
Right place of birth		95%	99%		
Smoking at time of delivery		<11%	9.5%		
Percentage of women placed on CoC pathway		35%	0		
Percentage of women on CoC pathway: BAME / areas of deprivation	**BAME**	75%	0	0	
	Area of deprivation				

Month/Quarter		Red flag alert	Open > 30 days	Unactioned Datix	Maternity Serious Incidents	Maternity Never Events	HSIB cases	Still Births (All / Term / Intrapartum)			HIE cases (2 or3)	Neonatal Deaths (Early / Late)		Notification to ENS	Maternal Mortality (direct / indirect)	
2020/2021	April	7	**25**	**0**	`0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	May															
	June															

Maternity Red Flags (NICE 2015)0

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

Assessed compliance with10 Steps-to-Safety

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

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

Evidence of SBLCB V2 Compliance

		April	May`	June
1	Reducing smoking			
2	Fetal Growth Restriction			
3	Reduced Fetal Movements			
4	Fetal monitoring during labour			
5	Reducing pre-term birth			

Assessment against Ockenden Immediate and Essential Action (IEA)

	April		May		June	
Audit of consultant led labour ward rounds twice daily						
Audit of Named Consultant lead for complex pregnancies						
Audit of risk assessment at each antenatal visit						
Lead CTG Midwife and Obstetrician in post						
Non Exec and Exec Director identified for Perinatal Safety						
Multidisciplinary training – PrOMPT, CTG, Obstetric Emergencies (90% of Staff)	CTG 81.5%	PROMPT 83.9%				
Plan in place to meet birth rate plus standard (please include target date for compliance)						
Flowing accurate data to MSDS						
Maternity SIs shared with trust Board						

KPIs: Targets & Thresholds

Ref	KPI	Measurement	Target	Green Range	Amber Range	Red Range	Source
S1	**Caesarean section rate** (Caesarean section targets are based on England HES data for 2019/20)	% Caesarean sections: elective & emergency	29% EL 13% / EM 17%	<30% / <13.2% / <17%	NA	> 33% / > 15% / > 19%	Trust / MSDSv2
S2	**Preterm birth rate** (Denominator = all births over 24 weeks gestation)	% Preterm birthrate: <27 weeks & <36 weeks	<6%	< 6% achieved in 12 months	N/A	> 6 achieved in 12 months	Trust
S3	**Massive obstetric haemorrhage** (Based on NMPA data for 2017/17 for women who give birth vaginally to a singleton baby in the cephalic position between 37+0 and 42+6 weeks)	Massive obstetric Haemorrhage >1500mls (denominator = total singleton cephalic births)	<2.9%	<2.9%	<3.5%	>=3.5%	Trust / MSDSv2
S4	**Term admissions to NICU** ((from all sources eg Labour ward, postnatal ward / community but not transitional care babies)	% Terms admissions to NICU	<6%	<6%	NA	>6%	Trust / Badgernet
S5	**3rd & 4th degree tear** (3rd/ 4th degree tears are based on NMPA data for 2017/17 for women who give birth vaginally to a singleton baby in the cephalic position between 37+0 and 42+6)	% 3rd & 4th degree tear: NMPA SVD & Instrumental 3rd & 4th degree tear (denominator total singleton cephalic SVD / total Instrumental births / total vaginal births)	NMPA SVD: 2.8% Instrumental: 6.8% Overall: 3.5%	< 3.5%	NA	>5%	Trust / MSDSv2
S6	**Right Place of Birth** (denominator = no of women birthing under 27, 28 with multiple or <800g)	% Right Place of Birth: <27 weeks or <28 weeks multiple & EFW <800g born in tertiary centre	95%	>90%	80% – 90%	<80%	Trust / Badgernet
S7	**Smoking at time of delivery**	% women smoking at time of delivery	6%	<11%		>11%	Trust / MSDSv2
S8	**Percentage of women placed on Continuity of Carer pathway** denominator = all women reaching 29 weeks gestation within the month	% women placed on continuity of carer pathway at 29 weeks gestation	35%	25% - 35%	15%-25%	<15%	Trust / MSDSv2
S9	**Percentage of BAME women or from areas of deprivation placed on Continuity of Carer pathway** (denominator as above)	% BAME women placed on continuity of carer pathway at 29 weeks gestation	75%	65% - 75%	55% - 65%	<55%	Trust / MSDSv2
	Red Flags						

Glossary of terms / Definitions for use with maternity papers

AN - Antenatal (before birth)

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

BAPM - British Association of Perinatal Medicine (neonatal)

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

Cephalic - Head down

CNST - Clinical Negligence Scheme for Trusts

CTG - Cardiotocography (fetal monitor)

CQC - Care Quality Commission (Our regulator)

Cooling - baby actively cooled lowering the body temperature

DoM - Director of Midwifery

EFW - Estimated fetal weight

FTSU - Freedom to speak up

G - Gravis (total number of pregnancies including miscarriages)

GIRFT - Getting it right first time (Benchmarking data)

HSIB - Health Service Investigation bureau

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

IUD - intrauterine death (in the uterus)

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

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

MSDS - Maternity dataset

NED - Non-executive director

NICU - neonatal intensive care unit

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

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

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

PFDR - Prevention of future deaths

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

PPH - Postpartum haemorrhage (after birth)

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

QI - Quality Improvement

RDS - respiratory distress syndrome (breathing problems)

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

RIP - rest in peace

SVD - Spontaneous vaginal delivery

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

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

Other information

Term is 37-42 weeks long

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

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

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

2306 - B3 BI-ANNUAL MIDWIFERY STAFFING REVIEW

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

10 minutes

REFERENCES

Only PDFs are attached

B3 - Midwifery Workforce Report.pdf

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	27 June 2023	**Agenda Reference:**	**B3**		
Report Title:	**Midwifery Workforce Report**				
Sponsor:	Karen Jessop, Chief Nurse				
Author:	Lois Mellor, Director of Midwifery				
Appendices:	None				

Report Summary					
Purpose of report:	To update the Board on the progress in the Maternity Service.				
Summary of key issues/positive highlights:	• Update on the current midwifery staffing position • Plans to mitigate risks due to vacancies • Ongoing recruitment				
Recommendation:	To note and take assurance.				
Action Require:	~~Approval~~	**Information**	**Discussion**	**Assurance**	~~Review~~

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

Implications	
Board assurance framework:	Safe and quality care SA1, SA2 and SA3
Corporate risk register:	Safe midwifery staffing levels CRR ID 16
Regulation:	CQC regulation 12 – safe and effective care
Legal:	Increased risk of serious incidents and / or poor experiences / outcomes for families
Resources:	

Assurance Route			
Previously considered by:	The draft report has been discussed at Children's & Families Board on 5th May 2023.		
Date :		**Decision:**	
Next Steps:			
Previously circulated reports to supplement this paper:			

Contents

1. Introduction

Birthrate Plus®

A robust tool called Birthrate Plus® (BR +) has been used in conjunction with professional judgement to calculate the workforce required to deliver safe maternity services at DBTH. The most recent assessment report was received in August 2022. There has been a specific birthrate+® paper that has been submitted to the Trust Board of Directors for approval to take a regional approach to the funding/recruitment challenges that the assessment has highlighted.

2. Birth Rate Plus Recommended Midwife WTE

	2019	2022
DRI	155.00	157.44
BDGH	63.71	63.63
Specialist / Managerial	16.4	22.11
Total	**218.71**	**243.18**

Skill Mixing

BR + © suggests up to 10% of the Whole Time Equivalent (WTE) registered midwife (RM) requirement can be skill mixed with Band 3 Maternity Support Workers (MSW) where clinically appropriate. Skill mixing can predominantly be undertaken on the post-natal ward, and in community, where band 3 MSWs can support midwives

3. Workforce Model for 23/24

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

Total Workforce by Role

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

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

4. Planned Versus Actual Staffing levels

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

Funded model		In post	Variance
Midwives	168.05	147.64	- 20.41
Managerial & Specialist	21.4	21.4	0

MSW Band 3	31	19.66	- 11.34
HCA Band 2	29.15	40.34	+ 11.09

Proposed model		**In post**	**Variance**
Midwives	195.7	147.64	- 48.06
Managerial & Specialist	22.34	21.4	- 1.04
MSW Band 3	27	19.66	- 7.34
HCA Band 2	30.2	40.34	+ 10.14

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

5. Recruitment & Retention

The service has been part of the direct support offer from NHSE, to support the recruitment and retention of midwives in the organisation. There is a robust action plan in place and regular support and webinars.

The service has invested in a pastoral team consisting of:

- A recruitment lead midwife
- Recruitment and retention midwife
- 2 practice development midwives
- Lead professional midwifery advocate (PMA) and a PMA team

This team has worked to support early career midwives, midwives who need additional support and midwifery support workers. The practice development midwives work in the clinical area to support anyone who requires it.

They also support all the preceptorship package and every newly qualified midwife receives a minimum of 7.5 hours one to one time in the first months of their preceptorship.

The team also provide pastoral support for anyone who needs it, with a friendly ear and safe space to talk. They also provide one to one conversations about flexible working, coaching and 'stay' conversations. These are conversations to gain an understanding of why midwives are thinking of leaving and what we can do to encourage them to stay. This has seen an improvement in the retention of midwives. They also support the international midwives, and flexi retirement.

The service has sent offer letters to 60.65 WTE third year student midwives who are due to qualify in September / October 2023. The attrition rate for the newly qualified midwives in South Yorkshire and Bassetlaw local maternity system was approximately 21% in 2022.

The students will be supported over the next few months by the pastoral team, and a robust preceptorship programme is in place to support them for the first two years of their career with the aim to keep the attrition rate to a minimum.

The pastoral team work to support midwives by:

- Having 'stay conversations'
- Discussing flexible working options
- Regular listening events
- Coaching conversations
- Retire and return discussions
- Targeted interventions and support

Monthly return to NHS E

	2021/2022	Oct	Nov	Dec	Jan 23	Feb	Mar
Turnover rate	35 midwives left	0%	0.47%	1.61%	0.76%	0.6%	0.68%
New starters		4	2	3	0	1	0
Stay conversations		1	1	2	1	0	0
Flexible working		2	1	2	2	2	2

We are also supporting:

- 1 midwifery apprentice
- 2 Registered Nurses (RNs) to undertake the conversion course to be a RM
- 3 international recruits in process, and 3 further are starting in May 2023

6. Midwife to Birth Ratio

The recommended midwife to birth ratio nationally is 1:28, and the current ratio (midwives in post) to births 4487 (DBTH). 3025 (DRI) and 1462 (BDGH) is:

TRUST - 1:26.54
DRI - 1:28.14
BDGH - 1:23.74

This ratio is a guide and needs to be used in conjunction with BR+ and clinical judgement, in consideration of the acuity To and dependency and individual needs of each woman. Staffing the Bassetlaw site requires a higher midwife to birth ratio to support safe clinical care because of the lower headcount of midwives. This is reflected above in the ratios, safely staffing the Doncaster site can be achieved with a lower ratio because this translates into a larger headcount of midwives that can be utilized across the service to mitigate the risks.

7. One to One Care in Labour

The aim is to achieve 100% one to one care in labour, this means one midwife for one woman once in established labour (4 cms dilated with regular painful contractions). The

midwife caring for a woman should not have any other women in her care, and this requirement forms part of the Clinical Negligence Scheme for Trusts (CNST) Safety Actions.

This is monitored on a monthly basis on the maternity dashboard and is reported non-compliant if during any period (however short) this has not been achieved. The current rates are described below for the last 4 quarters.

Month	June '22	Sept '22	Dec '22	Feb '23
Doncaster	92.86%	92.42 %	100 %	96.4%
Bassetlaw	98.33 %	97.87 %	100 %	97.81%

Where this cannot be achieved it is risk assessed by the Labour Ward Coordinator using the birthrate acuity tool, and the manager of the day is contacted to make an assessment of the whole of the maternity service. The manager of day will then redeploy staff in accordance with the risk assessment ensuring that this is achieved as soon as possible. If 1:1 care is not possible for further women in labour the escalation policy is activated.

8. B7 Labour Ward Coordinator

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

9. Mitigation of Risk

If the situation is escalating and assessed as unsafe, then the Maternity Escalation Policy is used. In the first instance a divert is put in place and women are redirected to the sister site, until the situation is resolved. If both sites subsequently are becoming unsafe the position is continuously reviewed and this may lead to service suspension (diversion to another provider) until the situation is resolved. There is a Local Maternity and neonatal System (LMNS) escalation policy that supports system wide support to the service that has declared OPEL 4 (suspension of services).

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

10. Red flags

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

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service should be

notified. The midwife in charge should determine whether midwifery staffing is a factor, and the action that is needed to resolve.

Below is the table of the reported Red Flags in the maternity service for the last five months. The number of red flags can vary month to month, depending on staffing levels and the number of births. It is a proactive way to monitor risks in the service and make management plans to address areas of risk.

Doncaster

Maternity Red Flags (NICE 2015)				
		Oct	Nov	Dec
1	Delay in commencing/continuing IOL process	37	13	35
2	Delay in elective work	0	0	0
3	Unable to give 1-1 care in labour	0	0	
4	Missed/delayed care for > 60 minutes	0	0	0
5	Delay of 30 minutes or more between presentation and triage (LWAU)	1	0	0

Maternity Red Flags (NICE 2015)				
		Jan	Feb	
1	Delay in commencing/continuing IOL process	31	2	
2	Delay in elective work	0	0	
3	Unable to give 1-1 care in labour	1	0	
4	Missed/delayed care for > 60 minutes	0	0	
5	Delay of 30 minutes or more between presentation and triage (LWAU)	0	0	

Bassetlaw

Maternity Red Flags (NICE 2015)				
		Oct	Nov	Dec
1	Delay in commencing/continuing IOL process	4	15	35
2	Delay in elective work	0	0	0
3	Unable to give 1-1 care in labour	0	0	0

4	Missed/delayed care for > 60 minutes	0	0	0
5	Delay of 30 minutes or more between presentation and triage (LWAU)	0	0	0

Maternity Red Flags (NICE 2015)0				
		Jan	Feb	
1	Delay in commencing/continuing IOL process	8	0	
2	Delay in elective work	0	0	
3	Unable to give 1-1 care in labour	0	0	
4	Missed/delayed care for > 60 minutes	0	0	
5	Delay of 30 minutes or more between presentation and triage (LWAU)	0	0	

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

The Induction of Labour (IOL) process has been amended to address the recent red flags related to delays in the IOL process, audit findings and a recent Health Services Investigation Bureau (HSIB) investigation. This has seen an improving picture, and a reduction in the number of the red flags reported related to delays in IOL.

11. Addressing areas of Risk

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

12. Action Plan

No.	Action	Lead	Target Date
1	Discuss plan to fund birthrate+® recommended midwifery staffing model with agreed target date	Karen Jessop - Chief Nurse	28th March 2023
2	Continue to retain and recruit midwives to meet birthrate+® recommendations	Lois Mellor - DoM	Review quarterly until the service achieves full recruitment
3	Ensure there is a robust plan in	Manager of the	Ongoing

	place to ensure safe staffing levels maintained on every shift	Day / Lois Mellor - DoM	

2306 - C TRUE NORTH SA4 - FINANCE AND PERFORMANCE

2306 - C1 CHAIR'S ASSURANCE LOG - FINANCE & PERFORMANCE COMMITTEE

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

5 minutes

** To follow - meeting on 26 June **

2306 - C2 OPERATIONAL PERFORMANCE UPDATE

Discussion Item | Denise Smith, Chief Operating Officer | 10:05

10 minutes

REFERENCES

Only PDFs are attached

C2 - Operational Performance Update.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	27 June 2023	**Agenda Reference:**	**C2**
Report Title:	**Operational Performance Update**		
Sponsor:	Denise Smith, Chief Operating Officer		
Author:	Laura Fawcett-Hall, Head of Performance Karen McAlpine, Deputy Chief Operating Officer (Elective) Suzanne Stubbs, Deputy Chief Operating Officer (Urgent & Emergency Care)		
Appendices:			
Purpose of report:	The report provides an update on • performance against the access standards • delivery of elective activity against plan • elective priorities for 2023 / 24 with Board assurance checklist		
Summary of key issues:	**ACCESS STANDARDS** **Emergency Care** • **4 Hour access**: 74.16% performance in May 2023 • **12 Hour waits –** in May 2023 2.59% of patients waited in the Emergency Department > 12 hour waits from time of arrival • **Ambulance handover** – In May 2023 65.25% of ambulance handovers took place within 15 minutes, 75.04% took place within 30 minutes and 98.19% took place within 60 minutes. **Elective Care** • **65 Week Breaches** – In May 2023, the Trust reported 248 breaches, an increase from 238 in April 2023. • **104-week waits** – At the end of May 2023, there was 1 patient waiting over 104 weeks. • **Referral To Treatment (RTT)** - In May 2023, the Trust delivered 66.64% performance within 18 weeks, below the 92% standard. This position is an improvement from April 2023 (65.6%) • **The total waiting list** increased during May 2023 to 51,036. The previous position in April was 50,862 and March was 50,052. **Diagnostics** - In May 2023, the Trust achieved 66.66% against a target of 99%. This is a decrease in performance from 67.66% in April 2023. The Trust remains an outlier in Diagnostic waiting times. **Cancer waiting times** • **2 Week Wait** – In April 2023 0 out of 2 nationally reported measures were achieved. • **Faster Diagnosis Standard –** In April 2023 the Trust achieved the FDS standard with performance of 76.9% • **31 Day Standard** – in April 2023 2 out of 3 nationally reported measures were achieved. • **62 Day Standard –** in April 2023 0 out of 2 nationally reported measures were achieved.		

	ELECTIVE ACTIVITY In May 2023 the Trust delivered the following activity against the plan for 2023/24: • Outpatient First: 100.9% • Outpatient Follow up: 94.5% • Day case: 98.4% • Elective: 92.4% **ELECTIVE PRIORITITES** The elective care for 2023/24 priorities are set out in a letter from NHS England, dated 23 May 2023, and are summarised below: 1. Excellence in basics 2. Performance and long waits 3. Outpatients 4. Cancer pathway redesign 5. Activity 6. Choice A self-assessment against the Board checklist, to provide assurance on the Trust plans to deliver the elective and cancer recovery objectives for 2023/24, is provided, noting that that the three key performance deliverables and metrics are: • Virtually eliminate waits of > 65 weeks by March 2024 • Continue to reduce the number of cancer patients waiting over 62 days • Meet the 75% cancer faster diagnosis ambition by March 2024.

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

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

Implications	
Board assurance framework:	SA1
Corporate risk register:	
Regulation:	
Legal:	
Resources:	

Assurance Route			
Previously considered by:	None		
Date:		**Decision:**	
Next Steps:			
Previously circulated reports to supplement this paper:			

1. Introduction

This paper details the following:

- performance against the access standards
- delivery of elective activity against plan
- elective priorities for 2023 / 24, as set out in the letter from NHS England, and Board assurance checklist

2. Access Standards

Emergency access within 4 hours: Trust wide 4-hour performance was 74.16% in May 2023, an improvement in performance from 68.2% in April 2023. The Trust's performance was third in the region and remains in the second quartile nationally with national performance of 73.4% for the month of May.

Emergency access within 12 hours: Trust wide 12-hour performance was 2.59% in May 2023, against the standard of 2%, an improvement in performance from 3.3% in April 2023. The Trust's is in the first quartile nationally with national performance of 7.2% for the month of May.

Ambulance handover: Ambulance handover within 15 minutes improved from 57.03% in April 2023 to 65.25% in May 2023. National average for May 2023 was 64.0%. Ambulance handover within 30 minutes declined from 85.01% in April 2023 to 75.04% in May 2023. National average for May 2023 was 78.2%. Ambulance handover within 60 minutes improved from 96.69% in April 2023 to 98.19% in May 2023. National average for April 2023 was 91.8%.

General and Acute (G&A) bed occupancy: Bed occupancy increased to 94.7% in May 2023, 4.2% higher than trajectory.

Diagnostic waiting times: Performance for May 2023 was 66.66%, a deterioration from the April 2023 position of 67.66%. At the end of May 2023, there were 12,847 waiters on the diagnostic waiting list, of which 4,297 had waited over six weeks from referral to diagnostic test.

18 weeks referral to treatment: The Trust Level month end performance for May 2023 is 66.64%, compared to 65.6 in April 2023.

Waits over 78 weeks for incomplete pathways: There were 17 incomplete pathways over 78 weeks at the end of May 2023. This is an increase of 3 compared to April 2023.

Waits over 65 weeks for incomplete pathways: There were 248 incomplete pathways waiting over 65 weeks at the end of May 2023. This is ten more than at the end of the previous month.

Breaches of the 28-day guarantee: There were no breaches of the 28-day guarantee in May 2023.

Urgent operations cancelled for a second time: There were no urgent operations cancelled for a second time in May 2023.

2-week wait from urgent referral for suspected cancer to first outpatient attendance: In April 2023, the Trust delivered 78.9% against a target of 93%. Out of 1500 attendances, 317 patients were not seen within 14 days.

2-week wait from urgent referral with breast symptoms (where cancer was not initially suspected) to first outpatient attendance: In April 2023, the Trust delivered 58.9% against a target of 93%. Out of 95 attendances, 39 patients were not seen within 14 days.

28 days from urgent referral to receiving a communication of diagnosis for cancer or ruling out of cancer: In April 2023, the Trust delivered 76.9% against a target of 75%.

31-day from diagnosis to first definitive treatment (all cancers): In April 2023, the Trust delivered 91% against a target of 96%. Out of 111 attendances, 10 patients were not treated within 31 days.

31-day for subsequent treatment (surgery): The standard has been met for April 2023 (100%)

31-day for subsequent treatment (chemotherapy): The standard has been met for April 2023 (100%)

62-day wait from referral from urgent referral to first definitive treatment for cancer: In April 2023, the Trust achieved 60.5% against a target of 85%.

62-day from referral from an NHS screening service to first definitive treatment (all cancers): In April 2023, the Trust achieved 53.8% against a target of 90%. All Breast Screening Pathways achieved the standard however; none of the 3 Bowel Screening Pathways met the standard. The Bowel Screening pathway delays were due to complex pathways, patient choice and inconclusive initial diagnosis. .

Patients on a cancer pathway > 62 days: There were 59 patients > 62 day against a trajectory of 70 patients. The main reasons for delays were complex pathways, patient choice, diagnostic delays and staging investigations. In April, the combination of Bank Holidays and Industrial Action also affected results review turnaround times and clinical administration.

3. Elective Activity

Outpatient New: In May 2023, the Trust delivered 100.9% of plan for new outpatients. This is an improvement from April 2023 where 95.7% of plan was achieved.

Outpatient Follow Up: In May 2023, the Trust delivered 94.5% of plan for outpatient follow ups. This is an improvement from April 2023 where 89.1% of plan was achieved.

Patient Initiated Follow Up: The Trust has exceeded the standard for PIFU in May 2023. This over delivery is being driven by one specialty, ENT.

Advice and Guidance: Advice and guidance is delivered through the E-Referral Service interactions and Consultant Connect. The Trust is currently delivering against plan.

Day case: In May 2023, the Trust delivered 98.4% of the day case plan. This is an improvement from the April 2023 position of 94.9%

Elective: In May 2023, the Trust delivered 92.4% of the elective plan. This is an improvement from the April 2023 position of 83.7%

4. Elective Priorities 2023/24

The NHS England letter of 23 May 2023 (Appendix A) sets out the following elective care priorities for 2023/24:

(i)	**Excellence in basics**	• Maintain a strong focus on data quality, validation, clinical prioritisation and maximising booking rates.
(ii)	**Performance and long waits**	• Continue to reduce waits of over 78 weeks and those waiting over 65 weeks. • Make further progress on the 62-day backlog, whilst pivoting towards a

		primary focus on achieving the Faster Diagnosis Standard.
(iii)	**Outpatients**	• Engage patients more actively and significantly re-focus capacity towards new patients.
(iv)	**Cancer pathway redesign**	• Implementation of priority changes for lower GI, skin and prostate pathways.
(v)	**Activity**	• Ensure that the increasing volume of diagnostic capacity now coming online is supporting your most pressured cancer pathways. • A step up in activity over the coming months, as we recover from the ongoing impact of industrial action.
(vi)	**Choice**	• Systems and providers to crystalize plans to work together (including IS) early in the financial year. • Patient choice expected to be an increasingly important factor this year, with some technological advances to support this. Further communication to be shared with Trusts.

The importance of continuing to recover elective services inclusively and equitably is also noted:

- Systems are expected to outline **health inequality** actions put in place and the evidence and impact of the interventions as part of the planning returns.
- Provider, system and regional plans should set out the actions that will be put in place to accelerate **Children and Young People** (CYP) recovery
- Systems are expected to continue to recover **specialised service activity** at an equitable rate to that of less complex procedures.

The letter also includes a board checklist; this is a tool to assess whether the Trust has plans in place to deliver against the objectives for 2023/24. The Trust self-assessment is detailed at Appendix B.

5. Recommendations

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

Appendix B Board Checklist

Assurance statement	DBTH Current Position	Monitoring / Assurance
1. Excellence in basics		
Has any patient waiting over 26 weeks on an RTT pathway (as at 31 March 2023) not been validated in the previous 12 weeks? Has the 'Date of Last PAS validation' been recorded within the Waiting List Minimum Data Set?	Yes - as at 31 March 2023 all patients waiting over 26 weeks on an RTT pathway had been validated in the previous 12 weeks Yes – all validation is recorded within the waiting list minimum data set	All validation is recorded within the waiting list minimum data set (WLMDS)
Are referrals for any Evidence Based Interventions still being made to the waiting list?	Possibly – However, the Trust has a SOP in place for all referrals for EBI to ensure these are managed appropriately	Annual audits to assess compliance are undertaken in conjunction with the ICB
2. Performance and long waits		
Are plans in place to virtually eliminate RTT waits of over 104w and 78w (if applicable in your organisation)?	Yes - the Trust has an activity plan in place to virtually eliminate RTT waits > 104 weeks and > 78 weeks and this is monitored through the weekly PTL meetings, led by the Deputy Chief Operating Officer. The following risks to delivery have been identified: • Long wait 'pop on' to the PTL as a result of a previous incorrect clock stop • Lack of mutual aid where internal capacity is insufficient to meet demand, this is currently a particular risk in ENT for particular procedures • Reductions in planned capacity due to ongoing industrial action An Escalation SOP is in place for long wait PTL 'pop on' patients	Weekly PTL meetings Weekly reporting to NHSE on all patients waiting > 78 weeks Monthly reporting to TEG, F&P and Trust Board Monthly oversight at the Acute Federation Diagnostic and Elective Oversight Group
Do your plans support the national ambition to virtually eliminate RTT waits of over 65 weeks by March 2024?	Yes - the Trust has an activity plan in place to virtually eliminate RTT waits > 65 weeks by March 2024 and this is monitored through the weekly PTL meetings, led by the Deputy Chief Operating Officer. Some specialties already have waits at or below 52 weeks and this will be maintained where possible.	Weekly PTL meetings Weekly reporting to NHSE on all patients waiting > 78 weeks Monthly reporting to TEG, F&P and Trust Board Monthly oversight at the Acute Federation

Assurance statement	DBTH Current Position	Monitoring / Assurance
	Specific plans are in place for the specialities at risk of non delivery (T&O, Urology, ENT, Gynaecology) There are a number of specialities with an increasing number of > 52 week waits. Demand and capacity analysis is being prioritised for these specialties. The following risks to delivery have been identified: • Long wait 'pop on' to the PTL as a result of a previous incorrect clock stop • Lack of mutual aid where internal capacity is insufficient to meet demand, this is currently a particular risk in ENT for particular procedures • Reductions in planned capacity due to ongoing industrial action An Escalation SOP is in place for long wait PTL 'pop on' patients	Diagnostic and Elective Oversight Group
3. Outpatients		
Are clear system plans in place to achieve 25% OPFU reduction, enabling more outpatient first activity to take place?	The Trust has an Outpatient Recovery and Transformation Programme in place and this incorporates GIRFT guidance to reduce outpatient follow up appointments, including: • Expansion of Patient Initiated Follow up • Continuation of Advice and Guidance • Review of Trust templates • Reduction in missed appointments	To be monitored through the Outpatient Recovery and Transformation Programme Outpatient Dashboard in place
Do you validate and book patients in for their appointments well ahead of time, focussing on completing first outpatient appointments in a timely way, to support with diagnostic flow and treatment pathways?	Validation - some validation of e-referrals is undertaken but not currently routinely for all Booking – the Trust has an access policy in place which requires 3 weeks notice of an outpatient appointment. The Trust is not currently compliant with this SOP for all appointment bookings.	Incorporate into the Outpatient Dashboard To be monitored through the Outpatient Recovery and Transformation Programme
4. Cancer pathway re-design		
Where is the Trust against full implementation of FIT testing in primary care in line with DBG / ACPGBI	Lower GI – current performance is that at least 80% of referrals are accompanied by a FIT result.	The information is available in Infoflex (cancer tracking system).

Assurance statement	DBTH Current Position	Monitoring / Assurance
guidance, and the stepping down of FIT negative (<10) patients who have a normal examination and full blood count from the urgent colorectal cancer pathway in secondary care?	The Trust has a SOP in place, developed by the LGI MDT and using the relevant national and regional guidelines. The SOP states that patients with a negative FIT test result (< 10) are either downgraded or have a face to face Consultant appointment.	Further work is required to develop systems and processes to monitor and report on this measure. To be monitored through the Cancer Quality Governance Group
Where is the Trust against full rollout of tele dermatology?	The Trust has fully rolled out tele dermatology and is also participating in the National E-Derma project (which is a national database of all Dermatology images)	
Where is the Trust against full implementation of sufficient mpMRI and biopsy capacity to meet the best practice timed pathway for prostrate pathways?	The Trust has dedicated capacity in place at DRI on a weekly basis, with 'hot reporting' in place.	
5. Activity		
Are clear systems in place to prioritise existing diagnostic capacity for urgent suspected cancer activity	Diagnostic demand for urgent suspected cancer referrals is routinely monitored and capacity, in medical imaging, is carved out.	To be monitored through the Diagnostic Improvement Programme Diagnostic Imaging Dashboard in place
Is there agreement between the Trust, ICB and Cancer Alliance on how best to ensure newly opening CDC capacity can support 62-day backlog reductions and FDS performance?	There is currently no formal agreement in place. However, the diagnostic modalities included in the local CDC will support cancer pathways. Existing 'one stop services currently in place are planned to continue rather than dismantle these are re-route the diagnostic element through the CDC. As part of the CDC, 3-5 year plan consideration is being given to potential relocation of some services, such as urology pathways.	
How does the Trust compare to the benchmark of a 10-day turnaround from referral to test for all urgent suspected cancer diagnostics?	The Trust is not currently compliant with a 10-day turnaround from referral to test for all urgent suspected cancer diagnostics. This is due to capacity constraints in some diagnostic services, such as imaging.	Diagnostic Dashboard in place

Assurance statement	DBTH Current Position	Monitoring / Assurance
Are plans in place to implement a system of early screening, risk assessment and health optimisation for anyone waiting for inpatient surgery? Are patients supported to optimise their health where they are not yet fit for surgery? Are the core five requirements for all patients waiting for inpatient surgery by 31 March 2024 being met? 1. Patients should be screened for perioperative risk factors as early as possible in their pathway. 2. Patients identified through screening as having perioperative risk factors should receive proactive, personalised support to optimise their health before surgery. 3. All patients waiting for inpatient procedures should be contacted by their provider at least every three months. 4. Patients waiting for inpatient procedures should only be given a date to come in for surgery after they have had a preliminary perioperative screening assessment and been confirmed as fit or ready for surgery. 5. Patients must be involved in shared decision-making conversations.	The Trust has pre-assessment processes in place but is not currently compliant with all of these requirements. Plans to implement these will be incorporated into the Theatres Improvement Programme for 2023/24.	To be monitored through the Theatres Improvement Programme
Where is the Trust / system against the standards of 85% capped Theatre Utilisation and 85% day case rate?	As at the end of March 2023, the Trust had uncapped theatre utilisation rate of 72% and day case rate of 79%	To be monitored through the Theatre Improvement Programme
Is full use being made of protected capacity in Elective Surgical Hubs?	The Trust has plans in place to open an Elective Surgical Hub at Mexborough (MEOC), due for completion by December 2023.	
Do diagnostic services meet the national optimal utilisation standards set for CT, MRI, Ultrasound, Echo and Endoscopy?	Slot length in CT, MRI and NOUS are consistent with national standards. Imaging utilisation is c. 80% currently.	To be monitored through the Theatre Improvement Programme
Are any new Community Diagnostic Centres	Imaging: the CDC planned for Mexborough is	

Assurance statement	DBTH Current Position	Monitoring / Assurance
(CDCs) on track to open on agreed dates, reducing DNAs to under 3% and ensuring that they have the workforce in place to provide the expected 12 hours a day, 7 day a week service? Are Elective Surgical Hub patients able to make full use of their nearest CDD for all their pre and post-op tests where this offers the fastest route for those patients?	expected to be operational by September 2024. Workforce plans are progressing. DNA rates are currently above 3% in some diagnostic modalities and plans to reduce DNA rates are included in the Diagnostic Improvement Programme for 2023/24. Endoscopy: mobilisation works for planned Endoscopy Unit planned at Mexborough are due to commence from 30 October 2023.	
6. Choice		
Are you releasing any Mutual Aid capacity which may ordinarily have been utilised to treat non-urgent patients to treat clinically urgent and long-waiting patients from other providers? Is DMAS being used to offer or request support which cannot be realised within the ICB or region?	The Trust is not currently releasing any mutual aid capacity. The Trust has sought mutual aid for a cohort of ENT patients, unfortunately, this is not available. The Trust is currently canvassing these patients to understand if they would be willing to travel outside of SYB for treatment. If they are, patient details will be uploaded to the Digital Mutual Aid System (DMAS).	
Has Independent Sector capacity been secured with longevity of contract? Has this capacity formed a core part of planning for 2023/24?	The Trust has secured IS capacity for T&O activity at the same level of Q4 in 2022/23. This IS capacity forms part of the core surgical capacity plan for 2023/24.	
7. Inclusive recovery		
Do recovery plans and trajectories ensure specialised commissioned services are enabled to recover at an equitable rate to non-specialised services? Do system plans balance high volume procedures and lower volume, more complex patient care	The Trust does not provide any specialised commissioned services.	
Have you agreed the health inequality actions put in place and the evidence and impact of the interventions as part of your operational planning return? Was this supported by disaggregated elective recovery data?	The Trust has recruited a Consultant in Public Health who is leading the on the development of the Trust health inequalities work plan.	

Assurance statement	DBTH Current Position	Monitoring / Assurance
Are children and young people explicitly included in elective recovery plans and actions in place to accelerate progress to tackle CYP elective waiting lists?	The Trust undertakes minimal paediatric surgery, in ENT, T&O and Ophthalmology. These cases are all clinically prioritised. Paediatric Ophthalmology is a single-handed service and this can therefore impact on waiting times.	

2306 - C3 FINANCE UPDATE

Discussion Item | Jon Sargeant, Deputy Chief Executive/Chief Financial Officer | 10:15

10 minutes

REFERENCES

Only PDFs are attached

C3 - Finance Update (Month 2).pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	27 June 2023	Agenda Reference:	**C3**
Report Title:	**Finance Update** – Month 2 (May) 2023		
Sponsor:	Jon Sargeant, Chief Financial Officer		
Author:	Alex Crickmar, Deputy Director of Finance Finance Team		
Appendices:			

Executive Summary	
Purpose of report:	To set out to the Board an update with regards to the Trust's financial position at Month 2.
Summary of key issues:	The Trust's reported deficit for month 2 (May 2023) was £4.1m, which was in line with plan. YTD, The Trust's reported deficit at month 2 was £7.8m, which again was in line with plan. This position assumes that the Elective Recovery Fund paid by Commissioners in month 1 and month 2 will not be clawed back, in line with national guidance. Excluding ERF, the YTD position would be a deficit of £8.4m which would be £0.6m adverse to plan. Pay spend is favourable to plan by c£0.7m YTD (£0.2m in month), mainly driven by Nursing which was underspent across all Divisions except Surgery and Women and Children's, reflecting the reduction in agency rates and usage and also bank incentive rates which is positive news. Medics are overspent by £0.4m (including reserves and recharges), which includes junior doctor strike costs of £0.4m. Non-pay spend (excluding recharges) was £0.1m adverse to plan. The main areas of overspend on non-pay related to the independent sector (£0.3m) and drugs (£0.1m). Financing costs are favourable to plan by £0.2m due to higher interest receivable than plan. This is as a result of a higher than expected cash balance in month 1. Overall the position is on plan at month 2, however it would have been adverse to plan if ERF was clawed back based on the activity performance of the Trust. **Capital** Capital spend in month 2 was £0.9m against a plan of £3.4m giving an in-month under-performance of £2.5m. The YTD position is £1m against a plan of £5.7m showing an under-performance of £4.6m. The main underspends are against MEOC of £3.7m and BEV of £1m. A revised cashflow for MEOC shows spend is in line and BEV is still waiting final approval. **Cash** The cash balance at the end of May was £12.6m (April: £29.6m), meaning cash has decreased by £16.8m in the month. This negative movement in cash is as a result of the Trust paying £9.3m in relation to Capital Creditors, paying down year end revenue creditors and having an underlying deficit position. The Trust is still expecting to need cash support in year and the central cash request for £4m for Q2 has now been submitted based on achieving plan. Under a downside case If CIP and ERF are not delivered the risk of is c£1.5m would be needed in each of July and August and £5.5m in September.

	CIPs In month the Trust has delivered £1.0m of savings versus the plan submitted to NHSE of £0.4m and therefore is 0.6m favourable to plan. YTD the Trust has delivered £1.4m of savings versus the plan submitted to NHSE of £0.9m and is therefore favourable to plan by £0.5m. Whilst the Trust is ahead of plan at this point, the majority of the CIP programme is phased after Q1 of the financial year. Significant work is underway to identify further opportunities to meet the full year target of £22.1m.
Recommendation:	The Board is asked to note: • The Trust's deficit YTD at month 2 (May 2023) was £7.8m, which was in line with plan assuming no clawback of ERF income as per national guidance.

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

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

Implications	
Board assurance framework:	This report relates to strategic aims 2 and 4 and the revised BAF risk F&P1.
Corporate risk register:	See above
Regulation:	No issues
Legal:	No issues
Resources:	No issues

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

FINANCIAL PERFORMANCE

Month 2 – May 2023

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

M2 May 2023

1. Income and Expenditure vs. Budget

Performance Indicator	Monthly Performance			YTD Performance		
	Actual £'000	Variance to budget £'000		Actual £'000	Variance to budget £'000	
Income	(46,456)	(366)	F	(90,359)	29	A
Pay	32,655	(202)	F	62,447	(714)	F
Non Pay	17,422	649	A	34,850	891	A
Financing Costs	477	(106)	F	937	(229)	F
(Profit)/Loss on Asset Disposals	0	0	A	0	0	A
(Surplus)/Deficit for the period	**4,098**	**(25)**	**F**	**7,875**	**(24)**	**F**
Adj. for donated assets	(41)	(7)	F	(82)	(13)	F
Adjusted (Surplus)/Deficit for the purposes of system achievement	**4,057**	**(32)**	**F**	**7,793**	**(38)**	**F**

Income: Over-achieved F | Under-achieved A

Key: **F** = Favourable **A** = Adverse

Expenditure: Underspent F | Overspent A

2. CIPs

Performance Indicator	Monthly Performance			YTD Performance			Annual Plan £'000
	Plan £'000	Actual £'000		Plan £'000	Actual £'000		
Local	150	855	F	309	952	F	3,780
Pay - Job Plans	17	0	A	33	8	A	500
Agency & Sickness Management	200	151	A	400	380	A	6,000
Procurement	23	27	F	46	46	F	720
NonPay	6	0	A	11	0	A	2,750
RPA	0	0	A	0	0	A	500
Unidentified	37	0	A	75	0	A	7,850
Total CIP	**433**	**1,032**	F	**874**	**1,387**	F	**22,100**

3. Statement of Financial Position

	Opening balance £'000	Closing balance £'000	Movement £'000
Non Current Assets	**293,405**	**306,879**	**13,474**
Current Assets	77,757	63,503	**-14,254**
Current Liabilities	-111,012	-102,706	**8,306**
Non Current liabilities	-17,088	-17,002	**86**
Total Assets Employed	**243,062**	**250,674**	**7,612**
Total Tax Payers Equity	**-243,062**	**-250,674**	**-7,612**

4. Other

Performance Indicator	Monthly Performance		YTD Performance		Annual Plan £'000
	Plan £'000	Actual £'000	Plan £'000	Actual £'000	
Cash Balance		12,577		12,577	1,900
Capital Expenditure	3,355	801	5,743	1,076	65,051

5. Workforce

	Funded WTE	Substantive WTE	Bank WTE	Agency WTE	Total in Post WTE
Current Month	6,732.22	5,947.27	347.85	154.95	6,450.07
Previous Month	6,631.16	5,928.33	376.60	130.93	6,435.86
Movement	101.06	18.94	-28.75	24.02	14.21

1. Month 2 Financial Position Highlights

Summary Income and Expenditure – Month 2

The Trust's reported deficit for month 2 (May 2023) was £4.1m, which was in line with plan. YTD, The Trust's reported deficit at month 2 was £7.8m, which again was in line with plan. This position assumes that the Elective Recovery Fund paid by Commissioners in month 1 and month 2 will not be clawed back, in line with national guidance. Excluding ERF, the YTD position would be a deficit of £8.4m which would be £0.6m adverse to plan.

Pay spend is favourable to plan by c£0.7m YTD (£0.2m in month), mainly driven by Nursing which was underspent across all Divisions except Surgery and Women and Children's, reflecting the reduction in agency rates and usage and also bank incentive rates which is positive news. Medics are overspent by £0.4m (including reserves and recharges), which includes junior doctor strike costs of £0.4m.

Non-pay spend (excluding recharges) was £0.1m adverse to plan. The main areas of overspend on non-pay related to the independent sector (£0.3m) and drugs (£0.1m).

Financing costs are favourable to plan by £0.2m due to higher interest receivable than plan. This is as a result of a higher than expected cash balance in month 1.

Overall the position is on plan at month 2, however it would have been adverse to plan if ERF was clawed back based on the activity performance of the Trust.

Capital

Capital spend in month 2 was £0.9m against a plan of £3.4m giving an in-month under-performance of £2.5m. The YTD position is £1m against a plan of £5.7m showing an under-performance of £4.6m. The main underspends are against MEOC of £3.7m and BEV of £1m. A revised cashflow for MEOC shows spend is in line and BEV is still waiting final approval.

Cash

The cash balance at the end of May was £12.6m (April: £29.6m), meaning cash has decreased by £16.8m in the month. This negative movement in cash is as a result of the Trust paying £9.3m in relation to Capital Creditors, paying down year end revenue creditors and having an underlying deficit position.

The Trust is still expecting to need cash support in year and the central cash request for £4m for Q2 has now been submitted based on achieving plan. Under a downside case If CIP and ERF are not delivered the risk of is c£1.5m would be needed in each of July and August and £5.5m in September.

CIPs

In month the Trust has delivered £1.0m of savings versus the plan submitted to NHSE of £0.4m and therefore is 0.6m favourable to plan. YTD the Trust has delivered £1.4m of savings versus the plan submitted to NHSE of £0.9m and is therefore favourable to plan by £0.5m. Whilst the Trust is ahead of plan at this point, the majority of the CIP programme is phased after Q1 of the financial year. Significant work is underway to identify further opportunities to meet the full year target of £22.1m.

Recommendation

The Board is asked to note:

- The Trust's deficit YTD at month 2 (May 2023) was £7.8m, which was in line with plan assuming no clawback of ERF income as per national guidance.

2306 - C4 NEW HOSPITAL PROGRAMME UPDATE

Information Item | Jon Sargeant, Deputy Chief Executive/Chief Financial Officer | 10:25

5 minutes **VERBAL**

2306 - D GOVERNANCE & ASSURANCE

2306 - D1 CHAIR'S ASSURANCE LOG ? AUDIT & RISK COMMITTEE

Discussion Item | Kath Smart, Non-executive Director | 10:30

5 minutes

REFERENCES

Only PDFs are attached

D1 - Chair's Assurance Log - Audit & Risk Commitee.pdf

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

Subject:	**Audit & Risk Committee Meeting**	**Board Date: June 2023**
Prepared By:	Kath Smart, Non-executive Director & Committee Chair	
Approved By:	Audit & Risk Committee Members	
Presented By:	Kath Smart, Committee Chair	
Purpose	The paper summaries the key highlights from the Audit and Risk Committee meeting held on 20 June 2023	

Matters of Concern / Key risks to escalate	**Major Actions Commissioned / Work Underway**
a) Limited Assurance Audit Reports i. Governance of Clinical Audit – Findings included the misalignment in the governance structure supporting clinical audit; challenges with Divisional engagement; reporting linked to patient outcomes & monitoring of completion of action plans. The 2 High Risk Actions have agreed timescales, although concern was expressed around Business Case approval as a solution, given financial constraints it was felt other mitigations would need considering by the MD. The report was referred into QEC for oversight of the issues; ii. Performance Management Framework Audit – Findings relate to the PAF (Performance Assurance Framework) control environments need concluding; approval of the new PAF; ensuring the IQPR is integrated into Board Committee's work; Development of the POSM (Performance, Oversight & Support Meetings) meetings. The 3 medium and 1 low risk actions have been agreed with timescales. The report was referred into F&P Committee for oversight of the issues. b) Head of Internal Audit Opinion (HOIA) – As anticipated is a "Moderate" outcome due to 3 factors:- 1. Audit Recommendations closure rate 64% (timeliness) – Moderate Assurance – target 75% minimum. 2. Individual audit Assignments – Limited Assurance following the outcomes of 3 audits concluded as Limited (Performance Framework; Clinical Audit; Recruitment) 3. BAF/ Risk Management – Moderate Assurance – actions agreed to improve process in 23/24 c) <u>Key risks to escalate</u> None	a) All the internal audit reports have agreed deadlines for implementation of actions. ARC will continue to monitor delivery b) ARC delegated final sign off (for any minor amendments) for the Annual Governance Statement to ARC Chair and CEO; and the Annual Accounts and Letter of Representation to ARC Chair and the CFO.

Positive Assurances to Provide	Decisions Made
a) GIRFT (Getting it Right First Time) Programme – Audit work showed there were improvements which could be made, but generally there was a high level of engagement with the GIRFT programme and the Trust should build on this; b) External Audit Results Report - ISA 260 – The external audit work had not yet fully completed, however, bearing this in mind, EY communicated that their outstanding work was unlikely to influence the current "clean opinion" on the Accounts. A revised final report will be received from EY. Key messages included:- • Good quality working papers, and quality/ speed of responses to EY queries; • The Auditors were comfortable with "Going Concern" and the mechanism for requesting additional cash & will not be including an emphasis in their reporting; • Resource difficulties with unplanned absence in the Finance team has impacted on finalising PPE (Plant Property & Equipment) areas of the accounts. This work is still to be completed. c) SBS (Shared Business Services) Annual Assurance Statement – demonstrating positive assurance for the Finance systems utilised by the Trust.	a) DBTH Annual report – This was approved by Audit Committee b) DBTH Annual Governance Statement – This was approved subject to minor changes by the Audit Committee c) DBTH Annual Accounts and Financial Statements – These were approved subject to minor alterations (if required) by the finalisation of External Audit work d) The Letters of Representation required from the Trust to the External Auditors were approved (subject to any minor amendment requests from EY)

2306 - D2 CHAIR'S ASSURANCE LOG ? CHARITABLE FUNDS COMMITTEE

Discussion Item | Hazel Brand, Non-executive Director | 10:35

5 minutes

REFERENCES

Only PDFs are attached

D2 - Chair's Assurance Log - Charitable Funds Committee.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Charitable Funds Committee Chair's Highlight Report to Trust Board		
Subject:	**Charitable Funds Committee**	**Board Date:** June 2023
Prepared By:	Hazel Brand, Non-executive Director & Committee Chair	
Approved By:		
Presented By:	Hazel Brand, Chair of the Charitable Funds Committee	
Purpose	The paper summaries the key highlights from the Charitable Funds Committee meeting held on 15 June 2023	

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The committee effectiveness review provided a baseline on the workings of the Charitable Funds Committee. There is room for improvement, but the report acknowledged recent membership changes and a new Chair and that a clear strategy/workplan is required.	• Fund balances and reserves policy discussed. More detail on the former to separate out the Fred & Anne Green Legacy: Charitable Funds Committee Chair to meet the Chair of the Board, Lucy Nickson and Jon Sargeant to agree content. Reserves policy to be re-issued. • Fund-raising/Grant-making strategy and operational plan. Due to be circulated prior to the meeting but not received so a separate workshop will be set up to discuss it, suggest any amendments, and approve at the September meeting. • Jon Sargeant to bring a paper to the next meeting (if the timing makes it feasible) with high-level outlines of the range of developments that the Fred & Anne Green Legacy could fund.
Positive Assurances to Provide	**Decisions Made**
• The Committee's Annual Report 2022/23 was approved. • Governor observations were positive.	• Approve funding of £25 voucher for staff for Christmas 2023. The future of this gift will be reviewed beyond 2023's donation, with emphasis on the fund-raising plan to support it. • Approve top-up funding for 7 internal candidates to undertake the Registered Nurse Degree programme. Further requests for funds not expected. • Charitable Funds Development Committee report received: more detail requested in future reports. • Ad hoc projects such as the North Notts Nectar Trail, which was time-consuming but financially unsuccessful, should be avoided. • The annual workplan was approved.

2306 - D3 NHS PROVIDER LICENCE - SELF-CERTIFICATION 2022/23

Decision Item | Fiona Dunn, Director Corporate Affairs / Company Secretary | 10:40

5 minutes.

** For ratification -approved 20/6/2023 ARC **

REFERENCES

Only PDFs are attached

D3 - NHS Provider Licence -Self-certification FT4 & G6.pdf

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	26 June 2023	**Agenda Reference:**	**D3**		
Report Title:	**Self-Certification against the conditions of the Provider License – 2022/2023**				
Sponsor:	Jon Sargeant, Chief Financial Officer				
Author:	Fiona Dunn, Director Corporate Governance/Company Secretary				
Appendices:	Self-Certifications conditions – FT4, G6, CoS7				
Report Summary					
Purpose of report:	To present the Trusts self-certification assessment against conditions of the NHS Provider Licence in accordance with the self-certification guidance and under specific conditions of the NHS Provider licence.				
Summary of key issues/positive highlights:	• Condition G6 (3) - The provider has taken all precautions to comply with the licence, NHS acts and NHS Constitution • Condition G6 (4) - Publication of condition G6(3) self-certification • Condition FT4 (8) - The provider has complied with required governance arrangements • Condition CoS7 (3) - The provider has a reasonable expectation that required resources will be available to deliver the designated services for the 12 months from the date of the statement. This only applies to FTs that are providers of CRS.				
Recommendation:	This paper asks if the Board is assured that the Trust complies with its License requirements as indicated in the responses completed in the appendices and to approve the self-certification?				
Action Require:	Approval	~~Information~~	~~Discussion~~	Assurance	~~Review~~

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

Implications	
Board assurance framework:	none
Corporate risk register:	F&P6 - Failure to achieve compliance with performance and delivery aspects of the SOF, CQC and other regulatory standards – No change
Regulation:	Required to self-certify whether or not they have complied with the conditions of the Provider Licence NHSE/I. (previously Monitor)
Legal:	Compliance with regulated activities and requirements in National Health Service Act 2006 and the Health and Social Care Act 2012.
Resources:	N/A

Assurance Route			
Previously considered by:		Audit & Risk Committee	
Date:	20/6/2023	**Decision:**	Approved
Next Steps:		*To ratify at Board 27/6/2023 then to publish on Trust website.*	
Previously circulated reports to supplement this paper:		*N/A*	

EXECUTIVE SUMMARY

All NHS Foundation trusts at authorisation are issued with a "provider Licence" that sets out conditions by which they should operate.

The NHS Provider licence forms part of the oversight arrangements for NHS Providers and to date NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the Provider Licence. The Licence itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution.

It is also a requirement to confirm that the required resources are available and if providing commissioner requested services, and that they have complied with governance requirements.

The Trust is required to self-certify against the following licence conditions:

Condition	
Condition G6(3)	The provider has taken all precautions to comply with the licence, NHS acts and NHS Constitution
Condition G6(4)	Publication of condition G6(3) self-certification
Condition FT4(8)	The provider has complied with required governance arrangements
Condition CoS7(3)	The provider has a reasonable expectation that required resources will be available to deliver the designated services for the 12 months from the date of the statement. This only applies to FTs that are providers of CRS.

The purpose of self-certification is to carry out assurance that the Trust continues to comply with its licence conditions. It is down to the Trust how it decides to do this, but templates have previously been provided by NHSI to assist in this process. (see link for Guidance document) The Trust's response is given as an appendix (below).

The completed self-certification templates are required to be made available via the Trust's website once approved.

2023 Introduction of the New Provider Licence – Changes and Requirements

On 27 March 2023 NHSE published the new NHS provider licence which will apply to all NHS providers (not just Foundation trusts) from 1 April 2023. Updates to the licence reflect changes to the statutory and operating environment including the shift of emphasis from economic regulation and competition to system working and collaboration. A detailed review of the Trust's compliance against the new conditions will be undertaken by the Director of Corporate Affairs, the results of this review and any actions required will be presented to the Board of Directors at a future date.

In publishing the new licence NHSE has streamlined reporting requirements to remove the following requirements for licensees to self-certify against the licence and for foundation trusts to report on past and future compliance with the licence and to prepare a Corporate Governance Statement.

As such, this will be the final time that the self-certification exercise is undertaken and presented to the Audit and Risk Committee for approval in this way. The Trust will continue to assess and demonstrate

compliance with corporate governance standards via statements made within the Annual Report, Annual Governance Statement and through Well-led reviews.

Recommendations

This process asks the Board to confirm its governance and License requirements presented. The self-certification assessment summary mitigates against the risk that the Trust fails to have in place adequate arrangements and is not complying with its regulatory duties. Therefore, it is required to:

- **NOTE** that NHSE's assessment in relation to condition FT4 has been considered in assessing the Trust's compliance and is reflected in the self-certification.
- **APPROVE** the content of the self-certification for signature by the Chair & CEO;
- **NOTE** that the self-certification must be published on the Trust's website following the Board of Directors' sign-off; and
- **NOTE** publication of a new NHS Provider Licence and plans to share further information relating to changes within the updated standard licence conditions with members of the Board.

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration"

Financial Year to which self-certification relates | **2022/2023**

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Trust monitors and reviews its systems and processes to ensure they comply with good governance. They were subject to internal audit and Core & Well Led CQC's inspections in 2019 and positive feedback was received with the Trust achieving overall CQC Good status. The Board is assured over its systems of corporate governnce from the work of the Audit Committee, its Internal and External Auditors and their opinions received during the year. The Board's view as to its governance processes is also reflected within the Trust's Annual Governance Statement.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	New requirements are highlighted through national and regional networks and the Board is appraised through the CEO's and Chairs report on a monthly basis. The Board through its development programme has engaged with the relevant ICS's to understand the chamging landscape and the Trust taskes an active role within each ICS at both Executive level but also through reporting to each Committee and direct to the Board.
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	The Board has clear terms of reference as detailed in the Trusts Standing Orders.The Board agreed a revised scheme of delegation, SFIs and standing orders in July 2022. Each of the Board Committees has agreed Terms of Reference which are regularly reviewed and each Board-Committee has a NED chair with NEDs being in the majority in each Committee. There are clear responsibilities for Board and Sub-Committees in place with Chairs of Sub-Committees clearly highlighting key risks/mitigations as required, as well as minutes of the meetings being received once approved. There are clear reporting lines throughout the organisation with a clear structure in place Accountability structures for corporate and clinical divisions are in place. Individual accountabilities are understood through job descriptions, contracts and appraisals. These processes were referred to and their effectiveness was considered by the Accounting Officer when drafting the Trusts Annual Governance statement with this descritpion then considered by the Audit & Risk Committee as it endorsed the AGS for submission to the Auditors.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	The committee architecture gives assurance to the Board that the Trust is operating effectively. The committees scrutinise areas of performance around finance, operations, quality and workforce and escalate appropriately. There are no conditions placed on the Tusts Licence. The Board of Directors monitors a series of quality measures and objectives on a monthly basis. Risks to the quality of care are managed and monitored through robust risk management and assurance processes. The committees of the Board, particularly the Quality and Effectiveness Committee and People Committee, play a key role in quality governance, receiving reports and using internal audit to test the processes and quality controls in place. This enables rigorous challenge and action to be taken to develop services to enable improvement. The Board gives regular consideration to ensuring service quality in all aspects of its work, including changes to services and cost improvement plans. The Board proactively works to identify and mitigate potential risks to quality. The Trust received a Good CQC rating in 2020. The Finance and Performance Committee provides assurance on the systems of control and governance specifically in relation to operational performance, workforce and financial planning and reporting. In the year the Committee has, on behalf of the Board has provided assurance on: - Current financial, workforce and operational performance, - Financial forecasts, budgets and plans in the light of trends and operational expectations, - Plans and processes for the implementation of Effectiveness and Efficiency Improvement plans, - Any specific risks in the Board Assurance Framework relevant to the committee. - Reviewed and developed strategy in relation to clinical site development, estates and facilities, IT and information and finance. - Undertaken deep dives into key service areas, effectiveness and efficiency plans and areas of performance. The Audit Committee's provides the Board of Directors with a means of independent and objective review of internal controls and risk management arrangements relating to: financial systems; the financial information used by the Trust; controls and assurance systems, risk management arrangements, compliance with law, guidance and codes of conduct, counter fraud activity. The Trust has clear SFIs and Scheme of Delegation that determines the framework for financial decision-making, management and control. Systems of internal control are subject to regular audit and the Audit and Risk Committee provides independent oversight and challenge. There are robust accountability systems in place to monitor effectiveness and efficiency schemes. The Trust has an annual planning process that ensures business plans are developed and supported. The Board committee calendar ensures up-to-date information is provided to meetings for scrutiny and assurance. The Trust has a Risk Identification and Management Policy in place and the Board Assurance Framework and Corporate Risk Register provide the framework through which high-level risks are considered. The Board and committees receive and review the BAF and CRR on a frequent basis. The governance, risk and control processes in place ensure the Trust remains compliant. A new Risk mamagment Board was introduced in October 2022 to furterh enhance the risk manamgement processes with in the Trust.

5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	There is clear leadership and accountability for the delivery of high quality and safe services within the Trust. This detailed within the Trusts Annual Report and the statements contained theirin. The Trusts quality priorities continue to be set having regard to feedback from our patients, carers, the Governors and other stakeholders with regular reporting to the Board, Council of Governors and to our Commissioners. There is an effective and robust objective setting and performance review process in place for board members, portfolios are reviewed on an annual basis and skills are refreshed and kept up to date through a range of development opportunities. Board members are actively involved in quality initiatives including ward walkabouts and membership of strategic and operational committees. One non-executive has taken on responsibility as a Freedom to Speak Up Guardian. As set out above the Board of Directors monitors a series of quality measures and objectives on a monthly basis. Risks to the quality of care are managed and monitored through robust risk management and assurance processes. The committees of the Board, particularly the Quality and Effectiveness Committee, play a key role in quality governance, receiving reports and using internal audit to test the processes and quality controls in place. This enables rigorous challenge and action to be taken to develop services to enable improvement. The Board gives regular consideration to ensuring service quality in all aspects of its work, including changes to services and cost improvement plans. The Board proactively works to identify and mitigate potential risks to quality. There are clear escalation routes throughout the Turst to ensure matters can be escalated and referred up to the Board and Board -Committees. Board committees Charis also have a standing item on each Board agenda allowing them to escalate to the Board.
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Trust has established a rigorous process that ensures that all Board Members are"fit and proper" persons and there is an annual review of all Board members continuation as fit and proper persons. The Board and its Committees through its receipt of Workforce reports has been assured over the actions being taken to manage the workforce risks in relation to recruitment and retention complimented and the Board's review of people BAF risks. Regular reporting is also provided to the Board on the Trust's compliance with the nursing safer staffing levels and the revalidation of its nursing and medical workforce. All transformation schemes are subject to a detailed quality impact assessment and this rigor includes those schemes which include any workforce reduction and through this process the Board is assured that the Trust retains an appropriately qualified workforce to deliver its services. The Trust has a number of established Executive and Senior Management development programmes and these activities are designed to support and strengthen the personnel on the Board, those reporting to the Board and those within the rest of the Trust

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature  **Signature** 

Name Richard Parker - Chief Executive **Name** Suzy Brain England - Chair

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A Not applicable.

OK

Worksheet "Training of governors"

Financial Year to which self-certification relates 2022/23

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Richard Parker	**Name**	Suzy Brain England
Capacity	Chief Executive	**Capacity**	Chair of the Board
Date	20 June 2023	**Date**	20 June 2023

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A	Not applicable

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions G6 and CoS7

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

NHS Improvement

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates 2022/2023

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Confirmed OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

Confirmed

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Department of Health and Social Care requires NHS Foundation Trusts to assess the going concern status on an annual basis, the 'Going Concern' principle being the assumption that the entity will remain in business for the foreseeable future.

The Trust's annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

After making appropriate and relevant enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. This is based on:

- Continuing support from local commissioners
- There are no licence conditions in place on the Trust from its regulatory body
- The Trust has received a Good rating from the CQC for use of resources during 2019/20.

Therefore, it is considered appropriate for the trust to continue to prepare its financial statements on a going concern basis and to make the necessary declarations as part of its annual report and annual accounts. However, the continued risks, particularly around the financial plan for 2023/24 will also be clearly stated in the 2022/23 annual report.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Richard Parker	**Name**	Suzy Brain England
Capacity	Chief Executive	**Capacity**	Chair of the Board
Date	20 June 2023	**Date**	20 June 2023

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

Not applicable.

2306 - D4 USE OF TRUST SEAL

Decision Item | Fiona Dunn, Director Corporate Affairs / Company Secretary | 10:45

5 minutes.

REFERENCES

Only PDFs are attached

D4 - Use of Trust Seal (1).pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	27 June 2023	**Agenda Reference:**	**D4**
Report Title:	**Use of Trust Seal**		
Sponsor:	Fiona Dunn, Director of Corporate Governance / Company Secretary		
Author:	Fiona Dunn, Director of Corporate Governance / Company Secretary		
Appendices:	None		

Report Summary	
Purpose of report:	The purpose of this report is to confirm use of the Trust Seal, in accordance with Section 14 of the Trust's Standing Orders.
Summary of key issues/positive highlights:	Seal No: 132 — Description: Contract relating to NEC3 - Option 3. Project 2A groundworks & Link Corridor relating to Modular Building — Signed: Richard Parker OBE, Chief Executive; Fiona Dunn, Company Secretary — Date of sealing: 18 May 2023 The contract has scrutinised, by Head of Procurement and Chief Financial Officer
Recommendation:	The Board is requested to approve the use of the Trust Seal

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

Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**

Implications	
Board assurance framework:	n/a
Corporate risk register:	n/a
Regulation:	Board of Directors Standing Orders
Legal:	
Resources:	none

Assurance Route			
Previously considered by:	Executive Team		
Date:		**Decision:**	Approved
Next Steps:	none		
Previously circulated reports to supplement this paper:			

2306 - E INFORMATION ITEMS (TO BE TAKEN AS READ)

2306 E1- SOUTH YORKSHIRE & BASSETLAW ACUTE FEDERATION ANNUAL REPORT 2022/23

Information Item | Richard Parker OBE, Chief Executive | 10:50

REFERENCES

Only PDFs are attached

E1 - South Yorkshire & Bassetlaw Acute Federation Annual Report 2022-23.pdf

NHS
South Yorkshire & Bassetlaw
Acute Federation

Annual Report
2022/2023

Barnsley Hospital NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust
Sheffield Children's NHS Foundation Trust
Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
The Rotherham NHS Foundation Trust

Contents

Lead Chair and Lead Chief Executive's Statement

Welcome to the South Yorkshire and Bassetlaw Acute Federation's Annual Report for 2022/23 which provides an overview of the progress made during the last 12 months.

Since the last South Yorkshire and Bassetlaw Acute Federation Annual Report, we have seen the introduction of new legislation to formalise integrated health and care systems in order to make it easier for organisations to deliver joined up care for their populations Health and Care Act 2022 (legislation.gov.uk). In it there is an emphasis on provider collaboration in recognition that the systemic challenges facing health and care organisations are more likely to be overcome through partnership working. Under this new legal framework, the Acute Federation, a provider collaborative of five acute Trusts in South Yorkshire and Bassetlaw, has made strides towards putting in place systems to strengthen our partnership working. This builds on South Yorkshire and Bassetlaw hospitals' history of working together and the success of collaborative working during the COVID-19 pandemic.

Our achievements in 2022/23 span a range of improvements for patients and staff. This year has seen the expansion of diagnostic testing capacity through the launch of three new Community Diagnostic Centres – at the Barnsley Glass Works centre, at the Breathing Space in Rotherham and at the Montagu Hospital in Mexborough - which will provide fast, convenient access to testing for the people of South Yorkshire and Bassetlaw. Elective care capacity is being increased for patients with the establishment of the Sheffield Elective Orthopaedic Centre at the Royal Hallamshire Hospital and forthcoming Montagu Elective Orthopaedic Centre.

To better enable collaboration across the Trusts, the Acute Federation has supported digital integration through a range of IT projects. Agfa Xero will enable clinicians to view medical images such as x-rays, CT and MRI scans across South Yorkshire and Bassetlaw hospitals. The clinical decision support system, iRefer, is being rolled out, starting in Rotherham, and will provide doctors and other health professionals with evidence-based guidelines to help decide the most appropriate imaging to perform in almost any clinical scenario. And digital solutions mean that patients are increasingly able to view details of their appointments, results and hospital letters online, with some able to rearrange appointments and provide updates to their clinician.

A network agreement is now in place for the single South Yorkshire and Bassetlaw Pathology service. Pathology services, involved in around 80% of diagnostic and treatment decisions, help in the study, diagnosis and management of disease and this project should benefit both patients and staff by ensuring patients receive an equal level of service and staff are part of a supportive, resilient team. And progress has been made towards standardising high-quality care through greater adherence to Getting it Right First Time (GIRFT) standards. To support our staff, we have invested in South Yorkshire training academies to increase access to high quality training and to make it easier for staff to work across the system as a networked workforce.

Progress in these areas has been supported through strong engagement with patients and the public to ensure we design and deliver services that meet their needs and help them to make informed decisions about their care.

Finally, our collaborative procurement efforts, working with the mental health Trusts in the system, have seen us make efficiency gains of £527,000 in collaborative efficiencies with an overall SYB Trust procurement saving of £2.96m.

This success has been achieved despite the difficult circumstances facing the NHS which include ongoing recovery of planned care following the pandemic, increased demand for healthcare services, growing financial pressures and industrial action.

This report sits alongside the Acute Federation's recently published Clinical Strategy document which aims to provide a framework for clinical collaboration because we know that strong clinical engagement and support for integrated working will be critical to the success of the Acute Federation.

We're proud of the last year's progress and grateful to all of the staff who have made it happen. However, we know that there is more to do in 2023/24 to capitalise on our alliance to deliver high quality, timely and efficient services for the 1.5 million people living in South Yorkshire and Bassetlaw.

Annette Laban

Annette Laban, Lead Chair for the South Yorkshire and Bassetlaw Acute Federation and Chair of Sheffield Teaching Hospitals NHS Foundation Trust

Ruth Brown

Ruth Brown, Lead Chief Executive for the South Yorkshire and Bassetlaw Acute Federation and Chief Executive of Sheffield Children's NHS Foundation Trust

Who we are and what we do

The South Yorkshire and Bassetlaw (SYB) Acute Federation is made up of five acute NHS Trusts: Barnsley Hospital NHS Foundation Trust, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, The Rotherham NHS Foundation Trust, Sheffield Children's NHS Foundation Trust and Sheffield Teaching Hospitals NHS Foundation Trust. Together we have committed to using our collective expertise and resources to ensure the people of SYB have prompt access to excellent healthcare through:

- Working together to drive the quality of care to be amongst the best in the country
- Taking a proactive approach to reduce health inequalities for the populations we serve
- Collaboratively developing our colleagues and teams so that we have happy staff
- Being a great partner to the rest of the health and care system in SYB
- Supporting each other to achieve all the NHS waiting time standards for local people
- Seeking innovative ways to more effectively use the NHS pound so there is enough resource for the whole system

The Acute Federation is led by the Trust Chairs and Chief Executives, alongside a range of professional partnership groups and is supported by a Managing Director and programme team.

Dr Richard Jenkins, Chief Executive

Sheena McDonnell, Chair

NHS
Barnsley Hospital
NHS Foundation Trust

Dr Richard Jenkins, Chief Executive

Martin Havenhand, Chair

NHS
The Rotherham
NHS Foundation Trust

Richard Parker OBE, Chief Executive

Suzy Brain England OBE, Chair

NHS
Doncaster and Bassetlaw
Teaching Hospitals
NHS Foundation Trust

Kirsten Major, Chief Executive

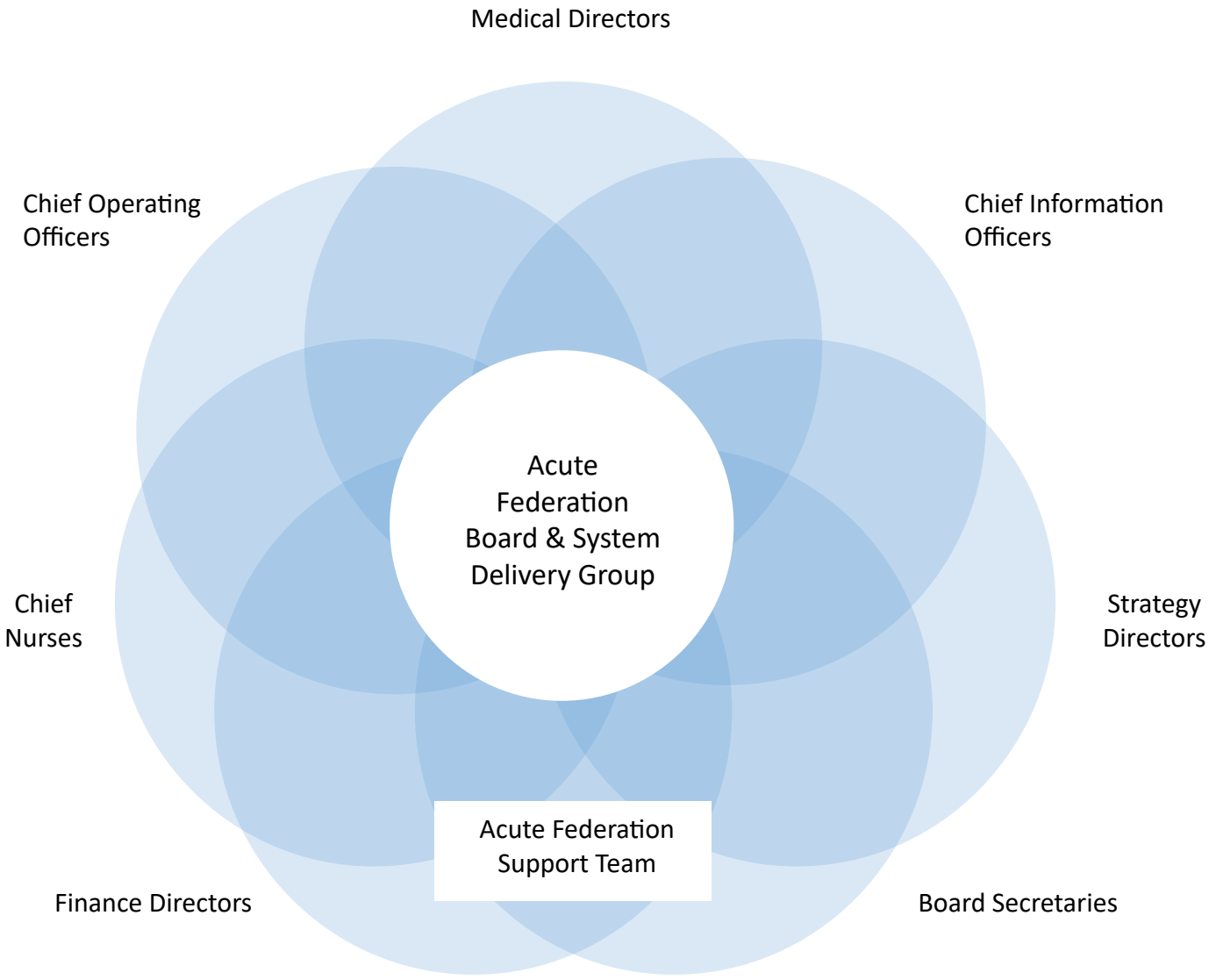
Annette Laban, Chair

NHS
Sheffield Teaching Hospitals
NHS Foundation Trust

Ruth Brown, Chief Executive

Sarah Jones, Chair

NHS
Sheffield Children's
NHS Foundation Trust



Progress against our 2022/23 priorities

2.1.1 Elective care recovery

Aim	Progress
To recover the elective waiting list to a safe and sustainable position in line with the national 18 week wait target.	Whilst there is still much to do to recover elective care waiting lists to pre-pandemic levels, the South Yorkshire Integrated Care System is in the top quartile in England for performance against the national referral to treatment target.

Increasing activity and expanding service capacity

There have been a range of successes in 2022/23 which will expand elective capacity over the next year and beyond, helping to put our ability to deliver high quality care for patients on a sustainable footing.

This includes two new elective orthopaedic centres in Sheffield and Doncaster.

Sheffield and Montagu Elective Orthopaedic Centres

Following an investment of £5.5 million capital funding, phase 1 of the Sheffield Elective Orthopaedic Centre (SEOC) opened on 3 April 2023 at the Royal Hallamshire Hospital with the theatre assessment unit admitting all elective orthopaedic inpatients and day case patients. The facility will be the new home for elective lower limb, foot and ankle, shoulder and elbow and knee surgery, with emergency orthopaedic and trauma care, spinal and limb reconstruction continuing to be delivered at the Northern General Hospital. Two additional theatres opened in April 2023 and new ward facilities and an enhanced care unit will follow in July 2023 and investment to increase staff numbers is ongoing.

The Montagu Elective Orthopaedic Centre (MEOC) is the product of a collaboration between Barnsley Hospital NHS Foundation Trust, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust and The Rotherham NHS Foundation Trust. An investment of £14.9 million will create a state-of-the-art hub in Mexborough with two theatres and 12 beds. Construction will commence in June 2023 and clinical service design and recruitment is underway for a scheduled opening in the winter of 2023. This centre is expected to provide around 3,400 high-volume low complexity orthopaedic procedures per year once it is fully operational. It will help reduce surgical waiting times for patients requiring orthopaedic procedures and release capacity at the host hospitals for other elective waiting list work.

Outpatient service improvements

General Practitioners (GPs) are increasingly able to access advice from another clinician or specialist to help identify whether a referral to an alternative service is required for a patient, and if so, to determine the most clinically appropriate pathway.

- The volume of specialist advice provided as a proportion of outpatient appointments has increased from 9% to 18.3% throughout 2022/23; more patients should be getting the right care from the right person in the right place as a result.
- We are giving patients more control over their follow-up care by expanding the use of patient initiated follow up (PIFU) across more clinical specialities and offering the opportunity to more patients (up from 1.66% to 2.15% of out-patient pathways) with work continuing to roll this out further. PIFU enables patients to avoid the inconvenience of appointments that are of low clinical value whilst enabling them to be seen quickly when they need to.

Getting it Right First Time

Trusts are using the national Getting It Right First Time (GIRFT) metrics in certain specialties to support clinical teams to discharge patients into the care of their GP where, if required, a patient can access medical support in an environment closer to home.

Throughout 2022/23 there have been targeted pieces of work to increase capacity whereby updating current practice and reducing inefficiencies has improved productivity.

- To reduce Did Not Attend (DNA) rates we have

introduced two-way text reminders for appointments in most services, where patients not only receive a reminder for their appointment but are also able to reply if the appointment is no longer required or they can not attend. This contributed to a reduction in DNA rates by almost 8% in one Trust, enabling them to utilise capacity for almost 2,200 patients across SYB.

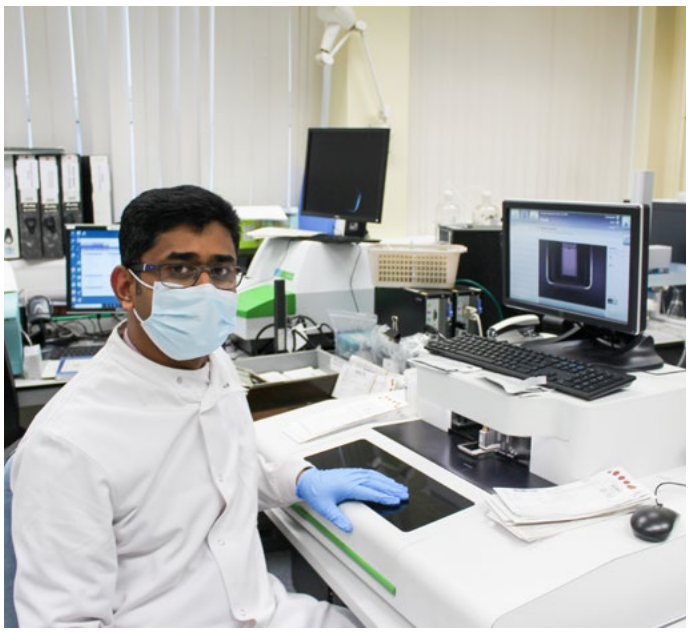
- By optimising and coordinating booking, scheduling and theatre processes, Trusts have been able to safely increase the number of procedures on theatre lists and waiting times for patients are reducing as a result.
- Theatre productivity has also improved, with one Trust improving its Day case rates (enabling patients to return home on the day of surgery rather than staying overnight) in two procedures by 25% and 38% thus releasing hospital beds for other patients with a greater clinical need. One Trust has doubled the number of patients added to their theatre lists, increasing utilisation (use of allocated theatre time) by 8%. Two Trusts have increased the number of patients requiring cataract procedures on theatre lists by 60%. This is reducing the length of time patients wait for their procedures.
- For cataract surgery, all Trusts are now using similar on-the-day pre-procedure checks which have reduced the number of patient appointments being cancelled on the day.

Primary and secondary care collaborative meetings continue to be held between Trusts to ensure patients are seen closer to home where possible, in services such as Ophthalmology, where local optometrist representatives are working closely with Trust Ophthalmology consultants, commissioning and contracting colleagues to ensure patients receive a streamlined service and only attend hospital when clinically necessary.

Digital integration for joined up patient care

The year has also seen progress towards digital integration in elective care.

- To improve collaboration between hospital Ophthalmology departments and Optometry/ Optician practices in the community, the EyeV electronic eye referral system is planned to go live in Sheffield in the first quarter of 2023/24. The system manages the clinical and administrative functions needed to deliver joined up high quality clinical services.



2.1.2 Diagnostic service recovery

Aim	Progress
Recovery of diagnostic waiting lists to a safe and sustainable position – within 6wks of referral - and delivery of Cancer Best Practice Timed Pathways.	Whilst there is also much to do to recover diagnostic waiting times to pre-pandemic levels, South Yorkshire and Bassetlaw has made progress towards the national target that 95% of patients should receive their test within 6 weeks of referral by March 2025. By February 2023 14.2% of patients were waiting over 6 weeks for a diagnostic test, a reduction from 27.7% in March 2022.

Endoscopy service expansion

Endoscopy, which enables a clinician to look inside the body in order to diagnose a health problem, is forecast to be the most challenged diagnostic service at system level over the next year and significant efforts continue to increase staff and facilities to address this.

- Expansion of the Endoscopy service at the Royal Hallamshire Hospital in Sheffield has been achieved using £4 million of capital funding combined with investment in additional staffing. The new unit opened in April 2023 and at full capacity will be able to undertake more than twice as many procedures as the previous unit. This will help reduce waiting times for patients and provide capacity to support the expansion of the Bowel Scope Screening Programme planned across England.

Community Diagnostic Centres

South Yorkshire and Bassetlaw patients are benefiting from faster and more convenient access to diagnostic tests following significant investment into three new Community Diagnostic Centres (CDCs).

- The first of its kind, a CDC sited in a town centre retail and leisure facility opened in the Barnsley Glassworks in April 2022 with capital investment of just under £3 million. The design and location of the CDC is proving very popular with patients and by encouraging attendance for scans and blood tests, it is expected to help with earlier detection of disease. Over 40,000 diagnostic tests were completed at Barnsley Glassworks in 22/23. With a further £1.4 million capital investment throughout 2023/24 and additional staff, the centre will offer a wider range of diagnostic tests and by 2024 will be completing more than 6,000 tests a month.
- Respiratory physiology testing services commenced at the Breathing Space CDC, Badsley Moor, Rotherham on 3 April 2023. Investment into facilities and equipment is supporting the provision of diagnostic testing needed for patients living with long-term respiratory conditions such as emphysema and chronic obstructive pulmonary disease (COPD); about 6000 tests will be completed in the first year. By increasing capacity and supporting testing in primary care/community settings, the CDC will help to enable early, accurate diagnosis to inform proactive treatment and modify interventions that contribute to improved outcomes.
- Over £16 million is being invested to create a large CDC at Montagu Hospital, Mexborough, that will provide Endoscopy services, MRI and CT scanning, cardiac and respiratory testing alongside blood and other diagnostic tests. The range of testing is opening in a phased approach as the building work and staff recruitment is completed. Endoscopy service provision will commence in Autumn 2023 and building for the medical imaging unit that will include CT and MRI, is due to be completed by July 2024. Over 8,000 tests were undertaken at the CDC in 23/24 and full implementation will see this increase to well over 30,000 in 23/24 and more thereafter. All South Yorkshire and Bassetlaw patients that require cardiac MRI testing currently have to travel to Sheffield however, with the investment into this technology at Montagu CDC, many patients will benefit from shorter travel times, helping to reduce health inequalities.

In 2023/24 the Acute Federation will work with the Integrated Care Board and Yorkshire and Humber Academic Health Science Network to evaluate the impact of the CDCs and future work will involve ensuring GP Direct Access to diagnostic tests is consistent across the region.

Pathology Network

Through the SYB Pathology Transformation Programme the five Acute Federation Trusts have developed ambitious plans to bring their separate laboratory services into a single service, hosted by Sheffield Teaching Hospitals NHS Foundation Trust on behalf of all, with a unified workforce delivering equitable access to high quality laboratory services across our network. Pathology involves the examination of tissues, organs, blood, other bodily fluids and autopsies in order to study, diagnose and manage disease and inform treatment decisions. Pathology is key to NHS services delivering essential patient care and is involved in around 80% of diagnostic and treatment decisions.

This work has been underpinned by a robust shared governance model and a collaborative principles-led approach, with plans shaped by extensive consultation with practitioners through expert reference groups. The programme has secured one of the largest national investments in digital infrastructure- £22 million- to be invested in a single Laboratory Information Management System (LIMS) to replace the currently separate individual systems, and to provide digital sharing of pathology images between sites.

Workforce development

There are a range of initiatives designed to improve recruitment and retention of staff and develop specialist skills in diagnostic methods.

- The SYB Ultrasound Teaching Academy continues to deliver additional activity to enable more clinicians to develop ultrasound skills with positive feedback from students. Our focus in the next year will be to ramp up the Academy's capacity.
- Discussions are also underway with the Allied Health Professionals Faculty regarding hosting a SYB radiographer bank which will enable easier access to healthcare professionals when they are needed.
- We are also contributing to scoping for a Pan-Yorkshire Endoscopy Academy.

Feedback from one of our trainee Sonographers:

"I would just like to say the help and guidance I received in regards to my scanning was very good. I found it very beneficial scanning with both Michelle and Richard. During my time scanning with the academy, I have adapted many skills which have helped me to develop as an aspiring sonographer. I have also had the opportunity to spend some time at Sheffield Teaching Hospital and this has allowed me to see how different trusts operate. I am really thankful to have had this opportunity and think this would be very beneficial for future students."

Digital integration

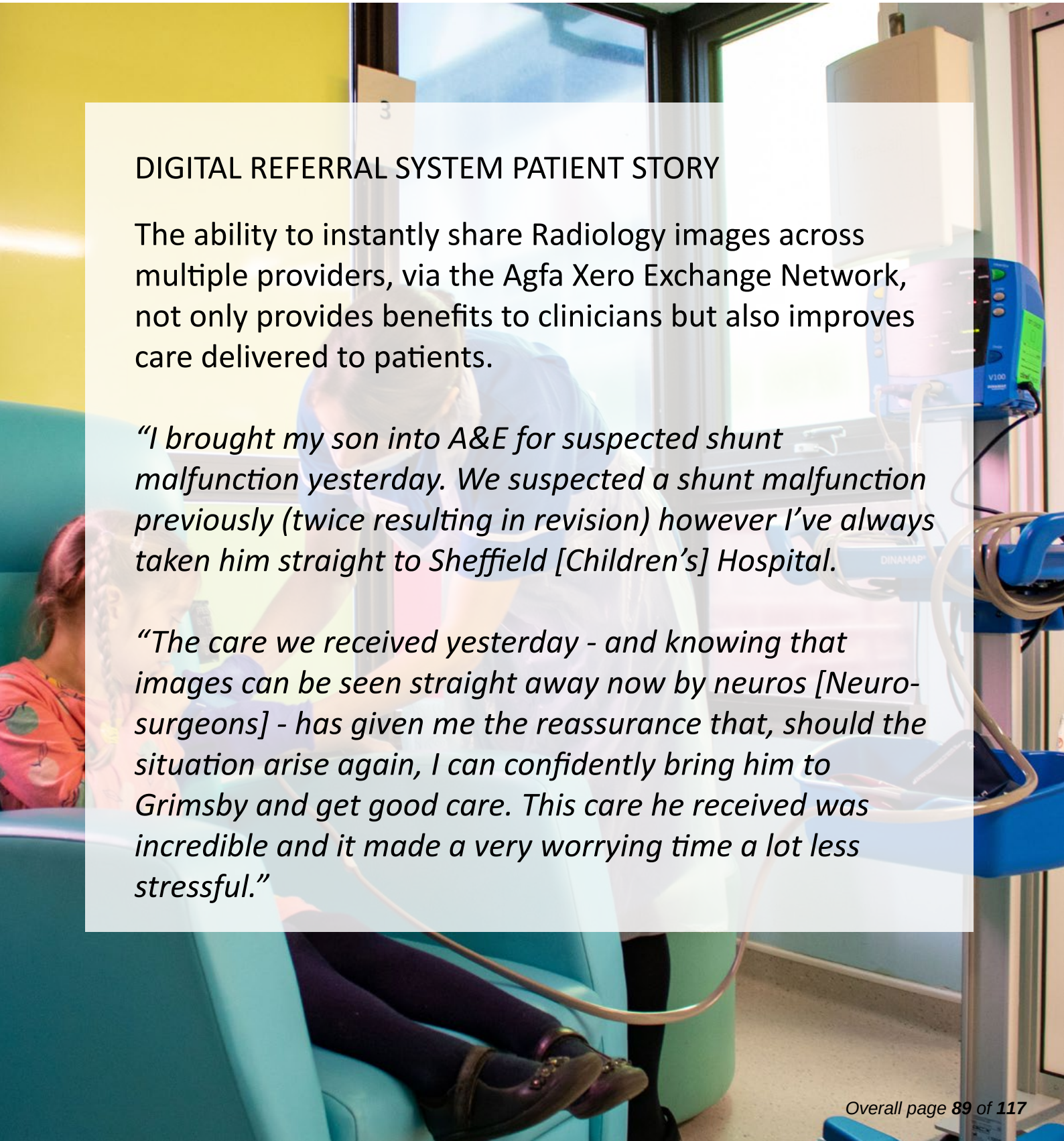
The ability to access IT systems across organisations and share data are key enablers to collaboration and so has been a priority in 2023/24. Progress has been made across a number of projects.

- Currently, a patient's medical image e.g. x-ray, MRI and CT is stored locally where the scan is taken and manual processes may be needed so that a clinician working in another SYB location can view it. To avoid the delay and inefficiency associated with such manual processes, the five Trusts agreed to procure and implement a common IT solution; four Trusts are already linked up with the final one expected to be live soon. In addition, an options appraisal is underway to help align image storage, workflow management and reporting IT systems across the five Trusts with the aim of enabling cross-site reporting, globalised scheduling and system use of capacity (including that at CDCs). The Acute Federation is working towards a common solution for Picture Archiving System (PACS) and Radiology Information System (RIS) to support these aims.
- Funding has been secured to support Artificial Intelligence (AI) research and pilots to support rapid and accurate diagnosis e.g. to test multiple AI algorithms on the early detection of lung cancer on chest X-ray.

Digital Referral System

The South Yorkshire & Bassetlaw Imaging Network is working with all acute providers on the utilisation

of Clinical Decision Support (CDS). iRefer is a CDS software tool that works within existing referral platforms to provide advice and guidance on the most appropriate diagnostic pathway into Imaging. CDS software is seen as key to ensuring patients receive the correct diagnostic test, first time, while also ensuring appropriate use of available capacity and rolling this out across SYB will mean patients receive the same standard of referral using evidence-based guidelines. Implementation is underway with Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust, Barnsley Hospital NHS Foundation Trust and The Rotherham NHS Foundation Trust, with systems expected to go live throughout 23/24.



DIGITAL REFERRAL SYSTEM PATIENT STORY

The ability to instantly share Radiology images across multiple providers, via the Agfa Xero Exchange Network, not only provides benefits to clinicians but also improves care delivered to patients.

"I brought my son into A&E for suspected shunt malfunction yesterday. We suspected a shunt malfunction previously (twice resulting in revision) however I've always taken him straight to Sheffield [Children's] Hospital.

"The care we received yesterday - and knowing that images can be seen straight away now by neuros [Neurosurgeons] - has given me the reassurance that, should the situation arise again, I can confidently bring him to Grimsby and get good care. This care he received was incredible and it made a very worrying time a lot less stressful."

2.2 Hosted clinical networks

Aim

Review existing hosted networks for Gastroenterology; Maternity; Paediatrics; Stroke services; Urgent and Emergency Care to ensure they are as effective and efficient as possible.

2.2.1 Stroke

The **South Yorkshire Integrated Stroke Delivery Network (SY ISDN)** supports national and local stroke priorities with both a strategic and operational focus. The ambition of the SY ISDN is to ensure that people within the region have equal and fair access to the highest quality stroke care across the whole pathway with good clinical outcomes, experience and safety. The ISDN brings people together empowering them to transform, innovate and develop Stroke services, improving outcomes for all involved.

The SY ISDN listens to and acts on the views of those people with lived experience of stroke, and they are at the heart of all the network does. Since the network was launched in 2020, it has successfully implemented shared clinical pathways and protocols, developed workforce capacity support and implemented a new Telemedicine system. The network has also secured funding to pilot pre-hospital stroke video triage, expand the use of stroke AI and improve stroke rehabilitation pathways. SY ISDN has established a regional Stroke Survivor and Carer Panel which continues to be an integral part of the network.

Through 2022/23, the network and its partners have continued to improve the urgent diagnosis and treatment pathway.

- The Hyper Acute Stroke Unit transformation is now well embedded and access to Mechanical Thrombectomy and CT Perfusion has been expanded this year into weekday evenings to give eligible patients a better chance of receiving clot removing treatment to prevent longer term disability.
- The Acute Bundle of Care for Intracerebral Haemorrhage (ABC) has been launched which standardises the management of those with haemorrhagic stroke leading to improved outcomes.
- Work has also been undertaken to refine Carotid Endarterectomy pathways to speed up referral to intervention times.
- Focus on rehabilitation pathways and collaborative gap analysis work of stroke rehabilitation and life after Stroke service has been undertaken. The findings from this work have helped to shape quality improvement work for 2023/24 which include a focus on social prescribing, psychological support, vocational rehabilitation, stroke reviews and aligning services to new guidance.
- This year the ISDN has taken an active role in the implementation of the national Patient Reported Experience Measure Survey with all organisations in the regional participating. This will provide invaluable insights into the experience of those with lived experience of stroke and findings will be cascaded in 2023/24.
- Through 2022, the ISDN worked in collaboration with the Local Knowledge and Intelligence Service to co-produce a SYB Stroke Health Inequalities Report to help inform targeted prevention and awareness raising work. This has provided us with new insight on which populations in the region are more at risk of stroke, experience stroke or have poorer outcomes.
- Finally, the SY ISDN has focused on the development of the stroke workforce hosting a regional conference, a bespoke leadership programme and regional training series.

Stroke Awareness Campaign

The SY ISDN has worked with young people at a local school on a Stroke Awareness project. A targeted campaign in Barnsley place has been launched and more community stroke teams are adopting blood pressure checks into routine practice. Data is being used to engage with Primary Care Networks and patients and the public, and strong links have been established with the SY Prevention Programme with plans to roll this out further in 2023/24.

Key priorities for Stroke services over the next few years include:

- Expanding Mechanical Thrombectomy services into weekends and then 24 hours day.
- Implementing the National Optimal Stroke Imaging Pathway (NOSIP)
- Improving Thrombolysis rates.
- A continued focus on improving the quality of Stroke services.
- Improving access to Transient Ischaemic Attack Clinics.
- Working to prevent more strokes and raise awareness of stroke across the region.
- Delivering the SY Cardiovascular Disease Plan in collaboration with the prevention and cardiac programmes.
- Aligning Stroke Rehabilitation services to national guidance and in particular the Integrated Community Stroke Services Model.
- Delivering the Social Prescribing in Stroke project which will embed social prescribing link workers into Integrated Community Stroke Service teams across the region.
- Developing and implementing the SY ISDN Workforce Strategy.

STROKE PATHWAY PATIENT STORY

'I had my stroke whilst at work in Barnsley and luckily my colleagues recognised the symptoms I was having as stroke. They rang 999 and the ambulance crew contacted the Hyper Acute Stroke Unit at Pinderfields Hospital using the 'pre-alert' system.

I was quickly taken to the stroke unit and received a 'clot busting' treatment called thrombolysis. I stayed in hospital for a few days and when I went home, I had help from the Community Stroke Team.

They were brilliant. I have made a good recovery, but I still struggle with the symptoms I have been left with.'

2.2.2 Paediatrics

The SYB Acute Federation is host to one of 11 specialist children's hospitals in England which offers the region clear opportunities to innovate in the field of Paediatric care.

The acute providers have established 'Level 1 Hosted Networks', which support working across the system on matters related to workforce, clinical standardisation and innovation. The Level 1 networks focus on supporting all Trusts equally. Two specific networks were developed and continue to function well; The Care of the Acutely Ill Child Network and the General Surgery and Anaesthesia Network. Both networks focus on building and maintaining a standardised approach to acute Paediatric services through the development of shared guidelines, joint training and education, consider system solutions to increasing waiting times and workforce pressures, the development of the Healthier Together website. These networks create a platform for building relationships across organisations a key enabler for creating at pace a SYB children's emergency surgery pathway to support acute Trusts at the height of the pandemic.

Acute Trusts have also explored 'Level 3 Hosted Networks', which involve a greater degree of integration between two or more Trusts. The aim of the Level 3 network is to allow one Trust which has a particular strength in a specialty to support one or more other Trusts in this area.

The Sheffield Children's NHS Foundation Trust and Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust have been building relationships to develop a Level 3 hosted network for acute Paediatric services. Their achievements include:

- **Joint working to address elective surgery waiting times**
  Clinicians and managers from the two Trusts have explored the possibility of developing a shared plan to reduce waiting times for Ear, Nose and Throat day surgery. This has laid the groundwork for sharing resources and risk management in readiness for future collaboration.

- **Building a sustainable pathology workforce**
  Three Joint Learning Event sessions took place during 2022 for pathology clinical leads and children's clinical directors across both organisations to share knowledge and insight and build working relationships to enable joint working. These sessions were extremely well attended with very positive feedback.

- **Bassetlaw Emergency Village (BEV)**
  The Paediatric network clinical leads have played a key role in supporting the design and development of the children's ward at the new BEV which will benefit hundreds of children each year. They have been instrumental in the Clinical Senate planning process, became active members of the clinical working groups and have ensured that the right experts are engaged in the development at the right time. The network leads contributed and supported the BEV public engagement consultation and contributed to the final business case. They have also worked to strengthen anaesthetist capability to ensure capacity by developing and implementing the Anaesthesia Training Plan.

- **Nurse Education**
  The nurse educators across both Trusts have worked together to agree competency and training requirements for triage and are currently working together with Barnsley and Rotherham nurse educators to ensure the training requirements to support children and young people with special educational needs and disabilities are being met in acute Trusts.

- **Complex System Leaders Face to Face Workshops**
  A series of workshops to support collaboration across the two Trusts designed for senior leaders, surgeons and for nurse educators has been delivered. Attendees found workshops extremely helpful giving staff a deeper understanding of how working together will benefit the children and young people using their services.

2.3 Clinical service development

During the year the SYB Acute Federation identified a number of clinical specialities expected to benefit from collaboration.

2.3.1 Urology

Aim

To work collaboratively across Urology services to improve the quality, safety and efficiency of care provided to patients across SYB and Chesterfield, an important partner in the local area.

Progress

- We have taken a network approach to getting the best outcomes for our patients following GIRFT principles to reduce variation, standardise care and give patients the best experience first time round.
- Work is well underway to create a collaborative clinical pathway on a regional basis to put in place sustainable on-call rotas. As part of this we are focused on agile staff working to ensure we deliver care closer to the patient wherever possible, with some of our Urologists already moving around the SYB and Chesterfield network to provide expert support and advice to clinical teams on complex procedures.
- Clinical leads have agreed new parameters for standards of care in the treatment of benign prostatic hyperplasia which should enable productivity improvements to free up time for patient care, and a range of GIRFT metrics for measuring progress have been identified.

We are now focused on ensuring capacity and demand for Urology services is evenly matched across the network to realise the patient benefits of collaboration.

2.3.2 Rheumatology

Aim

To work collaboratively across Rheumatology services to improve the quality, safety and efficiency of care for patients across SYB.

Progress

The focus of this workstream has been on:

- Demand management standardising and optimising GP referrals to reduce unnecessary activity beginning with a standard referral form for GPs across South Yorkshire and Bassetlaw and learning from each other on best practice in patient triage.
- Workforce resilience Developing workforce models which give greater service resilience across the patch.
- Workforce sustainability in the longer-term Work with NHS England's workforce, training and education teams on the future pipeline for rheumatology in South Yorkshire.
- Productivity Benchmarking SY Trusts against, and working towards GIRFT best practice.

2.3.3 Gastrointestinal bleeds

Aim

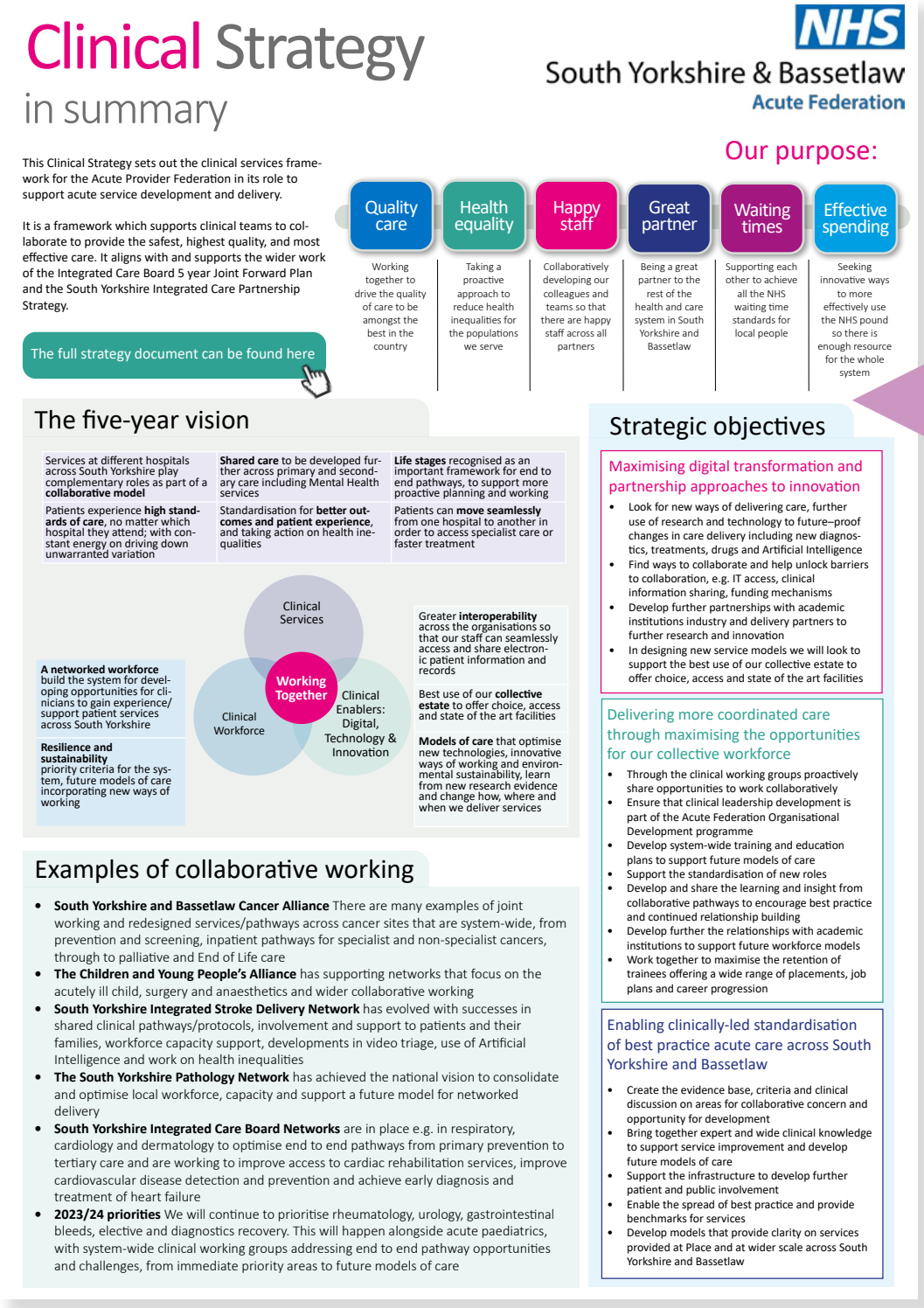
To work collaboratively across Gastrointestinal Bleed (GI) services to improve the quality, safety and efficiency of care provided for patients across SYB.

Progress

- Work to strengthen SYB GI Bleed services is being taken forward by the Endoscopy Network. Endoscopy is the main tool for helping doctors to identify for gastrointestinal bleeding. The Endoscopy Workforce Group is supporting the development of a workforce strategy.
- Progress continues on the Pan Yorkshire Training Academy for Endoscopy which is due to be mobilised in shadow form from June 2023.
- A preliminary evaluation of the GI Bleeds arrangements was carried out and a more detailed evaluation is required to include the number of patients transferred, the impact both positive and negative on patients and also what is considered best practice in other areas looking at a variety of models e.g. individual rotas/mixed approach/system rotas.

2.4 Clinical Strategy

Aim	Progress
To develop a framework which enables our clinical teams to collaborate to provide the safest, highest quality, and most effective care.	The Clinical Strategy has been developed in collaboration with clinicians and operational managers across the patch and sets out the five-year clinical services framework for the SYB Acute Federation in its role to support acute service development and delivery. It aligns with and supports the wider work of the Integrated Care Board 5-year Joint Forward Plan and the South Yorkshire Integrated Care Partnership Strategy.



Clinical Strategy
in summary

NHS
South Yorkshire & Bassetlaw
Acute Federation

This Clinical Strategy sets out the clinical services framework for the Acute Provider Federation in its role to support acute service development and delivery.

It is a framework which supports clinical teams to collaborate to provide the safest, highest quality, and most effective care. It aligns with and supports the wider work of the Integrated Care Board 5 year Joint Forward Plan and the South Yorkshire Integrated Care Partnership Strategy.

The full strategy document can be found here

Our purpose:

Quality care	Health equality	Happy staff	Great partner	Waiting times	Effective spending
Working together to drive the quality of care to be amongst the best in the country	Taking a proactive approach to reduce health inequalities for the populations we serve	Collaboratively developing our colleagues and teams so that there are happy staff across all partners	Being a great partner to the rest of the health and care system in South Yorkshire and Bassetlaw	Supporting each other to achieve all the NHS waiting time standards for local people	Seeking innovative ways to more effectively use the NHS pound so there is enough resource for the whole system

The five-year vision

Services at different hospitals across South Yorkshire play complementary roles as part of a **collaborative model**	**Shared care** to be developed further across primary and secondary care including Mental Health services	**Life stages** recognised as an important framework for end to end pathways, to support more proactive planning and working
Patients experience **high standards of care**, no matter which hospital they attend; with constant energy on driving down unwarranted variation	Standardisation for **better outcomes and patient experience**, and taking action on health inequalities	Patients can **move seamlessly** from one hospital to another in order to access specialist care or faster treatment

A networked workforce build the system for developing opportunities for clinicians to gain experience/ support patient services across South Yorkshire

Resilience and sustainability priority criteria for the system, future models of care incorporating new ways of working

Greater **interoperability** across the organisations so that our staff can seamlessly access and share electronic patient information and records

Best use of our **collective estate** to offer choice, access and state of the art facilities

Models of care that optimise new technologies, innovative ways of working and environmental sustainability, learn from new research evidence and change how, where and when we deliver services

Examples of collaborative working

- **South Yorkshire and Bassetlaw Cancer Alliance** There are many examples of joint working and redesigned services/pathways across cancer sites that are system-wide, from prevention and screening, inpatient pathways for specialist and non-specialist cancers, through to palliative and End of Life care
- **The Children and Young People's Alliance** has supporting networks that focus on the acutely ill child, surgery and anaesthetics and wider collaborative working
- **South Yorkshire Integrated Stroke Delivery Network** has evolved with successes in shared clinical pathways/protocols, involvement and support to patients and their families, workforce capacity support, developments in video triage, use of Artificial Intelligence and work on health inequalities
- **The South Yorkshire Pathology Network** has achieved the national vision to consolidate and optimise local workforce, capacity and support a future model for networked delivery
- **South Yorkshire Integrated Care Board Networks** are in place e.g. in respiratory, cardiology and dermatology to optimise end to end pathways from primary prevention to tertiary care and are working to improve access to cardiac rehabilitation services, improve cardiovascular disease detection and prevention and achieve early diagnosis and treatment of heart failure
- **2023/24 priorities** We will continue to prioritise rheumatology, urology, gastrointestinal bleeds, elective and diagnostics recovery. This will happen alongside acute paediatrics, with system-wide clinical working groups addressing end to end pathway opportunities and challenges, from immediate priority areas to future models of care

Strategic objectives

Maximising digital transformation and partnership approaches to innovation

- Look for new ways of delivering care, further use of research and technology to future–proof changes in care delivery including new diagnostics, treatments, drugs and Artificial Intelligence
- Find ways to collaborate and help unlock barriers to collaboration, e.g. IT access, clinical information sharing, funding mechanisms
- Develop further partnerships with academic institutions industry and delivery partners to further research and innovation
- In designing new service models we will look to support the best use of our collective estate to offer choice, access and state of the art facilities

Delivering more coordinated care through maximising the opportunities for our collective workforce

- Through the clinical working groups proactively share opportunities to work collaboratively
- Ensure that clinical leadership development is part of the Acute Federation Organisational Development programme
- Develop system-wide training and education plans to support future models of care
- Support the standardisation of new roles
- Develop and share the learning and insight from collaborative pathways to encourage best practice and continued relationship building
- Develop further the relationships with academic institutions to support future workforce models
- Work together to maximise the retention of trainees offering a wide range of placements, job plans and career progression

Enabling clinically-led standardisation of best practice acute care across South Yorkshire and Bassetlaw

- Create the evidence base, criteria and clinical discussion on areas for collaborative concern and opportunity for development
- Bring together expert and wide clinical knowledge to support service improvement and develop future models of care
- Support the infrastructure to develop further patient and public involvement
- Enable the spread of best practice and provide benchmarks for services
- Develop models that provide clarity on services provided at Place and at wider scale across South Yorkshire and Bassetlaw

Click here to enlarge

2.5 Financial improvement

We know that working together to share resources flexibly and align support services, where it makes sense to do so, will give us the best chance of enhancing productivity and value for money across SYB. Progress has been made in a number of areas.

2.5.1 Medical Agency

Aim

To reduce the numbers of vacancies for clinical roles and shift away from the use of medical agency and higher cost locum arrangements.

Progress

This year our nursing and medical leaders have worked as a network to focus on reducing variation in medical agency pay rates and standardise, where it makes sense to do so. They have shared best practice on permanent recruitment and retention of staff. This includes career development opportunities across the patch through joint appointments, where it is agreed there is a mutual benefit, matching capacity to demand through system-wide recruitment exercises such as in midwifery, recruitment from overseas and innovation in workforce and care models.

Developing a networked clinical workforce will be an important area of focus through the Clinical Strategy implementation in 2023/24.

2.5.2 Procurement

Aim

To reduce the cost of service provision through a set of targeted interventions which standardise goods and services and produce efficiencies.

Progress

We have achieved £527,000 in collaborative efficiencies with an overall SYB Trust procurement saving of £2.96m which is 83.95% of the target set in an extremely challenging year. This has been reached through:

- Implementation of a joint e-Tendering and Contract Management platform – Atamis- across the seven provider Trusts and Integrated Care Board in South Yorkshire.
- Rolling out a joint Work Planning Tool across 80% of SY ICS organisation with final 20% onboarding due in the first quarter of 2023/24.
- Delivering 85% of the recommended Procurement Target Operating Model objectives set by NHS England, the second highest in the country.
- Establishing a Consumables Resilience Group which manages, mitigates and works to prevent supply disruption issues across the South Yorkshire Integrated Care System and supports clinical staff to deliver uninterrupted high-quality patient care.
- Delivery of a collaborative procurement project on Hip and Knee procedures leading to cost pressure avoidance of £500,000 and delivery of Cost Improvement Programmes (CIP) saving £1.18m across the patch through clinically-led standardisation and product rationalisation across the Hips and Knees range. This flagship procurement exercise has taken two years to complete and involved over 40 clinicians from SYB Acute Trusts and Chesterfield Royal Hospital NHS Foundation Trust.
- Developing shared career opportunities across teams and supporting staff to progress and move across Trusts ensuring skills remain in South Yorkshire.
- Establishing a bi-monthly Procurement Newsletter to share useful across the SY Integrated Care System procurement community.
- Utilising a shared work environment on the NHS Futures platform for sharing information, storing data and a means for collaborative working across multiple organisations.

Because of this we have been in a strong position to nominate teams and individuals for national Healthcare Supply Association awards.

2.5.3 Hospital transfer waits

Aim

To improve operational efficiency and reduce bed days by reducing delays for inter hospital transfers.

Progress

A policy has been developed to standardise inter-hospital transfers of patients across SYB acute Trusts and rapidly escalate delays where necessary. The policy outlines the expectations of the transferring and receiving Trusts where a patient requires ongoing hospital care. It sets the timescales and escalation processes that should be undertaken to ensure patients are returned to their local Trust in a timely manner and when the patient is clinically safe to be transferred. The policy also includes full contact details for out of area agency contact details, these details are for patients who no longer require ongoing hospital care, but do require community care e.g. Physiotherapy and Occupational Therapy. This policy ensures patients are returned to their local Trust in a timely manner making it easier for family and friends to visit, the policy will also help to minimise delays in patients returning home or to other accommodation.

Operational management of this process will be via a single online dashboard which will allow operational teams to oversee medically fit patients being transferred to their destination.

2.6 Acute Federation organisational development – enabling collaboration

Aim

To build the SYB Acute Federation into an innovative value-adding partnership, a single point of contact for the ICB, a trusted partner to other provider collaboratives and be nationally recognised as a pioneering example of acute care integration.

Progress

This year the members of the Acute Federation have agreed their model of collaboration is one of purposeful active federation. Our shared principles are:

- We operate with mutual accountability.
- We are open with each other.
- We trust each other.
- We collectively hold high ambitions for the Federation.
- We are clear on our shared purpose.
- We support each other to 'land', in each other's organisations, decisions where one of us takes a cost for the team and in the interests of the people of SYB.
- We believe – and act – that we are mutually dependent in this interconnected system that is SYB.
- We communicate regularly and openly with each other.
- We talk positively and appreciatively about each other behind each other's backs.
- We know – and act – that our common purpose is in service of the health and wellbeing of the population of SYB.
- We ask for help from each other… and we readily offer help to each other across organisations.

In 2023/24 we intend to implement an organisational development plan that will help to further embed a collaborative culture across the members of the Acute Federation, break down organisational barriers and enable staff to work in partnership where it makes sense to do so, for the benefit of our patients.

The year ahead

Building on the progress made against priorities in 2022/23 the SYB AF's priorities for 2023/24 align with the South Yorkshire Integrated Care Partnership's strategy Integrated Care Partnership Strategy :: SYB ICS (syics.co.uk) for improved care and outcomes and include:

3.1 NHS recovery

We will continue to work together to recover elective and diagnostic services and reduce waiting times for patients, with specific focus on Orthopaedics, Ophthalmology, Ear, Nose and Throat and General Surgery.

3.2 Clinical Strategy

We will implement the Acute Federation clinical strategy to deliver improvements in care quality for the people of South Yorkshire & Bassetlaw, reduce unwarranted variation between providers, address inequalities in access and improve our resilience and efficiency. The Clinical Strategy covers:

- Clinical services which have been identified as likely to benefit from system collaboration. This will mean continuation of work on Urology, Rheumatology and GI Bleeds, spreading learning from collaboration e.g. Pathology Transformation Programme, Montagu Elective Orthopaedic Centre and developing a methodology for clinical service improvement across providers
- Clinical workforce – develop a networked workforce for resilience and sustainability.
- Clinical enablers: digital, technology, estates and innovation – we will focus on greater interoperability and data sharing across providers, better use of collective estate and models of care that optimise new technologies.

3.3 Innovative commissioning and financial models to improve efficiency and value for money

We will further explore opportunities to improve financial efficiency and integrate commissioning.

3.4 Flagship national innovator

Flagship national innovator scheme: Acute Paediatrics Innovator Programme – we will accelerate the design and implementation of the South Yorkshire & Bassetlaw collaborative model for acute Paediatric services as part of NHS England's national innovator scheme. The aim is to ensure timely access, outcomes and experience and reduce health inequalities for children and young people.

3.5 Engagement to drive collaboration

We will work with our staff on continued organisational development to strengthen the culture of collaboration.

South Yorkshire & Bassetlaw
Acute Federation

Designed by South Yorkshire & Bassetlaw Acute Federation © 2023

2306 - F OTHER ITEMS

2306 - F1 - ANY OTHER BUSINESS (TO BE AGREED WITH THE CHAIR PRIOR TO THE MEETING)

Discussion Item | Suzy Brain England OBE, Chair | 10:50

5 minutes

2306 - F2 GOVERNOR QUESTIONS REGARDING THE BUSINESS OF THE MEETING *

Discussion Item | Suzy Brain England OBE, Chair | 10:55

10 minutes

2306 - F3 MINUTES OF THE MEETING HELD ON 23 MAY 2023

Decision Item | Suzy Brain England OBE, Chair | 11:05

5 minutes

REFERENCES

Only PDFs are attached

F3 - Draft Public Board Minutes - 23 May 2023.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS – PUBLIC MEETING

Minutes of the meeting of the Trust's Board of Directors held in Public on Tuesday 23 May 2023 at 09:30 via MS Teams

Present:
Mark Bailey - Non-executive Director
Hazel Brand - Non-executive Director
Mark Day - Non-executive Director
Karen Jessop - Chief Nurse
Zoe Lintin - Chief People Officer
Lucy Nickson - Non-executive Director
Dr Tim Noble - Executive Medical Director
Richard Parker OBE - Chief Executive
Jon Sargeant - Chief Financial Officer
Kath Smart - Non-executive Director / Deputy Chair (Chair)
Denise Smith - Chief Operating Officer

In attendance:
Fiona Dunn - Director of Corporate Affairs / Company Secretary
Cathy Hassell – Managing Director, South Yorkshire & Bassetlaw Acute Federation
Lois Mellor - Director of Midwifery
Angela O'Mara - Deputy Company Secretary (Minutes)

Public in attendance:
Peter Abell - Public Governor Bassetlaw
Dennis Atkin - Public Governor Doncaster
Lauren Bowden - Divisional Director of Operations (Specialty Medicine)
Mark Bright - Public Governor Doncaster
Gina Holmes - Staff Side
Lynne Logan - Public Governor Doncaster
Andrew Middleton - Public Governor Bassetlaw
Pauline Riley - Public Governor Doncaster
Andrea Squires - Divisional Director of Operations (Urgent & Emergency Care)
Adam Tingle - Acting Director of Communications & Engagement
Mandy Tyrrell - Staff Governor

Apologies:
Suzy Brain England OBE - Chair of the Board
Jo Gander - Non-executive Director
Dr Emyr Jones - Non-executive Director
Lynne Schuller - Public Governor Bassetlaw

P23/05/A1 **Welcome, apologies for absence and declaration of interest (Verbal)**

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

P23/05/A2 **Actions from Previous Meetings (Enclosure A2)**

No active actions.

P23/05/B1 **Executive Medical Director Update including Q3 2022/23 Learning from Deaths Report (Enclosure B1)**

The Executive Medical Director's report provided an overview of the current programmes of work within his portfolio.

Non-executive Director, Emyr Jones had attended the Medical Advisory Committee this month and invitations would be extended to the remaining non-executive directors throughout the year.

In respect of the Hospital Standardised Mortality Ratio (HSMR) data, the provision of regional comparator data was noted, with a reduction seen in the Trust's overall and non-elective HSMR across the last three month's reports.

The Executive Medical Director confirmed that the scrutiny of adult deaths in the community had commenced with a small number of general practitioners, the national implementation had been paused pending the introduction of new legislation.

In response to a question from Non-executive Director, Lucy Nickson, the Executive Medical Director confirmed there was currently no evidence of harm arising from the junior doctors' industrial action. The impact on activity would be reported by the Chief Operating Officer at the Board's Finance & Performance Committee.

In respect of learning identified during the industrial action, the Executive Medical Director confirmed an increased consultant presence in the Emergency Department had positively supported the care pathway. Whilst learning would be considered in respect of a consultant delivered vs consultant led service, there was a need to take into consideration the impact on trainee learning opportunities.

Procurement of an online medical appraisal platform had commenced for a system replacement and was included within the 2023/24 capital plan.

Non-executive Director, Mark Bailey recognised the efforts to reduce the reliance on temporary medical workforce and enquired how the Trust would assess the effectiveness of its actions. The Executive Medical Director confirmed evidence would be seen through a reduction in agency spend. The Medical Director for Workforce & Specialty Development had explored a number of strategies at a specialty level to improve the Trust's ability to recruit and retain colleagues. Where posts remained difficult to recruit to nationally, alternative workforce models were being considered, such as the training programme for anaesthetists. The Chief Financial Officer noted the need to consider efficiencies which may arise from the national Getting it Right First Time Programme and Model Hospital through alternative operating models. Work to align job planning with capacity would be progressed throughout the year, with a view to embedding the practice into business as usual.

The Chief Executive confirmed the contractual requirement for an annual job planning discussion and acknowledged the cyclical process. There was a need to align the

consultant workforce with the provision of patient care and a movement from transactional to transformational conversations was expected.

The Q3 2022/23 Learning from Deaths summary report highlighted an increase in deaths as compared to the previous reporting period. In respect of inpatient deaths of adults with a learning disability, appropriate referrals had been made to the Learning Disability Mortality Review Programme. The Executive Medical Director confirmed that the national end of life care audit had been completed and feedback shared via workshops, with a quality improvement programme planned for Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) in June 2023.

In response to a question from Non-executive Director, Hazel Brand, the Executive Medical Director anticipated the full scrutiny of community deaths would commence later in the year and the Board's Quality & Effectiveness Committee would be kept appraised of developments.

The Deputy Chair enquired if the delayed implementation of community deaths would have any impact on the deceased's family. The Executive Medical Director did not foresee any issues, where a previous inpatient had been recently discharged and not seen by an alternative care practitioner the Executive Medical Director explained there may be a need for the Trust to issue the death certificate. The expectation was that this should be completed within five days, with an internal three day stretch target in place; the process had been subject to a quality improvement review.

The Board:

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

P23/05/B2 **Chief Nurse Update (Enclosure B2)**

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

Good progress was noted with the implementation of the Patient Safety Incident Response Framework (PSIRF) ahead of September, full details of which would be reported to the Board's Quality & Effectiveness Committee. Good system engagement was reported and links made with early adopters.

A reported 37% reduction in category two and above hospital acquired pressure ulcers (HAPU) was reported for 2022/23, work would continue towards achieving a 50% reduction in 2023/24.

The Chief Nurse confirmed the 2023/24 national threshold for Clostridium difficile was 42, progress would be reported through the Clinical Governance Committee and for assurance to the Board's Quality & Effectiveness Committee.

30% of complaints were closed in a timely manner in March, targeted work to improve responsiveness would be progressed and a bespoke training solution had been procured for use across the divisions and with the Patient Liaison & Advice Service.

Lucy Nickson, Non-executive Director acknowledged the significant improvement in HAPU performance, in response to understanding the reason for change, the Chief Nurse

confirmed the Skin Integrity Team had developed a clear strategy and demonstrated a commitment and passion of an evidence-based approach with the clinical teams, with learning driving the required improvements.

In respect of the complaints closure rate, the Chief Nurse acknowledged the impact of winter pressures and the difficulties in recovering the backlog position. All complaints were now reviewed by her prior to sign off by the Chief Executive and this increased level of oversight, supported by the training was welcomed. A review of the complaints policy and compliance would be undertaken by the internal auditors in Q2 2023/24.

Non-executive Director, Hazel Brand reported that recent national press coverage indicated almost 20% of nurses were international recruits and enquired what local solutions were being explored by the Trust. The Chief Nurse confirmed activities included nursing degree apprenticeships, dialogue with higher education institutions and a series of staff retention activities.

The Executive Medical Director confirmed the refreshed infection, prevention and control thresholds had been discussed at the Clinical Governance Committee and were recognised to be challenging.

The Board:

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

P23/05/B3 **Maternity & Neonatal Update (Enclosure B3)**

The Board received the Maternity & Neonatal Update, which provided the findings of perinatal deaths, Health Safety Investigation Branch (HSIB) referrals, training compliance, service user voice feedback and compliance in respect of the Clinical Negligence Scheme for Trusts (CNST) 10.

The Director of Midwifery confirmed that the Ockenden Oversight Committee continued to review training compliance, should no significant improvement be seen at the month end a deep dive would take place to understand the continued challenges.

In response to the reported redeployment red flags, the Director of Midwifery confirmed this was an indicator of temporary workforce moves from the usual place of work, to address peaks and troughs in activity. Moves were co-ordinated by the manager on call across both sites.

In response to a question from Mark Bailey, Non-executive Director, the Director of Midwifery acknowledged the continued national scrutiny of maternity services and the safety reviews undertaken to date. Despite this continued focus, the level of interest from student midwives, including those internationally educated, was encouraging and should all interest progress to recruitment, the Trust would be close to the Birthrate Plus® staffing requirements. The Trust had developed a reputation as an employer of choice, with strong pastoral provision. The positive engagement with the Maternity Voices Partnership was recognised, which provided a valuable insight of local families experience of the service.

In response to a question from the Deputy Chair with regards to learning from local maternity Care Quality Commission inspections, the Director of Midwifery confirmed

themes were as expected and focused on triage, midwifery staffing and the risk assessment of patients.

The Director of Midwifery advised Non-executive Director, Hazel Brand that feedback from a review of training compliance would be shared with the Board's Quality & Effectiveness Committee. There was a need to understand the factors preventing completion and agree an efficient and balanced approach between clinical and education needs.

Going forwards, the Chief Executive confirmed the need to focus on the single maternity delivery plan. Learning opportunities would be explored across the Local Maternity & Neonatal System to deliver against a set of national performance standards, to be benchmarked against peers. It was recognised that improvements to patient care would require delivery of an efficient and effective service, with the potential for a flexible workforce, to be supported by a shared understanding of technology across organisations.

The Board:

- ***Noted and took assurance from the Maternity & Neonatal Update***

P23/05/C1 **Chair's Assurance Log – People Committee (Enclosure C1)**

Mark Bailey shared the key highlights from the People Committee's Chair's Assurance log, which detailed a wealth of positive assurance. Work in progress included the proposed monitoring of operational plans to support delivery of the People Strategy and development of a workforce plan.

Work to improve compliance with the Violence Prevention and Reduction Standard was noted for Q1 2023/24.

P23/05/C2 **People Update to include the DBTH Way (Enclosure C2)**

The People Update provided an overview of activities to develop colleague engagement and experience. The Chief People Officer advised that the non-medical appraisal season was underway, the completion rate currently stood at 14.5%, with appraisals due for completion by 31 July 2023.

The final draft of "The DBTH Way" framework was received for review and approval. Following a review of alternative frameworks extensive engagement had taken place, the draft framework had been scrutinised at the Board's People Committee and agreed by the Trust Executive Group.

The Deputy Chair recognised the importance of a quality appraisal discussion and encouraged colleagues to make the necessary arrangements.

In response to a question from the Deputy Chair with regards to the development of workforce planning, the Chief People Officer acknowledged a maturing approach, linked to business planning, with improved processes and systems in place. The benefits of the deep dive workshops were acknowledged and the future use of the workforce planning tool would be a valuable resource.

The Board:

- ***Noted and took assurance from the People Update and approved The DBTH Way framework***

P23/05/D1 **Chair's Assurance Log – Finance & Performance (Enclosure D1)**

As Chair of the Finance & Performance Committee, Non-executive Director, Mark Day presented the Chair's Assurance Log. The level of cost improvement required to support delivery of 2023/24 business planning was at an unprecedented level and the continued development of plans was required at pace. A focused single agenda item meeting would be convened to include non-executive Committee members, the Efficiency Director and Chief Financial Officer.

In respect of the Urgent & Emergency Care Improvement Plan, the sign off across Place was welcomed and a need to swiftly agree measurable targets and milestone was required to track delivery of benefits in system capacity and flow.

The Board:

- ***Noted and took assurance from the Chair's Assurance Log – Finance & Performance Committee***

P23/05/D2 **Finance Update (Enclosure D2)**

The Chief Financial Officer provided an overview of the financial position for month one, the Trust reported a deficit of £3.7m, which was in line with the plan. The position assumed that the elective recovery funding (ERF) received in month one would not be clawed back due to the industrial action; if ERF was excluded the position would have been £1.5m adverse to plan.

The cash position had reduced in line with expectations, the Trust expected to require cash support during Q2 2023/24.

In respect of capital, the spend in month was £0.3m against a plan of £2.4m, the underspend was largely related to the Mexborough Elective Orthopaedic Centre and a review of the expected cash flow for the project was underway.

There remained a continued focus on the development of cost improvement plans, in month one savings were £100k adverse to plan.

In response to a question from Non-executive Director, Lucy Nickson, the Chief Financial Officer confirmed month one ERF was not expected to be clawed back in view of the impact of industrial action on activity levels. However, going forwards payment for 2023/24 would be based on meeting 103% or above of 2019/20's baseline activity.

The Board:

- ***Noted the Finance Update***

P23/05/D3 **Going Concern (Enclosure D3)**

As part of the annual accounts preparation there was a requirement to assess the status of the Trust as a going concern. The Finance & Performance Committee had been involved in extensive scrutiny of the draft accounts and cash position and was sighted on the need for central cash support and the internal processes in place to manage this, as previously shared with the Board of Directors. The Trust was expected to continue to provide NHS services and had no conditions restricting its licence to operate, and as such the recommendation was that the accounts be prepared on a going concern basis

The Chair of the Finance & Performance Committee confirmed he was assured by the level of understanding, sound planning and effective, transparent internal and external communication in respect of the financial position and supported the recommendation.

The Chief Executive acknowledged the return to post Covid financial arrangements and welcomed NHSE's support and shared his support of preparing the accounts on a going concern basis. He reiterated the need to spend wisely to reduce the deficit over time to move towards a balanced position.

In response to a question from Hazel Brand, Non-executive Director, the Chief Financial Officer confirmed the Nottingham & Nottinghamshire Integrated Care System continued to be engaged in a recovery support programme. In the South Yorkshire Integrated Care System, the Trust's deficit was the largest of all the providers, and as result a review by the national team had taken place, an action plan had been agreed, against which progress was being made.

In response to a question from the Chief Financial Officer, the Board confirmed authority be devolved to the Audit & Risk Committee to approve the finalised accounts post audit.

The Board:

- ***Supported the accounts being prepared on a Going Concern basis and agreed to devolve authority to approve the finalised accounts post audit to the Audit & Risk Committee.***

P23/05/D4 **Operational Performance Update (verbal)**

The Chief Operating Officer provided a verbal update in respect of the Trust's current operational performance and agreed to circulate the paper post meeting. **DS**

An improved position was noted in April across all ambulance handovers, with 57% taking place in 15 minutes, 85% in 30 minutes and 96% in 60 minutes.

An improvement was reported against all urgent and emergency care metrics, the Trust delivered 68% performance against the four hour access standard. In April 3.3% of patients waited in the Emergency Department for longer than 12 hours from the time of arrival, a reduction from the previous month's performance of 4.7%

A deep dive into diagnostic performance was scheduled for the next Finance & Performance Committee.

In terms of cancer standards, the Trust reported 85% of two week wait referrals had been seen in a timely manner in March, an increase in the number of referrals was noted and a minor impact on performance had been seen due to individual patient choice. A performance of 60% was reported against the 85% standard for the 62 day referral to treatment, an increase in the number of treatments had been seen from 80 in February to 113 in March. The Faster Diagnosis Standard had been achieved.

In response to a question from Non-executive Director, Lucy Nickson, the Chief Operating Officer confirmed that the improved performance in urgent and emergency standards had been seen due to increased grip and control, as yet there had been no pathway changes made.

The Board:

- Noted and took assurance from the Operational Performance Update

P23/05/D5 **Directorate of Recovery, Innovation & Transformation Update (Enclosure D5)**

The Chief Financial Officer provided an insight into the Directorate of Recovery, Innovation & Transformation's work, including changes to the structure, the launch of NHS Impact and the progress of capital projects.

Non-executive Director, Mark Bailey, welcomed the introduction of a standardised quality improvement approach and the links to the development of cost improvement plans.

The Board:

- ***Noted and took assurance from the Directorate of Recovery, Innovation & Transformation Update***

P23/05/D6 **Digital Maturity Assessment (Enclosure D6)**

The Chief Financial Officer shared with the Board the submission of the Digital Maturity Assessment. Alongside the self-assessment, the Trust had undertaken a peer review which indicated the Trust's preparedness was consistent with the assessment undertaken as part of the Digital Aspirant Plus Programme related to funding for the Electronic Patient Record.

In response to a question from Non-executive Director, Hazel Brand, the Chief Financial Officer welcomed the intelligence which supported planning of the Trust's digital development. The ongoing debate around system interoperability was noted.

P23/05/E1 **South Yorkshire Acute Federation Clinical Strategy (Enclosure E1)**

The Chief Executive welcomed the Managing Director of South Yorkshire & Bassetlaw Acute Federation to the meeting to share with the Board the Acute Federation Clinical Strategy 2023-28. The Managing Director was attending provider Trust Board Meetings to share the commitment of the Acute Federation to utilise the collective expertise and resource to provide access to high quality healthcare for the served population.

The strategy provided a framework to support clinical collaboration, develop a resilient

and sustainable workforce and maximise interoperability across providers in respect of models of care that optimise technology and estates.

The strategy had been subject to extensive engagement and aligned with and supported the Integrated Care Board five year Joint Forward Plan and the South Yorkshire Integrated Care Partnership Strategy. The Board's attention was drawn to page 15 of the strategy and the eligibility criteria.

The strategy had been well received to date, further clinical engagement was ongoing and the Board's support and endorsement of the strategy was sought and confirmed.

In due course, the strategy would be publicly available to staff and patients via the website and covered as part of colleague briefings, to highlight the benefits and opportunities to work collaboratively where there was value to be added.

In response to a question from Mark Bailey the sharing of developments and positive news stories would be well publicised and an Annual Report for the South Yorkshire & Bassetlaw Acute Federation would showcase examples of collaborative working.

The Executive Medical Director welcomed the strategy which actively supported the duty to collaborate, and recognised the opportunity provided to be involved with Medical Directors at a system level and the national paediatric innovator project.

In response to a question from Non-executive Director, Hazel Brand, the Chief Executive confirmed the wider collaboratives, including the mental health, learning disabilities and autism and primary care collaboratives came together with the acute providers for matters of joint interest. The maturity and pace of change across the two systems of South Yorkshire and Nottingham and Nottinghamshire was noted.

The Board:

- ***Noted the South Yorkshire Acute Federation Clinical Strategy***

P23/05/F1 **Board Assurance Framework – Review 2023/24 (Enclosure F1)**

The Company Secretary highlighted the ongoing development of the Board Assurance Framework, in line with internal audit recommendations. The next stage would be to refresh the risks linked to delivery of the strategic aims and a Board workshop would take place in June to progress this, including a review of the risk appetite.

The Chief Executive acknowledged the corporate objectives as key drivers of the strategic aims. Each quarter a progress update was provided to the Board of Directors, with the Q1 update scheduled for July 2023.

The Board:

- ***Discussed the Board Assurance Framework – Review 2023/24***

P23/05/F2 **Corporate Risk Register (Enclosure F2)**

The Board received the updated Corporate Risk Register, one corporate risk rated 15+ had been escalated from the Trust Executive Group, the mitigations were subject to review by the Chief Nurse and Executive Medical Director. A total of 93 risks were rated 15+, with 14 monitored via the Corporate Risk Register.

The Board:

- ***Noted the Corporate Risk Register***

P23/05/F3 **Terms of Reference – Finance & Performance Committee (Enclosure F3)**

The Board:

- ***Approved the Terms of Reference – Finance & Performance Committee***

P23/05/F4 **Terms of Reference – Audit & Risk Committee (Enclosure F4)**

The Chief People Officer identified that the People Committee had been omitted from the relationship to other Committees chart, the Company Secretary agreed to incorporate the change post meeting. **FD**

The Board:

- ***Approved the Terms of Reference – Audit & Risk Committee, subject to the above change***

P23/05/G **Information Items (Enclosure F1 – F9)**

The Board noted:

- G1 Chair and NEDs Report
- G2 Chief Executives Report
- G3 South Yorkshire & Bassetlaw Acute Federation Mutual Aid
- G4 Integrated Quality & Performance Report
- G5 Minutes of the Finance and Performance Committee 27 February & 23 March 2023
- G6 Minutes of the People Committee 7 March 2023
- G7 Minutes of the Quality & Effectiveness Committee 7 February 2023
- G8 Minutes of the Audit & Risk Committee 27 January 2023
- G9 Minutes of the Trust Executive Group 9 January, 22 March & 3 April 2023

P23/05/H1 **Minutes of the meeting held on 25 April 2023 (Enclosure H1)**

The Board:

- ***Approved the minutes of the meeting held on 25 April 2023.***

P23/05/H2 **Any other business (to be agreed with the Chair prior to the meeting)**

Following on from the discussions with regards to the work of the South Yorkshire Acute Federation and in order to deliver the national care standards by the end of the year, there would be a significant focus on being a provider and recipient of mutual aid, which would be subject to extensive board discussion.

P23/05/H3 **Governor Questions regarding the business of the meeting (10 minutes) ***

The Deputy Lead Governor asked the following question on behalf of the governors:

"When will the Board receive a workforce plan for the new facilities at Mexborough (MEOC and CDC) to provide assurance of sustainable services without diverting staffing from DRI, Bassetlaw, Rotherham and Barnsley Hospitals".

The Chief Financial Officer confirmed the project plan assumed that the workforce would be required prior to Christmas 2023. It was proposed that a dedicated anaesthetist would support the Centre, nursing colleagues would be internationally recruited and medical colleagues sourced via the partner organisations. The Deputy Chair highlighted an opportunity to recruit an additional surgeon had been taken as part of an earlier recruitment campaign. Whilst recruitment of clinical colleagues was identified as a potential risk, the prospect of working in the Elective Orthopaedic Centre was expected to be an attractive opportunity. The clinical model had been progressed and agreement to use a standardised prosthesis reached. The project was supported by appropriate internal processes and delivery of the plan would be the responsibility of the executive directors and their wider leadership teams. Should there be any areas of concern, and the Board Committees felt appropriate assurance was not available they would be able to escalate to the Board.

The Board:

- ***Noted the governor question***

P23/05/H4 **Date and time of next meeting (Verbal)**

Date: Tuesday 27 June 2023
Time: 09:30am
Venue: MS Teams

P23/05/I **Close of meeting (Verbal)**

The meeting closed at 12.16

2306 - F4 DATE AND TIME OF NEXT MEETING

Information Item | Suzy Brain England OBE, Chair | 11:10

Date: Tuesday 25 July 2023
Time: 09:30
Venue: MS Teams

2306 - F5 WITHDRAWAL OF PRESS AND PUBLIC

Suzy Brain England OBE, Chair

Board to resolve: That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

MEETING CLOSE

11:10

*Governor Questions

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

For Governors in attendance, the agenda provides the opportunity for questions to be received at an appointed time. Due to the anticipated number of governors attending the virtual meeting, Lynne Schuller, Lead Governor will be able to make a point or ask a question on governors' behalf. If any governor wants Lynne to raise a matter at the Board meeting relating to the papers being presented on the day, they should contact Lynne by 4pm the day before the meeting to express this. All other queries from governors arising from the papers or other matters should be emailed to Fiona Dunn for a written response.

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

Suzy Brain England OBE
Chair of the Board